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Rutland County Council

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Ladies and Gentlemen,

A meeting of the **RUTLAND HEALTH AND WELLBEING BOARD** will be held in the Council Chamber, Catmose, Oakham, Rutland, LE15 6HP on **Friday, 30th June, 2017** commencing at 2.00 pm when it is hoped you will be able to attend.

Yours faithfully

Helen Briggs
Chief Executive

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

A G E N D A

1) APOLOGIES

2) RECORD OF MEETING

To confirm the record of the meeting of the Rutland Health and Wellbeing Board held on 28 March 2017 (previously circulated).

3) DECLARATIONS OF INTEREST

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

4) PETITIONS, DEPUTATIONS AND QUESTIONS

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

The total time allowed for this item shall be 30 minutes. Petitions, declarations and questions shall be dealt with in the order in which they are received. Questions may also be submitted at short notice by giving a written copy to the Committee Administrator 15 minutes before the start of the meeting.

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

5) HEALTH PROTECTION BOARD: ANNUAL REPORT

To receive Report No. 130/2017 from Vivienne Robbins, Consultant in Public Health to provide assurance from the LLR Health Protection Board that it is meeting its statutory functions
(Pages 5 - 24)

6) DIRECTOR OF PUBLIC HEALTH: ANNUAL REPORT

To receive Report No. 131/2017 from Mike Sandys, Director of Public Health
(Pages 25 - 58)

7) SEND TRANSFORMATION PLAN AND INCLUSION STRATEGY

To receive Report No. 121/2017 from Bernadette Caffrey, Head of Families Support – Early Intervention on the SEND transformation plan and the SEND inclusion strategy
(Pages 59 - 88)

8) RUTLAND BETTER CARE FUND PROGRAMME 2017-18 - 2018-19

To receive a Report No. 126/2017 from Sandra Taylor, Health and Social Care Integration Manager, Rutland County Council
(Pages 89 - 120)

9) ANY URGENT BUSINESS

10) DATE OF NEXT MEETING

The next meeting of the Rutland Health and Wellbeing Board will be on Tuesday, 26 September 2017 at 2.00 p.m. in the Council Chamber, Catmose.

Proposed Agenda Items:

General Practice Five Year Forward View
East Midlands Ambulance Service: Rutland Listening Event – Final Report

Future meetings of the Rutland Health and Wellbeing Board will be held at 2.00 p.m. in the Council Chamber, Catmose on the following dates:

Tuesday, 26 September 2017
Tuesday, 5 December 2017
Tuesday, 6 March 2018

DISTRIBUTION
MEMBERS OF THE RUTLAND HEALTH AND WELLBEING BOARD:

1.	Cllr Richard Clifton	Rutland County Council
2.	Cllr Tony Mathias	Rutland County Council
3.	Dr Andy Ker	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)
4.	Fiona Taylor	Spire Homes
5.	Gavin Drummond	Leicestershire Constabulary
6.	Helen Briggs	Rutland County Council
7.	Jennifer Fenelon	Healthwatch Rutland
8.	Mike Sandys	Rutland County Council - Public Health
9.	Rachel Dewar	Leicestershire Partnership NHS Trust
10.	Roz Lindridge	NHS England Local Area Team
11.	Simon Mutsaars	Community & Voluntary Sector Rep
12.	Dr Tim O'Neill	Rutland County Council
13.	Tim Sacks	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)

OTHERS FOR INFORMATION

14.	Karen Kibblewhite	Rutland County Council
15.	Mark Andrews	Rutland County Council
16.	Sandra Taylor	Rutland County Council
17.	Wendy Hoult	NHS England Local Area Team
18.	Harpreet Kaur	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)

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DISTRIBUTION
MEMBERS OF THE RUTLAND HEALTH AND WELLBEING BOARD:

Mr R Clifton (Chairman)	
Mr A Mann	Dr A Ker
Ms F Taylor	Inspector Gavid Drummond
Mrs H Briggs	Ms J Fenelon
Mr M Sandys	Ms R Dewar
Ms R Lindridge	Mr S Mutsaars
Mr T Sacks	Dr T O'Neill

OTHER MEMBERS FOR INFORMATION

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Report to Rutland Health and Wellbeing Board

Subject:	**Leicester, Leicestershire and Rutland Health Protection Board Assurance Report** (Covering October 2015 to December 2016)
Meeting Date:	**30th June 2017**
Report Author:	**Mike Sandys/ Vivienne Robbins**
Presented by:	**Mike McHugh**
Paper for:	**Note / ~~Approval / Action/~~Discussion**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:

As a result of the Health and Social Care Act 2012 the local authority has a statutory function, via its Director of Public Health (DPH), to assure itself that relevant organisations have appropriate plans in place to protect the health of the population and that all necessary action is being taken. In order to discharge the health protection assurance responsibilities, a Leicester, Leicestershire and Rutland (LLR) Health Protection Board, (now LLR Health Protection System Assurance Group) was established as a sub-group of the three LLR Health and Wellbeing Boards.

The purpose of this report is to update the Health and Wellbeing Board of the role that the LLR Health Protection Board and more recently LLR Health Protection System Assurance Group is carrying out to provide assurance for whole system health protection across LLR. It also updates the boards on health protection performance, key incidents and risks that have emerged from October 2015 to end December 2016.

Financial implications:

None

Recommendations:

The Health and Wellbeing Board is recommended to;

- Receive the Health Protection Board Report October 2015- December 2016
- Note the specific health protection issues that have arisen locally and steps taken to deal with these.

Comments from the board:

Strategic Lead:	Mike Sandys/ Vivienne Robbins

Risk assessment: Appendix 1 shows the health protection risk log. This is updated on a quarterly basis for the LLR Health Protection System Assurance Group.

Time	L/~~M/H~~	LLR Health Protection Assurance Report covering October 2015 to end December 2016.
Viability	~~L/~~M/~~H~~	The LLR Health Protection Board was established in June 2013, governance arrangements have

		been reviewed to increase the effectiveness of the health protection assurance across LLR. A key viability risk is to ensure that key partners continue to support the health protection agenda. Key risks are included on the risk log.
Finance	L/~~M/H~~	No specific financial implications.
Profile	~~L~~/M/~~H~~	The LLR Health Protection System Assurance Group is a subgroup of the three Health and Wellbeing Boards. The key role of this group is to gain assurance from key partners (including Public Health England, NHS England, local Clinical Commissioning Groups, Regulatory Services, Local Resilience Forum etc) on health protection across the system.
Equality & Diversity	L/~~M/H~~	The LLR Health Protection System Assurance Group considers health protection assurance across different population and community groups characterised in the 2010 Equality Act (for example gender, ethnicity, disability etc).

Timeline:

Task	Target Date	Responsibility

Leicester, Leicestershire and Rutland Health Protection Board Assurance Report

Covering October 2015 to December 2016

1. Background

As a result of the Health and Social Care Act 2012 the local authority is required, via its Director of Public Health, to assure itself that relevant organisations have appropriate plans in place to protect the health of the population and that all necessary action is being taken.

The purpose of this report is to update the three Health and Wellbeing Boards for Leicester, Leicestershire and Rutland (LLR) of the role that the LLR Health Protection Board and more recently LLR Health Protection System Assurance Group is carrying out to provide assurance for whole system health protection across LLR. It also updates the boards on health protection performance, key incidents and risks that have emerged from October 2015 to end December 2016.

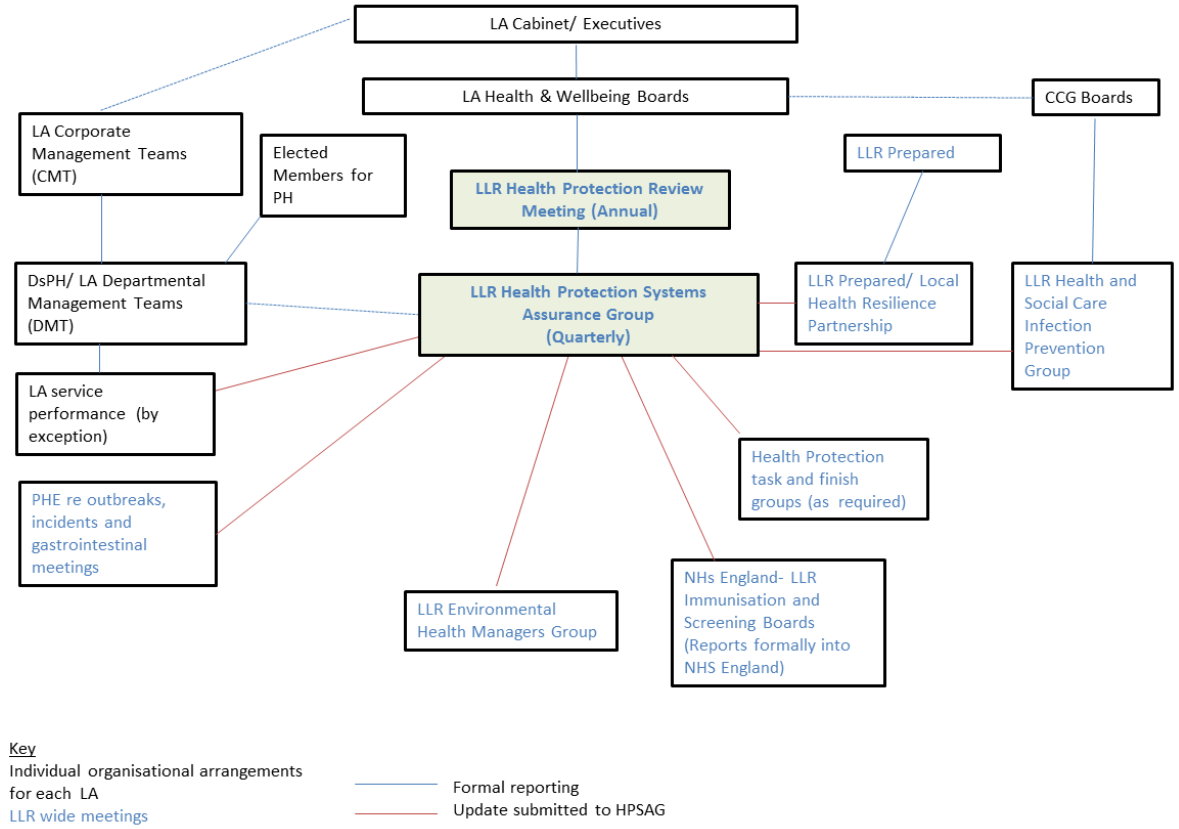
2. Changes to health protection governance arrangements across LLR

In order to discharge the health protection assurance responsibilities a LLR Health Protection Board was established in June 2013 as a sub-group of the three LLR Health and Wellbeing Boards. However some incidents during 2015/16 indicated that whilst all indicators and reports appeared to show that the system functions well, some gaps are present. It was therefore agreed that the current assurance system would be reviewed to ensure Directors of Public Health (DsPH) are appropriately sighted over these gaps.

Discussion with the DsPH and key stakeholders confirmed that although the Health Protection Board is an assurance committee, gaps in the system were not always identified and there was no obvious forum to take forwards strategic health protection work (for example national priorities such as anti-microbial resistance).

It was therefore agreed that a more systematic, confirm and challenge approach was needed. Fig 1 summarises the new approach to health protection assurance across LLR. It can be seen that the majority of assurance can be achieved through systematic quarterly data reports and more detailed verbal updates from key stakeholders. The LLR Health Protection Board has therefore been replaced by a smaller, more focused LLR Health Protection System Assurance Group. The assurance group membership consists of the DsPH, Public Health England (PHE) Consultants in Health Protection, and Local Authority Public Health Consultants who lead on health protection. The assurance group will feedback into each local authority departmental management teams (DMTs), an annual Health Protection Review meeting, and as appropriate Health and Wellbeing boards, Quality Surveillance Group, Corporate Management Teams and Cabinet.

Fig 1 Revised LLR health protection assurance mechanisms.



New ways of working

A key element to develop an effective health protection assurance approach is identification of key health protection risks (proactive and reactive) across the system. This is achieved by a health protection risk log (Appendix 1) and development of health protection dashboards. The dashboards use key data sets across all components of health protection including trend data split by local authority areas and comparisons to similar neighbours and national averages (Appendix 2). Quarterly dashboards, reports and/or updates are received and reviewed at the quarterly assurance group covering the following health protection components; incidents and outbreaks, immunisation and screening, health care associated infections, local authority service performance, environmental hazards and food safety, and emergency planning. This data will be reviewed by the group and if needed, stakeholders will be requested to produce more detailed assurance for the group on an exception basis.

To complement the assurance group an Annual Health Protection Review meeting was held in October 2016 to review the year's progress with all stakeholders and agree the LLR health protection strategic prioritises for the following year.

Initial strategic prioritises highlighted at the 2016 LLR Annual Health Protection Review meeting for development over the next 12-18months include;

- Anti-microbial resistance
- E.coli in urinary tract infections

- Ensuring the breast cancer screening programmes is accessible to women with learning disabilities

These pieces of work will be developed via existing programme boards or specific task and finish groups. Progress will report back to the Health Protection System Assurance Group.

3. Key health protection risks, emerging issues and mitigation

The Annual Health Protection Review provided an opportunity to review key LLR health protection incidents/situations over the previous year and the lessons learnt. Table 1 summarises the main incidents/ situations and confirms the areas for future development that will be followed up via the assurance group. Reoccurring themes from the outbreaks and situations include the importance of PHE leadership in managing local situations and outbreaks and the need to consider a more strategic approach to vulnerable people at risk of multiple drug resistant TB (such as the homeless.)

Other key health protection developments include;

- **Establishing a data sharing agreement between LLR local authorities and Leicestershire Partnership Trust for sharing of the school census data**. This will ensure appropriate delivery of public health services (including immunisations, national childhood measurement programme and 0-19 children's service) to all eligible students. This will reduce administrative workload for schools and LPT, whilst identifying the full cohort of students that need to be offered services.
- **LLR Prepared Assurance Framework** confirmed that partners are generally well prepared to respond to major incidents. Key areas for development include ensuring there is health capacity at coordinating groups (national issue) and that all local partners can maintain their response after the initial 48hr period.
- **LLR Prepared exercise on pandemic flu (Cygnus).** This live exercise tested the strategic coordinating groups, feeding into national COBR mechanisms in real time. Key learning included the need to set up a further pandemic flu exercise for 2-3 weeks following the initial event (due summer 2017), clarifying some roles and responsibilities and reviewing the current plan following the review of the national pandemic flu guidance. A further mass fatalities exercise (Jerboa) was also completed to test the initial blue light response (Jerboa 1) and communication between the strategic and tactical coordinating groups (Jerboa 2). This exercise was well received by all partners and a similar approach is likely to be taken in 2017.
- **Improved influenza vaccination uptake in Leicestershire County Council frontline staff** following an evaluation and more corporate approach to flu vaccination including access to flu clinics, vouchers and claiming expenses. Initial figures have identified an increase from 117 in 2015 to 466 frontline staff in 2016 accepting the offer of a free flu vaccination. N.B. Not all flu vouchers were used reducing actual uptake figures.

4. Health Protection performance

As discussed in section 2, health protection dashboards have been developed to support the DsPH to review health protection performance trends and identify areas for further investigation. Appendix 2 provides a local copy of the key health protection dashboards. Overall LLR performs similarly or better for health protection performance as compared to national and similar neighbours apart for the following exceptions;

Sexual Health

- In 2014, Leicester City and Leicestershire are below the England average for HIV testing coverage within the sexual health service at 56.5% and 66.2% as compared to 68.2%. Further investigation has suggested this is due to a coding error caused by the local integrated sexual health service including contraception in the data returns.
- In 2014, Leicester City had a higher HIV diagnosed prevalence of patients per 1,000 population aged 15-59 and late HIV diagnosis rate per 100,000 over 15years, than the England average and similar neighbours.
- In 2015, Leicestershire and Rutland have lower Chlamydia detection rates per 100,000 population aged 15-24years than the national average; however these are not statistically different to most similar neighbours.

Tuberculosis (TB)

- Leicester City had a higher TB (three year average) incidence than similar neighbours at 48.0 per 100,000 in 2012-14 as compared to 13.5 for England overall.
- When compared to similar neighbours, in 2014, a lower proportion of Leicester City TB patients starting treatment within four months of symptom onset.
- When compared to similar neighbours, a lower proportion of Leicester City and Leicestershire TB patients are offered a HIV test in 2014, however the recent trends do show improvement.

Immunisation and Screening

- In 2015/16, Leicester City performed lower than similar neighbours for population coverage for human papilloma virus (HPV) vaccine at 88.6%, even though this was above the England average at 86.7%.
- In 2015/16, Rutland performed lower than similar neighbours for the preschool diphtheria, tetanus, whooping cough and polio given by 5years old with 89.7% uptake. However performance is still above the England average at 86.9%. A similar trend is found with the 5year old MMR dose 2.
- LLR population flu vaccination uptake in over 65years and at risk groups decreased in winter 2015/16 following the national trend. However initial results for 2016/17 are showing improvement on last year's performance.
- In 2014/15, Leicester City performed lower than the England average for all screening programme indicators except the uptake of breast cancer screening within 6months of invitation in women aged 50-70years. Leicestershire and Rutland performed above the national average for all screening indicators.

Air Quality and Food Safety

- In 2013, Leicester City was ranked as having a higher fraction of mortality attributable to particulate air pollution than similar neighbours (ranked 15/16). Blaby, Charnwood and North West Leicestershire district councils were ranked as being within the bottom 26% of districts for the fraction of mortality attributable to particulate air pollution.

- There is a large variance in the number of food premises across each upper and lower tier local authority. Harborough was the only district to have a smaller proportion of food premises not achieving food standards A-E than the England average at 83% as compared to 86.2% nationally.

Health Care Associated Infections

- Leicestershire and Rutland CCGs are currently over their 2016/17 year to date C. difficile trajectory at 54 cases. Work is being completed with the CCGs to understand this trend and reduce future cases.

For more detail on overall health protection performance please see Appendix 2. Further health protection data can also be found using the Public Health England fingertips tool available at https://fingertips.phe.org.uk/profile/health-protection.

5. Conclusion

Overall the LLR DsPH are assured that the correct processes and systems are in place to protect the health of the population. Areas to continue to progress include ensuring health has the capacity to respond to major incidents (national issue), and maintaining and improving progress on key health protection indicators. The new health protection governance structure is now in place to provide improved oversight and risk management, and allow a more strategic approach to health protection across the LLR system. These structures will continue to monitor progress over areas identified within this report and will continue to report back to Health & Wellbeing Boards on an annual basis and exceptional basis as appropriate.

Table 1 Summary of key health protection outbreaks, incidents and situations across LLR from October 2015 to end December 2016.

	Outbreak/ Situation	Key Lessons Learnt	Areas for future development
Leicester City Council			
1.	**TB in homeless in Leicester City- Same strain as Loughborough** In May 2016 a case of TB was identified as a service user at the Dawn Centre. In July 2016 the Find and Treat Team screened 171/344 of people from the homeless population in Leicester. A number of acute and latent TB cases were identified and majority of these have now completed treatment. Sequencing and epidemiological data confirmed this outbreak was linked to the Loughborough outbreak (see below).	• Collaboration with CCG went well • Uncertainty as to whether the most effective use of Find and Treat was made • Resources to manage such incidents are limited both nursing and clinical	• More strategic approach needed for managing large TB outbreaks and particularly in the homeless population • Consider how this strain of TB will be managed longer term across LLR.
2.	**Extensively drug resistant TB cases** December 2015 TB case admitted to hospital with extensively drug resistant TB acquired outside of the UK. Family member diagnosed with extensively drug resistant TB in March 2016 and further cases were identified in family members following screening. Service issues due to identification of appropriate isolation facilities, locally and nationally. August- September 2016 further two children and student identified with extensively drug resistant TB cases.	• No negative pressure facilities for children in the Midlands • No appropriate isolation facilities for long term isolation • Public Health Law is inadequate to support solutions for the problems • Complexities of isolating extensively TB resistant cases for a prolong period of time.	• National specialised commissioning discussion needed regarding negative pressure facilities for children.

	Outbreak/ Situation	Key Lessons Learnt	Areas for future development
Leicestershire County Council			
3.	**Salmonella outbreak in pub restaurant in Blaby District** In March 2015, PHE were made aware of 21 cases with Salmonella typhimurium. Seven cases required hospitalisation and all cases were shown to be linked by whole genome sequencing of isolates. Further analysis over several months identified a total of 113 cases of which 103 were confirmed and 10 possible. PHE continued to lead outbreak control meetings for several months due to the ongoing source and number of cases identified. In November 2015 the drains of the pub were identified as the source of the infection by whole genome sequencing and final control measures were put in place to stop the outbreak.	• Methods of working – complex outbreaks need leading at the local level and not remotely • Questionnaires need to be developed in conjunction with EHOs • Lots of difficulties coordinating responses as many local authorities involved – need to use data sharing agreements drawn up with LLR Prepared.	• Consider more local PHE leadership approach in complex outbreaks. • Confirm data sharing agreements are already in place via the LLR Prepared for sharing of information in outbreak situations
4.	**TB in injecting drug user community in Loughborough**. In January 2015, PHE requested the DPH to chair a multiagency outbreak control meeting due to the identification of a cluster of highly infectious TB cases within the injecting drug user community in the Loughborough area. This was the follow on from a cluster originally identified in the 1990's. A multiagency approach was needed to include the local substance misuse, criminal justice and social care services to map patient networks and identify key individuals to target to attend a 'Find and Treat' van in May 2016. In total 136 cases were screened for TB and blood borne viruses. Small numbers of active and latent TB and Hepatitis B and C were identified and followed up.	• Strong multiagency approach to the outbreak. • Strong leadership from PHE due to dedicated senior registrar leading the outbreak management • Quick decision making and financial agreement from West Leicestershire CCG. • Learning translated to Leicester City TB outbreak (see above.) • Good proactive relationship with the media, providing information in advance meant they did not intervene on the day.	• Significant amount of PHE leadership capacity needed to organise the Find and Treat van event. • Need to engage district partners earlier on. • Consider how TB information and updates can be linked into substance misuse, social care and housing staff training.

	Outbreak/ Situation	Key Lessons Learnt	Areas for future development
5.	**Cryptosporidiosis in petting farm in Melton** PHE identified an excess of cases of Cryptosporidiosis in April 2016. Seven of the cases had visited a petting farm in Melton over the Easter holidays and had petted lambs. The facility was visited by environmental health officers and an improvement notice served to improve hand washing, provide hot water for handwashing and to improve advice given to customers about hand hygiene. Control measures reduced the exceedance in Cryptosporidiosis cases.	• Good working relationships between PHE and environmental health meant control measures were quickly put in place. • PHE led on reactive communication that was released due to media enquiry. • Lead members for Melton and Health were informed of incident early on.	• Continue to review petting farm hand washing facilities.
6.	**Asbestos in Wigston** In April 2016, PHE were notified of an asbestos situation affecting 15 properties following the spray washing of nearby private garage roofs. Local residents had contacted PHE following paying for a private asbestos assessment and contacting their local MP. Clean up took from April until end of September 2016 and has now been completed.	• Legislation not helpful in this area, making it difficult to confirm who was responsible for enforcing the clean-up when the landlord would not engage in the process. Oadby and Wigston borough council management team agreed to fund the assessment and clean up and recharge the garage owner. • Communication/ media response difficult due to no specific media post within the district. (This has now been rectified.)	• Use LRF media contact list to identify communication leads for each district or borough. • Ensure environmental health capacity in each district to support situations. • Need for debrief on long standing situations such as this.

	Outbreak/ Situation	Key Lessons Learnt	Areas for future development
Rutland County Council			
7.	No Rutland specific incidents. Individual cases have been managed through standard PHE operating procedures. Outbreaks of sickness and diarrhoea in nursing homes have been supported by the community infection prevention control service.		
8.	**Bird identified with Avian Flu** Dead bird identified with avian flu just before Christmas. Situation dealt with via Chief Vet and linked with PHE. National communication messages were incorrect stating Leicestershire.	• Difficult to informally notify Rutland chief officers and communication lead on the evening. • PHE produced advice for the public very quickly.	• Confirm routes to informally inform Rutland senior officers of incidents out of hours.
Leicester, Leicestershire and Rutland			
9.	**Flu incident at LRI – Haematology and Oncology** February 2016 small numbers of confirmed cases of Influenza H1N1 Swine on cancer haematology unit at Leicester Royal Infirmary. Following investigation 23 out of 45 patients were affected. Flu outbreak created significant additional winter pressure on UHL. However due to outbreak over 400 health care staff were vaccinated against flu taking UHL to the highest rate of vaccination for acute trusts in the East Midlands.	• Emergency coordination and management reviewed – issues now taken over by Urgent Care Board. • Needed a top down approach to ensure joined up approach across health and social care to reduce pressures on UHL. • Difficulties with communicating messaging and delivering a joined up response to the outbreak. • Outbreak improved flu vaccination uptake in staff.	• Health and social care management arrangements to be communicated across LLR. Role of Local Health Resilience Partnership confirmed as proactive system management rather than acute response. • Review and implement learning from exercise Cygnus (national pandemic flu exercise.)

