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Rutland County Council

Catmose, Oakham, Rutland, LE15 6HP
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Email: democraticservices@rutland.gov.uk

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 **Tuesday, 23rd April, 2024** commencing at **2.00 pm** when it is hoped you will be able to attend.

Yours faithfully

Mark Andrews
Chief Executive

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A G E N D A

1) WELCOME AND APOLOGIES RECEIVED

2) RECORD OF MEETING

To confirm the record of the meeting of the Rutland Health and Wellbeing Board held on 16th January 2024.
(Pages 7 - 14)

3) ACTIONS ARISING

There were no actions arising from the previous meeting.

4) 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.

5) 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 73.

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.

6) QUESTIONS WITH NOTICE FROM MEMBERS

To consider any questions from Members received under Procedure Rule 75.

7) NOTICES OF MOTION FROM MEMBERS

To consider any Notices of Motion from Members submitted under Procedure Rule 77.

8) RIGHT CARE, RIGHT PERSON: OVERVIEW AND UPDATE

10 MIN

To receive an update from Chief Inspector Audrey Danvers, Leicestershire Police.

9) RUTLAND HEALTH PROTECTION ANNUAL REPORT

10 MIN

To receive Report No. 59/2024 from Fiona Grant, Consultant in Public Health, Leicestershire County Council and Anuj Patel, Strategic Lead – Health Protection, Leicestershire County Council.
(Pages 15 - 38)

10) RUTLAND WHOLE SYSTEMS APPROACH TO HEALTHY WEIGHT

10 MIN

To receive Report No. 57/2024 from Adrian Allen, Assistant Director - Delivery, Public Health and Mitch Harper, Strategic Lead – Rutland, Public Health.
(Pages 39 - 46)

11) LEICESTER, LEICESTERSHIRE & RUTLAND (LLR) INTEGRATED CARE SYSTEM: UPDATE

10 MIN

To receive Report No. 62/2024 from Sarah Prema, Chief Strategy Officer,

Leicester, Leicestershire and Rutland Integrated Care Board.
(Pages 47 - 50)

12) JOINT STRATEGIC NEEDS ASSESSMENT: UPDATES & TIMELINE

A. MENTAL HEALTH AND DEMENTIA - ADULTS

15 MIN

To receive Report No. 60/2024 from Hanna Blackledge, Lead Public Health Analyst, Leicestershire County Council and Amy Chamberlain, Senior Public Health Analyst, Leicestershire County Council.
(Pages 51 - 208)

13) JOINT HEALTH AND WELLBEING STRATEGY

15 MIN

To receive Report No. 58/2024 from Katherine Willison, Health and Integration Lead, Rutland County Council.
(Pages 209 - 240)

14) BETTER CARE FUND

10 MIN

To receive Report No. 61/2024 from Katherine Willison, Health and Integration Lead, Rutland County Council.
(Pages 241 - 254)

15) UPDATE FROM THE SUB-GROUPS

20 MIN

A. CHILDREN AND YOUNG PEOPLE PARTNERSHIP

To receive an update from Dawn Godfrey, Strategic Director for Children and Families, Rutland County Council.

B. INTEGRATED DELIVERY GROUP

To receive an update from Debra Mitchell, Deputy Chief Operating Officer, Leicester, Leicestershire and Rutland Integrated Care Board.

C. RUTLAND MENTAL HEALTH NEIGHBOURHOOD GROUP

To receive an update from Emma Jane Hollands, Head of Community Care Services, Rutland County Council.

D. STAYING HEALTHY PARTNERSHIP

To receive an update from Adrian Allen, Assistant Director – Delivery, Public Health.

16) REVIEW OF FORWARD PLAN AND ANNUAL WORK PLAN

5 MIN

To consider the current Forward Plan and identify any relevant items for inclusion in the Rutland Health and Wellbeing Board Annual Work Plan, or to request further information.

The Forward Plan is available on the website using the following link:
https://rutlandcounty.moderngov.co.uk/mgListPlans.aspx?RPId=133&RD=0
(Pages 255 - 256)

17) ANY URGENT BUSINESS

5 MIN

To receive any items of urgent business, which have been previously notified to the person presiding.

18) DATE OF NEXT MEETING

Date/time to be confirmed

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DISTRIBUTION

MEMBERS OF THE RUTLAND HEALTH AND WELLBEING BOARD

Name		Title
1.	Diane Ellison (Councillor) CHAIR	Portfolio Holder for Adults and Health, RCC
2.	David Williams	Group Director of Strategy & Partnerships Leicestershire Partnership NHS Trust & Northamptonshire Healthcare NHS Foundation Trust
3.	Dawn Godfrey	Strategic Director of Children and Families (DCS), RCC
4.	Debra Mitchell	Deputy Chief Operating Officer, LLR ICB
5.	Duncan Furey	Chief Executive Officer, Citizens Advice Rutland
6.	Ian Crowe	Armed Forces Representative
7.	Janet Underwood (Dr)	Chair, Healthwatch Rutland
8.	Kim Sorsky	Strategic Director for Adults and Health (DASS), RCC
9.	Liam Palmer (Sgt)	Leicestershire Police
10.	Louise Platt	Executive Director of Housing, Care and Support, Longhurst Group
11.	VACANT	Clinical Place Lead – Rutland, LLR ICB
12.	Mike Sandys VICE CHAIR	Director of Public Health for Leicestershire & Rutland, LCC
13.	Sarah Prema	Chief Strategy Officer, LLR ICB

14.	Simon Barton	Deputy Chief Executive, UHL NHS Trust
15.	Simon Pizzey	Associate Director of Strategy and Partnerships, UHL NHS Trust
16.	Tim Smith (Councillor)	Portfolio Holder for Children and Families, RCC

OFFICERS ATTENDING

Name		**Title**
17.	Adrian Allen	Assistant Director - Delivery, Public Health
18.	Emma Jane Hollands	Head of Community Care Services
19.	Jane Narey	Scrutiny Officer, RCC
20.	Karen Kibblewhite	Head of Commissioning, RCC
21.	Katherine Willison	Health and Wellbeing Integration Lead, RCC
22.	Mitch Harper	Strategic Lead – Rutland, Public Health
23.	Susan-Louise Hope	Strategic Lead – Rutland Commissioning, Public Health

FOR INFORMATION

Name		**Title**
24.	Angela Hillery	Chief Executive, Leicestershire Partnership NHS Trust
25.	Glyn Edwards	Group Head of Strategy & Partnerships Leicestershire Partnership NHS Trust & Northamptonshire Healthcare NHS Foundation Trust
26.	Penny Sharp	Strategic Director of Places, RCC

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Rutland County Council

Catmose Oakham Rutland LE15 6HP
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Minutes of the **MEETING of the RUTLAND HEALTH AND WELLBEING BOARD** held in the Council Chamber, Catmose, Oakham, Rutland LE15 6HP on Tuesday, 16th January, 2024 at 2.00 pm

PRESENT

1.	Mike Sandys VICE CHAIR	Director of Public Health for Leicestershire & Rutland, LCC
2.	David Williams	Group Director of Strategy & Partnerships, Leicestershire Partnership NHS Trust & Northamptonshire Healthcare NHS Foundation Trust
3.	Dawn Godfrey	Strategic Director of Children and Families (DCS), RCC
4.	Debra Mitchell	Deputy Chief Operating Officer, LLR ICB
5.	Duncan Furey	Chief Executive Officer, Citizens Advice Rutland
6.	Ian Crowe	Armed Forces Representative
7.	Janet Underwood (Dr)	Chair, Healthwatch Rutland
8.	Kim Sorsky	Strategic Director for Adult Services and Health (DASS), RCC
9.	Tim Smith (Councillor)	Portfolio Holder for Children and Families, RCC

APOLOGIES:

10.	Diane Ellison (Councillor) CHAIR	Portfolio Holder for Adults and Health, RCC
11.	Liam Palmer (Sgt)	Leicestershire Police
12.	Sarah Prema	Chief Strategy Officer, LLR ICB
13.	Karen Kibblewhite	Head of Commissioning, RCC

ABSENT:

14.	Louise Platt	Executive Director of Housing, Care and Support, Longhurst Group
15.	Lynette Freire-Patino (Dr)	Clinical Place Lead – Rutland, LLR ICB

OFFICERS PRESENT:

16.	Adrian Allen	Assistant Director - Delivery, Public Health
17.	Jane Narey	Scrutiny Officer, RCC
18.	Katherine Willison	Health and Wellbeing Integration Lead, RCC
19.	Mitch Harper	Strategic Lead – Rutland, Public Health
20.	Susan-Louise Hope	Strategic Lead – Rutland Commissioning, Public Health

IN ATTENDANCE:

21.	Janet Harrison	Head of Service for Families, Young People & Children's Services, Leicestershire Partnership NHS Trust
22.	Ian Reynolds	Armed Forces Officer, RCC
23.	Jane Kibble	Principal Occupational Therapist, RCC
24.	Kelly McAleese	Adult Social Care Principal Social Worker and Quality Lead, RCC
25.	Sammi Le-Corre	Senior Integration & Transformation Project Officer, NHS Leicester, Leicestershire and Rutland

1 WELCOME AND APOLOGIES RECEIVED

The Vice Chair, Mike Sandys, welcomed everyone to the meeting and stated that he would be chairing the meeting in the absence of the Chair, Councillor Diane Ellison. Apologies were received from Councillor Ellison, Sergeant Liam Palmer, Karen Kibblewhite and Sarah Prema.

2 RECORD OF MEETING

The minutes of the Rutland Health and Wellbeing Board meeting held on the 10th October 2023 were approved as an accurate record.

3 ACTIONS ARISING

Action 1
An 'easy read' summary version of the Communication and Engagement Plan had been completed for public use and a copy would be sent to Healthwatch for comment.
Katherine Willison, Health and Integration Lead reported that the 'easy read' summary version would be reviewed/approved by the Patient Participation Group before being distributed.

Action 2
It was agreed that the Deputy Chief Operating Officer would check to ensure that the suggested health actions in the Area SEND Inspection Report were referenced in the Rutland Health Plan.
Debra Mitchell, Deputy Chief Operating Officer of the LLR ICB confirmed that the action was completed and that the suggested health actions were in the Rutland Health Plan.

4 DECLARATIONS OF INTEREST

There were no declarations of interest.

5 PETITIONS, DEPUTATIONS AND QUESTIONS

There were no petitions, deputations or questions.

6 QUESTIONS WITH NOTICE FROM MEMBERS

There were no questions with notice from members.

7 NOTICES OF MOTION FROM MEMBERS

There were no notices of motion from members.

8 SPEECH AND LANGUAGE THERAPY

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Janet Harrison joined the meeting at 2.06 p.m.
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A) RUTLAND SPEECH AND LANGUAGE THERAPY PERFORMANCE REPORT

Report No. 15/2024 was received from Janet Harrison, Head of Service for Families, Young People & Children's Services at Leicestershire Partnership NHS Trust. During the discussion, the following points were noted:

- The SALT service had experienced resource and capacity issues regarding their staffing levels and data recording system.
- These issues had now been resolved and the Speech and Language Therapy service would provide quarterly performance updates regarding Rutland children and young people to the Rutland Children and Young People Partnership.

RESOLVED
That the Board:

a) **NOTED** the current demand and waiting list position for Speech and Language Therapy in Rutland.
b) **SUPPORTED** the service's improvement plans and future reporting arrangements to the Rutland Children and Young People's Partnership.
c) **NOTED** the plans for strengthening SLT participation and impact in the response to the LGA mini review, aligning this with the Early Language Support for Every Child (ELSEC) pathfinder and SEND Change Programme Partnership.

B) EARLY LANGUAGE PATHWAY TASK AND FINISH GROUP

Report No. 07/2024 was received from Councillor Tim Smith, the Portfolio Holder for Children and Families, Dawn Godfrey, Strategic Director of Children and Families and Janet Dowling, the Family Hub Programme Manager at Rutland County Council. During the discussion, the following points were noted:

- It was confirmed that the information from the Speech and Language Therapy Service as requested by the Children and Young People's Partnership and detailed in 4.2 of the report, had been provided as part of the report presented by the Head of Service for Families, Young People & Children's Services at Leicestershire Partnership NHS Trust.
- The Board supported the future work being proposed including the stakeholder meeting in January 2024 and the creation of an Early Language Pathway Task and Finish Group.

RESOLVED
That the Board:

a) **NOTED** the contents of the report.

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Janet Harrison left the meeting and Duncan Furey and Ian Reynolds joined the meeting at 2.25 p.m.

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9 ARMED FORCES COVENANT DUTY AND HEALTH INEQUALITIES

Report No. 11/2024 was received from Karen Kibblewhite, Head of Commissioning & Procurement and Mitch Harper, Strategic Lead – Rutland, Public Health and was presented by Ian Reynolds, Armed Forces Officer at Rutland County Council. During the discussion, the following points were noted:

- Dawn Godfrey, Strategic Director of Children and Families (DCS) confirmed that RCC officers had been to Cyprus to work with armed forces colleagues before families moved to Kendrew Barracks. Each SEND child had been assessed regarding the level of support required and a school place found. This ensured that support already identified in a current Education, Health and Care Plan (EHCP) would continue without the need for a new EHCP to be completed when the family arrived back in the UK.
- Cases and referrals regarding the Armed Forces community could be made to the Op Community; an Armed Forces Single Point of Contact (SPOC).
- Ian Crowe, Armed Forces Representative, confirmed that funding for the Op Community had been extended until December 2024.

RESOLVED
That the Board:

a) **NOTED** the progress made against the action plan which supports the delivery of the Armed Forces Covenant Duty;
b) **ENDORSED** the approach to amalgamate actions from all previous needs assessments and surveys in relation to the Armed Forces in Rutland
c) **CONSIDERED** any additional actions partners could undertake to support the Armed Forces Community in Rutland, and any additional identified issues to be included.

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Ian Reynolds left and Sammi Le-Corre joined the meeting at 2.54 p.m.

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10 RUTLAND PRO-ACTIVE CARE DEMENTIA PILOT

The Board received a presentation from Sammi Le-Corre, Senior Integration & Transformation Project Officer at NHS Leicester, Leicestershire and Rutland. During the discussion, the following points were noted:

- Funding from the Better Care Fund (BDF) for a Social Prescriber to sit within the RISE team would be discussed at the next meeting of the Rutland Mental Health Neighbourhood Group.
- Pre-support was provided by Age UK to all people on the waiting list for the Memory Service though Dr Janet Underwood, Chair of Healthwatch Rutland noted the affordability implications to service users of the travel costs to/from the support group meetings.

- The Council's Adult Social Care Services such as RISE, Admiral Nurses, Care Co-ordinators etc all connected to and worked with external services.

RESOLVED
That the Board:

a) **NOTED** the progress to date and the projects achievements.
b) **SUPPORTED** the plan for a BCF funded Social Prescriber to sit within the RISE team.

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Sammi Le-Corre left the meeting at 3.17 p.m.
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11 LLR LEARNING FROM LIVES AND DEATHS: PEOPLE WITH A LEARNING DISABILITY AND AUTISTIC PEOPLE (LEDER)

Report No. 14/2024 was received from David Williams, Group Director of Strategy & Partnerships, Leicestershire Partnership NHS Trust & Northamptonshire Healthcare NHS Foundation Trust. During the discussion, the following points were noted:

- The median age at death for a person with a learning disability or autism in Rutland was 62 – same as the national average.
- Aspiration pneumonia was the biggest cause of death. Giving people extra time when eating would help prevent the inhalation of food.
- The LeDeR 'TOP TEN things you can do to help…' should be shared widely as a priority.
- The NHS priority care recording system included a 'disability marker'. This was not always used when information was entered so inaccurate records were produced. Discussions would be held with the different services e.g. care homes, GP's etc regarding the correct recording of information on to the system.

RESOLVED
That the Board:

a) **SHARED** the annual report widely;
b) **PROMOTED** the key learning points across all services;
c) **NOTED** the considerable disparity in life expectancy for people with a learning disability and autistic people;
d) **RECOGNISED** that one third of deaths were potentially preventable.

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Sammi Le-Corre and Kelly McAleese joined the meeting at 3.30 p.m.
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12 HEALTH AND CARE COLLABORATIVE (HCC)

A verbal update was received on the Health and Care Collaborative from Mitch Harper, Strategic Lead – Rutland, Public Health, Sammi Le-Corre, Senior Integration & Transformation Project Officer, NHS Leicester, Leicestershire and Rutland and Kelly McAleese, Adult Social Care Principal Social Worker and Quality Lead. During the discussion, the following points were noted:

- Rutland has a growing ageing population which was resulting in increased support costs so promoting 'healthy ageing' was a priority.
- Many factors influenced 'healthy ageing' such as physical health, mental health, financial security, lifestyle etc.
- The HCC was still in its early stages as a comprehensive approach was needed including short-term and long-term options.
- Feedback from residents had been gathered with a focus on wealth depleted residents and discussions were held with Healthwatch as part of the project planning stage.
- The message of 'healthy ageing' should be widely and positively communicated.

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Sammi Le-Corre and Kelly McAleese left the meeting at 3.47 p.m.

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13 JOINT STRATEGIC NEEDS ASSESSMENT: UPDATES & TIMELINE

A) CHAPTER: SUBSTANCE MISUSE (DRUGS AND ALCOHOL)

Report No. 09/2024 was received from Mike Sandys, Director of Public Health for Leicestershire & Rutland and Susan-Louise Hope, Public Health Strategic Lead. During the discussion, the following points were noted:

- Emerging addictions included such things cannabis edibles, prescription medication and anabolic steroids.
- Vaping was not included as an emerging addiction as there was currently not sufficient data to support this but work would continue with the stop smoking services.
- Joint working with partners e.g. armed forces, veterans, police, Citizens Advice and Healthwatch was important for the key recommendations to be successful especially regarding mental health and substance misuse.
- It was noted that substance misuse i.e. alcohol was linked to older people as 'self-medication' for health, financial or loneliness issues.

RESOLVED
That the Board:

a) **APPROVED** the recommendations in the substance misuse JSNA and **AGREED** the three key recommendations.
b) **ENDORSED** the JSNA.
c) **NOTED** the contents of the substance misuse JSNA.
d) **AGREED** that constructive engagement and promotion with partners at a local level would be required to ensure the success of the three key recommendations.

14 JOINT HEALTH AND WELLBEING STRATEGY

A) JOINT HEALTH AND WELLBEING STRATEGY: UPDATE

Report No. 08/2024 was received from Katherine Willison, Health and Integration Lead at Rutland County Council. During the discussion, the following points were noted:

- Data from Public Health was now up-to-date following conversations and work with Public Health colleagues.
- Work was ongoing to make the Joint Health and Wellbeing Strategy Delivery Plan more accessible to the public.

RESOLVED
That the Board:

a) **NOTED** the further development of the JHWS Delivery Plan.
b) **NOTED** the Public Health Data: Update for Rutland and the Public Health Outcomes Framework: Update for Rutland Report.

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Jane Kibble joined the meeting at 4.18 p.m.
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B) HIP FRACTURES AND FALLS PREVENTION

Report No. 10/2024 was received from Katherine Willison, Health and Integration Lead at Rutland County Council and Jane Kibble, Principal Occupational Therapist. During the discussion, the following points were noted:

- More falls were now being recorded as happening within a care home than at a person's own home.
- Support to Rutland residents and work with care homes continued to be provided to reduce the number of falls.

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David Williams left the meeting at 4.25 p.m.
---o0o---

- Not all cases of a fall in a person's own home were being reported.
- Services were working in partnership as part of the HCC to promote 'healthy ageing' as better health would help reduce the number of falls.

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At 4.27 p.m. the Chair proposed that the meeting be extended for a period of 15 minutes for the agenda to be completed. This was unanimously agreed.
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- It was suggested that data i.e. actual figures were required to better support the project report and its findings.

RESOLVED
That the Board:

a) **NOTED** the content of the report
b) **NOTED** the content of the 'Understanding Hip Fracture Data' report and the 'LLR Falls Steering Group – Collective Ambition Statement and Objectives.'
c) **CONSIDERED** any further commissioning needs or approaches in respect of falls prevention.

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Jane Kibble left the meeting at 4.39 p.m.

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15 BETTER CARE FUND: 2023-2025

Report No. 06/2024 was received from Katherine Willison, Health and Integration Lead at Rutland County Council. During the discussion, the following points were noted:

- Four of the five metrics were not on track to meet target but only by a small margin.
- Rutland data meant dealing with very small numbers so any changes in the numbers resulted in large changes in percentages being recorded.
- Rutland had set itself ambitious targets which were not nationally set targets.
- The work being done as part of the HCC would help support and improve Rutland's data.

RESOLVED
That the Board:

a) **NOTED** the content of the report.
b) **NOTED** that the Better Care Fund - Quarter Two Report 2023-24 gained approval from the Chair of the Health and Wellbeing Board and the ICB Executive Team and was submitted to the National BCF Team on 31 October 2023.

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At 4.44 p.m. the Chair proposed that the meeting be extended for a further period of 15 minutes for the agenda to be completed. This was unanimously agreed.

---oOo---

16 REVIEW OF FORWARD PLAN AND ANNUAL WORK PLAN

The work plan was discussed and the following amendments were agreed:

- The Strategic Director of Children and Families stated that the 'Early Language and Support for Every Child (ELSEC)' item planned for the next meeting could be removed as it had been covered in this meeting as part of the discussion on the Speech and Language Therapy service.
- The Strategic Director of Children and Families and the Public Health Strategic Lead – Rutland agreed to present a report on 'Stop Smoking Services: Vaping' at the next meeting.

17 ANY URGENT BUSINESS

There was no urgent business.

18 DATE OF NEXT MEETING

Tuesday, 30th April 2024 at 2.00 p.m.

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The Chair declared the meeting closed at 4.49 pm.

---oOo---

Report No: 59/2024
PUBLIC REPORT

RUTLAND HEALTH & WELLBEING BOARD

23 April 2024

RUTLAND HEALTH PROTECTION ANNUAL REPORT

Report of the Portfolio Holder for Adults and Health

Corporate Priorities:	Support the most vulnerable	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Diane Ellison: Portfolio Holder for Adults and Health	
Contact Officer(s):	Mike Sandys, Director of Public Health	Telephone: 0116 3054259 Email: mike.sandys@leics.gov.uk
	Fiona Grant, Public Health Consultant	Telephone 0116 3057929 Email: fiona.grant@leics.gov.uk
	Anuj Patel, Strategic Lead – Health Protection	Telephone 0116 3055439 Email: anuj.patel@leics.gov.uk
Ward Councillors	N/A	

DECISION RECOMMENDATIONS

That the Committee:

1. Notes the Rutland Health Protection Annual Report 2023.

2. Recognises the specific health protection issues that have arisen locally, the steps taken to deal with them and the particular areas of focus for the coming year.

1. PURPOSE OF THE REPORT

1.1 The purpose of the report is to update the Health and Wellbeing Board on health protection performance, key incidents, risks and other significant matters.

2. BACKGROUND AND MAIN CONSIDERATIONS

2.1 Health protection assurance is a statutory duty of the local authority, via the Director of Public Health. It is therefore a key element of the Joint Health and Wellbeing Strategy.

2.2 The key strands of health protection activity are:

i. Outbreaks and communicable disease (including COVID-19).
ii. Screening Programmes.
iii. Immunisation Programmes.
iv. Healthcare associated infections.

v. Preparedness and response to incidents and emergencies.

2.3 The Local Authority does not commission the majority of services which contribute to protecting the health of the population, but the Director of Public Health should be assured that arrangements are robust and that they are implemented in a way which meets the needs of the population for which they are responsible.

3. ALTERNATIVE OPTIONS

3.1 There are no alternative options.

4. FINANCIAL IMPLICATIONS

4.1 Most Health Protection actions and interventions are the financial responsibility of partners outside of Rutland County Council. This report has no implications for finance.

5. LEGAL AND GOVERNANCE CONSIDERATIONS

5.1 There are no legal or governance considerations.

6. DATA PROTECTION IMPLICATIONS

6.1 A Data Protection Impact Assessments (DPIA) has not been completed because there are no risks/issues to the rights and freedoms of natural persons.

7. EQUALITY IMPACT ASSESSMENT

7.1 An Equality Impact Assessment (EqIA) has not been completed at this stage because the report does not include a new service or a change in the service provision.

8. CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

8.1 Health protection is an essential element in local health, social care strategies and initiatives including Better Care Together/Sustainability Transformation Plan and also to urgent care work streams.

8.2 It is considered beneficial for the Health and Wellbeing Board to understand the assurance functions of the Leicestershire, Leicester and Rutland (LLR) Health Protection Assurance Board and receive an overview of the health protection performance, key incidents, risks and other significant matters which have arisen during 2023.

9. APPENDICES

9.1 Appendix A – Rutland Health Protection Annual Report 2023

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577

RUTLAND HEALTH PROTECTION ANNUAL REPORT

January 2023 – December 2023

PURPOSE OF REPORT

1. The purpose of this report is to provide a summary of the assurance functions of the Leicester, Leicestershire and Rutland (LLR) Health Protection Assurance Board. It also updates the Health and Wellbeing Board on health protection performance, key incidents and risks and other significant matters.

LINK TO THE LOCAL HEALTH AND CARE SYSTEM

2. Health protection assurance is a statutory duty of the local authority, via the Director of Public Health. It is therefore a key element of the Joint Health and Wellbeing Strategy and of Leicestershire County Council's (LCC's) core business. It is an essential element in local health and social care strategies and initiatives including Better Care Together/Sustainability Transformation Plan and to urgent care work streams.

3. Links to LCC strategic plan:

    - Safe & Well: Ensuring people are safe and well protected from harm, by working with partners.
    - Improved opportunities.

RECOMMENDATIONS

4. It is recommended that:

    a. The Health Protection Annual Report 2023 be noted.

    b. That in noting the report, The Health and Wellbeing Board recognise the specific health protection issues that have arisen locally, and the steps taken to deal with them, and the particular areas of focus for the coming year.

POLICY FRAMEWORK AND PREVIOUS DECISIONS

5. On 1st April 2013 implementation of the new NHS and Social Care Act (2012) resulted in most of former NHS Public Health responsibilities being transferred to upper tier and unitary local authorities (LAs) including the statutory responsibilities of the Director of Public Health. Each local authority is now 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.

6. Integrated Care Boards (ICBs) were legally established on 1 July 2022, replacing clinical commissioning groups (CCGs), taking on the NHS planning functions and absorbing some planning roles from NHS England. The former Public Health England organisation

was abolished in 2022 and a new organisation, the United Kingdom Health Security Agency (UKHSA), established.

7. The key strands of health protection activity are:

   i. Outbreaks and communicable disease (including COVID-19).
   ii. Screening Programmes.
   iii. Immunisation Programmes.
   iv. Healthcare associated infections.
   v. Preparedness and response to incidents and emergencies.

8. The Local Authority does not commission the majority of services which contribute to protecting the health of the population, but the Director of Public Health should be assured that arrangements are robust and that they are implemented in a way which meets the needs of the population for which they are responsible.

9. This is a local leadership function which requires the Director of Public Health and wider public health team to identify issues and advise appropriately; and to work in close liaison and cooperation with other contributing organisations. Responding to the Director of Public Health's information and advice is the responsibility of these other contributing organisations, who will also be accountable should unheeded advice result in any adverse impact.

10. It is considered beneficial for the Health and Wellbeing Board to understand the assurance functions of the Leicestershire, Leicester and Rutland (LLR) Health Protection Assurance Board and an overview of the health protection performance, key incidents and risks and other significant matters which have arisen during 2023.

BACKGROUND

11. The Leicester, Leicestershire, and Rutland (LLR) Health Protection Board reports into each of the three Health and Wellbeing Boards for Leicester, Leicestershire and Rutland and enables local authorities to discharge their health protection assurance responsibilities.

12. Dashboards, reports and/or updates are received and reviewed at the quarterly Board. They cover the key domains identified above. This data is reviewed by the group and if needed, stakeholders are asked to produce more detailed assurance for the group on an exception basis. The LLR Health Protection Board is linked into a number of other Health Protection groups across the local system.

KEY DOMAINS OF HEALTH PROTECTION ASSURANCE

Prevention And Control of Infectious Diseases

<u>Organisational Roles/Responsibilities</u>

13. UK Health Security Agency (UKHSA), formerly Public Health England (PHE) is an executive agency made up of both national specialist teams and regional health protection teams. UKHSA have established programmes to reduce the impact of common infectious diseases through detecting, analysing, responding, delivering, and engaging

with the wider health system. UKHSA lead on the epidemiological investigation and the specialist health protection response to public health outbreaks/incidents and has responsibility to declare a health protection incident, major or otherwise.

14. NHS England is responsible for ensuring that their contracted providers are mobilised to deliver an appropriate clinical response to outbreaks/incidents. This responsibility devolves down to local Integrated Care Boards (ICB) to use contractual arrangements with provider organisations to make relevant resources available (including screening/diagnostic and treatment services).

15. The Local Authority, through the Director of Public Health, has overall responsibility for the strategic oversight of an incident/outbreaks, and to gain assurance that the local health protection system is robust enough to respond appropriately.

COVID-19

16. The first confirmed case of COVID-19 in Rutland was recorded in March 2020. The first national lockdown was announced in March 2020, with schools reopening and certain restrictions easing in June 2020. The Director of Public Health produced a Local COVID-19 Outbreak Control and Prevention Plan to build upon existing health protection plans and response mechanisms put into place to contain any outbreaks. The plan prioritised preventing the spread of COVID-19 and associated disease, early identification and pro-active management of local outbreaks, coordination of capabilities across agencies and stakeholders and assuring the public that this was effectively delivered.
    A second national lockdown was announced in November 2020, a month before the rollout of the largest vaccination campaign in NHS history. A third national lockdown was introduced in January 2021.

17. A summary of COVID-19 cases recorded during the period of increased surveillance from February 2020 until October 2022 is given in Appendix 1. COVID-19 vaccination remains a vital tool in reducing the risk of ill health as a result of COVID-19 infection, particularly in those at higher risk of worse outcomes from infection owing to age, existing illness, or other vulnerability. A spring booster programme will begin in April 2024 for a smaller cohort than the previous winter booster programme.

Measles

18. England saw a resurgence of measles in 2023, with 368 cases confirmed across the Country, 44% of which (160 cases) were in the neighbouring West Midlands, and 8 cases recorded in the East Midlands. The majority of cases were identified from October 2023.

19. Having identified a downward trend in MMR (measles, mumps and rubella) vaccination uptake in June 2023, a local measles elimination group was established in LLR as a pro-active measure. NHS England released their vaccination strategy in December 2023 highlighting similar concerns of a decline in MMR vaccine uptake. Pro-active and preventative measures continue to be implemented in Rutland.

Diphtheria

20. In 2022, an outbreak of diphtheria nationally was reported among migrants arriving in small boats to England. 13 confirmed cases of diphtheria were identified in arrivals to Kent in 2023 with no onward transmission to the wider population linked to this group.

21. UKHSA revised national diphtheria guidelines to update advice on the management of suspected cases. Population based control measures have been in place since mid-November 2022, with mass antibiotic prophylaxis and vaccination recommended within 10 days of arrival for those who have transited through an initial reception centre.

22. An LLR Integrated Care System (ICS) led control centre was established in November 2022 involving a multi-agency group. Vaccination was delivered locally via a mobile vaccination unit. Local communications were developed and shared with primary care.

Immunisation and Screening

Organisational Roles/Responsibilities

23. Integrated Care Boards (ICBs) became legally and operationally established on 1 July 2022. For Section 7A NHS public health functions (Screening (cancer and non-cancer), Immunisations including COVID-19 and Influenza (flu), and Child Health Information Systems) commissioning responsibility currently remains with NHS England. Over the course of 2022/23, national and regional NHS England teams supported progress towards joint working. Formal joint working across ICBs and regional teams continues whilst we await assessment of readiness and final approval for delegation by ministers. Delegation is expected to be completed by April 2025

24. UKHSA is responsible for setting immunisation policy through expert groups (the National Screening Committee and Joint Committee on Vaccination and Immunisation). UKHSA will continue to support the NHS through provision of authoritative clinical guidance and coordinated procurement and supply of vaccines.

25. Local Authorities, through the Director of Public Health, require assurance that screening and immunisation services are operating safely whilst maximising coverage and uptake within their local population. This includes providing public health information and advice to relevant bodies within the local area, and collaborative activity to maximise vaccination uptake and coverage. Directors of Public Health and teams provide independent scrutiny of the arrangements of NHS England, UKHSA and providers of immunisation services.

Immunisation

26. The complete routine immunisation schedule is published annually by UKHSA and is available here. Counts for Rutland are combined with Leicestershire as the data is collated by the Primary Care Trust (PCT).

27. Coverage of childhood immunisations continues to be relatively high in Rutland, exceeding performance for all childhood immunisations compared to the England average. Good coverage helps ensure that the local population is protected and does not become susceptible to outbreaks of vaccine preventable diseases.

28. The COVID-19 pandemic led to the introduction of physical distancing measures across England, including school closures and advising against non-essential travel. The Joint Committee on Vaccination and Immunisation (JCVI) advised the childhood immunisation programme to continue according to the national schedule throughout the lockdown. Data has shown a national decrease in children receiving routine childhood immunisations since 2019. Leicestershire and Rutland have followed this national trend of reduced coverage, nonetheless, it still remains above the national average.

Human Papillomavirus (HPV)

29. From 1 September 2023, the HPV vaccine programme changed from a 2 dose to a single dose vaccine schedule for eligible adolescents and men who have sex with men (MSM) aged under 25 years, as advised by JCVI. Uptake rates in Rutland are given in the Appendix.

30. A significant decline in HPV vaccine uptake was observed in the 2020/21 academic year due to the impact of COVID-19 lockdowns. The service prioritised flu vaccine delivery over the winter term, and a national lockdown limited delivery of the HPV programme. Year 8 students who missed their 1st dose were offered a catch up at the start of 2021/22.

Seasonal Flu

31. Population flu vaccination coverage was updated for the 2022-23 season, and as with other vaccinations, counts have been combined with Leicestershire. Uptake has improved since the COVID-19 pandemic. In 2019, vaccination coverage in the population aged 65 and over was 74.1%. For the same cohort, this increased to 81.2% for the 2022-23 season, , compared to the England average of 79.9%, and greater than The World Health Organization (WHO) recommendation of 75% coverage.

32. The flu vaccination programme continued to be a priority during the 2022/23 programme, with a return to pre-pandemic cohorts eligible for a free vaccination. Multi-agency arrangements were established across Leicestershire and Rutland to manage the delivery of the seasonal vaccination programmes including both COVID-19 and Influenza. Flu uptake rates for 2022-23 are given in the Appendix.

Key Issues for 2024 (Immunisation)

- Increase uptake of MMR vaccine in line with national strategy.
- Maintaining uptake of influenza vaccine, particularly in at-risk groups including care home residents.
- Increase uptake of HPV amongst boys & girls, to reverse the downward trend in coverage.
- A new LLR immunisation board to be set up from April 2024.
- Delegation of commissioning responsibilities from NHS England to the ICB by April 2025.

Screening

33. The strategic framework of the Major Conditions Strategy focuses on primary prevention, secondary prevention, early diagnosis, prompt and urgent care, and long-term treatment and care. Screening plays a vital role in each of these. The purpose of screening is to detect conditions in the healthy population who have an increased likelihood of developing disease.

34. The framework can be found here: https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2

35. The Health Protection Team monitor and support service providers for the following screening programmes: bowel cancer, cervical and breast. Data is shared in the Appendix. Overall, cervical and breast screening programmes nationally have experienced a downward trend. Locally, Rutland has seen a downward trend in these screening areas, however, a similar or better than England average performance continues. Bowel cancer screening coverage and uptake rates have increased both locally and nationally

Key Issues for 2024 (Screening)

- Changes to the bowel screening eligibility.
- Continue to strengthen multi- agency regional and local plans to target areas of poor uptake and coverage for each of the screening programmes.
- Work with the ICB and Primary Care Networks to improve areas of performance to meet national targets.