	Outbreak/ Situation	Key Lessons Learnt	Areas for future development
East Midlands			
10.	**Pathway incident at Sexual Assault Referral Centre** In summer 2016, it was identified that 25 patients across the East Midlands had not been appropriately offered PEPSI (Post-exposure prophylaxis for HIV after sex) following a sexual assault. Serious incident called and Gold command in Nottinghamshire initiated. Full thematic review of incident completed and patients were contacted for follow up. DsPH across East Midlands drafted letter to NHS England to gain assurance that the incident was appropriately dealt with.	• Ensuring PHE is linked into the incident meetings early on. • Communication with all sexual health services and commissioners was needed (not just those attending the meeting.) • DsPH coordinating a letter to NHS England via the Regional DsPH meeting.	• Additional work is needed to confirm referral pathways between the SARC and each sexual health services across the East Midlands.

Appendix 1 LLR Health Protection Risk log (14.02.17)

Risk Ref	Link to Health Protection Area	Risk Description	Consequences / Impact	Risk Owner	Original Risk Score			Risk Action Tolerate / Treat / Transfer / Terminate	List of Current Controls / Actions Embedded and operating soundly	Current Risk Score (as at 01/04/2016)			Risk Action Tolerate / Treat / Transfer / Terminate	Further Action / Additional Controls	Action Owner	Action Target Date	Target Risk Score			Action Complete (Yes or No)	Q3 16/17 Risk Score			Q3 Comments
					I	L	Risk Score			I	L	Risk Score					I	L	Risk Score		I	L	Risk Score	
HP001	Public Health	DsPH do not gain 100% health protection assurance across the LLR system.	DsPH do not meet statutory responsibility. Following implementation of the Health & Social Care Act 2012, there has become more fragmentation in the system. Health Protection system may not be working effectively which could lead to increases in infectious disease, environmental incidents, poor response to major incidents etc. All leading to increased mortality, morbidity and health/ social care costs.	MS/RT	**4**	**2**	8	Treat	Revised health protection assurance governance arrangements to increase assurance of the system and add a strategic element to the work.	**4**	**1**	4	Treat	Review the effectiveness of the new governance arrangements after 12months.	MS/RT	Sep-17	**4**	**1**	4	**No**	**4**	**1**	4	New governance arrangements implemented. Review due Sep 2017.
HP002	Environmental Health	Lack of capacity in LLR environmental health & regulatory teams to deliver statutory functions.	EH statutory functions not delivered including food safety, food hygiene, environmental hazards etc.	Unitary/ District Council CE	**2**	**2**	4	Treat	Develop stronger links between EH managers group and HPSAG to highlight risks within individual teams. DsPH to contact individual districts/ teams if there are assurance concerns.	**2**	**1**	2	Tolerate		VR	Dec-16	**2**	**1**	2	**Yes**	**2**	**1**	2	Good links developed with EH Managers group. Further work is needed to confirm how air quality/ annual service plans are reviewed at Health Protection System Assurance Group (HPSAG).
HP003 CLOSED	Public Health	Restructure of Leicester City and Leicestershire County Public Health departments. Potential reduction in public health capacity.	Reduced capacity to for health protection assurance role. DPH's may not be assured of the health protection system.	MS/ RT	2	2	4	Treat	DsPH consider health protection assurance capacity within new Public Health department structures	1	1	1	Tolerate	County action plan complete. Change in consultant lead for health protection to Mike McHugh. City action plan being finalised, no impact on health protection assurance.	MS/RT	Oct-16	1	1	1	Yes			0	RISK CLOSED following discussion at HPSAG on 26.01.17
HP004	LLR Health & Social Care IPC Group	Delivery of AMR strategy across LLR.	Lack of progress made on AMR strategy resulting in an increased prevalence of AMR organisms across LLR. This could result in increased mortality, morbidity and health/ social care costs.	PM	3	3	9	Treat	Separate AMR groups have been set up for UHL and the community. These will report into the LLR Health & Social Care IPC Group, which will report to HPSAG. DsPH can request additional assurance from the group if needed.	2	2	4	Tolerate		PM/CT	Apr-16	2	1	2	Yes	2	2	4	AMR Summit arranged for end January 2017 to progress work. Longer term AMR lead needs identifying hence increased risk likelihood.
HP005	Infectious Disease control (PHE)	Well established LLR Consultant in Health Protection nearing retirement.	Loss of historical system knowledge and expertise across LLR.	DS	2	2	4	Treat	PHE already identifying and training possible consultant replacements. Vigorous interview process. DsPH linked into recruitment process.	1	1	1	Tolerate		DS	Apr-18	1	1	1	No	1	1	1	No immediate action needed. Senior registrar supporting LLR.
HP006	Infectious Disease control (PHE)	Increased prevalence of virulent strain of TB in Loughborough area and Leicester City.	More new cases of active and latent TB, further spread of disease. Potential for MDR TB to develop in chaotic cases that don't adhere to treatment. Increased morbidity, mortality and health care costs.	PM	4	3	12	Treat	PHE lead outbreak response. Outbreak control teams and find and treat vans commissioned for both Loughborough and City. Strategic multidisciplinary OTC booked for Dec 2016 to review progress. Discussion at HPSAG to review progress and next steps.	3	2	6	Tolerate		PM	Dec-16	3	1	3	Yes	2	2	4	Strategic OTC met in Dec 2017. Agreed that county risk has reduced due to prevalence identified in outbreak. More strategic approach to tackling vulnerable people such as homeless and links with TB, infectious diseases needed. On HPSAG agenda for Jan 2017.
C15 (LCC DMT)	Public Health	Implementation of the Leicestershire and Rutland Sexual Health Strategies.	Partners not engage with the strategy/ attend commissioners meeting, strategy is not delivered. Gaps in sexual health services and pathways. Impact potentially increased unplanned pregnancies, STI including HIV. Increased demand and treatment costs across the health and social care system.	VR	3	3	9	Tolerate	Buy in from boards who have nominated specific people to joining the group as well commissioning consultation in order to allow people to have opportunity to input. Discussion at the Health & Wellbeing board about the strategy to ensure buy in.	2	2	4	Tolerate		VR	Apr-17	2	2	4	Yes	2	2	4	Good engagement with strategy implementation and LLS SH commissioning meetings from CCGs and NHS England (imms & Screening). However engagement has been more difficult due to STP pressures.
HP007	Local Health Resilience Partnership (LHRP)	Changes to LLR operational health resilience groups.	Partners are not clear on the response structure to major incidents, causing delays in action and coordination of groups.	TT/MS	4	2	8	Treat	Communication of new operational health resilience arrangements to LHRP and wider partners.	**2**	**2**	4	Tolerate		MS	Apr-17	**2**	**1**	2	**No**	**2**	**2**	4	LHRP Capability Assessment template due for completion in early 2017.
HP008	Public Health/ Environmental Health	Possible reductions to local authority budgets following implementation of the business rates in 2018/19 national guidance.	Potential reductions in services including public health, environmental health and regulatory services.	LA CE	3	3	9	Tolerate	Funding decisions will be made to have the least impact on the wider health and social care system. Proposals will be discussed with key stakeholders/ partners and equality impact assessments completed.	3	3	9	Tolerate		MS/RT	Apr-18	2	2	4	No	2	2	4	Awaiting national guidance.
HP009	LLR Prepared/ LHRP	Health/ NHS England capacity to attend major incident meetings in national emergency.	Lack of NHS health system leadership in major incident.	TT/JD	4	3	12	Treat	Local arrangement that CCGs cover for NHS England in the case of a national major incident or when capacity is not available.	3	3	9	Tolerate	Further discussions at Local Health Resilience Partnership (LHRP) to confirm major incident cover especially over longer term major incidents.	MS	Apr-17	3	2	6	No	3	2	6	Ongoing discussions at LHRP.
HP010	LR Prepared	Some LLR organisations lack capacity to maintain attendance at Strategic coordinating group (SCG)/ Tactical Coordinating Groups (TCG)'s over 48hr period	Reduced LLR multiagency approach to prolonged major incident.	JD	5	2	10	Treat	LLR Prepared to work with partners to identify contingency plans for SCG/TCG attendance after 48hrs.	3	3	9	Tolerate		JD	Sep-17	5	2	10	No	5	2	10	Results from LLR Prepared assurance report completed at end 2016. Therefore follow up actions still to occur.

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Rutland Health Protection Dashboard (Page 1 of 5)

Indicator Group	Indicator	Latest Time Period 2	Target Type	Latest Value	England Value	Similar Neighbour Rank	Change Over Time	RAG	DoT
Cancer Incidence (LA/NHS E/CCG)	Incidence of breast cancer (ICD10 C50)	2012-2014	Eng	173.7	169.9	7/16	Low	Similar	Stable
	Incidence of cervical cancer (ICD10 C53)	2012-2014	Eng	13.0	9.6	16/16	Low	Similar	Stable
	Incidence of colorectal cancer (CD10 C17-C21)	2012-2014	Eng	79.5	72.9	13/16	Low	Similar	Stable
Hepatitis (CCG)	Hospital admission rate for hepatitis C related end-stage liver disease/hepatocellular carcinoma	2013/14	Eng	0.0	3.8	1/13	Low	Similar	N/A
	Persons in substance misuse treatment who inject drugs - % of eligible persons who have received a hepatitis C test	2014/15	Eng	83.3	81.5	11/16	None	Similar	Stable
Sexual Health (LA)	Gonorrhoea diagnosis rate per 100,000 population	2014	Eng	18.4	63.6	6/16	Low	Better	Stable
	HIV diagnosed prevalence rate per 1,000 aged 15-59	2014	Ben	0.5	2.2	3/16	None	Better	Stable
	HIV late diagnosis (%) (PHOF indicator 3.04)	2012 - 14	Ben	N/A	42.2	Null		N/A	N/A
	HIV testing coverage, total (%)	2014	Eng	65.0	68.3	11/16	High	Similar	Stable
	New HIV diagnosis rate / 100,000 aged 15+	2014	Eng	0.0	12.3	1/16	Low	Better	Getting Better
	Syphilis diagnoses rate per 100,000 population	2014	Eng	2.6	7.8	8/16	Low	Similar	Stable
TB (CCG)	TB incidence (three year average)	2012 - 14	Ben	5.3	13.5	12/16	Low	Better	Stable
	Treatment completion for TB (%)	2013	Eng	N/A	84.8	Null		N/A	N/A

Similar Better N/A

Getting Better No Change in Trend N/A

Target Type - Benchmarking against goal. Change over time: chart text (Low/High) indicates good performance. RAG is calculated in relation to Target Type.

Rutland Health Protection Dashboard (Page 2 of 5)

Indicator Group	Indicator & Age	Latest Time Period	Target Type	Latest Value	England Value	Similar Neighbour Rank	Change Over Time	RAG	DoT
Immunisation (NHS E)	12 months Dtap/IPV/Hib	2015-16	Ben	96.4	93.1	7/16	High		
	12 months Men C	2015-16	Ben	96.4	73.3	10/16	High		
	12 months PCV	2015-16	Ben	96.7	93.1	7/16	High		
	12 months Population vaccination coverage - 12 Months Rotavirus	2015-16	Ben	94.1	Null	5/14	High		
	24 months Dtap/IPV/Hib	2015-16	Ben	96.4	95.1	13/16	High		
	24 months Men C Booster	2015-16	Ben	93.7	91.0	12/16	High		
	24 months MMR	2015-16	Ben	93.7	91.4	11/16	High		
	24 months PCV Booster	2015-16	Ben	92.8	87.7	12/16	High		
	5 Years Dtap/IPV Booster	2015-16	Ben	89.7	86.9	14/16	High		
	5 Years Hib/Men C Booster	2015-16	Ben	92.9	92.5	15/16	High		
	5 Years Infant Hib	2015-16	Ben	96.0	92.7	13/16	High		
	5 Years MMR Dose 1	2015-16	Ben	94.9	93.9	14/16	High		
	5 Years MMR Dose 2	2015-16	Ben	88.9	87.7	15/16	High		
	Population vaccination coverage - HPV (females 12-13 years old)	2013/14	Ben	93.6	86.7	3/16	High		
Flu (NHS E)	3.03xiii - Population vaccination coverage - PPV	2015/16	N/A	70.8	70.1	8/16	High		
	3.03xiv - Population vaccination coverage - Flu (aged 65+)	2015/16	N/A	71.9	71.0	9/16	High		
	3.03xv - Population vaccination coverage - Flu (at risk individuals)	2015/16	N/A	42.6	45.1	16/16	High		
Screening (NHS E)	2.20xi - Newborn Blood Spot Screening – Coverage	2015/16	N/A	N/A	95.6	Null			
	Females, 25-64, attending cervical screening within target period (3.5 or 5.5 year coverage, %)	2014/15	Eng	78.7	Null	N/A	None		
	Females, 50-70, screened for breast cancer in last 36 months (3 year coverage, %)	2014/15	Eng	82.8	Null	N/A	None		
	Females, 50-70, screened for breast cancer within 6 months of invitation (Uptake, %)	2014/15	Eng	83.3	Null	N/A	None		
	Persons, 60-69, screened for bowel cancer in last 30 months (2.5 year coverage, %)	2014/15	Eng	66.7	Null	N/A	None		
	Persons, 60-69, screened for bowel cancer within 6 months of invitation (Uptake, %)	2014/15	Eng	66.9	Null	N/A	None		

Worse | Similar | Better | No Data/ Suppressed | N/A

No Change in Trend | Getting Worse | N/A

Target Type - Benchmarking against goal. Change over time: chart text (Low/High) indicates good performance. RAG is calculated in relation to Target Type. Immunisation data may differ from published figures due to aggregated data.

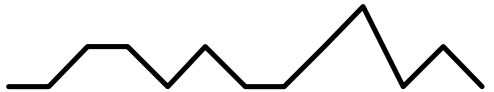
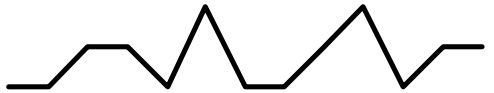
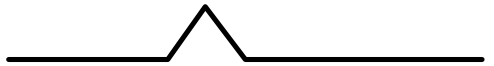
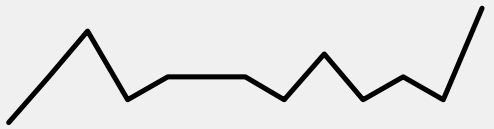
Rutland Health Protection Dashboard (Page 3 of 5)

Indicator Group	Indicator		Latest Time Period	Latest Value	England Value	Similar Neighbour Rank	Change Over Time	DoT
Air Quality (LA)	3.01 - Fraction of mortality attributable to particulate air pollution		2015	5	4.7	16/16	None	⬆
	Nitrogen Dioxide (ugm-3)	Leicester A594 Roadside	12-2016	N/A	Null	N/A		➡
		Leicester Centre		35	Null	N/A		+
		Leicester University		48	Null	N/A		⬆
Food Hygiene (LA)	Total establishments (including not yet rated & outside)		2015/16	447	Null	N/A		+
	Total % of Interventions achieved (premises rated A-E)		2015/16	100	Null	N/A		+
	Total Interventions Achieved (Premises Rated A-E)		2015/16	436	Null	N/A		➡
	Total Number of Establishments Subject to Formal Enforcement Actions		2015/16	2	Null	N/A		⬇
	Total Establishments Subject to Formal Enforcement Actions (%)		2015/16	0	Null	N/A		⬇
	Total of Broadly Compliant Establishments (Including not yet Rated)		2015/16	390	Null	N/A		➡
	Total % of Broadly Compliant establishments (including not yet rated)		2015/16	87	Null	N/A		+
	Broadly Compliant at C,D,E		2015/16	384	Null	N/A		➡
	Broadly Compliant at C,D,E (%)		2015/16	98	Null	N/A		➡
	Broadly Compliant at A, B		2015/16	6	Null	N/A		⬇
	Broadly Compliant at A,B (%)		2015/16	2	Null	N/A		⬇

⬇ Down + N/A ➡ Same ⬆ Up

Change over time: chart text (Low/High) indicates good performance. Air Quality Monitoring taken at three sites.

Rutland Health Protection Dashboard (Page 4 of 5)

Indicator Group	Indicator	Month, Year of Latest Time Period	Latest Value	Change Over Time	DoT
C. Diff (NHS E)	Monthly counts of C. difficile infection for patients aged 2 years and over by Acute Trust - Trust Apportioned only*	October 2016	5		⬇
E. Coli (NHS E)	Monthly counts of E.coli bacteraemia by Acute Trust - Trust Cases	October 2016	56		⬇
MRSA (NHS E)	Monthly counts of MRSA bacteraemia by Acute Trust - CCG Assigned Cases	October 2016	1		⬆
	Monthly counts of MRSA bacteraemia by Acute Trust - Third Party Cases	October 2016	0		⬇
	Monthly counts of MRSA bacteraemia by Acute Trust - Total Reported Cases	October 2016	1		➡
	Monthly counts of MRSA bacteraemia by Acute Trust - Trust Assigned Cases	October 2016	0		➡
MSSA (NHS E)	Monthly counts of MSSA bacteraemia by Acute Trust - Trust Apportioned only*	October 2016	5		⬆

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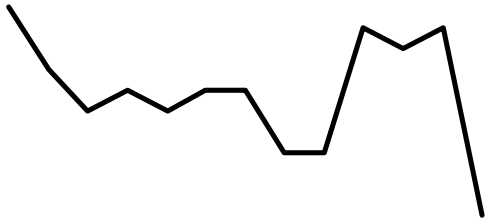
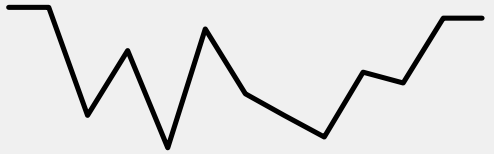
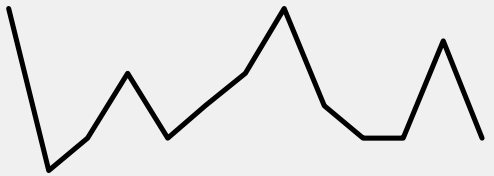
Data currently for UHL only.

East Leicestershire CCG Health Protection Dashboard (Page 5 of 5)

Indicator Group	Indicator	Month, Year of Latest Time Period	Latest Value	Change Over Time	DoT
C. Diff (NHS E)	Monthly counts of C. difficile infection for patients aged 2 years and over by CCG	October 2016	3		⬇
E. Coli (NHS E)	Monthly counts of E. coli bacteraemia by CCG	October 2016	24		➡
MRSA (NHS E)	Monthly counts of MRSA bacteraemia by CCG	October 2016	0		⬇
MSSA (NHS E)	Monthly counts of MSSA bacteraemia by CCG	October 2016	4		⬇

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Report to Rutland Health and Wellbeing Board

Subject:	**Director of Public Health Annual Report 2016**
Meeting Date:	**30th June 2017**
Report Author:	**Mike Sandys**
Presented by:	**Mike McHugh**
Paper for:	**Note /discussion**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:

The Director of Public Health's (DPH) Annual, report is a statutory independent report on the health of the population of Rutland.

The focus of this year's report is the analysis of health in Rutland provided by the national health profiles and the role that workplace health and economic development can play in improving health.

The report uses the analysis within the national health profiles to identify those areas where further investigation and work are necessary. These are the red indicators of 'recorded diabetes' and 'killed and seriously injured on roads' and the amber indicators of 'excess weight in adults', 'infant mortality', 'excess winter deaths', 'hospital stays for self harm' and 'hospital stays for alcohol related harm'.

The report also draws attention to data on the health of the working age population and advocates the use of the workplace wellbeing charter across the public and private sectors and the role that health impact assessment can play in maximising the health improvement opportunities of infrastructure developments.

Financial implications:

Dependent on the recommendations of the report and their implementation, the report may entail the reprioritisation of existing human and financial resources.

Recommendations:

That the board:

1. Receive the DPH Annual Report
2. Support the recommendations in the report

Comments from the board: (delete as necessary)

Strategic Lead:	Mike Sandys

Risk assessment:

Time	**L**/M/H	
Viability	L/**M**/H	
Finance	**L**/M/H	
Profile	**L**/M/H	

Equality & Diversity	**L**/M/H	
Timeline:		
Task	**Target Date**	**Responsibility**

ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2016

RUTLAND

OVERVIEW OF HEALTH IN RUTLAND & THE ROLE OF WORKPLACE HEALTH IN IMPROVING HEALTH

FOREWORD

Welcome to my annual report for 2016. In my last annual report I set out the case for the role of communities in improving health and well being. As can be seen in 'update on recommendations', there has been a renewed focus on community level work through the co-creation of the new integrated community prevention and wellness service.

Last year I also highlighted the findings of the Joint Strategic Needs Assessment 2015. Presenting the findings of the JSNA was well received by people and partners and reminded me that the annual report can be a useful way of sharing information on the health of the people of Rutland.

This year, I have split the report between a further information update and a focus on a topic important to health. In the first part of the report I have reviewed the Health Profile for Rutland. These are the nationally produced snapshots of health across the country and set what I believe to be the priorities for action for the forthcoming year.

For this year's topic I have looked at the importance of work and health, covering the health of the working age population and the importance of workplace health. I have also revisited the progress being made on 'the wider determinants of health' from my report of 2014, highlighting how this work will underpin economic development and improved population health.

As always, I hope you find this interesting, informative and a spur to further progress in improving the health of Rutland. I would like to thank Gabi Price, Michele Monamy, Stephanie Webb, Liz Orton and Rob Howard for their contributions to this report and the public health department for their continued hard work.

Mike Sandys

Director of Public Health

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7. Percentage of working hours lost to sickness by age group – 1993 (blue) and 2013 (orange)

8. Working-age client group – main benefit claimants (November 2015)

1. INTRODUCTION

Each year the Director of Public Health publishes an independent report on the health and wellbeing of the local population. This report is a statutory duty and intended to inform local strategies, policy and practice across a range of organisations and interests. The purpose of the report is to highlight opportunities to improve the health and wellbeing of people in Rutland.

Evidence suggests that good health should improve an individual's chances of finding and staying in work and of enjoying the consequent financial and social advantages. Furthermore work has an inherently beneficial impact on an individual's state of health (1). The review *'Is work good for your health and well-being?'* concluded that work was generally good for both physical and mental health and well-being. It showed that work should be 'good work' which is healthy, safe and offer the individual some influence over how work is done and a sense of self-worth. Overall, the beneficial effects of work were shown to outweigh the risks and to be much greater than the harmful effects of long-term worklessness or prolonged sickness absence (2). Illness is incompatible with being at work and that an individual should be at work only if 100% fit. This thinking underpins much of the current approach to the treatment of people of working age with health conditions or disabilities.

Personal characteristics, such as age, sex and ethnicity, are highly significant for health but cannot be influenced by public health. Consequently they sit at the core of the 1991 Dahlgren and Whitehead, wider determinants of health model (Figure 1). The basis of the model is the concept that some of the factors that influence health are fixed and others can be influenced. Individual lifestyle factors are behaviours such as smoking, alcohol and other drug misuse, poor diet or lack of physical activity. Lifestyle factors have a significant impact on an individual's health. Social and community networks are our family, friends and the wider social circles around us. Social and community networks are a protective factor in terms of health. Evidence tells us that important factors for life satisfaction are being happy at work and participating in social relationships (3). Living and working conditions include access to education, training and employment, health, welfare services, housing,

public transport and amenities. It also includes facilities like running water and sanitation, and having access to essential goods like food, clothing and fuel. General socio-economic, cultural and environmental conditions include social, cultural, economic and environmental factors that impact on health and wellbeing such as wages, disposable income and availability of work.

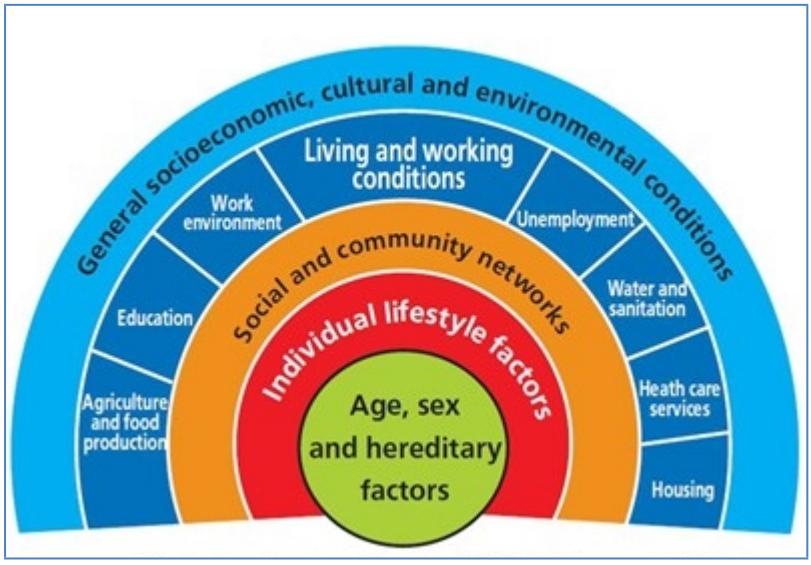

Figure 1 The wider determinants of health (4)

2. RECOMMENDATIONS

The recommendations have been developed along the three key roles for public health as defined by the World Health Organisation, which include public health as a leader; public health as a partner; and public health as an advocate. The recommendations are set out below:

A Leader – We will refresh our strategic work on overweight and obesity in adults in 2017

A Leader – Rutland Council has a key role to play in our work on the wider determinants of health. We will continue to provide specialist expertise on approaches to health impact assessment and health in all policies.

A Partner - As a partner to the NHS, we will work with University of Hospitals of Leicester Trust and Leicestershire Partnership Trust on joint approaches to

workforce health as part of the Leicester, Leicestershire and Rutland (LLR) response to the NHS 5 Year Forward View.