Sexual Health

36. Table 1 in Appendix 5 summarises diagnostic and detection rates for the main sexually transmitted infections in Rutland.

37. The integrated sexual health services (ISHS) detect, prevent and treat sexually transmitted infections (STI) in the local population. The service has comprehensive arrangements for STI testing and a variety of testing options for HIV.

38. The ISHS contract covering Rutland covers the period 1 January 2019 to 31 March 2024. From April 2024 the ISHS service provision, is being commissioned as an independent service. Rutland maintains the current agreement for one year to 31 March 2025 with the longer-term service provision to be procured in 2024.

39. The emphasis remains on self-managed care whilst preserving the quality of testing, results notification, and partner notification. The main site of delivery for Rutland services will be delivered from the satellite clinic and Rutland Memorial Hospital, supported by the Loughborough Hub.

40. There is also a separate online service due to commence 1 April 2024. The online service offers a range of testing options for STI and treatment for chlamydia. Online service access has increased since the COVID-19 pandemic and this service will enable those in our most rural areas to access services.

41. A sexual Health Needs Assessment (HNA) for Leicestershire and Rutland was completed in 2023 with several recommendations made around STIs.

Chlamydia Screening

42. It is recommended that work is carried out to better understand the poorer performance on chlamydia screening rates in Rutland, in the age groups 15 to 24 years old, and that appropriate action is taken to bring about improvements. This should be an area of focus for the next commissioning round for sexual health services. In Rutland in 2022, the proportion of 15- to 24-year-old screened for chlamydia, was significantly worse than the England average and on a downward trend.

Key Issues for 2024 (Sexual Health)

- Monitor the STI testing rate (excluding chlamydia aged under 25 years old) per 100,000 (all ages).
- Monitor gonorrhoea diagnostic rates due to recent increasing rates. Whilst an increase in rates can be positive if resulting from increased testing activity, this needs to be monitored locally to better understand the causes. The increase in rates in the latest year mirrors national trends and exceeds pre-pandemic rates and rates since 2012. Rutland still performs significantly better than England on the gonorrhoea diagnostic rate per 100,000 and there is no statistically significant change in trend over the last five years.

- Encourage early diagnosis in heterosexual and bisexual women in particular.

Tuberculosis (TB)

43. Prevalence of TB in Rutland remains lower than the England average, as well as the East Midlands rate.

44. The 2020-22 dataset is missing from the data source.

Key issues for 2024 Tuberculosis (TB)

- Improve BCG and TB screening and vaccination eligibility criteria awareness particularly for those with parents and or grandparents from a non-UK country of origin with a high incidence prevalence.
- Engaging with non-UK born arrivals at an early stage to encourage engagement on TB screening initiatives and uptake of BCG vaccination and screening in line with national recommendations. LLR TB Community Engagement will focus on this.

Health Care Associated Infections

45. Many healthcare associated infections (HCAI) are preventable. When they do occur, they can have a significant impact on patients and on the wider NHS and care systems.

46. LLR ICS is breaching all alert organism trajectories with Clostridiodes difficle (C. diff) at a significantly high number. This has been escalated with providers, and mitigating actions are detailed below along with ongoing routine monitoring, reporting and interventional processes. With the establishment of the ICB, annual trajectories now include community and indeterminate associated cases.

<u>Organisational Roles/Responsibilities</u>

47. The NHS Outcomes Framework (NHS OF) is a set of indicators developed by the Department of Health and Social Care to provide a framework in which to measure and monitor how well the NHS is performing. NHS England hold local ICBs to account for performance against indicators under this domain.

48. UKHSA, through its consultants in communicable disease control, will lead the epidemiological investigation and the specialist health protection response to HCAI outbreaks and has responsibility to declare a health protection incident.

49. The Local Authority through the Director of Public Health has overall responsibility for the strategic oversight of a HCAI impacting on their population's health. See Appendix 7 for information Healthcare Associated Infections Incidence in LLR for January- December 2023.

50. LLR Trusts continue to investigate HCAI alert organism cases, conducting Post Infection Reviews and Root Cause Analyses (RCAs) when required, cascading learning outcomes to relevant teams. Public Health Infection Prevention and Control (IPC) colleagues conduct reviews of C. diff cases within care homes, where necessary. If learning outcomes involve General Practice, the ICB IPC team support communication and escalate actions where necessary.

51. The ICB IPC team continue to provide operational support for General Practice, including assistance with community bacteraemia RCAs where necessary. Alert Organism guidance is advised and relevant shared learning from community RCAs discussed at ICB IPC Question and Answer (Q&A) sessions and forums for GP IPC Leads and Link Practitioners.

52. System IPC Leads continue to monitor respective bacteraemia cases and convene review meetings to discuss LLR bacteraemias, including source origins, possible interventions, and mitigations for improvement. This has included focus on antimicrobial prescribing practice (including avoidance of broad-spectrum antibiotic use except where necessary), operational groups to review monthly C. diff data and develop reduction action plans.

Meticillin-resistant Staphylococcus aureus (MRSA)

53. NHS Improvement has continued to set healthcare providers the challenge of demonstrating a 'zero' tolerance of MRSA blood stream infections (BSI), however, in March 2018 NHS Improvement announced a change in how MRSA BSI cases were to be reviewed. From April 2018 University Hospitals of Leicester (UHL) and LLR ICB were exempt from completing a formal post infection review as this was now only for organisations with the highest rates of infection.

Meticillin susceptible Staphylococcus aureus (MSSA)

54. Mandatory reporting of all Meticillin Sensitive Staphylococcus Aureus (MSSA) has been a requirement for provider organisations since January 2011. However, to date national trajectories to reduce these cases have not been set. Locally, the ICB continue to hold providers to account for the number of reported MSSA cases.

C.Diff Infection

55. NHS providers are required to input information to the UKHSA data capture system relating to information prior to admission to hospital. This information is intended to allow the categorisation of non-hospital onset cases based upon the timing of prior admissions to the reporting Trust. Locally, the ICBs continue to hold providers to account where, following a review of individual cases, a lapse in care was identified that may have contributed to the person acquiring a C. diff infection. During 2023-2024 both UHL and the ICB breached their nationally set trajectories.

56. The ICB IPC team have facilitated C. diff education sessions with the UHL C. diff Nurse Specialist at both Primary Care Webinars and IPC Lead/Link Practitioner Forums. There

are plans for collaborative working with the ICB IPC team and other stakeholders on community C. diff strategies.

Escherichia Coli (E. Coli) Bacteraemia

57. E.coli bacteraemia rates, chiefly community acquired, were static or increasing during the year and are a focus for ongoing IPC work. Efforts continue to engage the whole local health and social care economy continue to assess the overall approach to reducing E.coli blood stream infections.

Key Issues for 2024 HCAI

- For the year 2023/2024, the LLR ICS has a combined national trajectory of 204 C. diff cases (incorporating all 3 ICB Sub Sectors). This trajectory includes all healthcare, community, and indeterminate associated cases. Currently LLR ICS has an actual total of 266 C. diff cases (April 2023 to January 2024).
- The ICB IPC team and Local Authority Public Health IPC teams are in the process of sharing education resources, to expand IPC learning access for both General Practice and care home staff (including sessions on C. diff and Carbapenem Resistant Organisms).
- A new ICS IPC Community of Practice has been convened with relevant stakeholders and is in the process of identifying current system issues and developing/ co-ordinating relevant strategies.

Emergency Planning and Response (including severe weather and environmental hazards)

<u>Organisational Roles/Responsibilities</u>

58. Emergency planning has been a Local Authority function since before the Health and Social Care Act (2012), however with Public Health in the Authority there are additional opportunities to consider around the health protection aspects of this function.

59. The local authority continues to engage with the Local Resilience Forum in undertaking their annual exercise programme, responding to incidents, and undertaking learning as required.

60. The Local Health Resilience Partnership (LHRP) is co-chaired by LLR ICB and Local Authority Public Health. The LHRP provides a strategic forum for local healthcare organisations to facilitate preparedness and planning for health emergencies at a suitable system and Local Resilience Forum (LRF) level. The LHRP also supports NHS England, local Government and UKHSA, to ensure member organisations develop and maintain effective health planning arrangements for major emergencies and major incidents.

Key Issues for 2024 (Emergency Planning)

- Ensure partners are clear on the response structure to major incidents, the causes of delays in action and on the coordination of groups.
- Ensure that there is an on-going approach to learning from experience and that issues identified from real events are acted upon.
- Continue to review contingency plans as appropriate according to national and local guidance and ensure further testing response arrangements.

- Changes in average temperatures as well as an increased likelihood of extreme weather events, including prolonged hot periods, as well as heavier downpours.

Air Quality

61. Poor air quality is the largest environmental risk to the public's health, leading to significant levels of morbidity and premature mortality. Research in 2023 estimated that 48,625[1] adults die prematurely each year in the UK due to particulate matter pollution. The health risk is disproportionate in certain groups within the population, such as children and young people and older adults, and those that are pregnant or have long term health conditions. [1] https://www.ucl.ac.uk/news/2023/oct/uk-air-pollution-regulations-will-reduce-deaths-do-little-protect-ecosystems

62. The Pollution Control Team developed an Air Quality Annual Status Report (ASR). Rutland County Council does not currently have any declared Air Quality Management Areas (AQMAs). A local air quality strategy is being developed to prevent and reduce polluting activities.

63. Relationships have also been developed with LLR Air Quality Forum and a Public Health representative to link this research to the work of the Air Quality Partnership.

64. The LLR Respiratory Working Group, chaired by the ICB plays a key role in linking air quality monitoring data, health data and clinical colleagues and processes together (alongside housing).

Key Issues for 2024 (Air Quality)

- Continue to consult and monitor planning applications that may have a significant impact on air quality in Rutland.
- To provide local support and relevant information to encourage potential sustainable behavioural change and increased understanding of air quality in Rutland.

CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

65. Overall, the Rutland Director of Public Health is assured that the correct processes and systems are in place to protect the health of the population. Areas to continue to focus further progress on include:

    - Ensuring local health and care systems have the capacity to respond to major incidents (national issue), including emergency planning and response.

    - Maintaining and improving progress on key health protection indicators particularly relating to:

        - Communicable disease.
        - Screening.
        - Immunisation.
        - Hospital Acquired Infections.

BACKGROUND PAPERS

- Rutland Joint Health and Wellbeing Strategy 2022-2027: **https://www.rutland.gov.uk/sites/default/files/2023-10/Health%20and%20Wellbeing%20Strategy%202022-2027_0.pdf**

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APPENDICES

- Appendix 1 – COVID-19 Surveillance Report
- Appendix 2 - Childhood immunisations uptake
- Appendix 3 - Seasonal flu vaccine uptake
- Appendix 4 - Screening uptake
- Appendix 5 - Rutland Sexual Health Indicators
- Appendix 6 - TB
- Appendix 7 - Healthcare Associated Infections Incidence

CONSULTATION

There is no requirement for consultation in relation to this report.

RELEVANT IMPACT ASSESSMENTS

The JSNAs give due regard to the equality and human rights of different population groups, with particular focus within the JSNAs. Sources of inequalities and recommendations are designed to alleviate issues created through identified inequalities.

EQUALITY AND HUMAN RIGHTS IMPLICATIONS

There are no equality implications arising from this report. The report would seek to have a positive impact overall and would not have an adverse effect on any section of the community.

Certain socially excluded groups are at greater risk of environmental hazards e.g., poor air quality in areas of socio-economic deprivation. Some groups are at increased risk of particular infectious diseases e.g., TB in some migrants and asylum seekers. Certain groups

and individuals are also less likely to avail of the protection afforded by immunisation and screening e.g., in areas of socio-economic deprivation.

There are no human rights implications arising from this report.

COMMUNITY SAFETY IMPLICATIONS
This report has no community safety implications.

ENVIRONMENTAL IMPLICATIONS
No environmental implications

PARTNERSHIP WORKING AND ASSOCIATED ISSUES
Partnership working across health, local authorities, police, fire, districts etc remains essential to ensure robust health protection and emergency planning arrangements are in place.

FINANCIAL IMPLICATIONS
Most Health Protection actions and interventions are the financial responsibility of partners outside of Rutland County Council. This report has no implications for finance.

DATA PROTECTION IMPLICATIONS
A Data Protection Impact Assessments (DPIA) has not been completed as data presented is not patient identifiable.

APPENDIX 1: COVID-19 Surveillance Report

Weekly COVID-19 Surveillance Report in Leicestershire

Leicestershire County Council

Cumulative data from 27/02/2020 - 29/10/2022

Breakdown of testing by Pillars of the UK Government's COVID-19 testing programme:

Pillar 1 + 2
combined data from both Pillar 1 and Pillar 2 of the UK Government's COVID-19 testing programme

Pillar 1
data from swab testing in PHE labs and NHS hospitals for those with a clinical need, and health and care workers

Pillar 2
data from swab testing for the wider population, as set out in government guidance

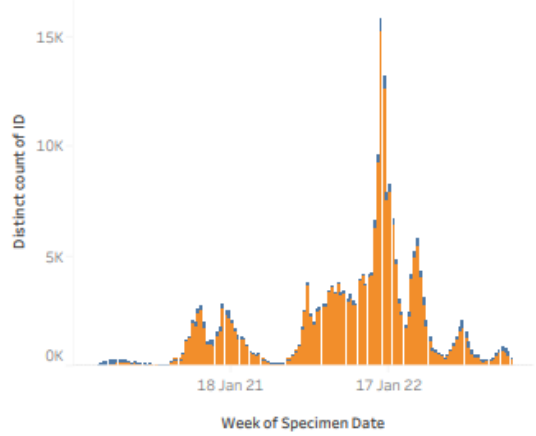
COVID-19 cases | Cumulative data from 27/02/2020 - 29/10/2022

254,660 cases | 16,009 Pillar 1 cases | 238,651 Pillar 2 cases

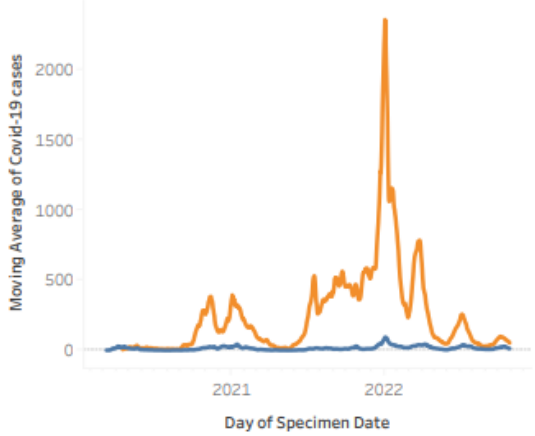
COVID-19 cases | Monthly data from 02/10/2022 - 29/10/2022

2,820 cases | 611 Pillar 1 cases | 2,209 Pillar 2 cases

Cases per week



Moving average of cases per day



APPENDIX 2: Childhood immunisations uptake

Quarterly Childhood Immunisations by Local Authority (Rutland)