An Advocate – The Public Health Department will work with the public and private sector organisations to advocate the use of the Workplace Wellbeing Charter by employers, as part of the approach to workplace health.

3. OVERVIEW OF THE HEALTH PROFILE 2016

Public Health England publishes health profiles for all local authorities in England on an annual basis.

Health Profiles provide useful, accessible summaries of the health of local populations, and help identify inequalities because they allow local authority populations to be compared with the average for England, and also allow comparisons between and within regions. The profiles assist in the planning and prioritisation of services. The indicators included in Health Profiles were chosen because they measure an important aspect of the health of the population and can be communicated easily to a wide audience.

Rutland - Health in summary

The health of people in Rutland is generally better than the England average. Rutland is one of the 20% least deprived counties/unitary authorities in England. However, about 7% (400) children live in low income families.

Health inequalities

Life expectancy for both men and women is higher than the England average.

Child health

In Year 6, 13.3% (41) children are classified as obese, better than the average for England. Levels of teenage pregnancy, GCSE attainment and breastfeeding initiation are better than the England average.

Adult health

The rate of alcohol-related harm hospital stays is 609 per 100,000 population, this represents 237 stays per year. The rate of self-harm hospital stays is 204.1 per 100,000 population. This represents 67 stays per year. 48 people died of smoking related deaths in Rutland in the last year. Estimated levels of adult smoking and physical activity are better than the England average.

Rates of hip fractures, sexually transmitted infections and TB are better than average. Likewise rates of violent crime, long term unemployment, early deaths from cardiovascular diseases and early deaths from cancer are better than average.

The rate of people killed and seriously injured on roads in worse than average.

The table below shows how people's health in Rutland compares to the rest of England.

Table 1 – Rutland Health Profile 2016

		Rutland UA
Our Communities	1 Deprivation score (IMD 2015)	
	2 Children in low income families (under 16s)	
	3 Statutory homelessness	
	4 GCSEs achieved	
	5 Violent crime (violent offences)	
	6 Long term unemployment	
Childrens and young peoples health	7 Smoking status at time of delivery	
	8 Breast feeding initiation	
	9 Obese children (year 6)	
	10 Alcohol-specific hospital stays (under 18)	
	11 Under 18 conceptions	
Adults health and lifestyle	12 Smoking prevalence in adults	
	13 Percentage of physically active adults	
	14 Excess weight in adults	
Disease and poor health	15 Cancer diagnosed at early stage	
	16 Hospital stays for self harm	
	17 Hospital stays for alcohol related harm	↓
	18 Recorded diabetes	
	19 Incidence of TB	
	20 New sexually transmitted infections (STI)	
	21 Hip fractures in people aged 65 and over	↑
Life expectancy and causes of death	22 Life expectancy at birth (male)	
	23 Life expectancy at birth (female)	
	24 Infant mortality	
	25 Killed and seriously injured on roads	↓
	26 Suicide rate	
	27 Deaths from drug misuse	
	28 Smoking related deaths	
	29 Under 75 mortality rate: cardiovascular	↑
	20 Under 75 mortality rate: cancer	
	31 Excess winter deaths	

	Significantly better than England average
	Not significantly different from England average
	Significantly worse than England average
	No significance can be calculated or data not available
	No comparison available from 2015 (either new indicator, change in definition, or comparison not possible for technical reasons)
↓	Rag rating has moved from green to amber or amber to red ie performance is not as good as 2015
↑	Rag rating has moved from red to amber or amber to green ie performance has improved from 2015

It is clear that Rutland performs well in many indicators. Rutland has 17 of the 31 indicators in the Health profile that perform significantly better than the England average.

There is 1 indicator where Rutland has performance significantly worse than the national average: recorded diabetes. However, it may be that higher recorded rates are actually a sign that GPs are recording diabetes more comprehensively than elsewhere.

Other indicators where the Rutland figure is worse than average, but not significantly so, are:

- Hospital stays for alcohol related harm
- Hospital stays for self harm
- Excess weight in adults
- Infant Mortality

Compared with all other county and unitary local authorities, Rutland is ranked in the best 10 performing authorities for 7 of the 31 indicators: Hip fractures in the over 65's (2nd), excess winter deaths (2nd), children in poverty (4th), violent crime (5th), smoking related deaths (6th), female life expectancy (7th),and teenage pregnancy (10th).

For the last two years (2014 and 2015) Rutland has been in the bottom 10 for performance on incidence of malignant melanoma. In 2016, though, Rutland no longer features in the bottom 10.

In 2016, Rutland has improved its performance in two indicators to now perform significantly better than the England average. These indicators are hip fractures in those 65 and over and under 75 mortality rate from cardiovascular disease.

Issues of concern

In 2016, Rutland has remained significantly worse than the England average for recorded diabetes. Rutland has decreased its rating for killed and seriously injured

on roads from ‘not significantly different to the England average’ in 2015 to ‘significantly worse’ than the England average in 2016.

There has been a decrease in rating for hospital stays for alcohol related harm from significantly better than England in 2015 to no significant difference in 2016.

It is important to remember that health profiles provide a snapshot of health over a particular reporting time period. Given statistical variation it is likely that the pattern could change next year. Further analysis of trends over time is necessary to establish what is real and enduring and what is artefact.

However, it is clear that some lifestyle behaviours present an enduring challenge to public health. The percentage of adults with excess weight (overweight and obese) adults mirrors the national trend. With around two thirds of adults being either overweight or obese being ‘amber’ compared to the national average is not a situation that allows complacency.

Whilst further analysis and interrogation of the data is needed to form a fuller picture, we need to focus the efforts of all parts of health and local government, not just the public health department in making the most of the resources and powers available to improve performance in these areas.

Recommendations

Leader and partner: That Public Health focus their work with NHS and partners on a fuller understanding of, and action on the red and amber indicators highlighted above.

4. THE ROLE OF WORKPLACE HEALTH IN IMPROVING HEALTH

4.1 HEALTH AND WELLBEING OF WORKING AGE ADULTS

Introduction

Despite life expectancy and numbers in employment being high in the UK, around 131 million working days were lost to sickness in 2013. This is equivalent to over 4 days for each working person. Minor illnesses were the most common reason given for sickness absence (30%) but more days were lost to back, neck and muscle pain than any other cause at 30.6 million days lost (Figure 2). Mental health problems such as stress, depression and anxiety also contributed to a significant number of days of work lost in 2013 at 15.2 million days (5).

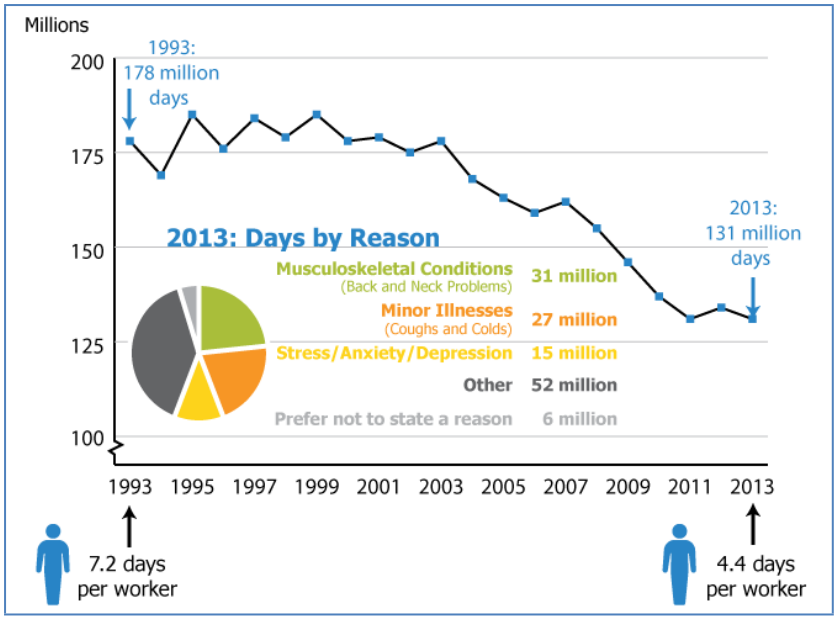

Figure 2 Number of working days lost due to sickness absence, 1993 to 2013, and the top reasons for sickness absences in 2013, UK (5).

Work and health

Employment levels provide a high-level indicator of the health of the working age population. Being in employment is a reflection of the health status of individuals, but also of the probability of being in work with a given health status (1). Between July 2015 – June 2016, in Rutland 16,700 (74.6%) people aged 16-64 were in employment; a rate that is higher than the regional (74.5%) and the national (73.8%)

average (6). A higher proportion of men (79.8%) than women (69.5%) were reported to have a job in 2015 (Figure 3).

	Rutland (Numbers)	Rutland (%)	East Midlands (%)	Great Britain (%)
All People				
Economically Active†	17,500	78.4	77.8	77.9
In Employment†	16,700	74.6	74.5	73.8
Employees†	13,100	60.1	64.5	63.1
Self Employed†	3,400	14.3	9.7	10.3
Unemployed (Model-Based)§	400	2.4	4.2	5.1
Males				
Economically Active†	9,400	84.2	83.1	83.1
In Employment†	9,000	79.8	79.5	78.7
Employees†	6,900	64.1	66.3	64.4
Self Employed†	2,000	15.7	13.0	13.9
Unemployed§	#	#	4.2	5.1
Females				
Economically Active†	8,100	72.5	72.6	72.7
In Employment†	7,700	69.5	69.5	69.0
Employees†	6,200	56.0	62.8	61.8
Self Employed†	1,400	12.9	6.4	6.8
Unemployed§	#	#	4.2	5.0

Source: ONS annual population survey
Sample size too small for reliable estimate (see definitions)
† - numbers are for those aged 16 and over, % are for those aged 16-64
§ - numbers and % are for those aged 16 and over. % is a proportion of economically active

Figure 3 Employment and unemployment (July 2015 – June 2016) – Rutland, East Midlands and Great Britain (6)

Although employment rates in Rutland are high, over 4,500 people aged 16-64 were economically inactive with nearly 3,800 (84.0%) stating that they do not want a job. Although the figures for people economically inactive account for students, individuals who are looking after family or home, or are retired, 800 people (17.4%) reported long-term sickness as the reason. This again is lower than regional and national average at 22.5% (6).

	Rutland (Level)	Rutland (%)	East Midlands (%)	Great Britain (%)
All People				
Total	4,500	21.6	22.2	22.1
Student	900	19.6	26.0	26.1
Looking After Family/Home	1,200	26.7	25.1	24.7
Temporary Sick	!	!	1.0	2.3
Long-Term Sick	800	17.4	22.0	22.5
Discouraged	!	!	#	0.4
Retired	1,100	25.1	14.2	13.6
Other	#	#	11.4	10.5
Wants A Job	#	#	24.0	24.5
Does Not Want A Job	3,800	84.0	76.0	75.5

Source: ONS annual population survey
Sample size too small for reliable estimate (see definitions)
! Estimate is not available since sample size is disclosive (see definitions)
Notes: numbers are for those aged 16-64.
% is a proportion of those economically inactive, except total, which is a proportion of those aged 16-64

Figure 4 Economic inactivity (July 2015 – June 2016) – Rutland, East Midland and Great Britain (6)

Supporting more people with a health condition into work will help to achieve the Government's aim of higher employment. Nationally the employment rate for disabled people has been gradually increasing (1).

However, there is still a stark difference between employment levels for those with a disability, and the population overall. In 2014/15, the gap in the employment rate between those with a learning disability and the overall employment rate in Rutland (69.2 percentage points) was higher than the gap for England (66.9).

Similar differences in employment levels are also seen for those in contact with secondary care mental health services (Figure 5). The gap for employment rate for those in contact with secondary mental health services and the overall employment rate in Rutland for the period 2014/15 at 74.6 percentage points, is higher than the gap recorded for England (66.1).

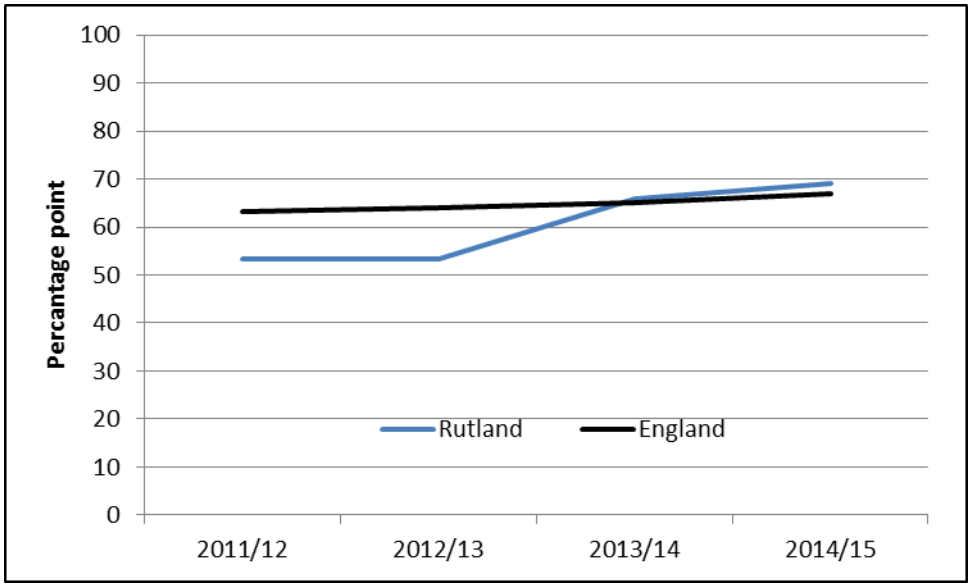

Figure 5 Gap in the employment rate between those with a learning disability and the overall employment rate

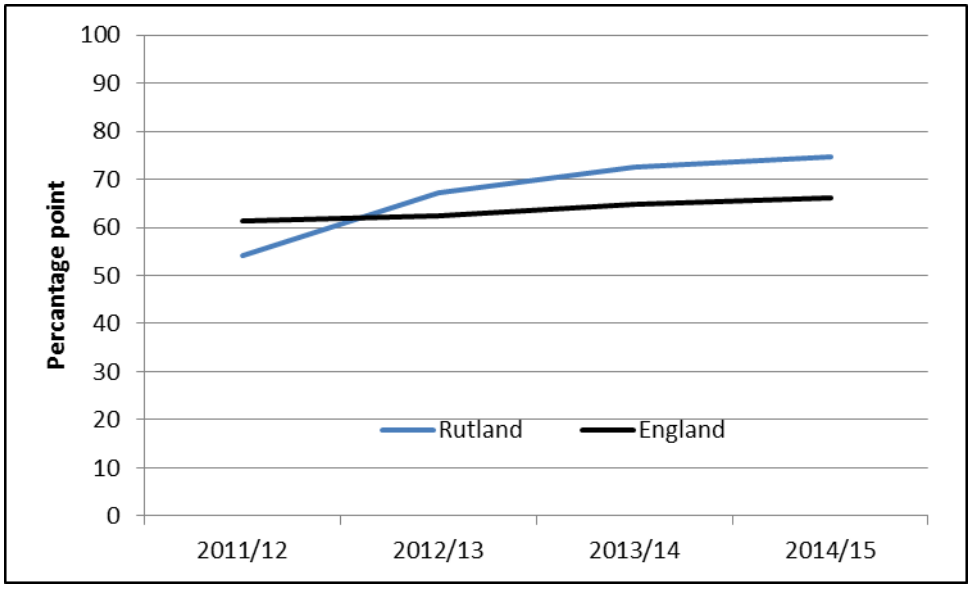

Figure 6 Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate [7]

When employees develop a health condition, it does not always lead to absence from work, but can lead to reduced performance on the job. Lower productivity may

also be linked to lower job satisfaction and wellbeing, which in turn may be due to workplaces that sap morale and energy. There is growing evidence that links employee morale and satisfaction with health outcomes as well as business performance measures (1). The proportion of population affected by long-term health problems and disability increases with age, whereas the proportion of people that report their health as good or very good decreases. Although nationally the percentage of working hours lost to sickness peaks at ages 50-64, this group had the greatest fall in sickness absence rates between 1993 and 2013. Older workers, aged 65 and over, had the smallest fall at 0.5 percentage points but the rate is lower than that recorded for ages 50 to 64 (Figure 7) (6)

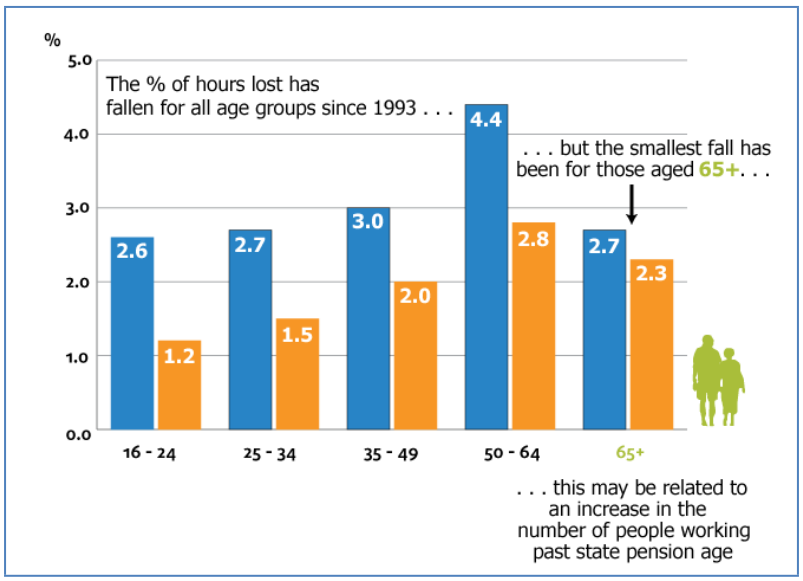

Figure 7 Percentage of working hours lost to sickness by age group – 1993 (blue) and 2013 (orange) (6)

Nationally sickness absence is generally lower than it was in the 1990s, however it is still substantial. The labour force survey provides self-reported information on the number of working days lost due to sickness absence during the previous week. According to the Labour Force survey in Rutland between 2011 and 2013, 2.0% of workers took a day off due to ill-health in the previous week. This is similar to the England average and it ranks 6 out of the 16 nearest neighbours (with 1 being the lowest value). For the same period, 1.1% of working days were lost due to ill-health. This is again similar to the England average of 1.5% and ranks 4 out of 16 nearest neighbours. Both percentages show a decreasing trend that is opposite to those

observed nationally with the former decreasing from 2.8% in 2009-11 and the latter from 1.5% (7).

Incapacity benefits are paid to those who are unable to work because of ill-health or disability. The proportion of the working age population on incapacity benefits – or the equivalent benefits that preceded it – has been increasing from 1970s to mid-1990s, with a small decline in recent years (1). In May 2016 in Rutland, 640 (2.8%) aged 16-64 were in the receipt of the Employment and Support Allowance (ESA) or Incapacity Benefits. This was lower than the regional (6.0%) and national (6.2%) average. 130 (0.6%) people were claiming benefits in Rutland because they were disabled which is again below regional and national average (0.8% and 0.9% respectively)

	Rutland (Numbers)	Rutland (%)	East Midlands (%)	Great Britain (%)
Total Claimants	1,220	5.5	11.1	11.5
By Statistical Group				
Job Seekers	90	0.4	1.2	1.3
ESA And Incapacity Benefits	640	2.8	6.0	6.2
Lone Parents	80	0.4	1.0	1.0
Carers	210	0.9	1.7	1.7
Others On Income Related Benefits	20	0.1	0.2	0.2
Disabled	130	0.6	0.8	0.9
Bereaved	50	0.2	0.2	0.2
Main Out-Of-Work Benefits†	830	3.7	8.4	8.7

Source: DWP benefit claimants - working age client group
† Main out-of-work benefits includes the groups: job seekers, ESA and incapacity benefits, lone parents and others on income related benefits. See the **Definitions and Explanations** below for details
Notes: % is a proportion of resident population of area aged 16-64
Figures in this table do not yet include claimants of Universal Credit

Figure 8) (6)

	Rutland (Numbers)	Rutland (%)	East Midlands (%)	Great Britain (%)
Total Claimants	1,220	5.5	11.1	11.5
By Statistical Group				
Job Seekers	90	0.4	1.2	1.3
ESA And Incapacity Benefits	640	2.8	6.0	6.2
Lone Parents	80	0.4	1.0	1.0
Carers	210	0.9	1.7	1.7
Others On Income Related Benefits	20	0.1	0.2	0.2
Disabled	130	0.6	0.8	0.9
Bereaved	50	0.2	0.2	0.2
Main Out-Of-Work Benefits†	830	3.7	8.4	8.7

Source: DWP benefit claimants - working age client group
† Main out-of-work benefits includes the groups: job seekers, ESA and incapacity benefits, lone parents and others on income related benefits. See the **Definitions and Explanations** below for details
Notes: % is a proportion of resident population of area aged 16-64
Figures in this table do not yet include claimants of Universal Credit

Figure 8 Working-age client group – main benefit claimants (May 2016) (6)

Employment rates in Rutland are high. Nevertheless over 4,500 people aged 16-64 were economically inactive with 3,800 (84.0%) stating that they do not want a job and 800 people (17.4%) reported long-term sickness as the reason. There is also a gap in the employment rate between people with a long-term health condition or some of the vulnerable population groups and the overall employment. For example, the gap for employment rate for those in contact with secondary mental health services and the overall employment rate in Rutland is higher than the gap recorded for England and it ranks 15 out of the 16 nearest neighbours (with 1 showing the smallest gap).

Long-term conditions can affect people's mental health and vice versa. They can also affect the ability to work, result in work absence and can reduce quality of life. In 2014/15 a higher proportion of people in Rutland than in England were registered with their GP as having diabetes, chronic kidney disease, cancer, atrial fibrillation, heart failure, coronary heart disease, obesity, palliative care and dementia.

4.2 WORKPLACE HEALTH

Whilst 'good' work is recognised to be good for health, staff health and wellbeing also plays an important role in the overall health and productivity of an organisation.

As described in the previous chapter, people who work are generally healthier than the non-working population (8) but it is known that certain factors in work, such as poor leadership, can lead to stress, burnout or depression (9). Additionally there is evidence to suggest that people who go to work when they are sick are more costly to the business than absenteeism (10). It is therefore important that the working environment is a good one that promotes positive, healthy values.

The national Workplace Wellbeing Charter (11) provides employers with a way to assess and then improve their commitment to the health and well-being of their staff.

What is the Workplace Wellbeing Charter?

The Workplace Wellbeing Charter is an opportunity for employers to demonstrate their commitment to the health and wellbeing of their workforce. It is a set of independent standards against which employers can audit and benchmark, allowing them to identify what they already have in place and to identify gaps in health, safety and wellbeing for their employees. This provides employers with an easy and clear guide on how to develop their health and wellbeing strategies and plans and how to make workplaces a supportive and productive environment. It involves 94 indicators grouped into different sections such as healthy eating or leadership. Employers complete the 94 questions and are able to identify areas that are good or need developing. The charter provides a framework for this development and organisations can be assessed against the national standard to achieve award status. Achievement of the Award enhances an organisations reputation as well as benefiting staff.

How does the standard work?

There are **3** key elements (**leadership, culture & communication**) and 8 standards in the charter:

• Leadership • Absence management • Health and safety • Mental health	• Smoking and tobacco • Physical activity • Healthy eating • Alcohol and substance misuse

The Standard has three levels:

1. **Commitment**

   The organisation has a set of health, safety and wellbeing policies in place and has addressed each area, providing employees with the tools to help themselves to improve their health and well-being.

2. **Achievement**

   Having put the building blocks in place, steps are being taken to actively encourage employees to improve their lifestyle and some basic interventions are in place to identify serious health issues.

3. **Excellence**

   Not only is information easily accessible and well publicised, but the leadership of the organisation is fully engaged in well-being and employees have a range of intervention programmes and support mechanisms to help them prevent ill-health, stay in work or return to work as soon as possible.

Employers can 'self-assess' themselves against the standards. To do this they need to register as a member on the Wellbeing Charter website: http://www.wellbeingcharter.org.uk/ This enables access to the self-assessment tool and a range of useful links and information.

Organisations can also be formally assessed against the Charter standards, giving further weight and recognition of their achievement. Once accredited, the organisation receives a certificate and the organisation is listed on the national register of award holders.

Conclusions

There is overwhelming evidence of financial and operational benefits to having a healthy workforce with lower than average sickness absence levels, greater retention and recruitment of the best candidates. Organisations that tackle workplace health can identify areas for improvement to reduce sickness absence and improve satisfaction of their employees. The national Workplace Wellbeing Charter provides one mechanism of analysing and addressing workplace health in a strategic and systematic way, underpinned by evidence. Finally there is an opportunity to embed workplace health into policy and strategy within organisations and at the regional level in order to reduce health inequalities, invest in all staff, attract the highest quality employees to posts and in doing so, improve the economic prosperity in Rutland.

Recommendations

A Leader -Public Health will advocate and lead the implementation of the workplace wellbeing strategy within Rutland County Council

A Partner - As a partner to the NHS, we will work with University of Hospitals of Leicester Trust and Leicestershire Partnership Trust on joint approaches to workforce health as part of the LLR response to the NHS 5 Year Forward View.

An Advocate - The Public Health Department will advocate the use of the Workplace Wellbeing Charter in private sector employers as part of our workplace health programme.