Cohort	Indicator	Lower threshold[1]	Standard[2]	Key	Geography	2016/17 Q1	2016/17 Q2	2016/17 Q3	2016/17 Q4	2017/18 Q1	2017/18 Q2	2017/18 Q3	2017/18 Q4	2018/19 Q1	2018/19 Q2	2018/19 Q3	2018/19 Q4	2019/20 Q1	2019/20 Q2	2019/20 Q3	2019/20 Q4	2020/21 Q1	2020/21 Q2	2020/21 Q3	2020/21 Q4	2021/22 Q1	2021/22 Q2	2021/22 Q3	2021/22 Q4	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4	2023/24 Q1	2023/24 Q2	2023/24 Q3
12 months	12m Denominator	N/A	N/A	N/A	Rutland	113	94	73	96	96	103	80	73	74	87	90	78	117	84	87	81	73	82	62	72	80	76	82	79	81	75	93	70	72	70	73
					England	#####	#####	#####	#####	#####	#####	#####	#####		#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	151,101	#####
	12m DTaP/IPV/Hib % [4]	90	95	< 90 90 - 95 ≥ 95	Rutland	96.5	96.8	97.3	96.9	93.8	94.2	93.8	97.3	94.6	90.8	97.8	97.4	95.7	95.2	90.8	97.5	95.9	93.9	96.8	94.4	97.5	98.7	96.3	97.5	96.3	96.0	95.7	95.7	88.9	95.7	98.6
					England	93.0	92.9	93.4	93.0	93.0	93.2	93.1	92.6		91.6	92.1	91.9	92.0	92.1	92.8	92.7	92.8	92.1	91.5	91.6	91.5	91.3	92.0	91.9	92.0	92.1	91.9	91.6	91.5	91.3	91.3
	12m PCV1 %	90	95	< 90 90 - 95 ≥ 95	Rutland																	100.0	98.8	98.4	98.6	97.5	100.0	98.8	98.7	96.3	97.3	97.8	97.1	91.7	95.7	100.0
					England																			96.3	93.4	93.7	93.3	94.1	94.1	94.0	94.1	94.0	93.6	93.6	93.4	93.5
	12m PCV2 %	90	95	< 90 90 - 95 ≥ 95	Rutland	97.3	96.8	97.3	89.6	94.8	94.2	95.0	95.9	95.9	83.7	97.8	97.4	95.7	95.2	92.0	97.5	97.3	93.9	90.3												
					England	95.2	94.7	93.6	84.7	93.3	93.5	93.5	92.8		92.1	92.8	92.5	92.6	92.8	93.3	93.3	93.3	92.4	90.6												
	12m Rota %	90	95	< 90 90 - 95 ≥ 95	Rutland	95.6	94.7	98.6	94.8	92.7	93.2	87.5	90.4	95.9	88.5	94.4	96.2	92.3	94.0	90.8	97.5	94.5	93.9	87.1	87.5	93.8	92.1	98.8	97.5	95.1	94.7	94.6	92.9	86.1	94.3	98.6
					England	93.1	89.3	90.1	90.1	90.2	89.9	90.6	90.3		89.1	90.0	90.1	90.0	89.6	90.5	90.7	91.0	90.4	89.9	90.0	90.2	89.2	90.4	90.5	89.3	89.0	89.3	89.0	88.7	88.2	88.9
	12m MenB %	90	95	< 90 90 - 95 ≥ 95	Rutland	93.8	95.7	94.5	94.8	93.8	94.2	93.8	94.5	95.9	89.7	97.8	97.4	94.9	95.2	92.0	97.5	95.9	93.9	96.8	97.2	97.5	98.7	96.3	97.5	96.3	97.3	94.6	95.7	88.9	95.7	100.0
					England	89.5	91.6	92.2	92.6	92.2	92.7	93.0	92.5		91.9	92.3	92.0	92.2	92.3	92.9	92.8	93.0	92.5	91.9	91.8	91.7	91.5	92.0	92.0	91.8	91.9	91.6	91.2	91.2	91.0	91.2
24 months	24m Denominator	N/A	N/A	N/A	Rutland	91	79	102	81	112	99	71	88	96	97	85	75	113	93	90	81	85	78	91	88	78	91	72	78	85	80	82	83	80	69	92
					England	#####	#####	#####	#####	#####	#####	#####	#####		#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####
	24m DTaP/IPV/Hib/HepB3	90	95	< 90 90 - 95 ≥ 95	Rutland	98.9	97.5	94.1	98.8	99.1	93.9	98.6	97.7	96.9	96.9	95.3	94.7	95.6	87.1	96.7	97.5	98.8	96.2	96.7	97.7	96.2	98.9	97.2	97.4	96.5	97.5	98.8	97.6	97.5	95.7	92.4
					England	95.1	94.9	95.3	95.1	95.2	95.3	95.2	95.0		94.4	94.2	94.0	94.2	93.5	93.8	93.7	93.9	93.9	94.2	94.0	93.8	93.4	93.0	93.0	92.9	92.9	93.0	93.0	92.8	92.9	92.8
	24m PCV Booster %	90	95	< 90 90 - 95 ≥ 95	Rutland	93.4	96.2	91.2	95.1	96.4	88.9	94.4	95.5	95.8	95.9	95.3	94.7	91.2	89.2	95.6	93.8	97.6	96.2	96.7	97.7	96.2	98.9	95.8	97.4	91.8	97.5	92.7	97.6	92.5	94.2	92.4
					England	91.4	91.4	91.5	91.3	91.0	91.3	91.3	91.2		90.0	90.1	90.1	90.3	90.0	90.4	90.7	91.0	90.6	90.3	89.1	88.9	88.3	88.3	89.1	89.3	89.4	88.5	89.3	89.0	88.8	88.2
	24m Hib/MenC %	90	95	< 90 90 - 95 ≥ 95	Rutland	93.4	96.2	91.2	95.1	98.2	89.9	94.4	95.5	95.8	95.9	95.3	94.7	91.2	90.3	95.6	93.8	97.6	96.2	95.6	96.6	96.2	98.9	94.4	97.4	91.8	97.5	92.7	97.6	93.8	94.2	90.2
					England	91.5	91.2	91.6	91.3	91.2	91.4	91.3	91.2		90.2	90.3	90.3	90.5	90.2	90.5	90.9	91.0	90.8	90.3	89.2	89.2	89.0	89.1	89.7	89.6	89.5	88.9	89.2	89.5	89.2	88.7
	24m MMR1 %	90	90	< 90 90 - 90 ≥ 90	Rutland	94.5	96.2	91.2	93.8	95.5	88.9	94.4	94.3	95.8	95.9	94.1	93.3	88.5	89.2	94.4	93.8	97.6	94.9	95.6	95.5	96.2	98.9	93.1	96.2	92.9	97.5	92.7	97.6	93.8	94.2	91.3
					England	91.4	91.2	91.6	91.2	91.0	91.1	91.1	90.8		89.9	90.0	90.0	90.3	90.1	90.4	90.8	91.0	90.7	90.3	89.3	89.0	88.6	88.9	89.7	89.7	89.7	89.0	89.5	89.5	89.4	88.6
	24m MenB booster %	90	90	< 90 90 - 90 ≥ 90	Rutland							90.1	89.8	92.7	92.8	91.8	92.0	90.3	87.1	94.4	93.8	97.6	94.9	95.6	95.5	96.2	98.9	91.7	96.2	91.8	97.5	93.9	96.4	92.5	92.8	88.0
					England							87.4	87.9		87.7	88.4	88.4	88.8	88.6	89.0	89.3	89.5	89.5	89.3	88.5	88.5	88.1	88.1	88.6	88.5	88.6	87.8	88.4	88.1	88.0	87.3
5 years 30	5y Denominator	N/A	N/A	N/A	Rutland	100	106	95	98	99	102	84	108	108	88	107	86	128	93	116	83	119	100	78	87	103	129	91	86	108	103	113	96	91	81	94
					England	#####	#####	#####	#####	#####	#####	#####	#####		#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####	#####
	5y DTaP/IPV/Hib/HepB3 %	90	90	< 90 90 - 90 ≥ 90	Rutland	97.0	96.2	98.9	98.0	99.0	97.1	98.8	100.0	98.1	98.9	92.5	96.5	99.2	98.9	94.0	98.8	99.2	99.0	100.0	100.0	98.1	98.4	95.6	98.8	98.1	100.0	95.6	99.0	95.6	95.1	96.8
					England	96.0	95.7	95.8	95.6	96.0	96.0	95.8	95.7		95.5	95.3	95.3	95.4	95.2	95.4	95.5	95.6	95.6	95.3	95.3	95.1	94.6	94.6	94.5	94.0	93.5	93.5	93.3	93.1	92.8	93.0
	5y MMR1 %	90	90	< 90 90 - 90 ≥ 90	Rutland	96.0	96.2	100.0	98.0	98.0	96.1	98.8	98.1	97.2	96.6	95.3	96.5	98.4	95.7	94.0	95.2	97.5	97.0	100.0	100.0	97.1	96.9	94.5	96.5	96.3	97.1	97.3	96.9	96.7	96.3	97.9
					England	95.0	95.0	95.2	95.1	95.6	95.3	95.1	95.1		94.7	94.6	94.7	94.7	94.5	94.6	94.6	94.7	94.4	94.3	94.3	94.1	93.7	93.5	93.5	92.9	92.9	92.9	92.7	92.5	92.3	92.3
	5y MMR2 %	90	90	< 90 90 - 90 ≥ 90	Rutland	90.0	88.7	85.3	93.9	87.9	89.2	94.0	91.7	92.6	93.2	87.9	91.9	95.3	93.5	94.0	88.0	90.8	97.0	100.0	98.9	97.1	92.2	93.4	95.3	92.6	91.3	93.8	86.5	91.2	90.1	92.6
					England	87.5	87.3	87.8	87.4	87.6	87.5	87.3	87.2		86.4	86.6	86.7	86.7	86.3	86.9	86.9	86.9	86.7	86.7	86.4	86.3	85.5	85.5	85.9	84.4	84.7	85.2	85.0	83.9	83.8	84.3
	5y DTaP/IPV %	90	90	< 90 90 - 90 ≥ 90	Rutland	86.0	87.7	89.5	91.8	87.9	85.3	91.7	91.7	91.7	95.5	87.9	90.7	89.8	88.2	85.3	88.0	89.9	96.0	96.2	96.6	93.2	93.0	91.2	95.3	98.1	95.1	86.7	84.4	95.6	95.1	92.6
					England	85.9	85.9	86.5	86.3	86.2	86.6	85.9	85.5		85.0	85.3	85.1	85.3	84.9	85.5	85.7	85.6	85.4	85.4	85.1	84.8	84.0	84.2	84.6	83.0	83.4	84.0	84.0	82.8	82.7	83.2
	5y Hib/MenC %	90	90	< 90 90 - 90 ≥ 90	Rutland	94.0	90.6	94.7	96.9	93.9	94.1	98.8	93.5	93.5	96.6	86.9	96.5	96.9	94.6	91.4	91.6	94.1	94.0	97.4	98.9	97.1	93.8	91.2	94.2	96.3	97.1	95.6	92.7	94.5	96.3	97.9
					England	92.6	92.9	92.7	92.8	93.0	93.1	92.8	92.7		92.7	92.6	92.7	92.6	92.6	92.8	92.8	92.9	92.7	92.6	92.5	92.6	92.0	92.0	92.0	91.3	91.2	91.0	90.7	90.5	90.2	90.0

Source: COVER, UKHSA

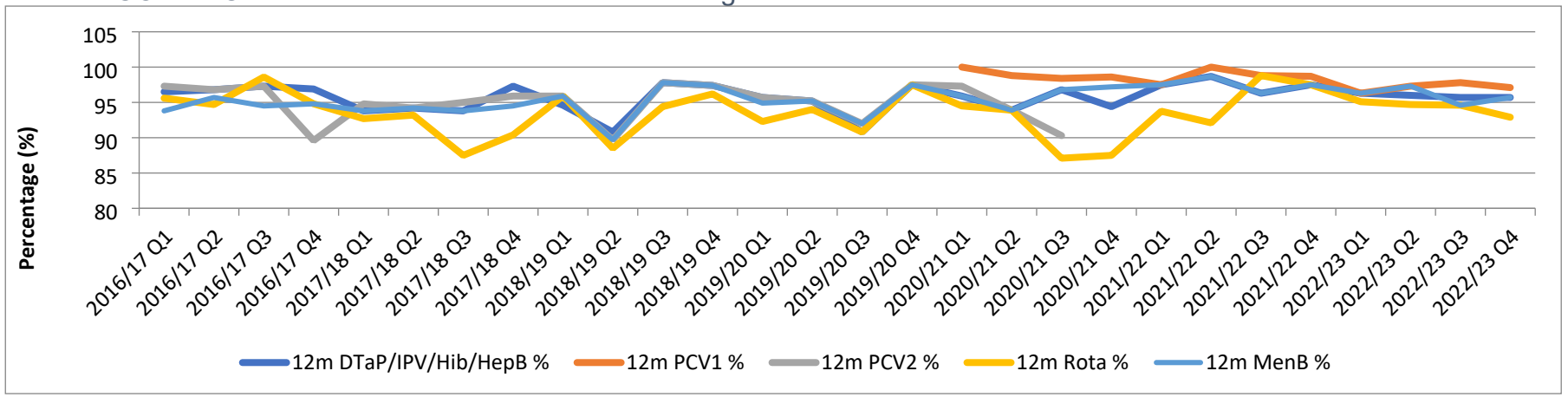
[1] Lower threshold based on the latest Public Health Functions Agreement

[2] Standard is the clinical standard required to control disease and ensure patient safety.

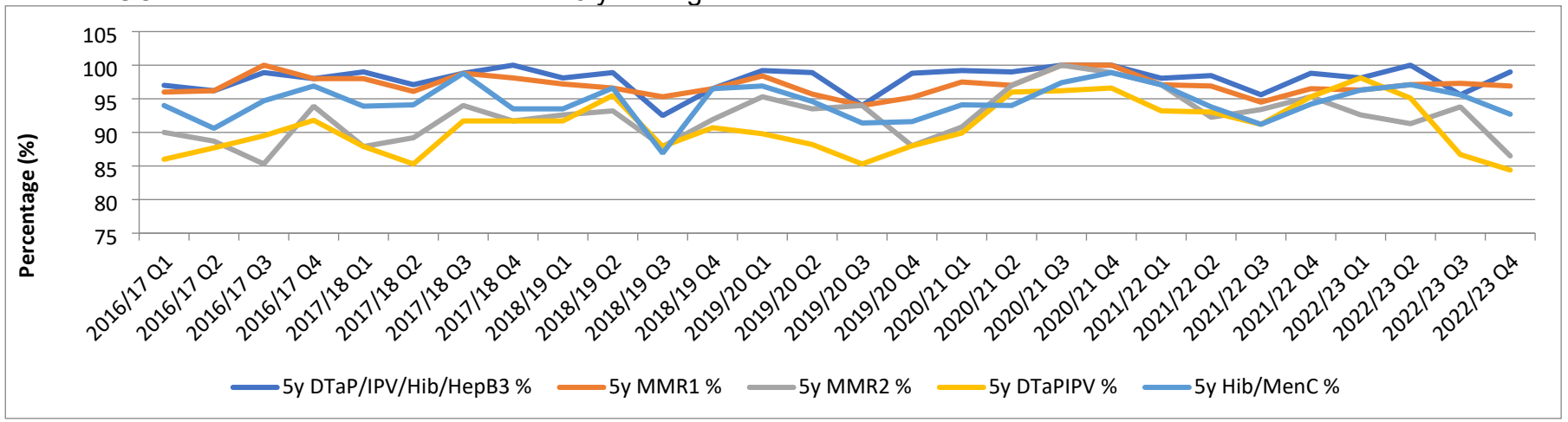
[3] COVER did not report England data for Q1 2018/19. The migration of GP data to the NE London CHIS hub has affected coverage estimates for many of the LAs reported by this hub. As a consequence, London-level coverage figures are under-estimated this quarter. Due to the impact London data has on national figures, England estimates have not been calculated for this report.

[4] 12 Month DTaP/IPV/Hib includes HepB from Q2 2018/19

Trend in COVER Childhood Immunisations for 12-month age cohort in Rutland



Trend in COVER childhood immunisations for 5 years age cohort in Rutland



Annual Other Immunisations - Rutland

Indicator	Lower threshold[1]	Standard[2]	Key	Geography	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
D04e - Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Female)	80	90	< 80 80 - 90 ≥ 90	Rutland				93.9	94.7	86.6	88.8	90.5	90.9	83.2	61.2	81.7	
				England				91.1	89.4	87.0	87.2	86.9	88.0	59.2	76.7	69.6	
D04e - Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Male)	80	90	< 80 80 - 90 ≥ 90	Rutland										78.8	62.5	81.7	
				England										54.4	71.0	62.4	
D04f - Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 year old) (Female)	80	90	< 80 80 - 90 ≥ 90	Rutland						85.2	75.8	68.0	90.1	87.0	88.7	66.5	
				England						85.1	83.1	83.8	83.9	64.7	60.6	67.3	
D04f - Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 year old) (Male)	80	90	< 80 80 - 90 ≥ 90	Rutland											89.7	69.5	
				England											54.4	62.4	
D04g - Population vaccination coverage: Meningococcal ACWY conjugate vaccine (MenACWY) (14 to 15 years)	80	90	< 80 80 - 90 ≥ 90	Rutland							79.5	95.3	94.7	89.6	87.5	91.6	
				England							82.5	84.6	86.7	87.0	80.9	79.6	
D06b - Population vaccination coverage: PPV	65	75	< 65 65 - 75 ≥ 75	Rutland				71.2	71.4	70.8	71.1	71.5	71.1	70.2	68.0		
				England	70.5	68.3	69.1	68.9	69.8	70.1	69.8	69.5	69.2	69.0	70.6		
D06a - Population vaccination coverage: Flu (aged 65 and over)	N/A	N/A	NA	Rutland												88.8	
				England	72.8	74.0	73.4	73.2	72.7	71.0	70.5	72.9	72.0	72.4	80.9	82.3	79.9
D05 - Population vaccination coverage: Flu (at risk individuals)	N/A	N/A	NA	Rutland												64.0	
				England	50.4	51.6	51.3	52.3	50.3	45.1	48.6	49.7	48.0	44.9	53.0	52.9	49.1
D03I - Population vaccination coverage: Flu (2 to 3 years old)	N/A	N/A	NA	Rutland												60.5	
				England					39.9	36.6	40.2	44.0	44.9	43.8	56.7	50.1	43.7
D04d - Population vaccination coverage: Flu (primary school aged children)[3]	N/A	N/A	NA	Rutland													
				England										60.4	62.5	57.4	56.3
D06c - Population vaccination coverage: Shingles vaccination coverage (71 years)[4]	50	60	< 50 50 - 60 ≥ 60	Rutland									35.9	31.4	19.6	32.2	
				England									49.1	48.2	42.1	44.0	

Source: Public Health Outcomes Framework

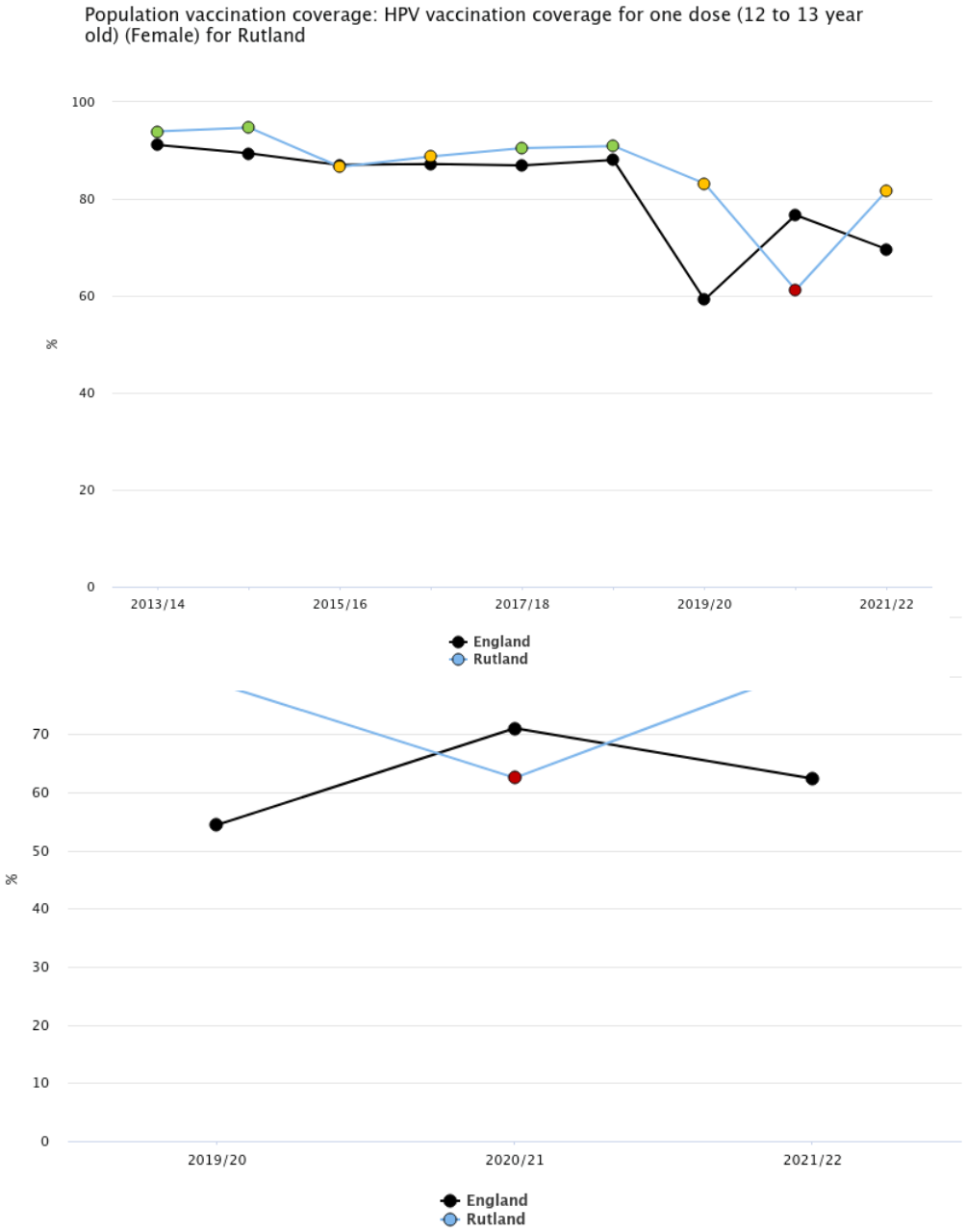
[1] Lower threshold based on the latest Public Health Functions Agreement

[2] Standard is the clinical standard required to control disease and ensure patient safety.

[3] Calendar year data for D04d is mapped to the closest financial year e.g. 2019 -> 2019/20

[4] In 2018/19 the Shingles vaccination coverage was expanded to 71 years old

HPV


Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Female) for Rutland
100
80
60
40
20
0
%
2013/14
2015/16
2017/18
2019/20
2021/22
England
Rutland
70
60
50
40
30
20
10
0
%
2019/20
2020/21
2021/22
England
Rutland

APPENDIX 3: Seasonal Flu vaccine uptake

Uptake for Leicestershire & Rutland (2022 & 2023) and England (2022).

Local Authority	65 and over (%)	Under 65 (at risk)	All pregnant women	All 2 year olds %	All 3 year olds %
Leicestershire and Rutland (2023)	81.2	44.0	39.8	49.2	49.5
Leicestershire and Rutland (2022)	83.6	53.2	40.8	45.9	50.2
England (2022)*	79.9	49.1	35.0	42.3	45.1
Target	75	55	55	48	48

*England data for 2023 has not yet been published
Source: Immform

APPENDIX 4: Screening uptake

Cancer Screening by Local Authority (Rutland)

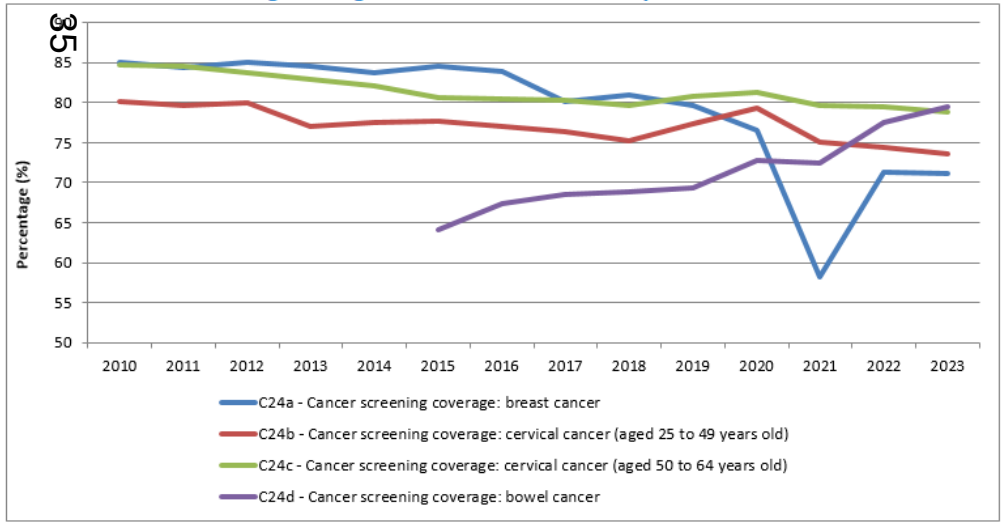
Indicator	Lower threshold[1]	Standard[2]	Key			Geography	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
C24a - Cancer screening coverage: breast cancer	70	80	< 70	70 - 80	≥ 80	Rutland	85.0	84.4	85.1	84.5	83.7	84.5	84.0	80.1	81.0	79.6	76.6	58.2	71.4	71.2
						England	76.9	77.1	76.9	76.3	75.9	75.4	75.5	75.4	74.9	74.5	74.1	64.1	65.2	66.2
C24b - Cancer screening coverage: cervical cancer (aged 25 to 49 years old)	80	N/A	< 80	≥ 80		Rutland	80.1	79.6	80.0	77.0	77.6	77.8	77.0	76.4	75.2	77.3	79.3	75.0	74.4	73.6
						England	74.1	73.7	73.4	71.5	71.8	71.2	70.2	69.6	69.1	69.8	70.2	68.0	67.6	65.8
C24c - Cancer screening coverage: cervical cancer (aged 50 to 64 years old)	80	N/A	< 80	≥ 80		Rutland	84.7	84.6	83.7	83.0	82.1	80.6	80.5	80.3	79.6	80.8	81.4	79.6	79.5	78.8
						England	78.7	80.1	79.9	79.5	79.4	78.4	78.0	77.2	76.2	76.2	76.1	74.7	74.6	74.4
C24d - Cancer screening coverage: bowel cancer	55	60	< 55	55 - 60	≥ 60	Rutland						64.1	67.4	68.6	68.8	69.4	72.9	72.5	77.5	79.5
						England						57.3	58.4	59.2	59.5	60.5	64.3	66.1	70.3	72.0

Source: Public Health Outcomes Framework

[1] Lower threshold based on the latest Public Health Functions Agreement

[2] Standard is the clinical standard required to control disease and ensure patient safety.

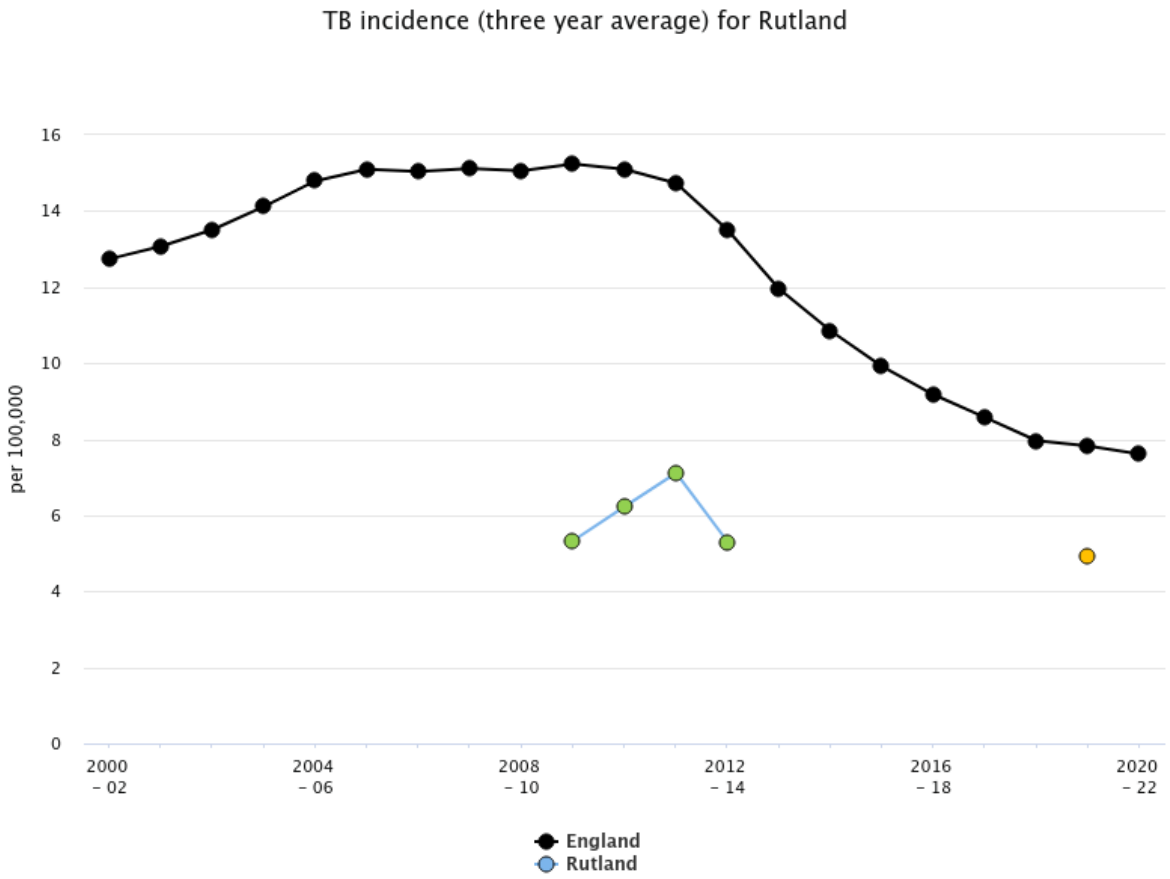
Trend in Cancer Screening coverage in Rutland Local Authority



APPENDIX 5: Rutland Sexual Health Indicators

Sexual Health Indicators Rutland	Indicator	Time period	Recent Trend	Benchmark	Value	England Value	CIPFA Neighbours Avg.
	Syphilis diagnostic rate per 100,000	2022	➡		12.1	15.4	6.2
	Gonorrhoea diagnostic rate per 100,000	2022	➡		58	146	61
	Chlamydia detection rate per 100,000 aged 15-24	2022	➡		1,520	1,680	n/a
	Chlamydia detection rate per 100,00- females 15-24	2022	➡	<2,400 2,400 to 3,250 ≥3,250	2,452	2,110	n/a
	Chlamydia proportion in females 15-24 screened	2022	New data		19.1%	21.2%	17.0%
	All new STI diagnoses per 100,000	2022	➡		465	694	400
	New STI diagnoses (excluding chlamydia under 25) per 100,000	2022	➡		246	496	n/a
	HIV testing coverage	2022	⬇		57.2%	48.2%	n/a
	New HIV diagnosis rate per 100,000	2022	➡		4.8	6.7	n/a
	HIV late diagnosis	2020-2022	-	<25% 25% to 50% ≥50%	100%	43.3%	n/a
	HIV diagnosed prevalence rate per 1,000 aged 15-59		➡	<2 2 to 5 ≥5	0.99	2.34	1.18

APPENDIX 6: TB



Source:

Fingertips

APPENDIX 7: Healthcare Associated Infections Incidence

LLR HCAIs April 2023 - January 2024

	April 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	YTD
CDI ELR	5	9	4	6	3	7	6	4	5	4			53
CDI LC	9	5	6	4	2	4	4	1	3	3			41
CDI WL	5	9	9	7	10	3	4	3	5	6			61
CDI UHL	17	19	17	15	14	14	14	7	10	12			139
E. coli ELR	7	6	3	5	5	5	6	4	2	2			45
E. coli LC	4	9	6	7	3	4	4	8	8	9			62
E. coli WL	4	8	4	4	6	6	6	8	7	5			58
Hospital onset E. coli UHL	0	0	0	0	0	0	0	0	0	0			0
Community onset MRSA BSA LC	0	0	1	0	0	0	0	0	0	0			1
Community onset MRSA BSA ELR	1	1	0	0	1	0	0	0	0	0			3
Community onset MRSA BSA LW	0	0	0	0	0	0	0	0	0	0			0

Report No: 57/2024
PUBLIC REPORT

RUTLAND HEALTH & WELLBEING BOARD

23 April 2024

WHOLE SYSTEMS APPROACH TO HEALTHY WEIGHT

Report of the Portfolio Holder for Adults and Health

Corporate Priorities:	Support the most vulnerable	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Diane Ellison: Portfolio Holder for Adults and Health	
Contact Officer(s):	Mike Sandys, Director of Public Health	Telephone: 0116 3054259 Email: mike.sandys@leics.gov.uk
	Mitch Harper, Public Health Strategic Lead - Rutland	Email: mitchell.harper@leics.gov.uk
Ward Councillors	N/A	

DECISION RECOMMENDATIONS

That the Committee:

1. Approves for a long-term Whole Systems Approach to Healthy Weight be developed for Rutland.

2. Approves the approach to be delivered by the Rutland Staying Healthy Partnership subgroup.

1. PURPOSE OF THE REPORT

1.1 The report presents a proposed approach to promote a 'healthy weight' environment, reducing ill health associated with being overweight, underweight, or obese. The causes of obesity are complex. Tackling such an ingrained issue requires a long-term, holistic approach that makes it everybody's business, is tailored to local needs and covers the life course.

2. BACKGROUND AND MAIN CONSIDERATIONS

2.1 Obesity is a complex problem with multiple causes and significant implications for health and wider society. With most adults in England overweight or obese, and a substantial number of children on the same trajectory, national and local action is needed. Focus should be broader than obesity alone, with a focus on 'healthy weight' factoring in other related areas, including malnutrition and underweight.

2.2 In 2014/15, the NHS spent an estimated £6.1 billion on overweight and obesity related ill health (PHE Health Matters: obesity and the food environment). Additional wider society costs were estimated at £27 billion. Both figures have likely increased since and is predicted to become more costly in future years. Obesity can be a cause of a wide range of preventable disease, including type 2 diabetes, cardiovascular disease and certain cancers.

2.3 In Rutland, 55.5% of the adult population are overweight or obese (2021/22). While this is better than the England average of 63.8%, it is not to be ignored given it still equates to the majority of the population. The figure equates to approximately 18,000 residents. For children, at reception age, the proportion is 22.6% and year 6 age 28.1%. There are therefore opportunities across the life course as prevalence increases with age.

2.4 The Office for Health Improvement and Disparities (OHID, previously Public Health England, PHE) has produced numerous resources to support local areas in promoting a healthy weight. The focus references looking across all causes with considerations for economic, environmental, social and psychological influences. Nine strands have been identified which are presented in appendix A with brief rational on why it is important in this context. While weight management services are delivered in Rutland to support residents in losing weight through behaviour change, they are unlikely to tackle the scale of the issue alone given the resource limitations and focus on individuals.

2.5 A guide for local approaches has been developed by OHID, setting out the need for the initial stages of building the narrative and mapping existing activity across different causes. Based on outcomes from the mapping, the process would move to action. Any identified actions will need to be considered in terms of priorities, resources available and capacity to deliver. This justifies the need for a long-term commitment, where actions can be delivered over time when it is deemed a priority and deliverable. Each action will contribute towards the bigger picture of promoting a healthy weight.

2.6 While there are a range of local opportunities at our collective disposal to explore, some of the progress is dependent on national policy, particularly around the food environment. Recent progress has included introducing the Soft Drinks Industry Levy, calorie labelling and the planned introduction of restrictions on advertising unhealthy foods. The majority of focus to date has been on childhood obesity.

2.7 Some local work has started in this area within the Staying Healthy Partnership. Partner engagement has happened within that group and initial narrative and mapping work has taken place. Initial desktop mapping has happened across the nine identified strands of the whole systems approach, focusing on current activity, gaps and opportunities. Not all areas are related to a lack of provision, with some around how we can do things differently, for example with some targeting to those most at risk. Each strand has then been scored based on the level of existing activity to help inform any prioritisation (Appendix B). This will likely change over time as more detailed mapping is completed and progress is made. There is also a reference to why each strand is important in promoting a healthy weight.

3. PROPOSAL

3.1 The report puts forward a proposal for Rutland to commit to a long-term whole systems approach to healthy weight, following the processes presented by OHID. The initial stages will develop more detailed mapping across the nine strands presented to assess priority areas. It is proposed that the Rutland Health & Wellbeing Board take

ownership, with development and oversight via the Staying Healthy Partnership. The partnership will then work collaboratively to start implementing actions and monitor long-term progress.

3.2 While some actions will likely be able to be delivered by doing things differently, some will likely require resource. As priorities are set and actions considered, any possible sources of funding or access to national grants will be factored in. It is acknowledged that lack of resource could hinder progress in some areas. However, by having a strategic focus on this issue, Rutland will be better placed to access national funds when they become available, of which there has been some around obesity in recent years.

3.3 **Phase 1 (setup) –** Raise awareness, seek senior level support and agree necessary governance. Project planning and working group (Staying Healthy Partnership) established.

Phase 2 (building the local picture) – Build a compelling narrative on the local importance and create a shared understanding on how to address the issues. Mapping current work, opportunities and gaps. Begin public consultations.

Phase 3 (mapping the local system) – Bring stakeholders together to create a comprehensive map of all contributing factors and create a shared vision.

Phase 4 (action) – Identification of priority areas and opportunities to shape local action. Implement a communications plan for activity and priorities.

Phase 5 (managing the system network) – Review progress within the Staying Healthy Partnership, wider stakeholders and Health and Wellbeing Board.

Phase 6 (reflect and refresh) – Maintain a dynamic process with opportunities to change and improve to adapt to circumstances.

4. CONSULTATION

4.1 Public consultation will form parts of the mapping and priority setting. The public voice will help to shape and inform the direction of travel and there will be continuous opportunities throughout delivery.

5. ALTERNATIVE OPTIONS

5.1 **Option 2** - continue with the existing approach. There is not an existing strategic focus on healthy weight in Rutland. While there is activity going on in all strands, without coordination it is difficult to know where gaps and opportunities are. Weight management services would continue to be delivered and support people to lose weight. However, they will only reach a small proportion of the population.