4.3 IMPROVING THE ECONOMY AND IMPROVING HEALTH BY TACKLING THE WIDER DETERMINANTS OF HEALTH

Background

We all know the old adage ‘health is wealth’. The vast majority of researchers, though, instead present the reverse argument, that wealth is health. Recent literature, however, reflects changes in the perception of health and longevity such that they are no longer viewed as a by-product of economic development but can drive economic development.

Better health does not have to wait for an improved economy. Measures to reduce the burden of disease, to give children healthy childhoods, to increase life expectancy, themselves contribute to creating richer economies

This chapter outlines how we intend to maintain our focus on wider determinants and take advantage of the opportunity public health has now that it is back 'home' within local authorities.

Creating Healthy Places

Creating healthy places is an essential component of our focus on prevention. Healthy places can enable people to make healthy choices; promote physical activity and active travel; provide access to green spaces, healthy food and warm homes. In addition creating employment and high quality training opportunities are inextricably linked to physical and mental health and wellbeing.

Social relationships, norms and networks – or the absence of these – have an impact on the development of, and recovery from, health problems such as heart disease. They also affect:

(a) our ability to maintain independence

(b) our resilience

(c) whether we take up and maintain unhealthy behaviours such as smoking.

Health in all Policies

To support the Health and Well Being Board in focusing on its impact on the wider determinants of health and wellbeing and measuring this impact, the Health and Wellbeing Board will make use of an existing tool and systematic approach called "health in all policies" (HIAP), which builds on the application of Health Impact Assessment (HIA). HIA is a systematic and objective way of assessing both the potential positive and negative impacts of a proposal on health and wellbeing and suggests ways in which opportunities for health gain can be maximised and risks to health and wellbeing assessed and minimised. HIA looks at health in its broadest sense, using the wider determinants of health as a framework. HIA highlights the uneven way in which health impacts may be distributed across a population and

seeks to address existing health inequalities and inequities as well as avoid the creation of new ones. HIA is a tool to implement a Health in all Polices (HIAP) approach.

HIAP describes a collaborative approach which emphasises the connections and interactions which work in both directions between health and policies from other sectors. Central to HIAP is the concept of addressing the social determinants of health.

During 2015/16 the Public Health Department piloted an approach to HIA/HIAP in Rutland focusing on healthy places.

Health in All Policies Case Study - Langham Neighbourhood Plan consultation response

The following comments from Rutland Public Health are in response to the Langham Neighbourhood Plan. Ideally a full health impact assessment would have been carried out in conjunction with the development of the plan but in the absence of this and in view of the quick turnaround required for comments, a brief scoping exercise has been carried out. This was a desk top exercise that reviewed the plan from a public health perspective. It has aimed to make comments that help to enhance the positive health aspects of the plan and mitigate any potential negative aspects that may be apparent.

Documents that have supported this process include:

- Improving the public's health: A resource for local authorities. By: David Buck and Sarah Gregory. The King's Fund.
- Mental well-being checklist. The National Mental Health Development Unit
- Health impact assessment: A practical guide. Wales HIA Support Unit

The plan only has a very small section under health which predominantly focuses on the need to have more access to a local GP and nurses – the remit of the CCG. However the themes and issues raised throughout the plan are important aspects of both physical and mental health and comments are included to highlight this.

1. Community asset: sense of community

It is apparent from the plan that Langham has a strong sense of community. There are a number of community initiatives, groups and information mechanisms that help to enhance this. A strong community can help to support community resilience, social capital and mental well-being: it therefore makes sense to use and support this asset wherever possible and appropriate. Conversely a strong sense of community can be potentially isolating requiring a need to identify those not involved. As an example there is recognition that there is little activity for teenagers within the village but no obvious consultation with teenagers on what they might like.

The plan highlights the risk of isolation in elderly housebound residents and a potential way to mitigate this could be by providing support to existing community groups and building on the assets that already exist. This could involve for example:

- Developing a befriending scheme for elderly residents
- Increasing support to ensure local information newsletters reach all houses

2. Community asset: environment

The plan is very clear on the need to recognise, maintain and enhance its natural and landscaped environment. Access to green space and natural environment is an important contributor to mental well-being and physical health. There are proposals to develop more appropriate footpaths and walking routes, particularly for those with reduced mobility and those who do not want to walk on bridleways. This would enhance the ability of all to access the surrounding countryside. Developing existing walking groups to include supported walking groups for those with limited mobility, for example, would support this process.

The organisation Living Streets (www.livingstreets.org.uk) work to enhance the safety and attractiveness of living spaces including streets. They have written a number of health, economic and social appraisals of better walking environments and may be able to provide support and advice on ways to enhance the walking environment of Langham.

The plan has proposed that the children's playground is developed. When doing this it may be useful to consider play activities for a wider range of children including teenagers, walking routes to and from the play area and seating areas.

The need to ensure green spaces including gardens into all new developments is a positive feature of the plan and helps to promote both mental and physical health. Gardens would need to be accessible and manageable by everyone including the elderly.

3. Community asset: community buildings

Langham has a number of 'community' buildings that help to support its sense of community. These include two pubs, a village hall, a school and churches. Community activities mainly take place in the village hall. The plan discusses the community wish to have a local shop but it is not clear that this would be financially viable. It may be more effective to either support the 'pop up' shop to increase its wares and hours or to develop the village hall to increase its capacity.

The village hall is an apparent focus of community activity and it may be worth exploring potential ways to enhance or develop this asset for the future.

There is recognition that the school has a number of assets such as its sports fields that could be better used by the community. Providing support to the school to carry out a cost effectiveness analysis of doing this may be a useful way forward particularly now that the school is an academy and so needs to be income generating.

4. Traffic and parking

Traffic and parking are common themes throughout the plan. Problems are increased by the main road running through the village, the lack of parking and the many houses that do not have off street parking spaces; parking is particularly problematic during school drop off and pick up times. The plan proposes that there is a 20mph zone introduced, HGVs over 7.5 tonnes are banned from the village, there are increased crossing places and that pavements are widened and improved.

The Department of Transport has produced a speed limit appraisal tool that helps councils assess the costs and benefits of introducing particular speed limits. This could potentially support the proposal to reduce speed limits; it may also be worth considering and assessing a further reduction in speed limits during school times.

As mentioned previously, Living Streets may be able to provide support and advice on enhancing the local walking environment including its safety.

The school is a focus for traffic and parking issues. There are not enough parking spaces for school and nursery staff and over half of the 218 pupils come from surrounding areas. There are a number of potential initiatives that could help to address this but all require a safe walking environment:

a. The development of school 'walking buses' where two volunteer adults walk children in 'high viz' jackets to and from school, picking them up and dropping them off at 'bus stops' along the way. A rota of volunteer parents would be required; a number of organisations provide donations of 'high viz' jackets including the Co-op.

b. The development of a staff and parent car share scheme

c. Negotiation with businesses, buildings or houses in the locality of the school that would allow on site staff parking during school hours that staff could then walk to school from.

d. Negotiation with business, buildings or houses in the locality of the school where parents driving in from surrounding areas could park temporarily to drop off or pick up their child.

Increasing walking has an added benefit of increasing physical activity levels and could usefully form part of a healthy school approach. Healthy schools adopt a 'whole school' approach to improving health that include healthy diets, physical activity, building self-esteem and supporting resilience. More information, if required, is available from Public Health.

5. Changing population

The number of elderly residents within the village is expected to increase. The main issue noted in the plan for this changing demographic is the lack of local GP services. This falls under the CCG remit. Other issues to consider include:

- Residents who may be asset rich but cash poor so have large houses but no ready cash for home improvements or keeping their homes warm. Older people living in cold houses are more likely to become ill in the winter and die.

- Increasing risk of isolation in older residents. People who are isolated are more at risk of physical and mental ill health.

- Reducing mobility. Older people with restricted mobility are at risk of falling and subsequent hospitalisation.

Ways to mitigate some of these risks include:

- Promotion of home improvement schemes such as warm home

- Developing village befrienders

- Developing community activity classes particularly for older residents

- Supporting older residents with garden maintenance

6. Other points of note

a. Housing development: future housing will be developed to strict criteria that will support health such as energy efficiency, green spaces etc. It is presumed that new houses will have space for off road parking and will be well connected with appropriate and adequate footpaths.

b. There are a growing number of home workers and developing a home worker network may help to decrease any isolation.

Health in All Policies Recommendations

A Leader – We build HIAP into work to maximise health benefits and mitigate health harms in all major RCC procurements.

5. FEEDBACK FROM RECOMMENDATIONS 2015

The co-creation of the new integrated wellbeing service has taken forward a number of recommendations made in the Annual Report last year in relation to involving community organisations in service design and commissioning and extending partnership working to more fully involve communities as the next step in engagement in planning.

Community engagement recommendations have been progressed in a number of ways including trialling approaches such as in-depth service user qualitative interviews to improve support people are offered in a particular service and ways of optimising self-care.

The approach taken in Langham has shown that HIA is a tool that can help highlight and promote the health improving opportunities of developments.

Progress has also been made on my recommendation on making it easier for people to find out what is available to support health and wellbeing locally with the re-development of the Rutland Information Service and the new integrated prevention and wellness service and pilot wellbeing advisor service.

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Report to Rutland Health and Wellbeing Board

Subject:	**SEND and Inclusion Transformation update**
Meeting Date:	**30th June 2017**
Report Author:	**Bernadette Caffrey**
Presented by:	**Bernadette Caffrey**
Paper for:	**The Board to;** **1. Comment on the draft Special Education Needs and Disability (SEND) and Inclusion Strategy and the update on the SEND transformation actions** **2. Consider how the Board may provide future oversight and scrutiny of the SEND transformation**

Context:

a). The SEND and Inclusion Strategy articulates the direction and vision for an inclusive Rutland and sets out the key objectives to bring about transformation of services for children and young people with special education needs and disabilities The SEND and Inclusion Strategy has been rewritten and is currently out for consultation, and as part of this exercise seek comments from the Board.

b). The presentation provides Board members with an update on the transformation activities within the service and across the partnership for children with SEN and disabilities.

There are statutory obligations placed on the Local Authority, health providers and schools, to support children with additional needs and disabilities, as set out in the SEND Code of Practice 2015, and the Safeguarding in Schools Guidance (DfE) 2015. This encompasses the Local Authority's obligation to provide/create sufficient places for all pupils including those with SEND and the requirement for the Local Authority with its partners to have a SEND 'Local Offer'.

A great deal of activity is underway both within the service and with health commissioners, education providers and children and families, to review the provision for children with SEN and disabilities, (SEND) in Rutland.

There is a culture shift in the service and across the partnership, and in case practice to be more customer focused and that Education Health and Care Plans (EHCP) are clearly articulating a child's health, education and social care outcomes and are preparing young people for adulthood. The service is reviewing its contracted services, such as the education psychology service and its independent advice service. It is undertaking an audit and quality assurance exercise of the Local Authority's and the Clinical Commissioning Groups' (CCG), commissioned provision, such as its 52 week residential and 38 week education placements for children with

SEND and additional needs.

Work is underway with our schools and education providers to secure the required range of specialist places within Rutland itself, or through utilising close geographical locations where specific provision is required, in addition to a greater focus on school autonomy and sector-driven improvement.

A number of engagement events, led by the local authority, health colleagues and community groups, with young people, with parents and carers, head teachers and special education needs co-ordinators, (SENCO), have taken place and their feedback has shaped the service Self Evaluation Form (SEF) and from it the creation of a SEND Action Plan and set of performance indicators which will set out action required, how success will be measured and timescales for completion. (Both documents appended to the SEND Strategy document).

Head teachers, health representatives and parents have expressed a commitment to forming a SEND Strategic Group to progress the wider transformation of SEND provision in Rutland and to securing the right set of skills and the appropriate provision so that more children are educated and enjoy a healthy family life, closer to home and at lower cost.

As the service develops its local offer for children with special education needs and disabilities it is reviewing its use of the High Needs funding and the system for responding to requests for statutory assessments, so that earlier targeted services can be offered and a secure pathway for support agreed without the need for a full assessment. It is intended that this process is in place from September 2017 onwards.

SEND and Inclusion services are subject to a Peer Review this will take place in Rutland on the 3/4th July 2017 and an Ofsted and CQC area inspection.(date to be announced). Ofsted and CQC will test how Rutland can evidence its progress against the key Ofsted/CQC judgement areas which are; how it identifies, assesses and meets needs and achieves outcomes for children and young people with a special educational need or disability.

Financial implications:

The demand for services and support for children with SEND in Rutland is growing; currently there are 194 children with Statements/EHC Plans compared to 174 in 2014/15. This reflects the national picture of an increase of 30,975 (12.1%) from January 2016 to January 2017. There has also been an increase in the number of children and young people refused assessments as Local Authorities develop their Local Offer and children can be offered the additional support they require through targeted services. (Source: DfE May 2017)

In the last five years expenditure on high needs in Rutland has increased by 31%

from £2.7m in 2012/13 to £3.5m in 2016/17. At the same time, funding from the Department for Education (DfE) has remained fairly static resulting in less funding being available to allocate directly to schools.

More Education Health and Care Plans (EHCPs) are being requested. Transition to EHCPs seems to have meant more expensive assessments, coupled with the improved identification of SEN which is driving up demand. National research suggests that the Children and Family Act 2014 has widened the opportunity for an EHC Plan from 0 to 19 to 0 to 25 years. It also gives more control and choice to parents in relation to their child's journey through education – both factors likely to contribute to the increase. Schools are applying for funding through EHCPs because there is not adequate funding within budgets to fund additional needs.

Challenges remain in accessing timely CAMHS services and in-patient health assessments. Hopefully the Transforming Care Partnership and Care Education and Treatment Review process (CTR) and the Future in Mind programme will address this.

SEND staffs including Education Psychology, (EP) services are challenged by the number of statements to EHCP conversions and annual reviews, to the extent that there is a backlog of assessments and case officers are not sufficiently involved in annual reviews. In Rutland there are 14 statutory assessments awaiting an EP assessment (7 transfers and 7 new EHC assessment requests) which will be cleared within 14 weeks, subject to further statutory requests coming in to the system during this period. There are a further 56 non-statutory EP requests outstanding. The backlog of assessments will be cleared during the Autumn term by utilising additional funds from the SEND Reform grant.

In March 2017, the Minister for Vulnerable Children and Families, Edward Timpson, announced a £215m capital fund over three years for Local Authorities. Every local authority will be allocated at least £500,000 over three years from the fund, with more than half receiving at least £1 million. Councils will be free to invest the funding as they see fit to help children and young people with education, health and care plans to get a high quality education. Rutland County Council's allocation is £500,000 over 3 years and the Council will be expected to consult with local parents, carers, schools, and others on how their funding allocations should be used. The Council will have to publish a plan showing how they will spend the funding and show how this fits in the wider context of strategic planning for SEND. Currently the £500k funding for SEND is not ring fenced and its release would need Council approval.

Recommendations:

That the board:

1. Comments on the SEND and Inclusion Strategy.
2. Notes the update on the SEND transformation and requests a progress update

on the SEND Action Plan in six months' time. 3. Notes the forthcoming Peer Review and Ofsted and CQC area inspection and prepares for and supports both events accordingly		
Strategic Lead:	Bernadette Caffrey	
Risk assessment:		
Time	M	The SEND Action Plan and capital project plan need to be in place by the Autumn term.
Viability	H	The transformation whilst driven by the Council has a high dependency on the partnership, especially health and education providers to bring about systemic change.
Finance	H	The current pressure on the High Needs budget is not sustainable
Profile	L/M/H	There is significant local and national interest on the demand management of SEND placements and on the outcome of the Ofsted/CQC inspection.
Equality & Diversity	L/M/H	The needs of both children and young people with additional needs and the impact on children in mainstream provision will be considered

Timeline:

Task	**Target Date**	**Responsibility**
Update to Childrens Scrutiny Panel	22nd June 2017	B Caffrey
Progress report on the SEND Action Plan to Children's Trust Board	Autumn 2017	B Caffrey
Request for release of Capital grant to Cabinet	August/September 2017	B Caffrey

Rutland
County Council

NHS
East Leicestershire and Rutland
Clinical Commissioning Group

Inclusive Rutland

Rutland's SEND and Inclusion Strategy

June 2017

EXECUTIVE SUMMARY

Our Vision

"In Rutland we are committed to being a County that promotes inclusion, maximises children's and young people's opportunities to be independent and focuses on their abilities not their disabilities. We want the information on support and the way to get support to be understood by our children and families and professionals and that the support will reflect the individual needs of a child. We believe that every child and young person with special educational needs and disabilities from Rutland should, wherever possible, have their needs met locally, so that they can enjoy a family life, be with friends and that they should expect to receive high quality education, health and social care provision that promotes their wellbeing and transition to adulthood.This includes access to universal services as well as targeted and specialist support where required."

Our Strategy

Our SEND and Inclusion Strategy will turn our vision into actions. Our Strategy provides us with an opportunity to create a shared view of the challenges faced by children and young people and our SEND Action Plan will put actions in place for children and young people with special educational needs and disability. It brings our health, education, and social care partners together and puts children and families at the centre of our services. There is recognition that there is increased demand and growing pressure on the system and that we need to work collaboratively so that we utilise our resources in a way that achieves maximum impact and the best outcomes for children and young people with special educational needs and disabilities (SEND). Our Strategy enables us together to identify the gaps in services, and challenge what needs to change and improve to achieve better outcomes for children and young people.

This document outlines Rutland's' '**Local Offer'** and informs the approach partners take in working with children and families and the design of future services. Our SEND and Inclusion Strategy takes into account national research and reviews, for example, by Frank Field and Graham Allen, with regards to the importance of the early years and early intervention.

Our offer also takes into account key messages from Working Together to Safeguard Children, (DfE 2015), the SEND Code of Practice (DfE/DoH 2015), and the Keeping Children Safe in Education Guidance (DfE 2016).

This Strategy sets out clear expectations of the Council and Clinical Commissioning Groups (CCGs), and other partners specially health and education providers, which reflects the statutory requirement under primary legislation, regulation and case law as set out in the SEND Code of Practice (2015), Section 28 Duty to Co-operate and the Local Safeguarding Board Safeguarding procedures. The expectations of professionals in Rutland as defined in the SEN and Disability Code of Practice (2015) include;

- Participation of and co-production with children and families in decision making about their support
- Services will work together to ensure that EHC Plans will identify not only a child's or young person's education needs and support but address their health and social care needs too. This will be tested though our partnership performance and quality assurance mechanisms
- Special educational provision is made available for those who need it and children with SEN are treated fairly
- Early years providers, schools and colleges know precisely where their children and young people with SEND are in their learning and development and provide suitable stretch and challenge in their education.
- Support children's successful preparation for transition through phases of their education and transition in to adulthood and employment

Where are we now?

The demand for, and the spending on services and support for children with SEND in Rutland have grown significantly in the last three years. Currently there are;

- 353 children living in Rutland with an SEN and /or Disability (LA: June 2017)
- 195 children living in Rutland are on an Education Health and Care (EHC)Plan, including those on a 'Statement ' transferring to an EHCP (LA: June 2017)
- Of the children on a statutory Plan or SEN Support –
    - Primary = 1.6% have a Statement or EHCP. 10.2% of children receive SEN Support (School Census: January 2017)
    - Secondary = 2.3% of secondary pupils have a statement or EHCP. 13.3% receive SEN Support (School Census: January 2017)
- 57 children living in Rutland attend an out of county special school (LA: June 2017)
- 40 young people living in Rutland attend Post-16 out of county colleges (LA: June 2017)
- 133 children with a disability are in receipt of Aiming High short breaks or positive activities (LA: June 2017)
- 23 children with a disability are in receipt of Social Care (CiN) care packages (LA: June 2017)
- In 2016, children who had been identified as requiring additional support or EHCPs/ Statements in Rutland schools, performed less well compared to similar children nationally, and both locally and nationally these children perform less well than children who do not have any identified additional need. Whilst it is worth noting the impact of relatively small numbers of children overall, indications are that performance gaps are wider at primary phases than secondary.
- According to the Labour Force Survey, disabled people are now more likely to be employed than they were in previous years, but still remain significantly less likely to be in employment than non-disabled people. In 2015 77.27% of Rutland 16-17 year olds were in education or training, compared with 87.3% nationally.

- The budget for high level SEND support in Rutland has increased by 31% from £2.7 million in 2012/2013 to £3.57million in 2017/2018.

1. What will we achieve?

1. Identify the needs of our children sooner and put support in place earlier, so we reduce the need for unnecessary assessments and intrusion in families' lives
2. More children will be able to maintain their education and their family life in Rutland when it is in their interest.
3. Children and parents will be encouraged to seek appropriate support and will have more choice and feel more in control of their support plan.

2. What are we going to do?

1. Monitor and review the services for children and young people with SEND and respond to them through evidence-based early support and intervention across our health, social care and education system.
2. Support our early years providers, mainstream schools and post 16 settings with the resources, training and time they need, so that they can provide effective provision for children and young people with emotional and behavioural difficulties and special educational needs and disabilities, so that children can maintain their education and make good progress in their learning.
3. Include children and young people with special educational needs and disabilities and their parents or carers, especially those who find it hard to access our services, in all decisions about their individual support and listen to and act on what they tell us about local education, health and care provision.

This Strategy will be supported by an **SEND Action Plan** containing, a detailed set of actions with timescales, outcome measures, and resource implications.

3. How will we know we have succeeded?

Partners in education, health, and social care through the Children's Trust partnership arrangements, will agree the key performance indicators to measure the impact and effectiveness of our Strategy to test the effectiveness of our '**Local Offer'** and to monitor if the outcomes for children and their families are being achieved.

Our performance indicators will measure key outcomes:

1. That timescales are met in assessing and responding to children's needs and the need for specialist services or unnecessary intrusions in families' lives is reduced.
2. Children and young people achieve their potential and educational standards at least in line with those seen nationally
3. More children retained and succeeding in mainstream educational settings if this is the most appropriate setting for them, through high quality education provision
4. Children and their families report improvements in their life at the end of an intervention.
5. The sustained and meaningful engagement of children and their parents is evidenced in their support plans
6. More young people are in training and employment
7. There is fair access to health and social care services for children, young people and their families across the county and across our geographical boundaries
8. Decisions are robust and can demonstrably evidence best value for money

Having completed a self-evaluation **(SEF)** of our services, we have identified key actions which are set out in our **SEND Action Plan.** We show the specific actions, how we will measure success, and the timescales for completion. We will review the Action Plan regularly over the timescale of the strategy. We will report on an annual basis and publish this on the Council Local Offer website.

See See Appendix 1 Self Evaluation Form (SEF) Summary, Appendix 2 SEND Action Plan

In summary the partnership and children and families, will know the progress we are making and why.

End

What is Inclusion?

Inclusive Rutland describes our positive response to individual needs, differences, abilities and disabilities by striving to meet the needs of different people and taking deliberate action to create environments where everyone feels respected and able to achieve their full potential. It means putting support in place when it is needed and knowing when to withdraw, adjusting an offer or an intervention to meet health, social care or education needs. In education, inclusion embodies the child's right to participate and the school's duty to accept the child and to take every action to ensure they succeed. This could include providing more accessible and understandable information, adjustment to the delivery of certain curriculum areas or providing one to one support in school or in college.

Being 'inclusive' requires us to meet the needs of children who may experience emotional and behavioural difficulties which challenges their education. It means through our **'early intervention'** support we will meet the needs of children as soon as additional needs start to emerge, or when there is a strong likelihood that an additional need or disability will emerge in the future.

Education settings – early year's settings, schools and colleges – should be able to meet the needs of most children with a learning disability and are required to make '**reasonable adjustments'** to be able to do so through quality differentiated teaching and learning.

SEN Support is the graduated process schools and other settings use to identify and meet the needs of children with SEN. This support should be regularly reviewed, utilising the, 'assess, plan, do, review' model, with support then adjusted where necessary to ensure it is still effective and leading to improved outcomes in line with the SEND Code of Practice (2015).

Some children and young people with SEN may also have a disability which does not affect their ability to learn but might stop them from being able to do certain day-to-day things. In this document the term SEN and Disability is used across the 0 to 25 age range and includes learning difficulties and disabilities.

Rutland is committed to safeguarding disabled children and young people, promoting safer care, and ensuring that children are appropriately protected.

Our '**Local Offer'** is for all children with additional needs that emerge at any point throughout childhood, adolescence and in to adulthood. The **'Local Offer'** includes universal services; such as early year's settings and schools, health visiting and GP services or adult learning, voluntary and community groups, one to one family support in the home, or the Aiming High for disabled children short breaks, and specialist services, such as social care or specialist health services.

Rutland's SEND Local Offer:
http://ris.rutland.gov.uk/kb5/rutland/directory/localoffer.page?localofferchannel=0

The financial context is increasingly challenging and will continue to be so, as recognised in the LLR's Sustainability Transformation Plan. Demands and pressures on services are increasing while resources become more constrained. There are likely to be further changes during the life of this Strategy that we will need to take account of.

We will manage and monitor the equitable use of this funding to make sure we get the best outcomes for children and young people with higher level needs and the most value for money. In this context it is more important than ever that all partners work together to share information, expertise and resources to meet needs and ensure positive outcomes for children and young people with SEND.

We will operate our High Needs Panel supported by partners to ensure we have robust decision making and accountability for the decisions we make in assessing and responding to children and young people's needs.