5.2 **Option 3** - focus on work in one strand of the approach. For example, the focus could be solely on the food environment. While this can help to be very focused on a particular area, it limits the impact of promoting a healthy weight as progress will be limited in other strands linked to causes of obesity.

6. FINANCIAL IMPLICATIONS

6.1 There are no initial financial implications as the mapping and planning will be delivered within the existing capacity. As mentioned above, there could be financial implications

for certain actions to be delivered, but these will be considered on an ad hoc basis within any relevant funding opportunities that may present at the time.

7. LEGAL AND GOVERNANCE CONSIDERATIONS

7.1 Governance considerations have bene outlined previously, with a proposed Health and Wellbeing Board oversight with the Staying Healthy Partnership responsible for delivery and monitoring.

8. DATA PROTECTION IMPLICATIONS

8.1 A Data Protection Impact Assessments (DPIA) has not been completed because there are no risks/issues to the rights and freedoms of natural persons.

9. EQUALITY IMPACT ASSESSMENT

9.1 An Equality Impact Assessment (EqIA) has not been completed at this stage because the current proposal does not include a new or change in service provision. If actions arise with relevance to new or changing activity, an EqIA will be completed.

10. COMMUNITY SAFETY IMPLICATIONS

10.1 None

11. HEALTH AND WELLBEING IMPLICATIONS

11.1 The proposal will provide significant opportunity for improvements to the health and wellbeing of the Rutland population. The reasons are outlined above within the background narrative.

12. CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

12.1 Taking forward this approach will greatly increase the potential for progress around promoting a healthy weight in Rutland. It will help with a coordinated effort across different workstreams and partners to ensure we are all contributing towards the same aims, resulting in benefits to all.

13. BACKGROUND PAPERS

13.1 OHID Whole Systems Approach to Obesity (**https://www.gov.uk/government/publications/whole-systems-approach-to-obesity**)

13.2 OHID Health Matters: Obesity and the food environment (**https://www.gov.uk/government/publications/health-matters-obesity-and-the-food-environment/**)

14. APPENDICES

14.1 Appendix A – Whole Systems Approach to Healthy Weight Strands

14.2 Appendix B – Desktop mapping and scoring

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577

APPENDIX A: WHOLE SYSTEMS APPROACH TO HEALTHY WEIGHT STRANDS

The school and childcare setting

Why is it important?

- Pregnancy and the early years provide a great opportunity to support development with healthy, varied textures and tastes.
- Breastfeeding can reduce the risk of childhood obesity, as the mother produces milk to meet nutritional needs.
- A healthy and varied diet in the early years supports positive food choices into childhood and adulthood.
- Infant weaning and introduction to solid foods provides a key opportunity to provide varied, healthy choices.

Planning a healthy food environment

Why is it important?

- The 'out of home' food environment is important, with a large proportion of food intake from restaurants, cafes, leisure centres, schools etc.
- Providing healthier options for people through 'out of home' food provision could be explored e.g. accreditation schemes and procurement.

Increasing healthy food consumption

Why is it important?

- There are opportunities to explore home and community growing initiatives, supporting communities to access free (or cheap) healthy food.

Creating healthy workplaces

Why is it important?

- With the large amount of time spent working, workplaces provide an opportunity to engage and improve health and wellbeing.
- Workplace teams, norms and policies have the potential to influence individual's physical activity and food intake.
- Workplaces can miss out on productivity and absenteeism due to obesity related ill-health.

Increasing active travel

Why is it important?

- The evidence base is extensive showing the benefits of active travel for health and preventing obesity.
- Opportunity to tackle wider issues such as congestion, air pollution and sedentary behaviours.
- There is an economic cost to households and the public sector of reliance on private cars including obesity related ill-health and wider issues above.
- Opportunity to integrate into daily lives for some areas (acknowledging rural challenges) including schools, workplaces and social.

Planning and creating an environment that promotes physical activity

Why is it important?

- The built environment has an important role to play in maximising the opportunities to be active.
- Planning policy and housing developments can support (or hinder) the opportunity for physical activity through infrastructure.

Educating people about the benefits of healthy eating and physical activity

Why is it important?

- Mixed messages on healthy eating can lead to confusion. Some people may want to eat healthily but are following incorrect advice and guidance.
- Breaking down barriers to eating healthily are important, including affordability, transport and mobility.

Promoting local opportunities and community engagement

Why is it important?

- Increasing awareness of what is available locally is crucial.
- Engagement with communities helps understand barriers and gaps in provision.

Providing access to weight management support

Why is it important?

- Some individuals need and want to have direct support in losing weight with direct advice and guidance.
- Individualised support can benefit some but will have limited impact on population prevalence alone.

APPENDIX B: DESKTOP MAPPING AND SCORING

Using the mapping of current activity, gaps and opportunities, each strand has been scored based on the below assessment. Scoring will be reviewed as part of progress monitoring.

1 – very limited/no activity, a lot of opportunity and gaps

2 – limited level of activity, some opportunity and gaps

3 – moderate level of activity, some opportunity and gaps

4 – good level of activity, a few opportunities and gaps

5 – excellent level of activity, no/very few opportunities and gaps

Strand	Score	Summary
Planning a healthy food environment	2	More could be done around new developments and design standards relating to the food environment.
The school and childcare setting	4	Widespread general health promotion activity is in place through different services. A chance to review the offer linked to food and physical activity opportunities.
Increasing healthy food consumption	2	Opportunity for 'grow your own' or 'community allotment' schemes. Community led initiatives in rural villages at micro level.
Creating heathy workplaces	3	Healthy Workplaces Rutland programme now in place. Opportunities around additional business offers to support on food availability and physical activity.
Increasing active travel	2	More strategic focus recently including Local Cycling and Walking Infrastructure Plan (LCWIP). Funding and rurality make progress challenging.
Planning and creating an environment that promotes physical activity	2	Some good policies within the Local Plan but could be strengthened further. More could be done to create active environments within rural areas where transport is difficult.
Educating people about the benefits of healthy eating and physical activity	3	Some good individual work in existing services (Weight Management, Active Referral). Opportunities for population approaches, e.g. health promotion campaigns.
Promoting local opportunities and community engagement	3	Infrastructure in place to promote (Joy, RISE etc) and community engagement. More can be done in rural villages and isolated areas building community capacity.
Providing access to weight management support	3	All tiers of service provision are in place. There are difficulties reaching large proportion of the population with limited resource. Opportunities could include targeting based on health inequalities.

Report No: 62/2024
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

23 April 2024

LEICESTER, LEICESTERSHIRE AND RUTLAND (LLR) INTEGRATED CARE SYSTEM (ICS) UPDATE

Report of the Portfolio Holder for Adults and Health

Corporate Priorities:	Support the most vulnerable	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Diane Ellison: Portfolio Holder for Adults and Health	
Contact Officer(s):	Sarah Prema, Chief Strategy Officer, LLR ICB	Email: sarah.prema@nhs.net
Ward Councillors	N/A	

DECISION RECOMMENDATIONS
That the Committee: 1. Notes the update from the LLR ICS.

1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to give members an update from the Leicester, Leicestershire and Rutland Integrated Care System.

2. UPDATE

2.1 In November 2023, Andy Williams retired from his role of Chief Executive of Leicester, Leicestershire and Rutland Integrated Care Board after a long career in the NHS. He was appointed to the role of Chief Executive of the Leicester, Leicestershire and Rutland Clinical Commissioning Groups in 2019 and then into the role of Chief Executive of the LLR ICB in 2021. The LLR ICB has appointed Caroline Trevithick as their new Chief Executive Officer from the end of November 2023. Caroline was previously the Chief Nurse for the ICB.

2.2 The Chair of the Leicester, Leicestershire and Rutland Integrated Care Board, David Sissling, has step down due to ill health. A recruitment process is underway to appoint a new chair which is hoped to be concluded by the end of April 2024.

2.3 From 1st April 2024 the LLR ICB has taken on the delegation of 59 specialised services from NHS England. These include renal, cardiac and cancer services. The LLR ICB will work with the other 10 ICBs across the Midlands to manage these services through

joint arrangements. The delegation will allow ICBs to focus resource to deliver more joined-up care for patients, improving their experiences and outcomes. It provides opportunities for prevention measures and to tackle health inequalities.

2.4 The LLR ICB now as delegated responsibility for the 59 specialised services together with primary care, dentistry, optometry and pharmacy which were delegated in 2023. Further work will be undertaken in 2024/25 with NHS England to delegate additional 29 specialised services over to ICBs together with immunisations and vaccination programmes.

2.5 Work is ongoing to develop the LLR ICB Operational Plan for 2024/25. This sets out how resources will be allocated, what activity will be undertaken by providers in year, what changes to workforce will be required, what performance levels the system is aiming for and what priorities the system will deliver. The national guidance asks systems to focus on:

- maintaining our collective focus on the overall quality and safety of our services, particularly maternity and neonatal services, and reduce inequalities in line with the Core20PLUS5 approach.
- improving ambulance response and A&E waiting times by supporting admissions avoidance and hospital discharge and maintaining the increased acute bed and ambulance service capacity that systems and individual providers committed to put in place for the final quarter of 2023/24.
- reducing elective long waits and improve performance against the core cancer and diagnostic standards.
- make it easier for people to access community and primary care services, particularly general practice and dentistry.
- improving access to mental health services so that more people of all ages receive the treatment they need.
- improving staff experience, retention and attendance.

2.6 The final Operational Plan is due to submission to NHS England on the 2nd May 2024.

2.7 The Health and Wellbeing Partnership meet in January 2024. At this meeting, an overview of current work being undertaken in Childrens and Young Peoples Mental Health together with a presentation on the role of the partners in the LLR ICB have as anchor organisations. There was a particular focus on the workforce in the anchor discussion.

2.8 An expression of interest has been made to pilot the Work Well initiative in LLR. This is a programme from the Department for Work and Pensions and the Department of Health and Social Care to tackle ill-health related economic inactivity and support individuals with a disability or long-term health condition to start, stay and succeed in work. The local bid identified that the initiative would benefit a minimum of 1,000 participants over two years. Successful bids will be notified in April 2024.

3. CONSULTATION

3.1 This report is an update for information; no consultation is required.

4. ALTERNATIVE OPTIONS

4.1 This report is an update for information; no alternative options are required.

5. CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATION

5.1 That the Rutland Health and Wellbeing Board notes this update from the LLR ICS.

6. APPENDICES

6.1 There are no appendices.

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Report No: 60/2024
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

23 April 2024

JOINT STRATEGIC NEEDS ASSESSMENT (JSNA): MENTAL HEALTH AND DEMENTIA - ADULTS

Report of the Portfolio Holder for Adults and Health

Corporate Priorities:	Support the most vulnerable	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Diane Ellison: Portfolio Holder for Adults and Health	
Contact Officer(s):	Mike Sandys, Director of Public Health	Telephone: 0116 3054259 Email: mike.sandys@leics.gov.uk
	Hanna Blackledge, Lead Public Health Analyst, BI, Leicestershire County Council	hanna.blackledge@leics.gov.uk T: 0116 3055509 (team line)
	Amy Chamberlain, Snr Public Health Analyst, BI, Leicestershire County Council	amy.chamberlain@leics.gov.uk T: 0116 3058846
Ward Councillors	N/A	

DECISION RECOMMENDATIONS

That the Committee:

1. Approves the Mental Health and Dementia JSNA for publication.

2. Supports the findings and recommendations of the JSNA.

3. Notes the contents of the JSNA.

1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to present to the Health and Wellbeing Board the Mental Health and Dementia (Adults) chapter of the Joint Strategic Needs Assessment for Rutland.

1.2 To seek approval for publication from the Health and Wellbeing Board of the Mental Health and Dementia JSNA and the recommendations for action.

2. BACKGROUND AND MAIN CONSIDERATIONS

2.1 The development of a Joint Strategic Needs Assessment is the responsibility of the Health and Wellbeing Board. This responsibility is laid down in the Health and Social Care Act of 2012, with the expectation that the JSNA will inform the Health and Wellbeing Strategy.

2.2 The Mental Health and Dementia JSNA will be a chapter in a larger suite of reports where each has a specific theme. Chapters already completed and available for 2022-25 are Demography and Growth, Health Inequalities, End of Life Care and Support, Oral Health, Substance Misuse and Alcohol.

2.3 The previous Mental Health JSNA was updated in 2018 and there has been a delay in updating the JSNA as a result of the COVID-19 pandemic.

2.4 The 2022-25 Mental Health JSNA for Rutland includes a more detailed section on dementia than was available in the previous JSNA for Rutland.

3. SUMMARY OF FINDINGS

3.1 As proposed by the World Health Organisation, 'mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes.' Thus, mental health is a dynamic and evolving aspect of a person's life, influenced by various factors, including genetics, environment, life experiences and personal choices.

3.2 Demographics and Populations at Risk

- The population of Rutland is older than the national average, with a steeper projected rise in the older age groups than nationally over the next decade which is likely to have a significant impact on mental health morbidity and multimorbidity.
- Rutland is predominantly a rural county, with most of the population living in population sparse areas linked to issues of rural deprivation, social isolation, loneliness, poor access to services all with potential negative impact on mental health.
- Rutland is home to two British Army Barracks with a significant Armed Forces population.

3.3 Mental Health Needs

- **Common Mental Disorders (CMD)** - given the current population estimates, around 5,500 adult residents of Rutland could be suffering from a CMD, including 1,900 cases of general anxiety disorder (GAD), 1,100 cases of depression, 720 phobia sufferers and a similar number of those with dementia.
- In 2022/23 there were more than 3,940 adults with depression on Quality Outcomes Framework (QOF) registers, with 400 new cases every year, and just under 360 dementia cases.
- The rates of depression on QOF registers have more than doubled since 2013/14, in accordance with the national trend.

- **Dementia** - the prevalence rate of dementia on GP registers is significantly lower (worse) than the national average (49% of estimated cases in Rutland, vs. 63% nationally). This indicates that more than a half of dementia cases could be

undiagnosed and not receiving treatment. The rates of dementia on QOF registers remained stable since 2013/14.

- Dementia prevalence is projected to increase – between 2023 and 2040 the number of people aged 65 and over in Rutland with dementia is estimated to increase by nearly a half (49%), while in persons aged 85 years the increase is expected to be over 70%.

- **Severe Mental Illness (SMI)** - the estimated number of adults in Rutland suffering from an SMI is 790; with just over 310 patients having an SMI diagnosis on the GP register, according to the 2022/23 QOF figures. This rate of registered SMI in Rutland is significantly below the national average and suggests that a substantial number of people with SMI could be undiagnosed.
- The rates of physical illness in this group of patients are high, however only 45% of people registered with SMI across Leicestershire and Rutland have a full health check, below the national average of 52%. The uptake of breast screening for women with SMI is also low when compared to that in general population (34% screened vs. 72%).
- In 2019/20 there were around 7,750 attended contacts with community and outpatient mental health services in Rutland and 2,220 new referrals to secondary mental health services in the same time period.

- **Suicide and Self-harm** - the absolute numbers of suicides in Rutland are low (a total of seven between 2020 and 2022). The rate of emergency hospital admissions for intentional self-harm in Rutland seems to be significantly below the national average (106 per 100,000 population vs. 164/100,000 in 2021/22).
- However, it is estimated that the number of people having thoughts of self-harming and/or attempting suicide each year in Rutland could be in a ballpark of 2,000, suggesting a higher level of need in the population.

- **Neurodevelopmental disorders** – includes Autism Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) which can co-exist, and often persist into adulthood; ASD is regarded as a life-long disorder. It is estimated that as many as 700 adults could have ASD and 3,000 ADHD in Rutland. At the national level, the numbers of people of all ages waiting for an autism assessment have risen at least 6-fold since April 2019 and average waiting times were reaching 300 days in the last quarter of 2023. The local (East Leicestershire and Rutland) data suggest lower than national waiting times for adults (100 days vs. 300 days) and a higher proportion getting a first appointment in the NICE recommended time (under 13 weeks) – 26% rather than 5% nationally.

- **Access to Mental Health Services** - in 2022/23, there were 2,055 people in contact with NHS funded secondary mental health, learning disabilities and autism services for residents in Rutland. Of these, 40 (equivalent to nearly 2%) were admitted as an inpatient. There has been a 14% increase in the number of people in contact between 2021/22 and 2022/23 in Rutland, compared to a 10% rise nationally.
- The rate of mental health bed occupancy, expressed as the number of in-year bed days per 1,000 population was significantly lower in Rutland (65 per 1,000) than the national average (168 per 1,000).

3.4 **Mental Health Services**

- Mental health services for adults are provided through the NHS and other community organisations. The NHS services are traditionally grouped as primary,

secondary, and tertiary care, but transformation is ongoing to create integrated community mental health services.

- Services are primarily commissioned and operate across Leicester, Leicestershire and Rutland (LLR) and cover a range of talking therapies, mental health units and teams, inpatient and outpatient services, services for specific mental health conditions, services provided specifically for older people, support provided by police, mental health practitioner and substance misuse practitioner partnerships and voluntary and community-based services.
- Most of data on services are available at ICB or sub-ICB level.
- The report, and its expanded Appendix, describe details of services (inpatient, community, specialist and other), provided for adult residents of Rutland.

3.5 **Identified Needs and Gaps**

- Several issues relevant to the mental health of adults emerged from the examination of population trends, including a steep growth in numbers of older adults resulting in high projected prevalence of mental conditions, and multimorbidity, affecting both mental and physical health needs of adults in Rutland.
- The prevalence of dementia alone is likely to increase by 40% by 2040.
- There are gaps between the estimated prevalence of severe mental illness in the population and numbers of patients diagnosed and registered with on general practice registers, indicating a substantial gap in treatment.
- Only about half of people with severe mental illness are receiving full physical health checks; the rates of breast screening for women with SMI are generally low and premature cancer mortality in SMI patients is higher than expected.
- There is rising demand across all mental health services (potentially 14% year-on-year increase), and on specific services such as the perinatal services.
- The care for people with a personality disorder (PD) is fragmented, despite rising evidence of its effectiveness.
- There are perceived gaps in the continuity of care between emergency department and general practice for people self-harming, particularly those without a permanent local address.
- Although some work to understand the health and wellbeing needs of Rutland's armed forces population has been undertaken recently, the small numbers of respondents make it difficult to draw conclusions on the wider needs of this population, particularly as this population has recently changed.