See Appendix 3 - SEND Panel Terms of Reference

Key Principles

Rutland County Council and East Leicestershire and Rutland Clinical Commissioning Group and its partners' commitment to an Inclusive Rutland is central to the delivery of the Sustainability and Transformation Plan, the Children and Young People's Plan, the Health and Well Being Strategy and the Education Improvement Framework, with inclusion cutting across key priority outcomes which are underpinned by a key set of principles, as set out in the SEND Code of Practice, (2015) and reflect our Leicester, Leicestershire and Rutland (LLR) Thresholds Document (LSCB 2016) http://lrsb.org.uk/uploads/thresholds-for-access-to-services-for-children-and-families-feb-2015.pdf

Principles underpinning early intervention and inclusion

- Identify in the early years utilising the **Integrated Development Assessment,** children and young people's needs and put in place early intervention to support them
- Support the participation and co-production of children and their parents in decision making and strive to offer greater choice and control for young people over their support
- Promote inclusive practice and removing barriers to learning and access to health and social care services
- Reduce duplication of assessment so that children, young people and their families do not tell their stories multiple times to health, education and social care professionals
- Support young people to make successful transitions through phases, (e.g. primary to secondary transfer) and/or types of provision and to adulthood and independent living and employment
- Our workforce will be supported to be multi-skilled, to be creative and tenacious and adopt the principle of the Signs of Safety model of working with families to identify strengths and to resolve challenges.
- The services will offer best value for money and utilise shared expertise and resource across partnerships.

Early Intervention

Rutland County Council provides the 'front door' through which parents and professionals can access additional support at any level, including early help advice and support.

All children and families can access universal public health services, such as their midfwife, health visitor and GP. **Integrated health assessment** are offered at key developmental points in a child's life, to support early identification of needs and to support access to timely intervention.

Referrals to specialist services may be recommended for further assessment before returning to universal services from General Practitioners, Health Visiting or School Nursing.

The critical features of effective **Early Intervention** which have been identified nationally and on which Rutland's process is founded are:

- a multi-disciplinary approach that brings a range of professional skills and expertise to bear through a "**Team Around The Family"** approach
- a relationship with a trusted **Lead Professional** who can engage the child and their family, and if necessary co-ordinate the support needed from other agencies around a family
- practice that empowers families and helps them to develop the capacity to maintain a family life and fulfil their caring duties
- a holistic approach that addresses children's education, health and social care needs in the wider family and whenever possible in their community
- a published local offer of support, services and provision, how to access it and how to raise concerns or seek redress and a simple and streamlined referral and assessment processes
- Increased integration of services and joint commissioning across the LA and Health services.

Identifying children who would benefit from early intervention

The Children and Families Act 2014 (sections 22 -24), clearly sets out the Local Authority's and the NHS's duties to identify all children and young people in their area who may have special educational need or have or may have a disability. 'Working Together to Safeguard Children (DfE 2013, revised 2015) and Rutland's Early Help Strategy puts the responsibility on all professionals and educators to identify emerging needs and to take professional responsibility to ensure that if a family does not meet the thresholds for specific services, that action is taken to prevent the lower level needs escalating.

Key professionals and educators working in universal services in Rutland are best placed to identify children or their families, who have or may have an SEN or disability and therefore at risk of poor outcomes. Health providers, schools and settings have a duty to ensure that all children achieve well and that those with additional needs have an educational offer which enables them to succeed and reach their potential. Early intervention is essential, with high quality teaching reflecting the need of the child and adjusted to enable the child to access a curriculum through which they develop skills which will improve their life chances. Wherever it is appropriate to do so, children with additional needs should be supported to access a mainsteam setting and have support for their health and social care needs.

This is achievable and will be central to the success of the Rutland SEND and Inclusion Strategy.

Alongside this, we will utilise local intelligence such as the Joint Strategic Needs Assessment (JSNA), school's census data, data collated through the 0 to 19 Healthy Child programme and our Children's Centre programme, to understand local need and inform joint commissioning arrangements.

Who can Access Support?

The provision of early help and inclusion services forms part of Rutland's continuum of help and support to respond to the different levels of need of our individual children and families. In Rutland this is described in our LLR LSCB Thresholds document updated September 2016.

Leicester, Leicestershire and Rutland (LLR) Thresholds Document (LSCB 2016) http://lrsb.org.uk/uploads/thresholds-for-access-to-services-for-children-and-families-feb-2015.pdf

How to access support

To ensure that the best possible and earliest support is provided to children and families, there needs to be easy and accessible support through the **'Local Offer** and an **Early Help Assessment**, which will consider a child's developmental needs, family and environmental factors and parenting capacity.

All staff should be aware of the early help process, and understand their role in it. This includes identifying emerging problems, liaising with the designated safeguarding lead, sharing information with other professionals to support early identification and assessment and, in some cases, acting as the lead professional in undertaking an early help assessment. (Keeping Children Safe in Education DfE 2016)

In some cases a health, or social care professional or educator will be able to identify a specific need, but may not be able to provide appropriate support. In this instance the Early Help co-ordinator or Inclusion Officer will support the referrer to the appropriate services or intervention.

Where the assessment identifies early help that cannot be met by a single agency or service, there needs to be a coordinated response with local agencies working together to support the family. **The Team**

around the Family (TAF) model is used in Rutland to bring together a range of different practitioners from across the children and young people's workforce and where necessary adult services.

If a child's needs are too complex to be supported successfully through the early help offer, then the child or young person, their parents, school or college can request either an assessment which may lead to an **Education, Health and Care Plan** (EHCP) or a **Single Assessment.** Both assessments should be conducted in a timely way, with all partners providing effective support and provision towards the best outcomes for the child or young person through regular review. Strategies and planning should be in place to promote independence and 'stepping down' of provision if support is no longer needed or appropriate.

Referral Pathway to All Rutland's Children's Services – June 2017

General enquiries and information about services and support for Children and Families
For information about services, organisations, events and activities, please visit the RCC Services Directory at http://www.rutland.gov.uk/education_and_learning/family_information_service.aspx **where you will find information relating to services for:**

- **Families, children and young people aged 0-19 years**
- **Families with children and young people who have special education needs and disabilities aged 0–25 years (The SEND Local Offer) ***

Concern raised about a child or a child in need of support?
Professionals working with children, young people and families
Member of the public
Parents/Carers/Children/Young People

Contact the RAIS (Referral, Assessment & Intervention Service) providing integrated support for children
Telephone – 01572 722577 ext. 8407
Option 1 – Concerns about a child's welfare/ safety
Option 2 – Support services and advice and guidance, such as Early Help/ SEND/ Inclusion
Option 3 *– If you know the extension you require, please dial this now)*

Safeguarding Emergencies only - *outside office hours and at weekends and bank holidays:* Tel: (0116) 305 0005 - OR the police: Tel: (0116) 222 2222
Or email **childrensduty@rutland.gcsx.gov.uk**
Or earlyhelp@rutland.gcsx.gov.uk – Only if your enquiry is not concerning the welfare or safety of a child

Option 1 – Concern about a child's welfare/ safety
Calls will be screened by the RAIS Social Worker
(Supported by Early Help Coordinator)

Option 2 – Support services and advice and guidance, such as Early Help/ SEND/ Inclusion
Initial screening by an Early Help Coordinator
(Supported by the RAIS Social Worker)

Safeguarding or Child in Need

Safeguarding/ Child in Need
Threshold met for social care intervention
RAIS Social Worker commences Single Assessment
Outcome recorded
Referrer advised
Where s47 this will be completed by RAIS Team
Where s47 and child is known to the CWD Social Worker this will pass to the CWD Social Worker and Manager to complete

Children in Need - with a Disability
Threshold met for social care intervention for Child with a Disability
Child with Disability Social Worker commences Single Assessment
RAIS Team complete Single Assessment when disability not ascertained at point of referral
Outcome recorded
Referrer advised

Early Help Assessment or Targeted Intervention/ Educational Health & Care/Inclusion
Does not meet threshold for Social Care statutory intervention.
Single-agency/Multi-agency response and Early Help Assessment needed
Referral supported by Early Help Co-ordinator and directed to Early Help services, Targeted Intervention/ Inclusion (SEND) Service
Outcome recorded

Information, Advice and Guidance
Does not meet threshold for any statutory intervention
Can be supported in Universal Services
Referrer advised and information provided
Outcome recorded

Conclusion

The 'Local Offer' for children and families across the partnership in Rutland requires further development and there is now a greater need for ensuring that our offer to children with SEN and disability is progressed and for our actions to be robustly driven forward by the Children's Trust Partnership. Parents and professionals have expressed a real commitment to inclusion development and progressing services and support for children with SEND in Rutland which will be taken forward by our multiagency **SEND Strategic Group**.

References

1. Working Together to Safeguard Children – A guide to inter-agency working to safeguard and promote the welfare of children (March 2013, revised 2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf
2. Field, F. (2010) The Foundation Years: preventing poor children becoming poor adults
3. Allen, G (2011), Early Intervention: The next steps
4. SEN and Disability Code of Practice 0 to 25 years – statutory guidance for organizations which work with and support children and young people who have a special educational needs or disability (January 2015) https://www.gov.uk/government/publications/send-code-of-practice-0-to-25
5. Keeping Children Safe in Education – statutory guidance for schools and colleges (September 2016) Equality Act 2010 http://www.legislation.gov.uk/ukpga/2010/15/contents
6. Children and Families Act 2014 http://www.legislation.gov.uk/ukpga/2014/6/contents/enacted
7. Care Act http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
8. DfE Guidance on Equality Act for Schools May 2014 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/315587/Equality_Act_Advice_Final.pdf
9. SEN and Disability Regulations 2014 http://www.legislation.gov.uk/uksi/2014/1530/pdfs/uksi_20141530_en.pdf
10. Transitions Guidance (Statements to EHCs) https://www.gov.uk/government/publications/send-managing-changes-to-legislation-from-september-2014--3

Useful Contacts:

Rutland County Council
http://www.rutland.gov.uk/

Rutland Family Information Service
http://www.rutland.gov.uk/education_and_learning/family_information_service.aspx

Rutland Children's Duty Team
Email: childrensduty@rutland.gcsx.gov.uk

Local Safeguarding Children's Board (LSCB)
www.lrsb.org.uk

Thresholds of Access to Services for Children and Families in Leicester, Leicestershire & Rutland
http://lrsb.org.uk/uploads/thresholds-for-access-to-services-for-children-and-families-feb-2015.pdf

Working Together to Safeguarding Children (2015)
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

NSPCC
http://www.nspcc.org.uk/

Citizens Advice (RIASS)
https://www.citizensadvice.org.uk/

Rutland Parent Carer Voice
https://www.rutlandpcv.com/

Independent Supporters (RAISS)
http://www.sendiassleicester.org.uk/about-independent-support-leicester-leicestershire-and-rutland

East Leicestershire Clinical Commissioning Group
https://eastleicestershireandrutlandccg.nhs.uk/

Leicestershire Partnership Trust
http://www.leicspart.nhs.uk/

Appendix 1

Rutland Local Area SEND Self Evaluation Summary - Apr 2017
SECTION A: How effectively does the local area identify children and young people who have special educational needs and or disabilities?
Strengths: What's working well
• There is good partnership working in place, especially with health services and early years providers, which is helping to improve the identification of the needs of children at the earliest stages (live birth data, SEND toolkit, Inclusion Network, SENCO meetings, Early Years Practitioner training). • The operation of a single front door to early intervention support is widely promoted and enables co-ordinated responses to families when needs are first identified. • There are a range of clear assessment processes, utilising national assessment tools, which are undertaken by practitioners to help identify the needs of children at the earliest stages e.g. ASQ, integrated reviews. Assessments for children across early help and statutory services are reviewed routinely and capture the views of practitioners, parents and children to ensure they are relevant to their needs. • The integration of the SEND and Inclusion service with Early Intervention is helping to join up and support effective identification at the very earliest stages. • Social care needs are identified quickly through joined up working alongside Early Intervention services. • A range of tools are in place for supporting the effective transition of children and young people between education providers (tapestry, one page profiles, off to a Flying Start, Transition Operational Group). • Good working relationships with many of our schools who will request support in early identification of need and in meeting emerging needs including environmental needs through a 'Team around the Family ' approach.
Areas for Improvement: What are we worried about
• The local area has slightly higher levels (3%) of EHCPs compared to mean levels nationally (2.8%) and there are concerns regarding the quality and appropriateness of some requests for EHCs. A higher level of assessment requests at Year 6 suggests that there is low confidence amongst primary schools in the effective transition of children to secondary school; a view supported by SENCOs. • There is a backlog in non-statutory Educational Psychology assessments and CAMHS assessments meaning the needs of children are not identified as quickly as we would like. • Although regular health screening checks are in place information is not always shared across the partnership to help join up responses to families. In addition the impact of therapeutic services provided to children following initial referral is not known as they are not yet routinely evaluated, this means we cannot be fully confident the early support is effective in preventing the escalation of needs. • Although our performance for the completion of statutory EHCPs assessments within the 20 week timescale stands at 77%, compared to 55% nationally, we would like to achieve 100% within timescale. • Our performance for undertaking annual reviews of EHCPs stands at 78% and our capacity limits the attendance at annual reviews and the quality of reviews undertaken by schools is variable.

- The local area has developed its use of local data and utilises school census, attainment and health information to understand need at case level, however it could be used more effectively to inform the commissioning of services across the partnership.
- Analysis of existing EHC plans has highlighted that the use of SMART action planning and outcome setting in support plans for children could be improved to help monitor the effectiveness of support.
- Evaluation of services is not routine and whilst impact can be demonstrated on a case by case basis broader analysis of support and overall impact of our approach is limited.

SECTION B: How effectively does the local area assess and meet the needs of children and young people who have special educational needs and/or disabilities?

Strengths: What's working well

- We have a strong child centred approach and the views of children and parents are captured in assessments using a range of mechanisms (Signs of Safety (, My Story) which means the support reflects individual needs. This is reinforced by practitioners and practice standards which involve capturing child voice throughout the period of support.
- The views of parents and children are actively sought (DYF, RPCV) and are influencing service changes at both an operational and strategic level (developing our local offer, Children's Trust representatives, involved in recruitment, service contract reviews, preparing for adulthood consultations, you said we did).
- There are robust independent support services available which are utilised and valued by families. RIASS and SENDIASS are actively engaged in the arena and working to improve services for families.
- Information sharing across partnerships is pursued and is supported by information sharing agreements to support exchange (sharing of live birth and school destination data). Consent is sought for information sharing within early intervention services to improve the co-ordination of agency information in response to child needs.
- Local arrangements for EHC assessments are good with multi-agency oversight at our EHC and high needs funding panel and relevant decision making forums.
- Processes for co-ordinating assessment information pertaining to children are helping to ensure the needs of children are captured, this includes weekly allocation meetings.
- Satisfaction data is captured on services provided to children and families with evidence of high satisfaction in certain areas (Aiming High, Annual EHCP Review process, Children Centre).
- Workforce development across the partnership to support front line staff to recognise need and develop inclusive practice and partner agencies are involved to join LA training events.
- Children with disabilities are safeguarded through the CiN process and robust management oversight and regular supervision.

Areas for Improvement: What are we worried about

- The quality of 'voice' work is contrasting between schools and audits of EHCPS has highlighted that the voice of children does not always influence the support plans that are developed for children and young people.
- Evaluation of services and satisfaction data are not utilised routinely to inform service change.
- Whilst social care input to joint working with early help services is strong their involvement within the statutory EHCP process has been limited meaning the broader social care needs of children have not always been considered or reflected in assessments.
- The information provided in EHC assessment requests received by schools, including information about the needs and the support provided to children to meet needs is not always clear which is undermining decision making and effective responses to children.

- The paperwork and guidance for EHCP requests could be simplified and SENCOs have reported feeling unsure as to what evidence needs to be provided as part of the statutory assessment process.

SECTION C: How effectively does the local area improve outcomes for children and young people who have special educational needs and/or disabilities?

Strengths: What's working well

- There are some good examples of preparing young people for adulthood which have provided positive outcomes – (TOG, Off to a flying start, independent living programmes).
- Analysis of the achievement of children with SEND at a national level shows that pupils with SEN support, statements or EHCs are achieving a good level of development in the Early Years Foundations Stage profile, with 33% achieving a good level of development opposed to national figure of 26%.
- Rutland has a strong performing educational infrastructure with 11 educational establishments rated as outstanding which includes both in county special school provisions which are utilised for some children with EHCs. 37 Establishments are rated as good with only 4 settings within requires improvement.
- There is a high degree of area senior leadership ownership and oversight of the SEND agenda and the steps required for improving the offer within the local area. This is evidenced within the new SEND and inclusion strategy which sets a clear vision for improvement.
- Robust governance structure including the Children's Trust, Children's Centre Governance Group and Children's Scrutiny Panel.
- Increase investment in early intervention and SEND capacity in the Council is enabling more capacity to improve the quality of our offer to children and young people.
- The Aiming High offer is supporting whole families to care for children with disabilities at home and the 'short breaks' offer is effective in enabling children with disabilities to enjoy a normalised 'family life ' and supporting parents to fulfil their caring responsibilities.

Areas for Improvement: What are we worried about

- Information pertaining to the progress and achievement of children and young people with SEND is not routinely analysed to understand impact and drive service delivery. Mechanisms to support this through SMART planning, graduated responses and robust contracting are still in development, to this end the effectiveness of the local area in improving outcomes for children is not easily demonstrated.
- Audits of EHCPs has highlighted that preparing for adulthood is not evident in planning for children and young people at an early stage. Plans are not always aspiring and it is unclear the outcomes which are sought in later life and therefore assessing the effectiveness of support is limited.
- Evidence of the progress children and young people make following support is difficult to establish due to poor baselining during initial assessment.
- The Performance and QA Framework relating to SEND is under developed. Performance across national indicators highlights children and young people with SEND in Rutland achieve below national averages (KS1&2)
- Consistent use of graduated responses in schools to identify and address the needs of children makes it difficult to establish need and impact of support provided by schools.
- There is limited tracking of SEND cohort up to age 25 and their destinations into further education, employment and training and therefore the benefit of support in the long term is unknown.

Appendix 2

SEND Action Plan 2017 – V2 (01.06.17)							
REF	**Key Improvement Action**	**Expected Outcomes**	**Lead**	**Start Date**	**End Date**	**Rag**	**Progress**
Section A: How Effectively does the local area identify children and young people who have SEND							
A1: Timeliness	Implement the new front door incorporating SEND services and service requests.	A single mechanism for referral into services is in place for practitioners and families and timely responses enabled.	BC	Mar 17	Sep 17		Process designed and consultation on model undertaken. Go live scheduled for September.
	Introduce response timescales for SEND inclusion and education psychology referrals and assessment.	Clear expectations for families, practitioners and timely responses to need in place.	KQ	Jun 17	Sep 17		EP service currently under review. Inclusion referrals allocated through weekly allocations and aligned to early intervention practice standards.
	Develop process for quantifying impact of inclusion support for settings and families.	Impact of support at early years stages are better evidenced	FD/DG	Jul 17	Sep 17		Not yet started.
	Introduce a level of involvement framework to determine case officer attendance at annual reviews.	Increased involvement and oversight of EHCPs with a focus on the most complex cases.	KQ/ DG	Jun 17	Sep 17		Not yet started. Additional case officer in post June 2017
	Review the SEND annual review process, including post 16 transfer process.	Annual reviews are undertaken within statutory timescales and post 16 transfers are more effective in preparing young people for FE.	SW, CM, KQ	May 17	July 17		Process drafted, new process scheduled for launch in July. 2017
	Develop process for monitoring the Ofsted rating for schools for SEND children.	Ensures changes in status are responded to and children's needs in their provision are being met.	RS	Mar 17	Jun 17		Completed. Changes to school Ofsted grades a school responsibility to inform RCC included in contracts.
	Clear the current back log of non-statutory educational psychology assessment requests from schools.	Children's needs are assessed and understood to inform next steps.	KQ	Sep 17	Jan 18		Additional SEND reform grant allocated to EP, agreed programme to expedite assessment with provider from September to December 2017.
A2:Quality	Develop a quality assurance process for analysing routinely the involvement of children and parents in services including within initial assessment.	Plans reviewed regularly and improvements identified ensuring effective plans in place for children and young people.	JT/DG	May 17	Jun 17		Case audit tool developed and implemented in June, process to align within existing children's service QA process.

	Utilise Joint Strategic Needs Assessment (JSNA) with increased focus on SEND intelligence.	Needs across local area are known and used to inform commissioning of services.	JA/BC	Jan 18	Jun 18		To be included in next JSNA.
	Develop and deliver a training plan for schools and SENCOs, including SMART Action plan training, identifying ASD.	Quality of EHCPs and support plans are improved and enables service to better measure impact.	GC/ FD	Sep 17	Mar 18		Consultation with SENCOs on potential training completed. Training programme from September 2017
	Review EHC assessment request paperwork to ensure it supports consistent information gathering.	Quality of requests improves supporting decision making.	DG/CM/KQ	Jun 17	Sep 17		Paperwork under review as part of introduction of Liquid Logic.
	Develop/Encourage person centred reviews for EHCP annual reviews.	Parent / child views collected and evidenced within EHCP.	DG	Sep 17	Mar 18		Practitioners and partner agencies receiving SOS training.
A3: Identification	Implement the new front door incorporating SEND service and service requests.	A single mechanism for referral into services is in place for practitioners and families.	BC	Apr 17	Aug 17		Process designed and consultation on model undertaken. Go live scheduled for September.
	Develop a model for supporting transition between primary and secondary schools.	More effective transition of young people in education, reduced need for statutory assessment.	GC	Sep 17	July 18		Action not yet started.
	Review section 23 form and process for sharing with LA and develop training programme for health practitioners to increase uptake in use.	Practitioners screen effectively and needs of children are identified early and information is shared.	DK/SL	Sep 17	Dec 17		Action not yet started.
	Review role of health visitors in supporting attendance at early years settings to improve support for identification.	Settings more confident in raising concerns and discussing needs.	DK/TC	Sep 17	Dec 17		Action not yet started.
	Review the use of date from health visiting 2 year reviews and CAMHS for ensuring timely responses when needs are identified.	Information generated is used effectively for ensuring children receive appropriate support.	DK/SL	Sep 17	Dec 17		Action not yet started.
	Support schools in the development of an effective graduated approach to the identification of and response for children with additional needs.	Responses to needs better understood and impact demonstrated, supporting effective escalation in support where required.	RS/GC	Sep 17	Jul 18		Action not yet started.
	Develop system one template to facilitate reporting of ASQ attendances, outcomes etc within LPT.	Needs identified and understood to inform targeting those who require additional support early.	DK	Jan 18	Mar 18		Action not yet started.
	Deliver awareness training to CAMHS staff re reporting on information on statutory assessment to facilitate decision making and inform EHCs.	Information shared routinely, informing decision making.	DK	Jan 18	Mar 18		Action not yet started.
	Further embed SEND toolkit with follow up awareness training events for schools.	Schools identify the needs of children and provide appropriate responses.	FD	Sep 17	Dec 17		Action not yet started.
Section B: How effectively does the local area assess and meet the needs of children and young people who have SEND							

B1: Engagement	Deliver child centred practice training to SENCOs to support annual reviews including One page profiles.	Child centred approaches routinely adopted within assessments and informing plans.	FD/DG	Sep 17	Dec 17		Action not yet started.
	Develop process for capturing social care oversight on development and sign off of EHCPs.	All plans reflect wider social care considerations.	KD/DG	Jun 17	Sep 17		SC now members of EHC and high need funding panel.
	Improve the promotion of SENDiass and RIASS services through leaflets distributed with assessments.	Children and families are aware of and access independent advice and support when required.	LH	May 17	Jun 17		Action complete, new leaflets distributed with letters.
	Introduce information sharing agreement for integrated reviews.	Information from reviews is shared so needs are known and support offered where required.	TC/JS	Jun 17	Sep 17		Initial discussions on ISA have taken place, currently reviewing existing ISA to see if these can be amended for this purpose.
	Review Local Offer website forms and content to ensure they are explicit (who for etc) including the removal of acronyms.	Forms and information on accessing services are clear for families.	LH	03/17	07/17		Underway.
	Develop an easy read EHC and Local offer guide to support children and parents to refer.	Information is more accessible for children and families with SEND.	LH/AP	April 17	July 17		Guides complete, due to be published on the website during June.
B2: Local Arrangements	Undertake review of EHCP plans to ensure they capture partnership accountability and who will do what.	Accountability and ownership improved.	DG	Sep 17	Dec 17		QA testing underway with LA and Health.
	Review the EHC panel format and arrangements including review of EHC panel TOR and group responsibilities.	Processes and decision making clear.	BC	Jun 17	Aug 17		Review underway with initial review meeting undertaken.
	Review the arrangement of use of Higher Needs funding to provide solutions outside of statutory assessment arrangements.	Earlier support provided to prevent escalation and unnecessary lengthy assessments processes.	BC/KQ/CM/GC	Sep 17	Sep 17		Initial discussions have taken place, planned discussions with school forum to formalise local approach.
	Develop clear process for alignment of CLA PEP and EHCP processes.	Duplication of assessment avoided, information joined up.	KD/ KQ/ DG	Jun 17	Sep 17		Initial agreement in place, process to be formalised.
B3: Satisfaction	Review the process for EHCP and annual reviews evaluation and data gathering.	Evaluation of services routine and satisfaction of families is known and acted upon.	LH/SW	Jul 17	Aug17		Survey developed. Process for collation of information in design.
	Develop clear transition to adulthood pathway and year 9 review process.	Preparing for adulthood focus of all plans and clear offer for young people in place.	LH/SW/LT	Jul 17	Dec 17		Integral part of the development post 16 offer under development.
	Commission a revised RIASS service, consulting	RIASS service is effective and meets the needs of	LH/KQ	Jun 17	Dec 17		RFQ process underway.

	with children and families to inform design.	families.					
Section C: How effectively does the local area improve outcomes for children and young people who have SEND.							
C1: Improve Outcomes	Support schools in the development of an effective graduated approach to the identification of and response for children with additional needs.	Responses to needs better understood and impact demonstrated, supporting effective escalation in support where required.	RS/GC	Sep 17	Jul 18		Action not yet started.
	Review EHC panel process and sign off of plans to ensure SMART actions are in place.	Plans are focussed and SMART.	BC/KQDG	Jun 17	Sep 17		Review underway.
	Review tracking arrangements for 18-25 who are SEND with EHCP in place.	Long term impact of support understood and demonstrated.	GC/BS	Sep 17	Mar 17		Action not yet started.
A2:Reporting Outcomes	Develop service performance framework for tracking service impact.	Performance monitored and driving action.	KQ	Jul 17	Jul 17		Draft performance framework established.
	Review contracting arrangements with schools to ensure clear performance indicators are in place, ensuring Individual Education Plan reviews (3 times per annum) are included in the monitoring requirements of EHCPs, including within school contracts.	Enables evidence of progress to be monitored and early intervention when plans are not meeting planned outcomes.	RS/CM	Mar 17	Jun 17		Process for sharing built into school contracts.
A3: Leaders Assessment	Develop multi-agency strategic group supporting the strategic direction of SEND approaches across the local area.	Partners engaged in the strategic design and decision making of SEND services.	BC/GC	Jun 17	Aug 17		Discussions with head teachers and schools forum on membership underway.
	Introduce SEF and annual conversation process to provide annual scrutiny and inform service direction.	Strengths and weaknesses identified and services commissioned effectively.	KQ	Mar 17	May 17		First service SEF completed, involvement of Children's Trust, Parents and Education in contributing. Annual conversation to be held next year.

- **Ashley Poulton (AP), Bernadette Caffrey (BC), Bob Shore (BS), Claire McArthur (CM), Darrell Griffin (DG), Dawn Kimberly (DK), Fiona Douglas (FD), Gill Curtis (GC), Joanne Tyler (JT), Kevin Quinn (KQ), Lesley Hawkes (LH), Sharon Williams (SW), Suzanne White (SW)**

	Action on target and key milestones met
	Potential risk of delay or missing target
	Off target, milestones not met

Appendix 3

Rutland County Council

Special Educational Needs and Disabilities (SEND) Panel

Terms of Reference

The SEND Panel acts in an advisory capacity for Rutland's decision in the SEND assessment and planning process. Having regard to the SEND Code of Practice 2014 we aim to work together to have a clear and transparent decision making structure.
These terms of reference are designed to be realistic, practical and to promote robust decision making and accountability for the decisions we make in assessing and responding to the needs of children with SEN and disability.

Purpose and Functions of the Panel

- Review each case on an individual basis and reflect on each child's individual needs
- Create a pause to ensure we have considered all the available options and the interests of the child.
- To consider requests from parents and professionals for EHC Needs Assessments
- To consider if an EHC plan is appropriate and should be issued or whether SEN Support provided by a school is applied
- To consider requests to changes in care packages for Children in Need (CiN) with disabilities
- To consider alternative resources for children and young people with SEND to divert the need for an EHCP
- To consider the implications for transport arrangements,

Membership

Core

- Head of Service/ Service Manager (Chair)
- Service Managers EI and SEND
- Service Manager Social Care
- Educational Psychologist
- SEN Senior Practitioner
- SEN Case Officer relevant to the case
- Schools Representative
- Health Representative
- Transport Officer as the need arises
- SEN Operations Office: Minute Taker
- Independent Voice - PCV representative

By request

- Early Years Representative

Panel members and their responsibilities

Panel members are expected to:

- Provide expertise in their own area and offer impartial advice on individual cases
- Use their experience and knowledge to offer views on assessments, outcomes, provision and alternative course of action
- Offer relevant advice about legislation, codes of practice, reforms or priorities
- Advise on the effectiveness of proposed EHC plans, SEND procedures, provision and communication

Frequency
Panel with meet every two weeks to address the business describe above or other related matters.

Confidentiality
Panel members must uphold confidentially in all cases considered at the panel. They should act in accordance with the Data Protection duties of Rutland and Working Together to Safeguard Children.

Chair
The SEND panel will be chaired by the Head of Service or delegated Manager whose role is to ensure all cases are considered fairly and that there is consistency in decision making. When the Head of Service cannot attend, responsibility for this function will be delegated to the Service Manager.

Panel Procedures

- The Professional presenting the case should ensure that the relevant paperwork is completed fully and to a high quality and sets out a clear rationale and sent to SEN Operations Officer 2 days before the panel date.
- SEND Panel members should read the papers prior to the SEND panel
- Cases are considered individually and questions can be asked to clarify where needed or provide alternative courses of action or resource options
- Following the discussion, the Chair will ask for panel members views and a decision will be made or deferred with agreed timescales if further information or action is needed
- The decisions will be recorded
- The decision will be signed by the Chair and passed to the relevant Chief Officers in due course for approval

Declaration of Interests
Panel members are required to declare any personal interests in a case in advance of the Panel discussions. If a Panel member has a personal interest in a case they will be required to leave the meeting for that case and will play no role in the Panel discussions.

Report to Rutland Health and Wellbeing Board

Subject:	**2017-18 - 2018-19 Better Care Fund Programme**
Meeting Date:	**31 May 2017**
Report Author:	**Sandra Taylor**
Presented by:	**Mark Andrews**
Paper for:	**Noting and decision**

1. Introduction

1.1 This report updates Rutland Health and Wellbeing Board (HWB) members on the closure of the 2016-17 Rutland Better Care Fund programme and progress on planning the follow-on Programme for 2017-18 to 2018-19.

2. Recommendation

2.1 The Board is requested to:

2.1.1 Note the budget position, with increased funding available.

2.1.2 Note the position in relation to the new 2017-18 - 2018-19 BCF programme, where national delays have impacted.

2.1.3 Confirm interim approval for the actions in Appendix 1 to continue or proceed, pending national readiness.

2.1.4 Confirm support to review and approve the final BCF plan by correspondence if the eventual timetable does not coincide with a scheduled HWB meeting.

3. Policy framework and context

3.1 The Rutland Better Care Fund is a joint health and social care integration programme managed operationally by the Rutland County Council People Directorate, in conjunction with the East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG) and delivered under the oversight of the Rutland HWB.

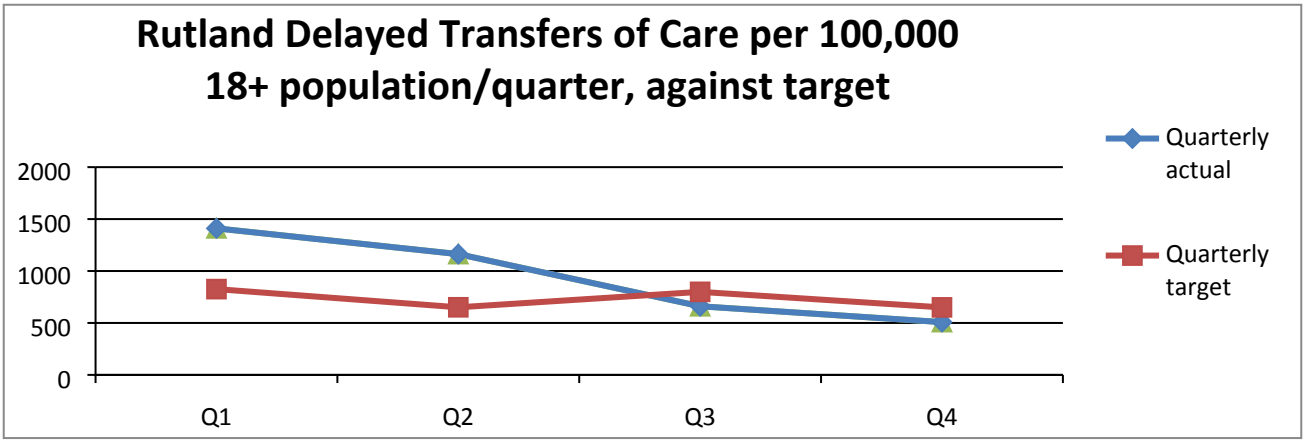
3.2 The 2016-17 Better Care Fund programming period has ended. The programme was delivered successfully, as reported to the HWB in January 2017, also performing well in terms of the national metrics, meeting most of its ambitious targets (see Appendix 2):

- The rate of people entering permanent council funded residential care was 118 per 100,000 65+ population, half last year's level and just a third of the annual target of 355.
- In Q4, 97% of people receiving reablement in Q3 were still at home 91 days after hospital discharge, against a target of 83.3%.
- Emergency admissions reduced by 2% relative to 2015-16 and met the annual target.

- Injuries due to falls fell by 9% relative to 2015-16 and met the annual target.

- Some 91.4% of service users confirmed that care and support services helped them have a better quality of life. This was an improvement over 2015-16's rate of 87%, but did not quite reach the very high target of 93.1%.

3.3 Delayed transfers of care (DTOC) was the most challenging indicator. After a difficult start to the year for hospital discharge delays, the level of delayed transfers of care was driven down quarter on quarter through a concerted focus on process and system improvement, until Q3 and Q4 levels were not only on target, but seeing levels of performance as good as the average rates in the two best performing regions of the country, London and the North East. Although the local annual target was not in the end met, the level of ambition of the target motivated rapid, robust improvements to discharge processes which we anticipate will be sustained into the next programming period, to the benefit of both patients and the wider health and care system.



3.4 Some actions in the programme took longer to be implemented than anticipated. The resulting carry forward (£277k on plans totalling £2.447m) will be reinvested in health and care improvement in the next programme, much of it targeting further reductions to non-elective admissions, which should also help to reduce the number of patients needing discharge support.

4. Funding available for 2017-18 to 2018-19

4.1 Overall funding available for Better Care activity in 2017-18 - 2018-19 is set out in the below table and now consists of five elements:

- **Better Care Fund.** Exact sums are still to be confirmed, but anticipated to equal last year's amount (£2.061m) plus an almost 2% increment each year for inflation. Set amounts of this budget (sums to be confirmed) must continue to be spent on social care and out of hospital services.
- **Disabled Facilities Grant.** Capital funding for home adaptations, confirmed as £203k for 2017-18, up from £186k in 2016-17.
- **Improved Better Care Fund (i-BCF**). This budget, with allocations across three years (£203k, £168k then £77k), was announced in the 2017 Spring Budget and is intended for social care, although channelled through the BCF mechanism. It must not substitute any of the social care minimum allocation required under the main

BCF budget.

- **Underspend from 2016-17 of £277k.** This sum will be focussed towards interventions with potential to reduce non elective admissions as this is anticipated to bring sustainable savings to the local health economy.
- **A voluntary additional contribution to the BCF by the Council of £136k.** This one-off social care grant payment from government will fund a pilot of a new model of homecare, providing additional capacity to the community based health and care system.

Better Care Fund funding components	Reference: 2016-17	2017-18	2018-19	Conditions on use of the funding
Core BCF	£2,061k	c£2,061k	c£2,061k	Complying with the BCF policy framework. Will largely be used to continue successful 2016-17 activity.
Disabled Facilities Grant	£186k	£203k	TBC	Capital grant. Use must comply with DFG legislation.
i-BCF (Spring budget 2017, social care relief)	-	£203k	£168k	Draft grant conditions state the funding is: "to quickly provide stability and extra capacity in local care systems." This includes reducing DTOCs.
Social care one-off grant	-	£136k		Must be spent on social care.
2016-17 BCF underspend, carried over	-	£277k		Local agreement, March Partnership Board (RCC/ ELRCCG): to be focussed towards investments aiming to reduce ELRCCG costs, notably associated with the number and duration of hospital admissions.

5. 2017-18 to 2018-19 programmes: Strategic and policy context

5.1 Publication of the BCF planning framework and budget for 2017-18 to 2018-19 remains significantly delayed, currently as a result of the national election. In the interim, BCF areas have been asked to proceed with planning their new programmes based on the policy framework and with reference to a number of draft planning documents released to BCF programmes on an informal basis in May 2017 by the LGA.

5.2 They have also been asked to proceed as soon as possible to spend the Improved Better Care Fund (i-BCF) allocations, which have already started to be distributed, particularly where this will ease pressure on capacity in acute health care.

5.3 To support early spend of the i-BCF, and in readiness for when the final guidance and planning templates are published, an updated strategy and spending plan have been drafted for the 2017-18 - 2018-19 period.

5.4 The outline spending plans have been reviewed and agreed in principle by the

following:

- the Portfolio holder for Health and Care and Leader of the Council,
- the Section 75 Partnership Board (consisting of the plan's funders, ELRCCG and RCC),
- the Rutland Integration Executive,
- the LLR AE Delivery Board, where the proposals were presented in April and "very well received", leading to confirmation on 27 April 2017 that "LLR AEDB is happy for the additional investment to be used as proposed"… and …"to see if some aspects could be replicated …if they are successful".

5.5 A positive assurance meeting has also been held with the NHS England East Midlands BCF lead, Wendy Hoult.

5.6 Approval in principle of the outline plans set out below is also sought from the Rutland Health and Wellbeing Board.

6. Renewing the Rutland BCF plan

6.1 The provisional BCF plan has been defined relative to a number of reference points:

- Formal guidance and requirements
  - The published BCF policy framework and draft planning documents released to Local Authorities by the LGA.
- The local strategic framework
  - The Leicester, Leicestershire and Rutland Sustainability and Transformation Plan (LLR STP) and its relevant workstrands eg. around the Integrated Locality Team model, Prevention, Home First hospital at home and Vanguard approaches to management of urgent care demand.
  - The Rutland Health and Wellbeing Board strategy, the ELRCCG Operating Plan and the RCC Adult Social Care strategy.
- Local reference points
  - The evolving Rutland context, including up to date data about patterns of health and care need and use of available health and care services (notably analysis of hospital episode data).
  - Partnership-based in-house evaluation of the 2016-17 BCF programme, including its performance against key metrics.
  - Involvement of local partners in shaping proposals and in agreeing the approach.
  - Relevant local factors including the decision of Rutland GP practices to develop a 'Primary Care Home' model of care in Rutland, and proposals to develop integrated health and social care facilities under the One Public Estate banner.
- Good practice frameworks

- Wider studies reviewing best practice in health and social care improvement, both in the UK and wider, including the Nuffield Trust review of the effectiveness of different care initiatives (Shifting the Balance of Care – Great Expectations,(2017)).
- Better Care Fund technical assistance guidance and case studies.
- The High Impact Change Model for Managing Transfers of Care, which was already used to shape the 2016-17 Delayed Trandsfers of Care Action Plan.

6.2 There has been consensus across the Partnership around sustaining the ambition of Rutland's existing BCF programme objective, aiming to achieve a well-integrated and well-understood health and care system by 2018:

> "By 2018 there will be an integrated social and health care service in Rutland that is **well understood** by users and providers and **used appropriately**, has **reduced the demand for hospital services** and **puts prevention and self-management at its heart**, including by building on existing community assets.
>
> Beyond 2018, integrated working, iterative system improvement and personalised care will be the norm, in a more sustainable system that improves outcomes for patients and service users."

6.3 As reported to the HWB in January 2017, the 2016-17 programme evaluation, undertaken with BCF partners, confirmed the overall wisdom of sustaining the actions contained in the 2016-17 programme, with scope for adjustment or reorganisation where this was likely to improve potential outcomes (eg. transitioning some dementia care to a more specialist Admiral Nurse post, reallocating parts of measures to improve visibility or synergies). Therefore, the draft programme proposes strong continuity, remaining structured into four priorities as follows, shown with 2017-18 indicative budgets.

6.4 Meanwhile, the additional sums that have become available since the January 2017 HWB meeting offer the opportunity to support a number of new activities developing the next phase of health and care integration at pace, particularly around health and care services supporting the population who already have impaired health and are the most likely to call on health and care services.

Priority	**Indicative funding allocations, 2017-18 (For full 2017-18 - 2018-19 breakdown, see Appendix 3)**					
	Core BCF	**DFG**	**i-BCF**	**ASC one off**	**2016-17 carry-over**	**Total**
1. Unified prevention	£227k		£58k		£116k	**£401k**
2. Holistic health and wellbeing in the community (Long Term Condition management)	£808k	£203k	£76k	£136k	£43k	**£1,266k**
3. Hospital flows	£936k		£26k		£20k	**£982k**
4. Enablers	£73k		£43k		£22k	**£138k**

6.5 The measures to be supported under each of the four priorities are set out in Appendix 1.

6.6 The Health and Wellbeing Board are asked to confirm their support for the planned actions to proceed or continue, and for the new programme, when finalised, to be reviewed and approved by the most practical method at the time. The timing of this is dependent on progress nationally.

7. Financial implications

See above.

8. Recommendations

8.1 That the Health and Wellbeing Board:

1. Note the position in terms of renewing the 2017-18 - 2018-19 BCF programme, and note the proposed actions to be funded.
2. Confirm their support for the planned actions to proceed.
3. Confirm their support to approve the final plan by correspondence when this becomes possible, if the timing does not coincide with a scheduled HWB meeting.

9. Risk assessment

Time	M	Owing to national delays, a pragmatic approach is being taken nationally in which areas are continuing BCF actions from 2016-17, with additional actions being approved to proceed as soon as possible through local governance. The key priority here is to ensure the i-BCF can start to relieve budget pressure on Adult Social Care and acute services. Groundwork has been done such that it will be possible to finalise the BCF plan rapidly when the final guidance and planning framework are issued by government. Submissions will be due 5-6 weeks after guidance is issued.
Viability	L	The 2017-18 - 2018-19 BCF programme builds on the positive partnership and progress made in health and social care integration in Rutland since 2014. Most of the proposed measures continue 2016-17 activities, ensuring that the programme will sustain momentum in spite of the delayed renewal process resulting from national delays.

		Groundwork has been done for key new proposals, such as the holistic homecare service to help to ensure rapid start-up.
Finance	M	In the absence of an approved programme for 2017-18 - 2018-19, 2016-17 BCF funded activities have been continued into the new financial year, effectively relying on previous approval and local evaluation evidence that they are worthwhile to continue. We have been assured by national Better Care contacts that this approach is reasonable and acceptable in the face of national delays. In parallel, areas have been encouraged to confirm early agreement locally around planned actions, both for core BCF activity and, urgently, for i-BCF actions aiming to relieve pressure on social care and health services. The financial risk is considered low if the HWB is supportive of the proposals put forward. We anticipate that actions approved to progress will contribute to relieving local health and care budget pressures. Given this year's delays to BCF announcements, to avoid high underspends, any new funding has been programmed into the BCF plan with budgets only to cover the remaining 3 quarters of this year.
Profile	L	The programme has a high profile at national, regional and local level and is well integrated as a complementary part of Leicester, Leicestershire and Rutland Better Care Together activity. The HWB will hold both RCC and ELRCCG to account for the delivery of the BCF.
Equality & Diversity	L	The BCF plan will have a positive impact on members of the Rutland community requiring health, care and wellbeing services and opportunities.

Appendix 1: Summary of proposed Rutland BCF priorities 2017-18 - 2018-19

1. Priority 1: Unified Prevention

Progress to date

1.1 The strong focus on prevention, aiming to keep people well, active and engaged in their communities, has been a distinctive aspect of Rutland's BCF programme, recognised by the national NHS England Better Care Fund Programme.

1.2 Many Rutland residents have benefitted from the diverse BCF prevention measures (including assistive technology, falls prevention schemes and support from the Community Agents on life issues). New activities such as the Men in Sheds project at the museum and telephone befriending (also as a follow-on to Community Agent support), were also welcomed, including for their anticipated contribution to mental wellbeing and social connection.

1.3 Disabled Facilities Grants (DFGs) for home adaptations continue to be delivered to help people to remain living at home and support their independence and quality of life, with most projects involving the installation of adapted bathrooms, stairlifts, ramps and/or ceiling hoists.

1.4 At the same time, there is a need to ensure that services are modelled sustainably and are not over-fragmented, intervene earlier to be truly preventative and reach as many potential beneficiaries as possible.

1.5 It is proposed to sustain the relative prominence of prevention measures under Priority 1. This is in recognition of the importance of intervening earlier to help extend healthy life expectancy and thereby reduce demand on the health and care system in the longer term. Local commitment to this principle is reflected in the current Rutland Health and Wellbeing Board strategy.

- Providers of prevention-related services suggested that they would like to work more closely to better support potential synergies – enabling communication, coordination and connection. Therefore, improving coordination across and between available services and providers and proactively promoting services to the public remain key priorities.
- Also important is the provision of services supporting individuals to help themselves and to tackle issues early which could otherwise have a greater impact on their health and wellbeing (Community Prevention and Wellbeing Services and the pilot GP based Wellness Advisors).
- Alongside the more mainstream community outreach services supporting members of the public, i-BCF funding will be used to fund two specialist social care posts who will work with 'hard to reach' individuals considered to be at risk of harm. This is part of the Vulnerable Adult Risk Management (VARM) safeguarding response in Rutland and aims to enable social care to intervene much earlier to support people considered to be at risk but who do not yet have eligible social care needs. The aim is to prevent later deterioration and crisis which can be harmful to the individual, and is complex and resource intensive to manage.

- As physical activity and social connectedness are increasingly recognised as the lynchpins for continued good health, there will be scope to support more activities enabling more people to become more active and to connect socially, including addressing some of the barriers to activity and building on local community assets. This is anticipated to contribute to mental and physical wellbeing and to healthy life expectancy.
- Falls prevention activities delivered well in 2016-17, as reflected in reduced falls injuries, but were somewhat fragmented. A more strategic approach is being pursued, including opting into new LLR wide falls prevention services.

Priority 1: Summary of 2017-18 - 2018-19 Measures

Priority 1: Unified prevention		**Lead**	**2017-18**	**2018-19**
1.1 Communication and coordination Continuing and broadened	A. **Enhance the Rutland Information Service (RIS) online directory of local services** for consistent and reliable prevention signposting. B. **Establish a network of prevention-related organisations** to coordinate services and enhance prevention capabilities. C. **Developing community capacity**, including via the Community Wellness and Prevention contract, building on existing community assets.	RCC (carry over)	£26k	£0k
1.2 Prevention and Wellbeing Services Continuing and broadened	**Support for early prevention:** • **Community Wellness and Prevention Services** including the Community Agents. • **Wellbeing Advisors** at the GP surgery. • **Adult Social Care early prevention service** targeting hard to reach people at risk (in the Vulnerable Adults Risk Management framework).	RCC ELRCCG (carry over) RCC (i-BCF)	£147k £90k £77k	£147k TBC £77k
1.3 Active and connected	**Raising healthy life expectancy by increasing activity levels and social connectedness.** Targeting barriers to people	RCC	£80k	£80k

Refocussed. Assistive tech and DFGs moved to Priority 2.	becoming and staying active and involved, including: • Awareness and availability of suitable opportunities. • Motivation. • Physical and psychological access barriers. Falls prevention remains a focus, coordinating local activities with the wider LLR falls prevention strategy.			

2. Priority 2: Holistic health and wellbeing in the community

2.1 Work with people with ongoing health issues was felt to be going in the right direction in 2016-17, as reflected in key BCF indicators, including a year on year reduction to emergency admission rates and the maintenance of low levels of permanent care home admissions.

2.2 Building on this foundation, long term condition management is the main focus for innovation in 2017-18. Priority 2 will progress the next stage of reshaping health and care services in Rutland, prioritising holistic, person-centred care models that help to maintain wellbeing, independence and quality of life for those with significant health and care needs. This will bring about an increase in self care and bring about further integration across primary, community and social care.

2.3 Improved management of the health of complex patients could be the most powerful means to delay or minimise the impact of illness, reducing the number of non elective admissions and overall demand on the health and care system.

2.4 Numbers of people with one or more long term conditions are growing as the population ages and life expectancy increases, with growing numbers having complex and variable health and care needs. This has a significant impact on those individuals, who may experience disjoints between the many different elements of care they receive and who may not feel 'in the driving seat' in terms of their own care and wellbeing. It also places significant demands on local health and care systems.

2.5 The 2016-17 programme invested significantly in building up effective working relationships between teams supporting people in the community with long term conditions, including through collocation and leadership development. It also funded a number of new or ongoing schemes that form a toolkit of tailored support to people with ongoing health issues (dementia support, carers' support, and, under the Prevention heading, assistive technology and Disabled Facilities Grants). These activities will be sustained and further evolved. In particular, the discretionary scope of adaptations that can be funded under the DFG scheme has been more clearly defined via a DFG

policy so that the funding can increase or sustain the independence of more individuals.

2.6 Alongside this, additional one-off funding for 2017-18 – 2018-19 has allowed a number of further ambitious schemes to be developed that could deliver a step change in the care of people with complex needs. These aim to improve the coordination and coherence of care and to increase the involvement of patients in their own care, improving quality of life, avoiding crisis and reducing the need for hospital admissions.