4. RECOMMENDATIONS

4.1 Following a consultation with stakeholders, several recommendations were drafted, including:

- To seek opportunities for prevention and early detection of mental health conditions, including raising awareness of the risk factors of dementia and prevention measures for these.
- To monitor and improve uptake of physical health checks, particularly among those with serious mental illness or dementia.
- As Rutland is predominantly rural, issues of access to services and hidden pockets of deprivation should be recognised and address at a local level, through improved joint working.
- To enhance the continuity of care for self-harm, including emergency, primary, social care and other local services.

- To enhance local data collection on mental health inequalities, prevention and services, including mapping of services and patient pathways, particularly for vulnerable groups such as pregnant women and armed forces populations.
- Further modelling of the impact of current demographic trends on future mental health needs and demand for health care, particularly for dementia and more granular and up-to-date local information on services provided for the Rutland population.

5. CONSULTATION

5.1 Consultation was undertaken with key stakeholders through the Rutland Mental Health Neighbourhood Group as well as a presentation of the data and the distribution of draft documents. This afforded the members of the group to comment, make additions and offer any supporting evidence for the JSNA.

6. ALTERNATIVE OPTIONS

6.1 JSNA development is a statutory requirement. Reducing health inequalities is a crosscutting priority in the Rutland Health and Wellbeing Strategy. The update to the Mental Health JSNA was undertaken to inform health and social care on the recent trends in mental health needs of the population, examine health inequalities, and to assess the impact of the COVID-19 pandemic. It aims to provide an evidence base for local mental health and care commissioning.

7. FINANCIAL IMPLICATIONS

7.1 Completion of the needs assessment was within existing capacity within the Public Health team, with partner support. Whilst the report findings do not carry any financial implications directly, its recommendations may require resources to deliver.

8. LEGAL AND GOVERNANCE CONSIDERATIONS

8.1 The JSNA is a statutory document. It must meet the requirements for production of such documents and must be approved by the Health and Wellbeing Board.

9. DATA PROTECTION IMPLICATIONS

9.1 All data presented in the report follow the data protection guidelines. The information is mostly derived from public domain sources, with any additional data on individuals rounded or suppressed, as appropriate.

10. EQUALITY IMPACT ASSESSMENT

10.1 An Equality Impact Assessment (EqIA) has not been completed; however, the report highlights the mental health needs of many population groups, including those with protected characteristics, and aims to reduce health inequalities locally. The recommendations will underpin service developments and updates to commissioning strategies which themselves will be subject to the Equality Impact Assessment process.

11. COMMUNITY SAFETY IMPLICATIONS

11.1 Not applicable.

12. HEALTH AND WELLBEING IMPLICATIONS

12.1 The report enhances awareness of current mental health issues in the adult population of Rutland, leading to more informed and equitable commissioning of services for the local population. Its recommendations aim to improve health and wellbeing outcomes for those most in need.

13. ORGANISATIONAL IMPLICATIONS

13.1 Environmental Implications: There are no direct environmental implications.

13.2 Human Resource Implications: There are no direct human resource implications of the report, however, implementation of some its recommendations may result in human resource implications in the future.

13.3 Procurement Implications: Not applicable.

14. CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

14.1 The report highlights specific issues affecting mental health of the adult population of Rutland, indicating increasing prevalence of mental health problems and increasing demand for services. Epidemiological estimates suggest that there could be substantial numbers of people with severe mental illness who are not diagnosed and not receiving treatment, highlighting a need for improvement in early detection and prevention. There is scope for improving prevention of physical disease in people with SMI, through increasing rates of health checks and cancer screening. For those diagnosed and accessing services, improvements in service provision through joint working, including enhanced continuity of care, improved transition between children's and adults' services, and of treatment of personality disorders are all recommended.

15. BACKGROUND PAPERS

15.1 There are no additional background papers supporting the report.

16. APPENDICES

16.1 Appendix A: Mental Health and Dementia – JSNA for Adults – Main Report

16.2 Appendix B: Mental Health and Dementia - JSNA for Adults – Appendix

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577

RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2024

MENTAL HEALTH AND DEMENTIA - ADULTS

March 2024

Business Intelligence Team
Leicestershire County Council

Public Health Intelligence

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Foreword

This document presents a three-year update of the Joint Strategic Needs Assessment (JSNA) for mental health and mental wellbeing among adults in Rutland. It reviews the population health needs in relation to mental health, its socio-economic determinants, impact on health outcomes, outlines the relevant policy and guidance, existing services and the range of services that are currently provided. It also estimates the unmet needs and presents recommendations based on the findings.

In general, the purpose of a JSNA is to:

- Improve the health and wellbeing of the local community and reduce inequalities for all ages.
- Determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- Provide a source of relevant reference to the Local Authority, Integrated Care Board (ICB) and NHS England for the commissioning of any future services.

The Local Authority and ICBs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Rutland, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs. The JSNA offers an opportunity for the Local Authority, ICBs and NHS England's plans for commissioning services to be informed by up-to-date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, ICBs and NHS England must be able to explain why.

The Health and Wellbeing Board has agreed that the JSNA will be published in subject-specific chapters throughout a three-year time period. Chapters will be developed in line with ICBs and local authority commissioning cycles. As many of the relationships required for the JSNA in Leicestershire are wide ranging, a relevant working group was created. The outputs of the JSNA may include:

- Subject-specific chapters of an assessment of current and future health and social care needs
- An online infographic summary of each chapter
- An online data dashboard that is updated regularly to allow users to self-serve high level data requests.

Please note, the majority of the indicators presented in this needs assessment are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. It should be noted that where local context has been provided for Rutland, data often includes small counts and as such caution should be taken when drawing conclusions.

Contents

Figures

Tables

Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
AMHPs	Approved Mental Health Professionals
APCC	Association of Police and Crime Commissioners
APMS	Adult Psychiatric Morbidity Survey
ASB	Antisocial Behaviour
ASD	Autism Spectrum Disorders
ASPD	Anti-Social Personality Disorder
BMI	Body Mass Index
BPD	Borderline Personality Disorder
CBT	Cognitive Behavioural Therapy
CHD	Coronary Heart Disease
CIPFA	Chartered Institute of Public Finance and Accountancy
CIS	Clinical Intervention Schedule
CMD	Common Mental Disorders
CNA	Certified Normal Accommodation
CSEW	Crime Survey for England and Wales
DHSC	Department of Health and Social Care
DMS	Defence Medical Services
ELSA	English Longitudinal Study of Ageing
ESA	Employment Support Allowance
FTRS	Full Time Reserve Service
GAD	Generalised Anxiety Disorder
GP	General Practitioner
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
IMHA	Independent Mental Health Advocacy
JSNA	Joint Strategic Needs Assessment
LGBT+	Lesbian, Gay, Bisexual, Transgender and others
LLR	Leicester, Leicestershire, and Rutland
LSOA	Lower Layer Super Output Area

LTC	Long Term Condition
OCD	Obsessive-Compulsive Disorder
ONS	Office for National Statistics
MCN	Multiple Complex Needs
MHB	Mental Health Bulletin
MOD	Ministry of Defence
MUS	Medically Unexplained Symptoms
NHSMHD	NHS Mental Health Dashboard
NICE	National Institute for Care Excellence
NOS	Not Otherwise Specified
NPCC	National Police Chiefs' Council
PFA	Police Force Areas
PTSD	Post-Traumatic Stress Disorder
QOF	Quality and Outcomes Framework
RCRP	Right Care Right Person
SAMHSA	Substance Abuse and Mental Health Services Administration
SMD	Severe and Multiple Disadvantage
SMI	Severe Mental Illness
VAP	Violence Against the Person
YOI	Youth Offender Institution

1. Executive Summary

This Joint Strategic Needs Assessment (JSNA) aims to provide an understanding of adult mental health issues and mental wellbeing in Rutland. It incorporates national and local evidence to support local priority setting. Not all information is available at county or district level, particularly as commissioning data are now largely published at ICB level, and where available, numbers may be too low to reach robust statistical conclusion. Where appropriate, local Leicestershire and Rutland context is provided in such cases.

Population

- Rutland's population is on average older than the national average – one in four (25%) are older adults, compared to 19% nationally (Census 2021). The projected increase in the oldest groups (85+) is by 45% in the next decade, with significant implications for mental and physical morbidity and multi-morbidity (40% increase in people with four or more conditions).
- Although Rutland's population can be regarded as relatively affluent according to standard socio-economic indicators, there are pockets of deprivation, particularly of rural character. Issues deriving from loneliness, barriers to housing, or poor access to services can have significant impact on mental wellbeing.

Who is at Risk

- Nationally and locally, there are increasing numbers of women accessing perinatal mental health services, indicating a growing need in this population group.
- There are indications that the rates of access to mental health treatments for prison populations is still below the pre-pandemic levels.
- Nationally, the rates of mental health problems among students are rising, with more than 5% prevalence reported recently, although there are no data to confirm this at a local level.
- Local survey suggests high mental health needs among the armed forces personnel, with relatively low accessibility of services for this group. Rutland has proportionately high numbers of UK armed forces personnel and veterans. Enhanced local data collection for this group has been recommended.

Mental Health Needs

- Of the estimated 5,500 Rutland residents with a **common mental health disorder (CMD),** approximately 4,000 are diagnosed (on GP registers), thus as much as 1,500 are potentially

undiagnosed.

- This includes a total of 720 estimated cases of dementia, of which less than a half are registered with GPs in 2023. This is well below the national standard to dementia diagnosis.
- Access to Talking Therapies is below the target (just over 60%); spend has also fallen in 2022/23 to 80% of the target (latest financial data available only at LLR level), with higher than national proportion of people waiting over 90 days in-treatment.
- For **dementia**, Rutland has higher than average prevalence of conditions which are risk factors, such as hypertension, stroke and CHD but lower than expected lifestyle factors (e.g. obesity or smoking) – there is scope for further enhancing early detection and treatment of cardiovascular conditions to help prevent rise of dementia in the future.
- Community-based memory services in Rutland are accessed at slightly higher than national rate (by around 210 individuals per year).
- There are around 70 deaths due to dementia every year in Rutland; statistically this is not significantly different than national rate.
- Nationally the waiting times for those with suspected **neurodevelopmental disorders** (ASD/ADHD) are rising. However, looking at local indicators (such as average waiting times and proportions of those receiving assessment under 13 weeks), these compare favourably with national average.
- For **severe mental illness (SMI)** there is also a gap between the estimated prevalence of 790 (bipolar disorder plus other psychotic disorders) and diagnosed (GP-registered) prevalence of just over 310.
- Nationally, the risk of premature mortality in people with SMI is almost four times higher compared to those without SMI, this disparity is even higher in Rutland (4.5 times higher risk). A large component of this appears to be cancer mortality, although local numbers are too low to draw robust statistical conclusions.
- Less than a half of people with SMI in East Leicestershire and Rutland had a full physical health check (as of June 2023). Breast screening rates for women with SMI are only half of those in the general population.
- The annual rate of **suicide** in Rutland is relatively low (less than 3 per year, on average) and hospital admission rates for self-harm (45 admissions in a year) are lower than the national average. However, it is estimated that the number of people having thoughts of self-harming and/or attempting suicide each year in Rutland could be in in a ballpark of 2,000.
- Nearly 70% of those entering **drug treatment** in Rutland have mental health needs, as well as over 60% of those entering alcohol-only treatment, according to drug and alcohol misuse services. However, the rates of hospital admission for alcohol-related mental health issues

appears to be significantly lower than elsewhere in England (about a third of the national rate, depending on methodology).

- The rates of contact with **secondary mental health services** are rising nationally as well as locally (by as much as 14% year-on-year recently). In 2022/23, over 2,000 Rutland adults were in contact with services, 1.9% (N=40) were admitted as inpatients, a proportion which is lower than national average of 2.6%. Furthermore, the mental health rate of bed occupancy (in-year occupied bed-days) in Rutland is relatively low, about a third of the national rate.

Mental Health Services

- A number of statutory and non-statutory services are working together to provide mental health and wellbeing support.
- Services are primarily commissioned and operate across Leicester, Leicestershire and Rutland (LLR) and cover a range of services, such as talking therapies, community teams, early intervention teams, recovery teams, crisis support, dementia services and a number of specialist services. All services are described in more details in the report.

Return on Investment

- Evidence indicates that there is a positive return of around £5.30 on every £1 spent on mental health interventions in the workplace, although many other programmes can have significant economic impact, including perinatal depression prevention, parenting programmes, early identification of mental disorders in young and older people and psychological interventions in patients with long-term conditions.

Gaps and Recommendations

- Currently, the care for people with personality disorders (PD) is fragmented with gaps in service, and poor access due to stigma. There is increasing evidence that treatment for PD is effective and should be made more accessible. The estimated prevalence of PD is at least 4,000 in Rutland.
- There is a lack of flexible mental health outreach for people who sleep rough and may have dual diagnosis with substance misuse.
- It is recognised that 50% of mental health problems are established by age 14 and 75% by age 25, there is a need for earlier diagnosis and treatment and better transition from children's mental health services.
- There are gaps in the continuity of care for people self-harming, attending Emergency Department and returning back to locality Primary care and local services, particularly for those

at university who may be at a part-time address.

- Improve rates of physical health checks and cancer screening in people with SMI.
- Enhance engagement with the voluntary and community sector.
- Develop prevention services for carers of people with mental health difficulties to provide support before that person reaches a crisis.
- Although some work to understand the health and wellbeing needs of Rutland's armed forces population has been undertaken recently, the small numbers of respondents make it difficult to draw conclusions on the wider needs of this population, particularly that this population has recently changed.
- Further modelling of the impact of current demographic trends on future mental health needs and demand for health care, particularly for dementia, would be recommended to understand growing health needs better.
- There is perceived need for more granular and up-to-date local information on services provided for Rutland population.

Some of the identified gaps and recommendations apply across the local commissioning footprint.

2. Policy and Guidance

2.1. National Mental Health Policy and Guidance

2.1.1. NHS Long Term Plan (2019)[1]

The National Health Service (NHS) Long Term Plan, published in January 2019, outlined key strategies and commitments regarding mental health services in England. It offered a comprehensive approach to improving mental health services in England, with an emphasis on prevention, early intervention, integration, and innovation. It set out a number of goals to address the growing demand for mental health support and improve outcomes for individuals. Focusing on early intervention and prevention, increasing access to services, service integration, increasing funding and resources for children and young people, improving perinatal mental health services, developing mental health workforce, it highlighted the role of harnessing digital technology and reducing stigma surrounding mental health issues and ultimately reducing the number of suicides and addressing the underlying social and economic factors contributing to mental health problems.

2.1.2. Advancing Mental Health Equalities Strategy (2020)

The Advancing Mental Health Equalities Strategy by NHS England[2] outlined a comprehensive approach to address disparities and promote equity in mental health care through a number of aims such as addressing the underlying factors contributing to mental health inequalities, improving access to mental health services for marginalized and underserved communities, targeted interventions in schools, workplaces, and communities, tackling stigma and discrimination, or tailored support and interventions for specific population groups. The Strategy puts an emphasis on the importance of data on mental health inequalities, collaboration and partnership working, workforce diversity, and monitoring and evaluation.

2.1.3. National Disability Strategy (2021)[3]

The National Disability Strategy in the UK outlines a comprehensive plan to address the barriers and challenges faced by disabled people across various aspects of life, including independent living, employment, skills, education, transport and public spaces. It focuses on improving access to health and social care services for disabled people, mental health and rehabilitation support, and personal care.

2.1.4. National Partnership Agreement: Right Care, Right Person (2023)

Set out around the Right Care, Right Person approach, which aims to ensure that individuals in mental health crisis are seen by the right professional, the agreement between the Department of Health and Social Care (DHSC), Home Office, NHS England, National Police Chiefs' Council (NPCC), Association of Police and Crime Commissioners (APCC) and College of Policing [4].

The Right Care, Right Person (RCRP) framework was developed to help police to make decisions about when to respond to incidents.

2.1.5. Suicide Prevention Strategy (2023)

In September 2023, the Government published the Suicide prevention strategy for England: 2023 to 2028[5].

The strategy and corresponding action plan set out ambitions for the next five years a) to reduce the suicide rate, with initial reductions made within at least half this time, b) to improve support for people who have self-harmed, and c) improve support for people who have been bereaved by suicide.

The strategy includes over 100 actions focused on improving data, providing targeted support to these priority groups, addressing common risk factors linked to suicide, promoting online safety, providing crisis support, reducing access to means of suicide, and providing bereavement support.

2.1.6. Major Conditions Strategy and A Mentally Healthier Nation (2023)

In April 2022, the Government launched a Mental health and wellbeing plan: discussion paper and call for evidence, intended to inform a new 10-year, cross-government mental health strategy. The discussion paper and consultation questions focused on promotion of mental wellbeing, prevention of mental health conditions, early intervention, quality and effectiveness of treatment, support for people with mental health conditions and support for people in crisis. The responses to the consultation for the 10-year strategy were to be used to inform the Major Conditions Strategy and to develop the new Suicide Prevention Strategy (see 2.1.5). In January 2023, the Government announced that it will publish a Major Conditions Strategy that will include mental health to ensure that mental health conditions are considered alongside physical health conditions.

In response, mental health charities, including the Mental Health Foundation, Mind and Rethink Mental Illness, with many other mental health charities and organisations published in January 2023 a document entitled Mentally Healthier Nation, setting out priorities for a ten-year, cross-government mental health strategy. The document includes policies on prevention, equality, and support that the group would like to see implemented following the next general election [6].

2.1.7. NHS Long Term Workforce Plan (2023)

The NHS Long Term Workforce Plan was published in June 2023 by the Department of Health and Social Care. The plan estimates a shortfall of over 15,800 full time-equivalent mental health nurses by 2036/37[7]. The plan sets out an ambition to increase training places for mental health nursing by 93% to over 11,000 places by 2031/32. This would start with an increase in mental health nursing places of 38% by 2028/29. The increase in places would include an expansion of the nursing apprenticeship scheme so that by 2028/29, 28% of mental health nurses are qualifying via this route.