2.7 Two projects are proposed responding to the call to increase self care promoted by National Voices and underlined in the 2017-19 BCF Policy Framework. They recognise the strong potential of self care for delivering tangible improvements in care, as reflected in the March 2017 Nuffield Trust review of the effectiveness of potential interventions 'Shifting the balance of care':

- A pilot project funded by carry-over funds will introduce a personalised care planning toolkit into primary care including self care tools for patients who want to take a greater role in tracking and maintaining their own health and wellbeing. It is anticipated that personalised 'whole person' care and improved self management will improve patient wellbeing and reduce GP demand, enabling GPs to manage their patients by exception. It will also improve the flow of information enabling other involved care providers to work together in a coherent way with the patient. This toolkit has wider potential if successful, eg. being used to support the monitoring of care home residents or to encourage people who could benefit from lifestyle changes.
- The rate of personal social care budgets will also be enhanced to encourage more people to shape their own personalised care packages, meeting needs in ways unique to them (via i-BCF).

2.8 For those with significant care needs who continue to live at home, a new holistic model of homecare will be piloted in which more highly skilled homecare assistants work in stable area-based teams, building relationships with their clients and undertaking a broader set of tasks, including some routine healthcare. This is anticipated to improve the user experience of care, to be more efficient and responsive to demand and to improve the ability to maintain wellbeing and prevent avoidable deterioration leading to emergency admissions. It also has the potential to support end of life care choices.

2.9 Alongside this, primary, community and social care services will continue to find new ways to work closer, aiming to streamline and consolidate care roles and services, reducing duplication while improving the coherence and effectiveness of care.

2.10 In parallel, there will be work to support the wellbeing of residential and nursing home residents, for example through pre-emptive therapies avoiding falls, also drawing on lessons learned from LLR Integrated Locality Team pilot projects.

Priority 2: Summary of Measures

Priority 2: Holistic health and care services		Lead and source	2017-18	2018-19
2.1 Integrated health and care services Merges 2 pre-existing measures (integrated community care, care coordinator) .	**Further integrate local community, social and primary care services,** particularly benefitting people with long term conditions, frailty and complex needs. Mechanisms to include: Integrated Care Coordinator, and multidisciplinary coordination of care.	RCC BCF ELRCCG BCF	£153k £405k	£153k £405k
2.2 Self care New	A. **Individuals empowered to play a greater role in maintaining their wellbeing** and to be at the centre of their care, through personalised care planning at the GP, supported by an online self care toolkit. B. **Encouraging take up of personal budgets for social care** through increased funding. Bringing forward a change already factored into the mainstream 2018-19 ASC budget.	BCF carry over RCC i-BCF	£43k £70k	£43k -
2.3 Holistic homecare New	**'Whole person' model of domiciliary care** which prioritises relationships and continuity and is responsive to the evolving wishes and needs of individuals. Funding for a pilot of the new approach and transition to 'business as usual' if successful.	RCC (ASC grant and i-BCF)	£142k	-
2.4 Health and wellbeing in care homes New	**Supporting care homes in the management of complex and frail residents**, including via pre-emptive therapy to prevent falls, assistive technology, etc.	£TBC	£TBC	

2.5 Support services sustaining wellbeing and independence Continuing schemes, reconfigured as a 'toolkit' or menu of support options	**Support helping individuals living with long term conditions and their carers to sustain wellbeing and independence**: • Dementia care • Carers support, including respite • Disabled Facilities Grants • Assistive Technology • Falls prevention interventions for people who have already fallen	 RCC RCC DFG RCC RCC	 £100k £85k £203k £65k £TBC	 £100k £85k £203k £65k £TBC

3. Priority 3: Hospital flows – crisis response, reablement and transfers of care

3.1 The focus of the Crisis Response, Transfer of Care and Reablement priority is on managing and reducing demand for hospital services.

3.2 Investment in 7 day crisis response services will continue in 2017-18 - 2018-19, with revised services currently being put in place across the LLR area, reflecting learning from the previous two years. There will also be further work to review the prevention and management of crisis, for example working with care homes.

3.3 The 2016-17 programme already allocated significant resources to reducing delayed transfers of care (DTOCs). The model developed then refined delivered progressive improvements across 2016-17, reflected in quarter on quarter reductions in DTOCs, until Rutland DTOC levels have come consistently within the very ambitious targets set. It is proposed that the approaches developed should be sustained into 2016-17, and further improvements progressed, eg. earlier engagement for people being admitted for planned care.

3.4 Partners will continue to work iteratively, informed by data, to identify and address issues and disjoints in transfer of care processes so that discharge delays, and their impact on patients and the wider health care system, are reduced to a minimum.

3.5 Proposed improvements are largely around working to accelerate the discharge of planned care patients by starting preparations for their discharge before they are admitted (anticipating their post-treatment needs, optimising their resilience through pre-operative therapies, arranging equipment, etc).

3.6 We also propose to review step up step down arrangements to explore whether the use of virtual wards could be increased. For example, through clinical agreement in defined circumstances, patients could be transferred

sooner from acute hospitals to the local virtual ward offer to continue their treatment, avoiding protracted hospital stays.

3.7 Reablement services have been successfully ensuring that patients discharged from hospital are not readmitted and this service will be continued and further evolved.

Priority 3: Hospital flows		**Lead and source**	**2017-18**	**2018-19**
3.1 Integrated urgent response Continuing and broadened	Continuing 7 day crisis response services. Broadened to consider whether there is further potential to reduce 'just in case' hospital admissions (eg. care home support, virtual ward step up)	RCC BCF ELRCCG BCF BCF carry over	£125k £115k £20k	£125k £115k £20k
3.2 Transfer of care and reablement Continuing, with ongoing rapid cycles of change	Continuing the effective arrangements already in place for reablement and transfers of care. Implementing a further DTOC Action Plan (Appendix 3) to further raise the maturity of the system. Addition of a technical instructor role to work with planned care patients pre-admission. (Would also support 2.4 care home pre-emptive reablement)	RCC BCF ELRCCG BCF RCC i-BCF	£561k £135k £26k	£561k £135k £35k

4. Priority 4: Enablers

4.1 A broad range of enabling activities provided inputs that enriched and improved the effectiveness of the 2016-17 programme.

4.2 There is now a clear, prioritised work programme for IT and IG, firmly linked to the LLR IT roadmap and more of the technical and governance related building blocks for integration are in place.

4.3 IT projects are being progressed to support integrated working, notably the joint laptop solution delivered in early 2017.

4.4 Data has been more central to shaping policy responses and we have increased our involvement in wider projects and toolsets able to support evidence based change, including the PI Care and Health Trak system.

4.5 User engagement in shaping services has been strengthened, notably through the HealthWatch project listening to service user experiences of transfers of care.

4.6 It is proposed that the funding for programme management and analytics should be continued, with support for an updated set of complementary enablers activities supporting the 2017-18 - 2018-19 proposals, including:

- Funding to improve the IT equipment and systems available to mobile social care and community health staff who work directly with service users, enabling them to collect information and transact in more efficient ways and to involve the individuals they are working with more effectively in defining their needs and shaping their care (enabled by i-BCF and 2016-17 carry over funding).
- Funding to build on the 'Transfers of care user engagement project' undertaken in 2016-17, for example to understand the experiences of people with complex care needs, so that services can be shaped in ways that are more customer focussed.

Priority 4: Enablers		**Lead and source**	**2017-18**	**2018-19**

4.1 Enablers
 	
Continuing.
 	
Activity tailored to current integration needs
	Programme management and analytics supporting evidence based change, plus a number of further areas of activity.
	• Improved IT hardware for mobile working
	• Integration between IT systems
	  ○ Single trusted assessment for community health and social care
	  ○ Access to the GP Summary Care Record for community health and social care
	• Information Governance assurance and data sharing arrangements supporting integrated working
	• Research into the user experience of new services and approaches
	• Provider engagement and workforce development supporting new models of care
		RCC BCF
		
		RCC i-BCF 2016-17 carry-over
		
		£10k
			£73k
			
			£33k
			£22k
			
			£14k
				£73k

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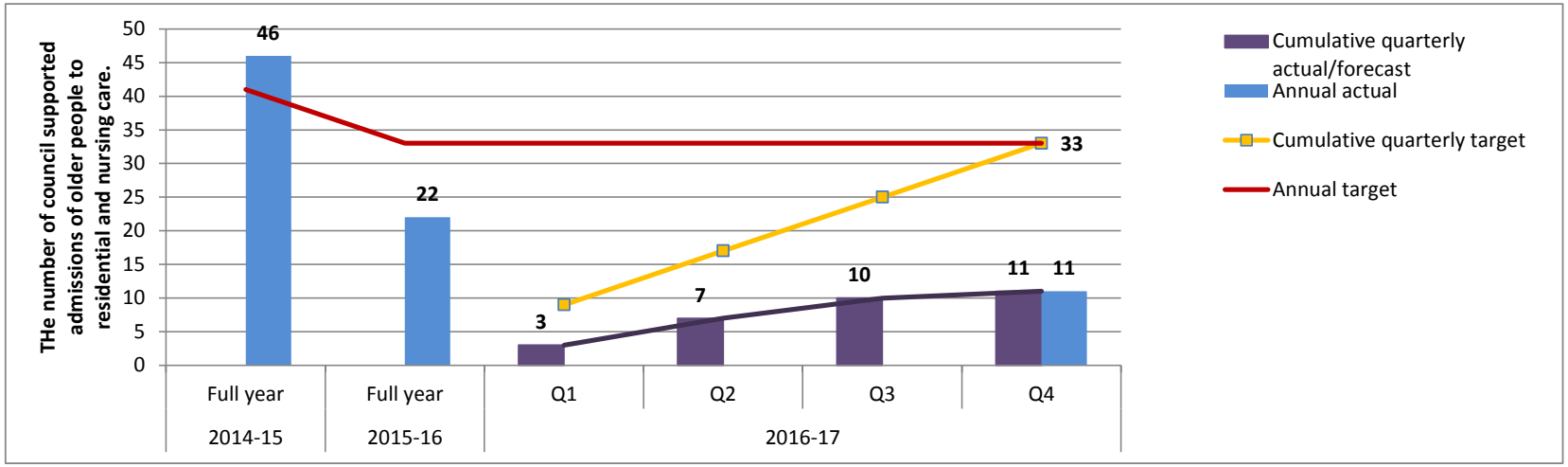
Metric 1 - Residential Admissions

GREEN: Well established good performance against this metric continued across 2016-17, with just 11 people permanently entering Council funded residential or nursing care across Q1-Q4, just 33% of the target ceiling of 33 by the end of the year, and half the number of people admitted in 2015-16.
This equates to a rate of 118 per 100,000 65 and over popoulation for the year, against a target of 355.

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes



Outcome Sought:
Reducing inappropriate admissions of older people (65+) in to residential care

Rationale:
Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care.

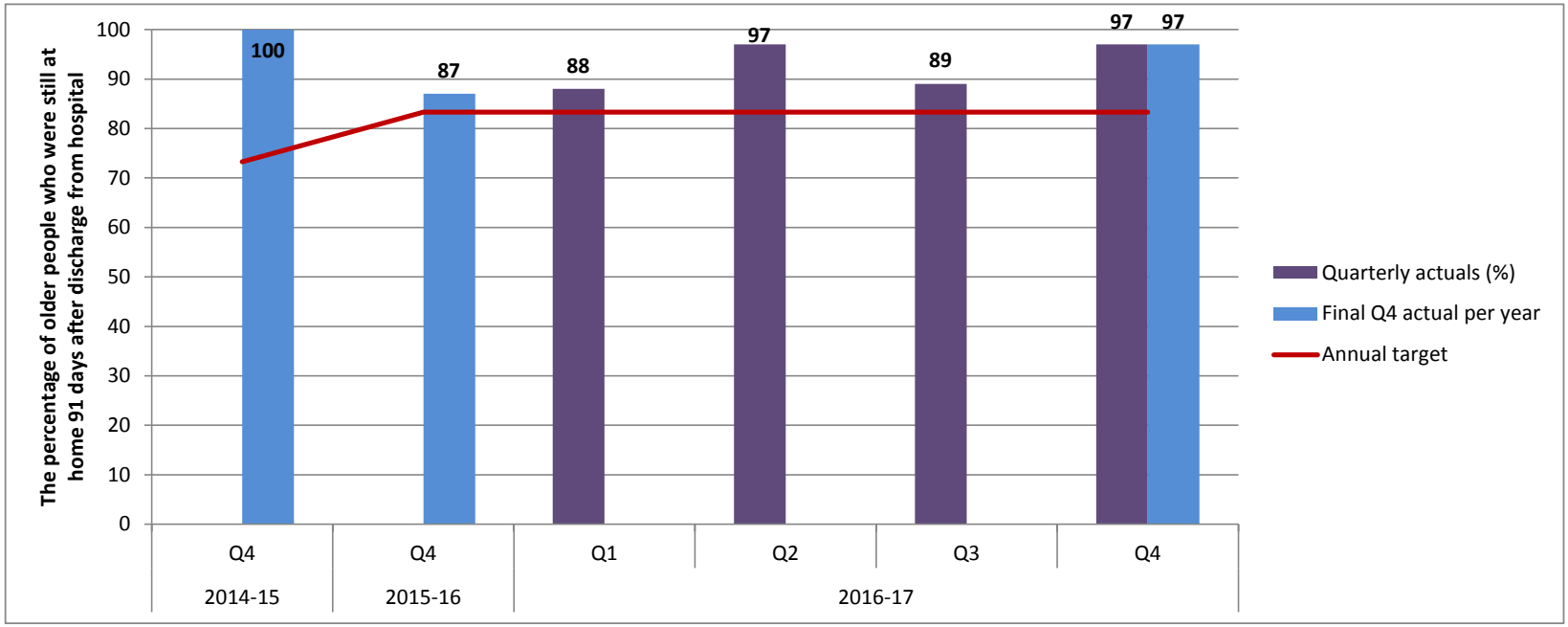
Definition:
The number of council-supported permanent admissions of older people to residential and nursing care, excluding transfers between residential and nursing care (aged 65 and over).

Reporting Schedule:
Metric will be reported quarterly. Q1 update early Aug 2017.

Metric 2 - Reablement

GREEN: The pattern of people receiving reablement services and remaining at home 91 days after discharge remained consistently above the target of 83.3%, across the year. **Formal final BCF reporting is based on Q4 performance, when 97% of recipients were still at home 91 days after discharge into reablement services, 13.7% above target.** The average rate of success across the year was 93%.

Percentage of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
NB: Q4 data forms the official annual return



Outcome Sought:
Increase in effectiveness of these services whilst ensuring that those offered service does not decrease

Rationale:
Improving the effectiveness of these services is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal

Definition:

This measures the number of older people aged 65 and over discharged to their own home or to a residential or nursing care home during a 3 month period (October-December), who are at home or in extra care housing or an adult placement scheme setting three months (91 days) after the date of their discharge from hospital as a percentage of all those who were offered rehabilitation services following discharge from hospital.

Reporting Schedule:

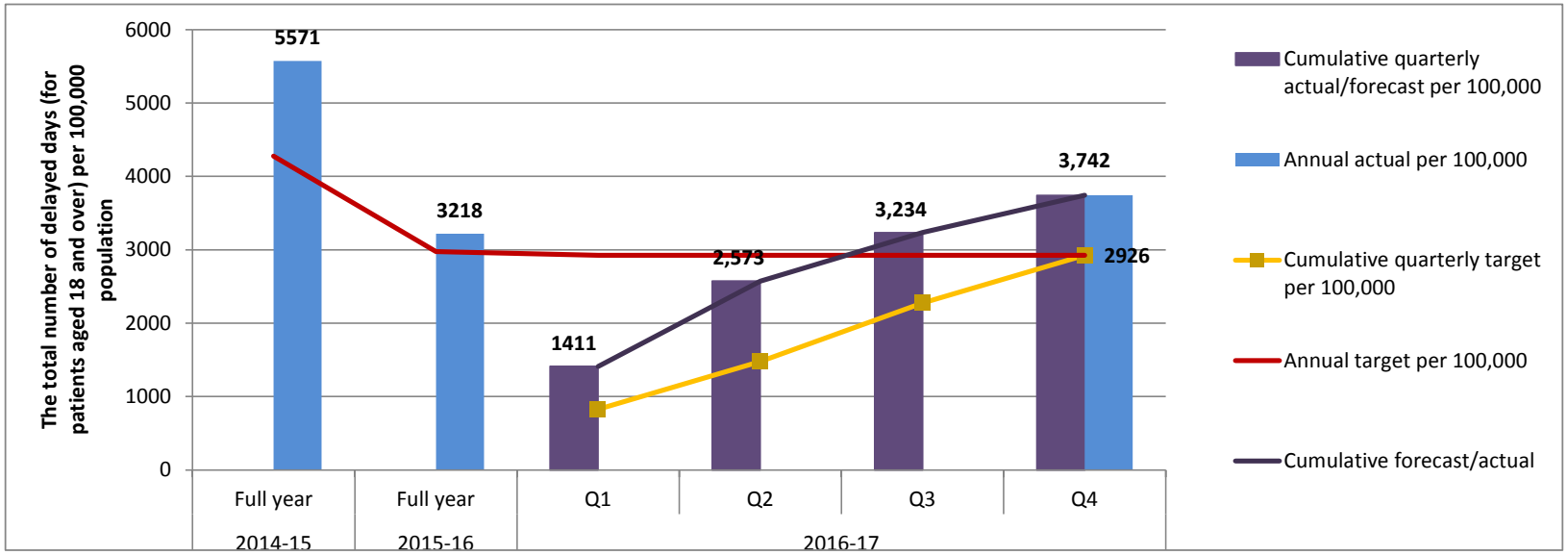
Formally, the metric is updated annually. The number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital is collected **1st October to 31st December** for the relevant year. Same individuals are then checked 91 days later (i.e. January to March). Next formal update March 2018.

Local quarterly updates are calculated alongside this. Q1 update early Aug 2017.

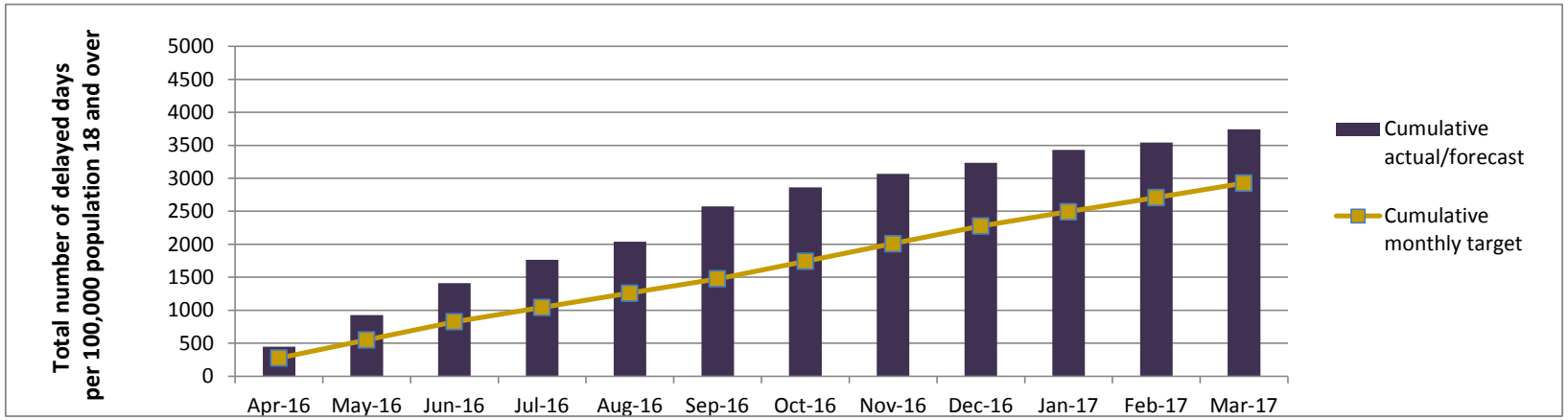
Metric 3 - Delayed Transfers of Care

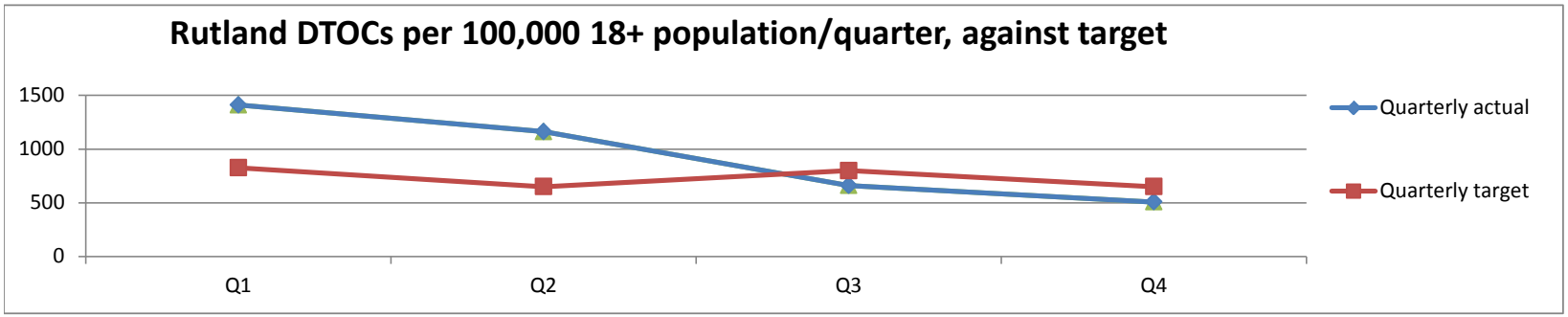
AMBER on the overall year's performance, as the very ambitious target set by Rutland for total DTOCs was exceeded, BUT GREEN for Q3 and Q4 when DTOC rates have been brought below the target ceiling and sustained there. Following a difficult start to the year, DTOC rates were brought down quarter on quarter across the year, until they are now running at the average rates achieved by the two best performing areas nationally (London and the North East). Continuing proactive management of DTOCs through successive rounds of process and system improvement has delivered strong results. In September 2016, it was predicted that the year's outturn would be 174% of the annual target, whereas by year end, this had reduced to 128% - still over target for the year overall, but markedly less so. In addition to the performance charts below, month by month DTOC detail is available on the sheet 'Additional Tables - DTOCs'.

Delayed transfers of care (delayed days) from hospital (aged 18+), per 100,000 population - performance by quarter



Delayed transfers of care (delayed days) from hospital (aged 18+), per 100,000 population - performance by month





Outcome Sought:
Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.

Rationale:
This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.

Definition:
Delayed transfer of care per 100,000 population per month.

Reporting Schedule:
Full Q1 data available mid Aug 2017.

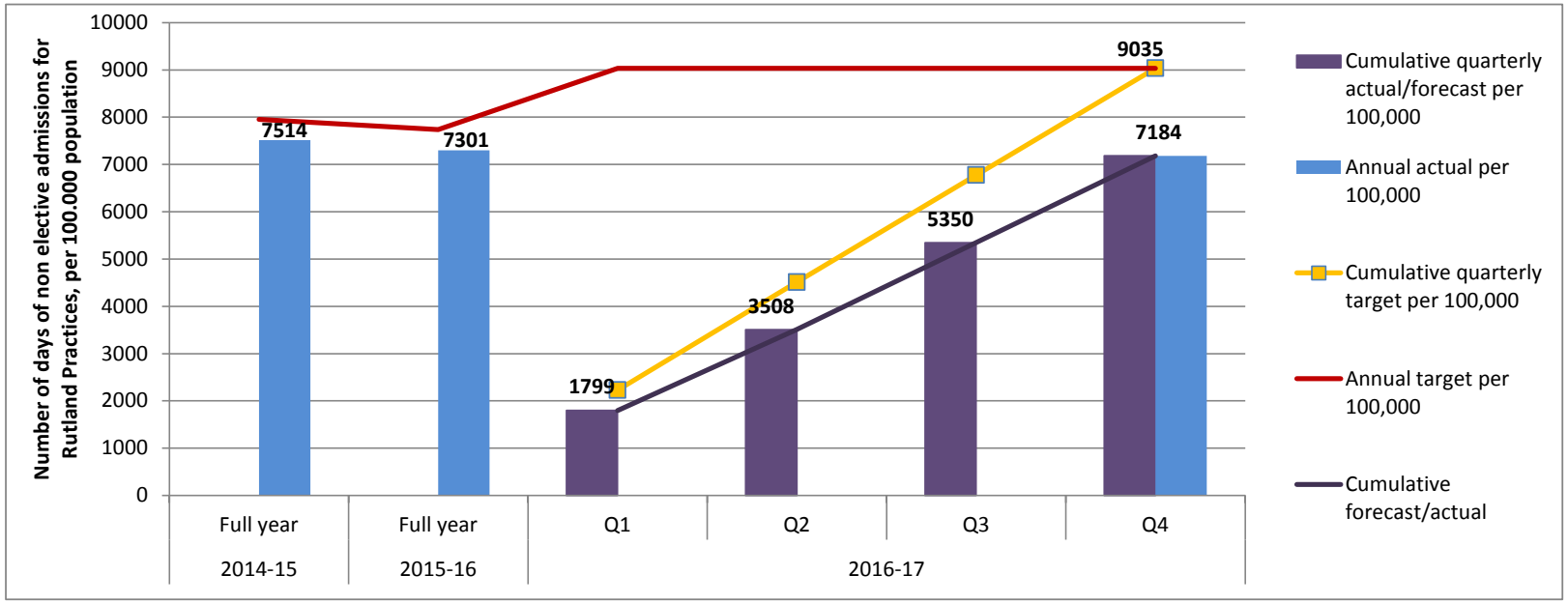
Metric 4 - Non-Elective admissions (general and acute) - Risk share associated metric

GREEN: Rutland both met its annual target for non elective admissions in 2016-17 and had fewer non elective admissions in 2016-17 than in the two previous years. Across the year, Rutland saw 7,184 days of emergency admissions per 100,000 18+ population, relative to a target for the year of 9,035 (a variance of -1851). There were 117 fewer nights per 100,000 18+ population than in 2015-16.

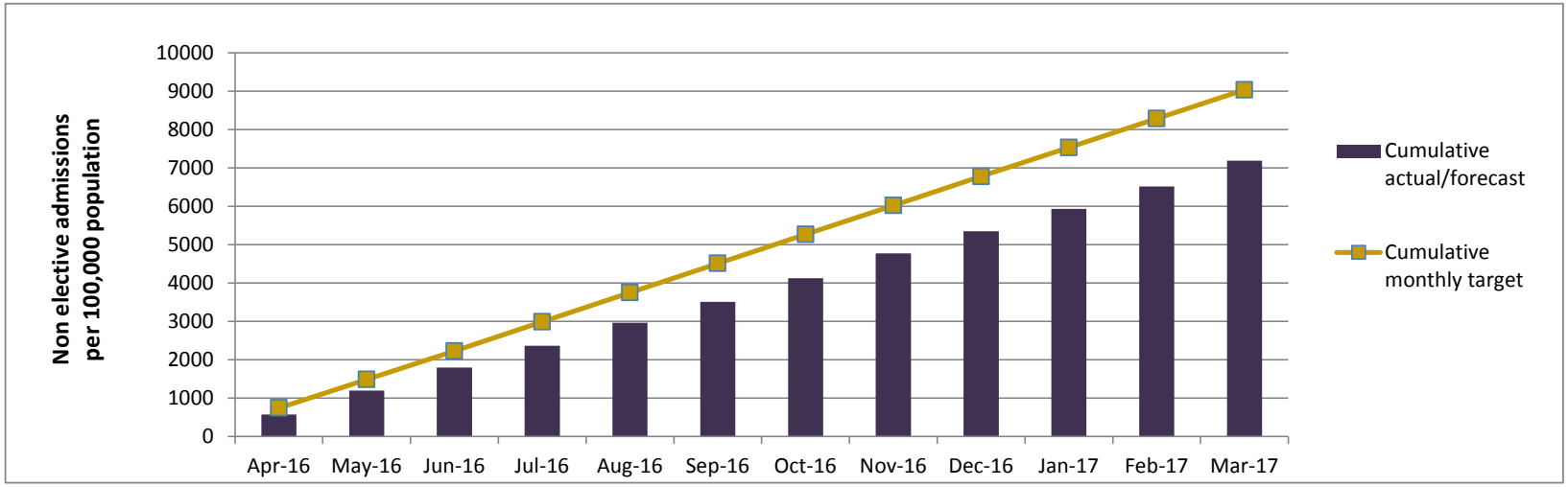
Active work continues locally to manage health and social care services in ways that help to avoid hospital admissions wherever possible and actions are being identified to further strengthen admissions prevention in the next BCF programme.

NB: The data has changed slightly relative to previous reports due to a change in calculation method arising from the change of Commissioning Support Unit. In this case, it has marginally reduced admissions, improving reported performance.

Total non-elective admissions in to hospital (general and acute), all ages. Per 100,000 population - quarterly



Total non-elective admissions in to hospital (general and acute), all ages. Per 100,000 population - monthly



Outcome sought:
Reduce non-elective admissions which can be influenced by effective collaboration across the health and care system

Rationale:
Good management of long term conditions requires effective collaboration across the health and care system to support people in managing conditions and to promote swift recovery and reablement after acute illness. There should be shared responsibility across the system so that all parts of the health and care system improve the quality of care and reduce the frequency and necessity for non-elective admissions

Definition:

Non-Elective admission data are derived from the Monthly Activity Return, which is collected from the NHS. It is collected by providers (both NHS and IS) who provide the data broken down by Commissioner.

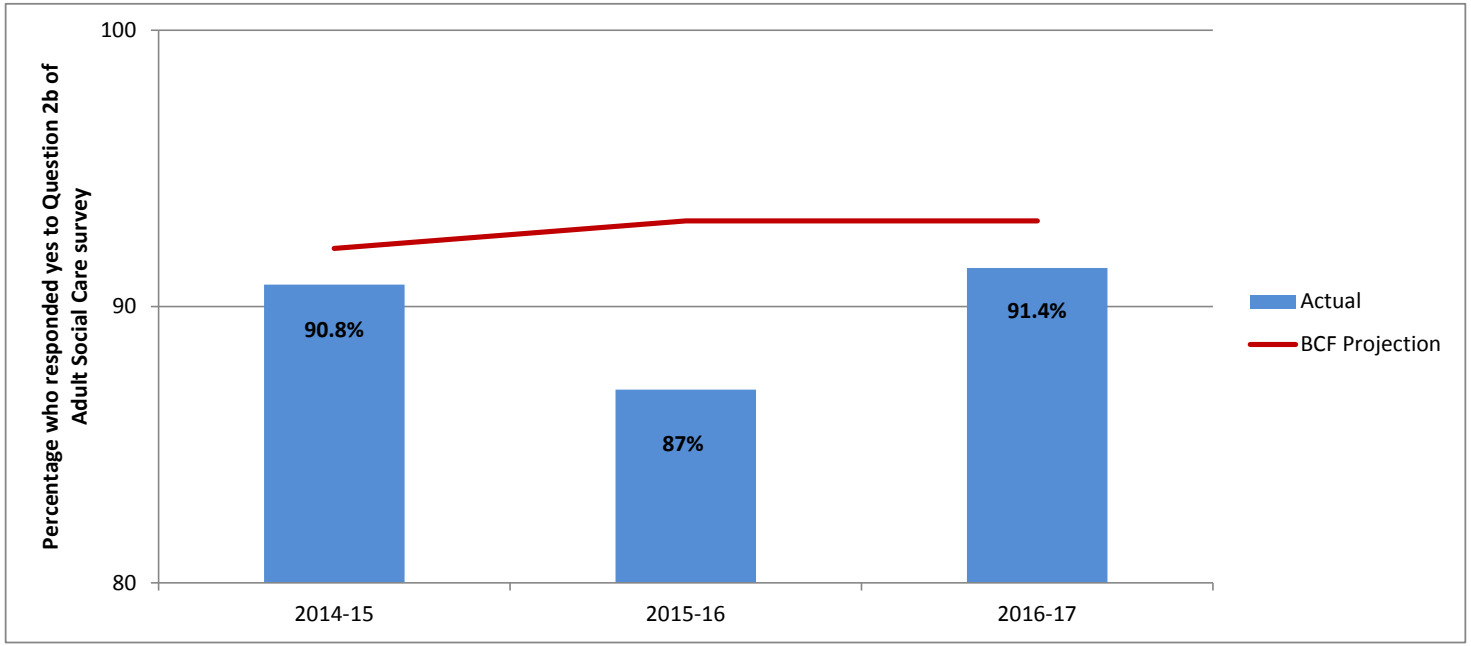
Reporting Schedule:
Updated quarterly from non elective admission statistics for Rutland practices supplied by GEM CSU (Greater East Midlands Commissioning Support Unit). Next quarter available Aug 2017.

Metric 5 - Patient/Service User Experience

AMBER: The unvalidated data for 2016-17 indicates that 91.4% of respondents agreed that care and suport services helped them to have a better quality of life. Although this figure falls slightly short of a very challenging target (93.1%) it is the highest figure achieved over the last three years (90.8% in 2014/15 and 84% in 2015-16). Further analysis will be undertaken once national data is published to benchmark the figure and trend both nationally and in other, similar areas.

The Council will also continue to look at ways to learn more about user experience and user satisfaction in 2017-18.

Do care and support services help you to have a better quality of life?



Outcome Sought:

To take steps to begin to understand patient experience in relation to the delivery of integrated care.

Rationale:

Effective engagement of patients, the public and wider partners in the design, delivery and monitoring of services.

Definition:

Based on the percentage who responded yes to survey Adult Social Care survey question 2b. " Do Care and Support Services help you to have a better quality of life".

Reporting Schedule:

Data reported from annual Adult Social Care users survey. Next update will be April/May 2018.

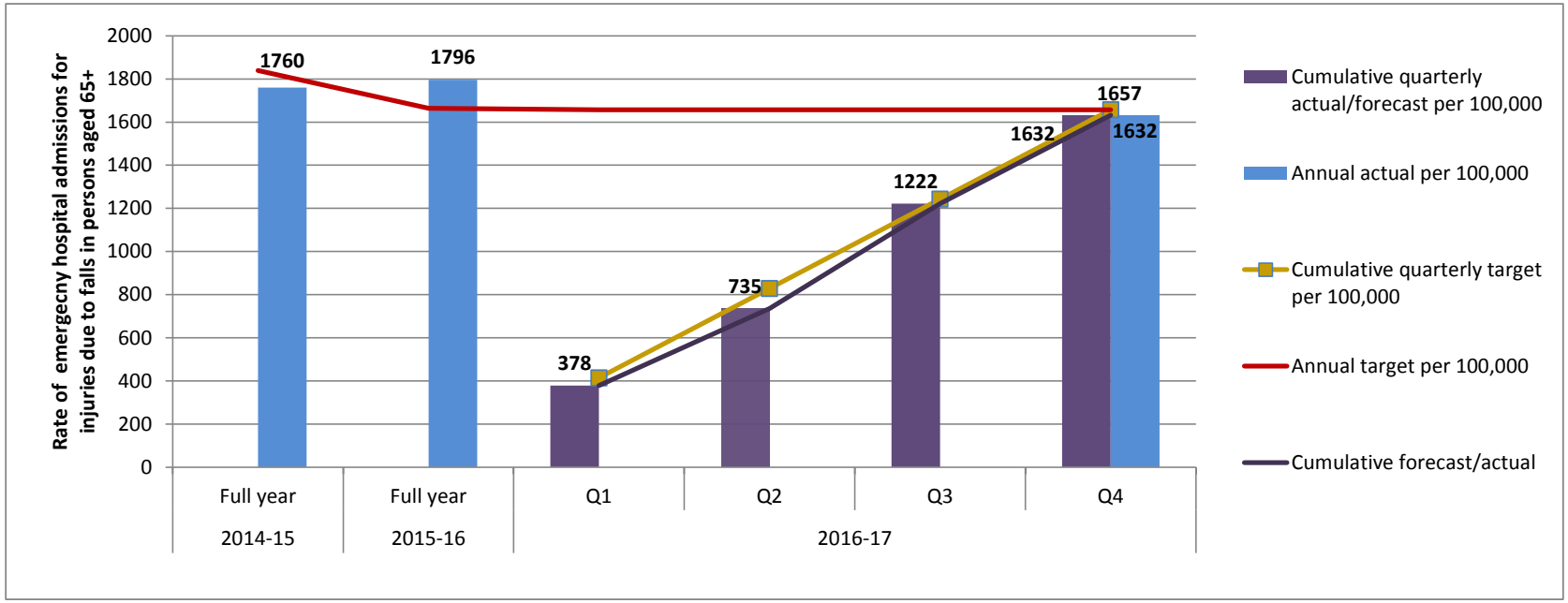
Metric 6 - Local Metric - Over 65s Falls

GREEN: Due to a difference in methodology between the former and new Commissioning Support Units, the number of admissions attributed to falls injuries has risen. **By year end, the number of falls was still nevertheless under the ceiling target, but with a narrower margin than previously reported.** There were 1,632 falls per 100,000 65+ population, relative to a target ceiling of 1,657. Just three additional falls injuries would have exceeded the target.

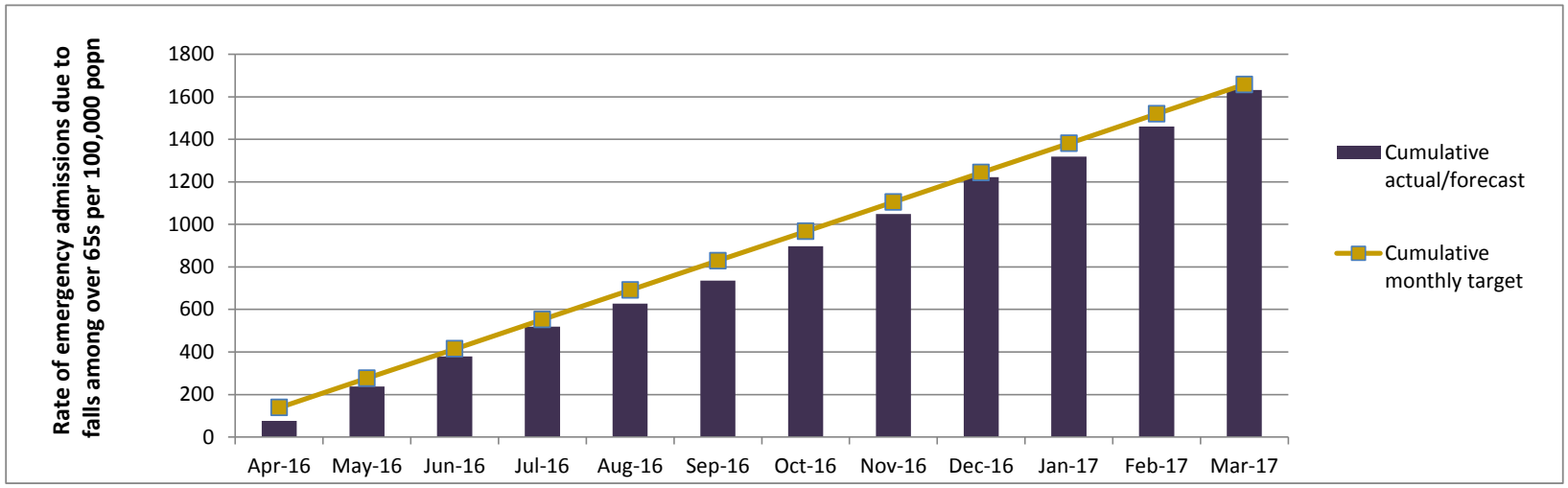
Complementing this metric, the Public Health Outocmes Framework released new figures in May relating to falls admissions. Rutland has 2 green and 6 amber indicators relating to falls, with better performance on falls in the 80+ population than those 65-79, underlining the need to continue to be proactive in falls prevention.

Falls prevention interventions are being defined for the next programme, alongside LLR BCT/STP work to define a set of LLR wide falls prevention and management interventions. An increased focus on care home falls prevention, for example, inclduding via pre-emptive therapies and increased use of assistive technology are anticipated, as well as increased work encouraging people to remain active in the community.

Rate of emergency hospital admissions for injuries due to falls in persons aged 65+, per 100,000 population - quarterly



Rate of emergency hospital admissions for injuries due to falls in persons aged 65+, per 100,000 population - monthly



Outcome Sought:

To reduce the number of admissions for injuries due to falls

Rationale:

Falls are frequent but often preventable events, rather than an inevitable part of ageing, and preventing them supports the other objectives of the BCF plan, including the prevention agenda, avoiding non-elective admissions to hospital and avoiding or posponing permanent admissions to residential homes. Once a fall has occurred, reablement activities can also help to ensure people remain out of hospital once discharged.

Definition:

Age-sex standardised rate of emergency hospital admissions for injuries due to falls in persons aged 65+, per 100,000 population

Reporting Schedule:

Sourced from Public Health Outcomes Framework, last update 14/15. Currently working with Arden & GEM CSU data processed by Leicestershire County Council Public Health analysts. Transitioning to data provided by Midlands and Lancashire CSU. Q1 data due mid Aug 2017.

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					Annual budget		2017-18 (£k)					2018-19 (£k)				2019-20 (£k)	Contribution to BCF metrics				Local metric
Priorities and measures	**What is included?**	**Use of budget**	**Lead sponsor**	**Source**	**2017-18 (£k)**	**2018-19 (£k)**	**BCF**	**DFG**	**ASC one-off**	**iBCF - for social care**	**2016-17 carry over**	**BCF**	**DFG**	**iBCF - for social care**	**2016-17 carry over**	**iBCF - for social care**	**Non elective admissions**	**Delayed transfers of care**	**Permanent care home admissions**	**Reable-ment success**	**Falls prevention**
1. Unified prevention																					
1.1 Communication and coordination	Enhance the **Rutland Information Service** online directory of local services. **Network of prevention-related organisations** **Develop community capacity**	One-off: staffing, software, network	RCC	Carry over	26	0	0	0	0	0	26	0	0	0	0						**Y**
1.2 Community wellbeing advisors	**Community wellness and prevention services**	Ongoing: Commissioned service	RCC	BCF	147	147	147	0	0	0	0	147	0	0	0		**Y**		**Y**		
	Wellbeing advisors in primary care	1 year pilot: Commissioned service	ELRCCG	Carry over	90	0	0	0	0	0	90	0	0	0	0		**Y**		**Y**		
	Social care outreach for hard to reach individuals at risk (Vulnerable Adult Risk Management - social care requirement)	*New Ongoing cost: 2x specialist posts 2017-18 = budget for Q2-4 only	RCC	i-BCF	58	77	0	0	0	58	0	0	0	77	0	77	**YY**				**Y**
1.3 Active and connected	**Extending healthy life expectancy by increasing activity levels and social connectedness.**	Commissioned services and grants to raise activity levels, increase social connectedness and prevent falls.	RCC	BCF	80	80	80	0	0	0	0	80	0	0	0		**Y**		**Y**		**YY**
Priority 1 Totals					401	304	227	0	0	58	116	227	0	77	0	77					
2. Holistic management of health and wellbeing in the community (current LTC priority)																					
2.1 Integrated health and care services	**Further integrate local community, social and primary care services,** particularly benefitting people with long term conditions, frailty and complex needs. MDTs, Integrated Care Coordinator.	Ongoing: staffing, including Integrated care coordinator.	RCC	BCF	153	153	153	0	0	0	0	153	0	0	0		**YY**	**Y**	**YY**		**Y**
		Ongoing: staffing	ELRCCG	BCF	405	405	405	0	0	0	0	405	0	0	0		**YY**	**Y**	**YY**		**Y**
2.2 Self care	**Self care** - **personalised care planning at the GP**, supported by an online self care toolkit, targeting specific cohorts.	* New Pilot: Method, software integrated with SystmOne, telehealth equipment, project support. Transition to primary care business as usual if successful.	ELRCCG	Carry over	43	43	0	0	0	0	43	0	0	0	43		**Y**		**Y**		**Y**
	Self care: Enhance social care personal budgets - increased choice helping more people to sustain independence.	*New One-off: Social care payments. Enhanced payments already factored into ASC 2018-19 budget. Funding would enable it to be started sooner. If more funding, could bring forward further (max	RCC	i-BCF	70	0	0	0	0	70	0	0	0	0	0				**Y**		**Y**
2.3 Holistic homecare	**Holistic 'whole care' model of domiciliary care** with skilled, stable area-based teams providing enriched social care.	*New 'One-off: Funding to trial Q2-4 and transition if successful. Staffing, training, evaluation. Transition to business as usual if successful.	RCC	ASC one-off	142	0	0	0	136	6	0	0	0	0	0		**YY**	**YY**	**YY**		**Y**
2.4 health and wellbeing in care homes	Actions to include pre-emptive therapy to support falls prevention. Actions based on Vanguard learning and on LLR Integrated Locality Team care home pilot actions. Crossover with 2.2. Self care toolkit and 3.2 Transfer and Reablement		ELRCCG	Carry over	?	?	0	0	0	0	?	0	0	0	?		**YY**				**YY**
2.5 Support services sustaining wellbeing and independence	Notably:						0	0	0	0	0	0	0	0	0						
	Dementia care	Ongoing: 50:50 staffing and commissioned service	RCC	BCF	100	100	100	0	0	0	0	100	0	0	0		**YY**		**YY**		**Y**
	Carer support, including respite	Ongoing: care payments	RCC	BCF	85	85	85	0	0	0	0	85	0	0	0		**YY**	**Y**	**YY**		**Y**

					Annual budget		2017-18 (£k)					2018-19 (£k)				2019-20 (£k)	Contribution to BCF metrics				Local metric
Priorities and measures	**What is included?**	**Use of budget**	**Lead sponsor**	**Source**	**2017-18 (£k)**	**2018-19 (£k)**	**BCF**	**DFG**	**ASC one-off**	**i-BCF - for social care**	**2016-17 carry over**	**BCF**	**DFG**	**iBCF - for social care**	**2016-17 carry over**	**iBCF - for social care**	**Non elective admissions**	**Delayed transfers of care**	**Permanent care home admissions**	**Reable-ment success**	**Falls prevention**
	Assistive technology	Ongoing: Commissioned service	RCC	BCF	65	65	65	0	0	0	0	65	0	0	0		Y	YY	YYY		YY
	Disabled Facilities Grants	Ongoing: DFG capital grants	RCC	DFG	203	203	0	203	0	0	0	0	203	0	0			Y	YYY		YY
Priority 2 Totals					1266	1054	808	203	136	76	43	808	203	0	43	0					

					Annual budget		2017-18 (£k)					2018-19 (£k)				2019-20 (£k)	Contribution to BCF metrics				Local metric
Priorities and measures	**What is included?**	**Use of budget**	**Lead sponsor**	**Source**	**2017-18 (£k)**	**2018-19 (£k)**	**BCF**	**DFG**	**ASC one-off**	**i-BCF - for social care**	**2016-17 carry over**	**BCF**	**DFG**	**iBCF - for social care**	**2016-17 carry over**	**iBCF - for social care**	**Non elective admissions**	**Delayed transfers of care**	**Permanent care home admissions**	**Reable-ment success**	**Falls prevention**
3. Hospital flows – step up step down arrangements providing the right level of care in the right place at the right time																					
3.1 Crisis response	7 day crisis response services	Ongoing: staffing	RCC	BCF	125	125	**125**	**0**	**0**	**0**	**0**	125	0	0	0		**YYY**	**Y**			
		Ongoing: commissioned services	ELRCCG	BCF	115	115	**115**	**0**	**0**	**0**	**0**	115	0	0	0						
	Identifying routes to manage crisis locally without hospitalisation where appropriate eg. increasing virtual ward step up, avoiding 'just in case' admissions, patient tracking to differentiate levels of acuity, etc. Link to potential CCG savings.	*New, one-off Use to be confirmed with partners.	Joint	Carry over	20	20	**0**	**0**	**0**	**0**	**20**	0	0	0	20		**YY**	**Y**			
3.2 Transfer of care and reablement	Sustaining the 'pull model' of transfer of care, in which an integrated health and social care team proactively identifies Rutland patients needing discharge support and facilitates their transfer of care back to the community when fit for discharge.	Ongoing: staffing	RCC	BCF	561	561	**561**	**0**	**0**	**0**	**0**	561	0	0	0		**Y**	**YYY**	**Y**	**YYYY**	**YY**
	Progressing further improvements to transfer of care processes via an agile improvement approach and the DTOC Action Plan whose key 2017-18 - 2018-19 development focus is on health in care homes, optimising hospital flows for planned care patients through actions prior to admission and accelerating step down to hospital at home.	Ongoing: commissioned staffing	ELRCCG	BCF	135	135	**135**	**0**	**0**	**0**	**0**	135	0	0	0		**Y**	**YYY**	**Y**	**YYYY**	**YY**
		*New, additional technical instructor role helping to optimise planned admissions - supporting pre-admission preparation.	RCC	i-BCF	26	35	**0**	**0**	**0**	**26**	**0**	0	0	35	0		**Y**	**YY**	**Y**	**YYY**	**YYY**
Priority 3 Totals					982	991	**936**	**0**	**0**	**26**	**20**	**936**	**0**	**35**	**20**	**0**					
4. Enablers																					
4.1 Programme management, analytics and enabling actions	Programme management and analytics	Ongoing: Staffing, comms	RCC	BCF	73	73	73	0	0	0	0	73	0	0	0		**Y (indirect)**	**Y (indirect)**	**Y (indirect)**	**Y (indirect)**	**Y (indirect)**
	Improved IT for mobile working and single assessment	One-off: 2 in 1 laptop/tablet devices. Licences, training etc for single assessment	RCC	i-BCF	33	-	0	0	0	33	0	0	0	-	0		**Y**				
			Joint	Carry over	22		0	0	0	0	22	0	0	0	0						
	User experience research, including relating to new approaches to holistic care.	Independent capacity to capture user experiences and feed them back into solution design.	RCC	i-BCF	10	14	0	0	0	10	0	0	0	14	0		**Y**	**Y**	**Y**	**Y**	**Y**
Priority 4 Totals					138	87	73	0	0	43	22	73	0	14	0	0					
		Total above			2787	2436	0 2044	203	136	203	201	2044	203	126	63	77					
		Budget available to allocate					2061	203	136	203	278	2061	203	168	0	77					
		Remaining unallocated					17	0	0	0	77	17	0	42	-63	0					

					Annual budget		2017-18 (£k)					2018-19 (£k)				2019-20 (£k)	Contribution to BCF metrics				Local metric
Overall aim	**Measure**	**Use of budget**	**Lead sponsor**	**Source**	**2017-18 (£k)**	**2018-19 (£k)**	**BCF**	**DFG**	**ASC one-off**	**i-BCF - for social care**	**2016-17 carry over**	**BCF**	**DFG**	**iBCF - for social care**	**2016-17 carry over**	**iBCF - for social care**	**Non elective admissions**	**Delayed transfers of care**	**Permanent care home admissions**	**Reable-ment success**	**Falls prevention**

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