However, it is expected that there will continue to be shortfalls in mental health staffing in the medium-term.

Prior to 2019, the following key policies were published:

2.1.8. Mental Health Act (1983)

The Mental Health Act (1983) in the UK is legislation that provides a legal framework for the care and treatment of individuals with mental disorders. It balances the need to protect the rights of individuals with mental disorders while ensuring they receive appropriate care and treatment when necessary. It provides a legal framework for the detention, assessment, and treatment of individuals with mental health needs, with safeguards in place to protect their rights and interests.

The Act has undergone various reforms over the years, with the most recent amendments introduced by the Mental Health Act 2007 and ongoing discussions about further reforms to modernize and improve mental health legislation, including the **2018 Review of The Mental Health Act,** an independent review of the Mental Health Act 1983, published in December 2018[8].

In June 2019, the then-Government accepted further recommendations to tackle the disproportionate number of people from Black, Asian and minority ethnic groups who are detained under the Act, and further steps to end the use of police stations as a place of safety.

2.1.9. The Five Year Forward View for Mental Health (2016)[9]

The Five Year Forward View for Mental Health, a report from the independent Mental Health Taskforce to NHS England, was published in February 2016. The Taskforce made a series of recommendations, including achieving parity of esteem between mental and physical health, wider, cross-government action across areas such as employment, housing and social inclusion, Tackling inequalities. It also addressed inequalities in access to services among certain black and minority ethnic groups, whose first experience of mental health care often came when they were detained under the Mental Health Act, often with police involvement.

It made specific recommendations for supporting more new and expectant mothers through maternal mental health services each year, providing mental health care to more children and young people, increasing access to talking therapies, improving integrated care for people living with long-term physical health conditions, meeting the physical health needs of people with a severe mental illness and helping this group find and stay in employment. It also recommended making a community-based crisis response available across England and providing a mental health liaison service for people of all ages in every acute hospital. It also made a commitment to reducing suicides by 10%.

2.1.10. NICE Guidance

The National Institute for Care Excellence (NICE) issued the following guidance documents for mental health:

- *Social, Emotional and Mental Wellbeing in Primary and Secondary Education (NG223)* published in 2022 - covers ways to support social, emotional and mental wellbeing in children and young people in primary and secondary education, and people with special educational needs or disability in further education colleges[10].
- *Depression in Adults: Treatment and Management (NG222)* published in 2022 – deals with identifying, treating and managing depression in people aged 18 and over, provides advice on preventing relapse, and managing chronic depression, psychotic depression and depression with a coexisting diagnosis of personality disorder[11].
- *Mental Wellbeing at Work (NG212)* published in 2022 – provides best evidence on how to create the right conditions for mental wellbeing at work[12].
- *Antenatal and Postnatal Mental Health: clinical management and service guidance (CG192)* published in 2014, updated 2020 - covers recognising, assessing and treating mental health problems in perinatal period[13].
- *Generalised Anxiety Disorder and Panic Disorder in Adults: management (CG113)* published in 2011, updated 2020 - covers the care and treatment of people aged 18 and over with chronic anxiety or panic disorder (with or without agoraphobia or panic attacks), aiming to help people achieve complete relief of symptoms, better functioning and a lower likelihood of relapse[14].
- *Decision-Making and Mental Capacity (NG108)* published in 2018 - discusses decision-making in adults (aged 16 and over) who may lack capacity now or in the future, providing health and social care practitioners to support people to make their own decisions where they have the capacity to do so[15].
- *Eating Disorders: Recognition and Treatment (NG69)* published in 2017 – covers assessment, treatment, monitoring and inpatient care for children, young people and adults with eating disorders[16].
- *Mental Health of Adults in Contact with the Criminal Justice System (NG66)* published in 2017 - covers assessing, diagnosing and managing mental health problems in adults (aged 18 and over) who are in contact with the criminal justice system[17].
- *Transition Between Inpatient Mental Health Settings and Community or Care Home Settings (NG53)* published in 2016 - covers the period before, during and after an admission to, and discharge from, a mental health hospital, aiming to improve experience of transition[18].
- *Workplace Health: Management Practices (NG13)* published in 2015 - covers how to improve the health and wellbeing of employees, with a focus on organisational culture and the role of

line managers. The 2016 update covered recommendations about older employees, aged over 50 in paid or unpaid work [19].

- *Older People: Independence and Mental Wellbeing (NG32)* published in 2015 - covers interventions to maintain and improve the mental wellbeing and independence of people aged 65 or older[20] .
- *Mental Wellbeing in Over 65s: Occupational Therapy and Physical Activity Interventions (PH16)* published in 2008 - covers promoting mental wellbeing in people aged over 65 focusing on practical support for everyday activities, based on occupational therapy principles and methods[21] .

2.1.11. NICE Quality Standards

- *Decision Making and Mental Capacity (QS194)* published in 2020[22] - aims to support the implementation of the aims and principles of the Mental Capacity Act 2005 and relevant Codes of Practice.
- *Promoting Health and Preventing Premature Mortality in Black, Asian and Other Minority Ethnic Groups (QS167)* published in 2018[23] – includes quality statements on support for people with mental health problems and physical health checks for people with serious mental illness.
- *Mental Health of Adults in Contact with the Criminal Justice System (QS163)* published in 2018[24] – sets out standards for recognising, assessing and managing mental health problems in adults who are in contact with the criminal justice system.
- *Transition Between Inpatient Mental Health Settings and Community or Care Home Settings (QS159)* published in 2017[25] – contains quality statements on access to independent advocacy services, out-of-area admissions, communication on discharge and suicide risk.
- *Violent and Aggressive Behaviours in People with Mental Health Problems (QS154)* published in 2017[26] - covers short-term prevention and management of violent and physically threatening behaviour among adults, children and young people with a mental health problem.
- *Healthy Workplaces: Improving Employee Mental and Physical Health and Wellbeing (QS147)* published in 2017[27] - describes high-quality care in priority areas for improvement.
- *Learning Disability: Identifying and Managing Mental Health Problems (QS142)* published in 2017[28] - covers the prevention, assessment and management of mental health problems in people with learning disabilities in all settings.
- *Mental Wellbeing and Independence for Older People (QS137)* published in 2016[29] - describes high-quality care in priority areas for improvement, including statements on physical activity, social participation and risk of decline.
- *Antenatal and Postnatal Mental Health (QS115)* published in 2016[30] - covers the organisation

of mental health services for women during and after pregnancy, describes high-quality care in priority areas for improvement.

- *Mental Wellbeing of Older People in Care Homes (QS50)* published in 2013[31] – sets out a number of quality statements on recognition of mental health conditions, sensory impairment, physical problems and on access to healthcare services in this group.
- *Service User Experience in Adult Mental Health Services (QS14)* published in 2011 and updated in 2019[32] - covers improving the experience of people using adult NHS mental health services.

2.1.12. NICE Clinical Knowledge Summaries

NICE also publishes accessible summaries of the current evidence base and advice on best practice across clinical areas (full list at https://cks.nice.org.uk/), including mental health:

- Antenatal and postnatal depression (revised in April 2022)
- Attention deficit hyperactivity disorder (revised in August 2023)
- Autism in adults (revised in May 2020)
- Bipolar disorder (revised in January 2024)
- Dementia (revised in January 2024)
- Depression (revised in December 2023)
- Eating disorders (revised in July 2019)
- Generalized anxiety disorder (revised in February 2024)
- Mental health in students (October 2020)
- Obsessive-compulsive disorder (revised in February 2024)
- Post-traumatic stress disorder (revised in December 2023)
- Psychosis and schizophrenia (revised in September 2021)
- Self-harm (revised in November 2023)

2.2. Rutland Joint Health and Wellbeing Strategy

The Rutland Joint Health and Wellbeing Strategy: The Rutland Place based Plan 2022 – 27[33], includes seven priority themes. Of these, the 'cross-cutting themes' priority brings together three themes which interlink with multiple priorities across the strategy. One of these themes is 'supporting good mental health'.

The Leicester, Leicestershire and Rutland (LLR) vision for mental health of both children and adults across the system is 'We will deliver the right care to meet the needs of individual patients at the right time. We will integrate with health and social care partners to care for people when they feel they have mental health needs'.

The Rutland Joint Health and Wellbeing Strategy 2022-27 will progress the Rutland place specific elements of this work to champion Rutland's needs and support the delivery of mental health prevention, care and treatment services that improve local patient experience and outcomes.

2.3. Dementia Policy and Guidance

2.3.1. National Dementia Strategy[34]

This is a best practice guideline compiled by the Department of Health with the support of over 50 stakeholders. The aim of the strategy is to ensure that significant improvements are made to dementia services across three key areas: improved awareness, earlier diagnosis and intervention, and a higher quality of care. The strategy identifies 17 key objectives which, when implemented, should result in improvements in the quality of services provided to people with dementia and should promote a greater understanding of the causes and consequences of dementia. This strategy was published in 2009.

2.3.2. Prime Minister's Challenge on Dementia[35]

Originally launched in 2012, a programme of action to deliver sustained improvements in health and care, create dementia friendly communities and boost dementia research. With a republish in 2015, the government's key aspirations include improved public awareness and understanding of the risk factors of dementia, equal access to diagnosis, coordination and continuity of care for people with dementia, dementia training for all NHS staff, dementia friendly health and care settings, dementia friendly businesses and all tiers of local government being part of a local Dementia Action Alliance. It also announced that funding for dementia research was on track to be doubled by 2025.

2.3.3. NICE Guidelines[36]

A NICE guideline of particular note is "Dementia, disability, and frailty in later life – mid-life approaches to delay or prevent onset.'[37] It includes recommendations on promoting a healthy lifestyle to reduce the risk of, or delay the onset of, disability, dementia and frailty by helping people to: stop smoking, be more active, reduce their alcohol consumption, improve their diet and lose weight and maintain a healthy weight if necessary.

2.3.4. NHS England Transformation Framework – The Well Pathway for Dementia[38]

A transformation implementation plan which covers preventing well, living well, supporting well and dying well. The pathway also covers areas such as researching, integrating, commissioning, training and monitoring well.

2.3.5. Dementia: Good Care Planning – information for primary care and commissioners[39]

Aimed at primary care and commissioners, particularly GPs, who provide care plan reviews. It is

designed to help improve care planning in dementia by supporting a standardised approach, highlighting good practice, ensuring alignment with relevant cross condition care plans and helping to reduce local variation in the process.

2.3.6. Royal College of Psychiatry – Dementia care pathway[40]

This document outlines the pathway to help support the delivery of care around people with dementia or mild cognitive impairment (both medically and socially). One of the main aims of this pathway is to standardise timely diagnosis and post diagnostic care (for patients and carers).

It defines benchmarks for the Dementia Care Pathway, including achieving and maintaining a diagnosis rate of at least two-thirds, increasing the number of people being diagnosed with dementia and starting treatment within 6 weeks of referral and improving the quality of post-diagnostic treatment and support for people with dementia and their carers.

2.3.7. NHS Leicester, Leicestershire and Rutland Integrated Care Board Five-Year Plan 2023/24 – 2027/28[41]

Sets out how care and outcomes for patients will be improved, the equity gap across LLR will be reduced and financial stability will be achieved. Specifically with regards to dementia, the approach includes improving the dementia care pathway to support delivery of the Living Well with Dementia Strategy (see 2.3.8 below).

2.3.8. Leicester, Leicestershire and Rutland (LLR) Living Well with Dementia Strategy (2019-2022) and 2024-2028 draft[42]

This strategy looks to support those with dementia and carers for those with dementia, using NHS England Well Pathway for Dementia as a framework. It aims to improve the experience of people throughout their journey with dementia.

The principles of this joint strategy are guided by NICE guidelines, the Organisation for Economic Co-operation and Development framework for Dementia and the Dementia I-statements from the National Dementia Declaration, as well as the NHS England Well Pathway for Dementia, and similarly is divided into the following chapters: Preventing Well, Diagnosing Well, Supporting Well, Living Well and Dying Well. Consultation on the Strategy closed in September 2023. The draft document provides an update to the strategy developed in 2019, reflecting priorities for 2024-2028.

2.3.9. Other

There are also a range of other relevant local documents which include:

- Leicester, Leicestershire and Rutland Joint Carers Strategy Refresh 2022-2025[43], which establishes priorities in order to provide better support to carers locally.
- Leicestershire Dementia Joint Strategic Needs Assessment 2018-2021[44]

- Leicestershire County Council Strategic Plan 2022-2026[45] outlines the county council's vision and priorities.

3. Who is at Risk

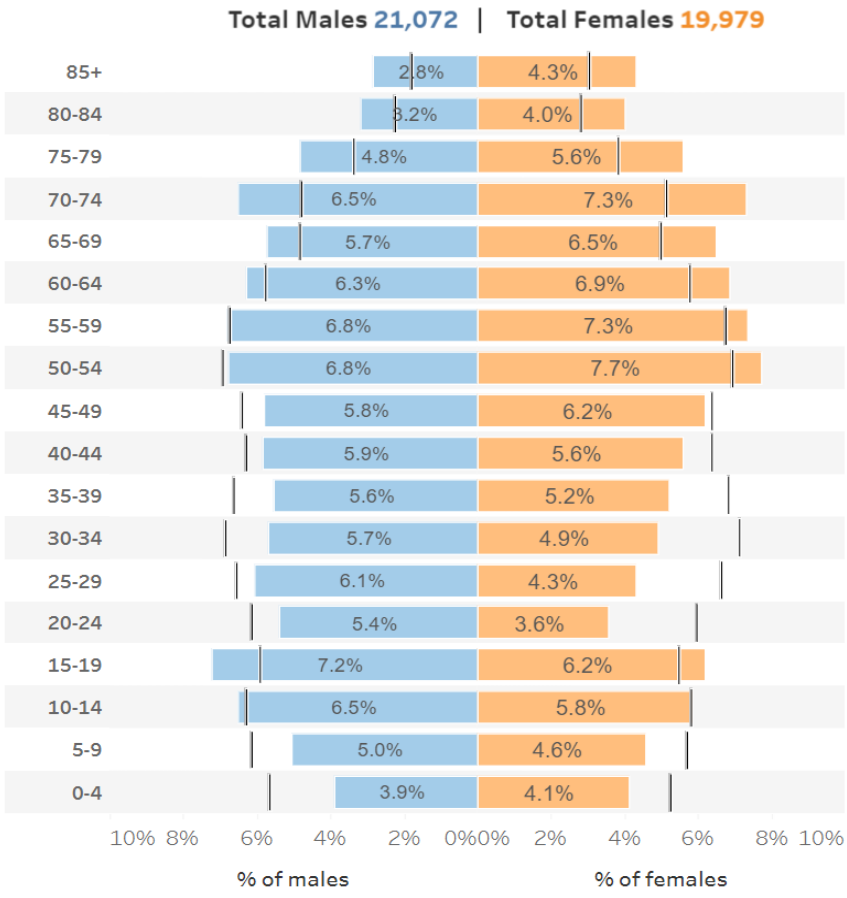
This section presents current insights into the population of Rutland, highlighting groups which may be at higher risk of mental health issues and evidence as to why this might be the case. Some important population factors, rather than specific groups, are also described.

3.1. The population of Rutland

The 2021 Census estimated the resident population of Rutland to be approximately 41,050. There were approximately 1,093 fewer females (19,979) than males (21,072). Compared to nationally, Rutland has a higher proportion of the population aged over 65 and over 85. Approximately 25.3% (10,386 people) of the population in Rutland is aged 65 and over and 3.5% (1,456 people) of the population in Rutland is aged 85 and over, compared to 18.5% and 2.4% respectively across England (Figure 1).

Figure 1. Rutland population - Census 2021

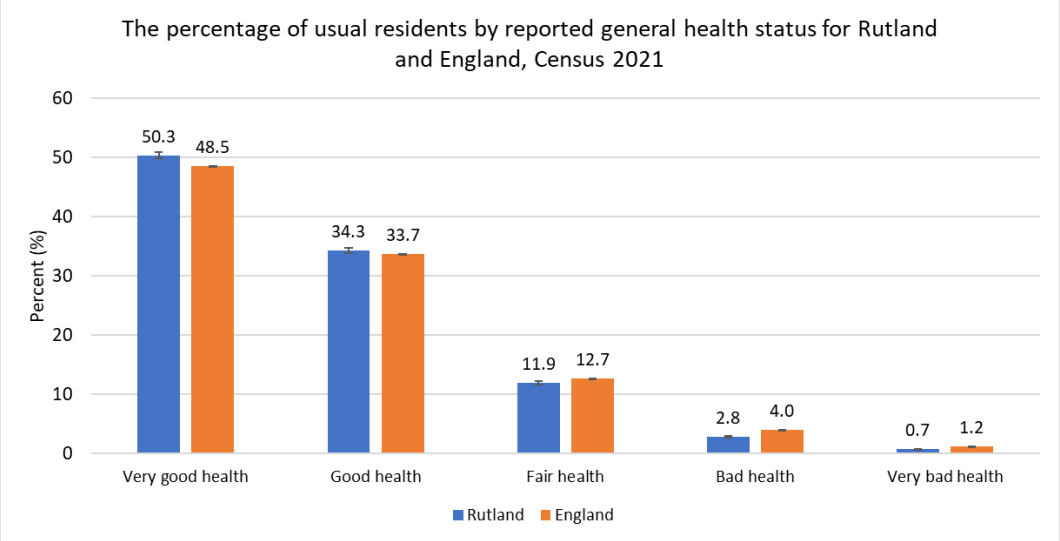
Rutland population estimate by sex and five year age band as a percentage of the population and compared to national estimates (black lines)



(Source: ONS, Census 2021)

According to the 2021 Census, a significantly larger proportion of the usual resident population in Rutland is reported to be in very good health or good health when compared to the resident population in England. A significantly smaller proportion of the resident population in Rutland is reported to be in fair health, bad health or very bad health than nationally (Figure 2).

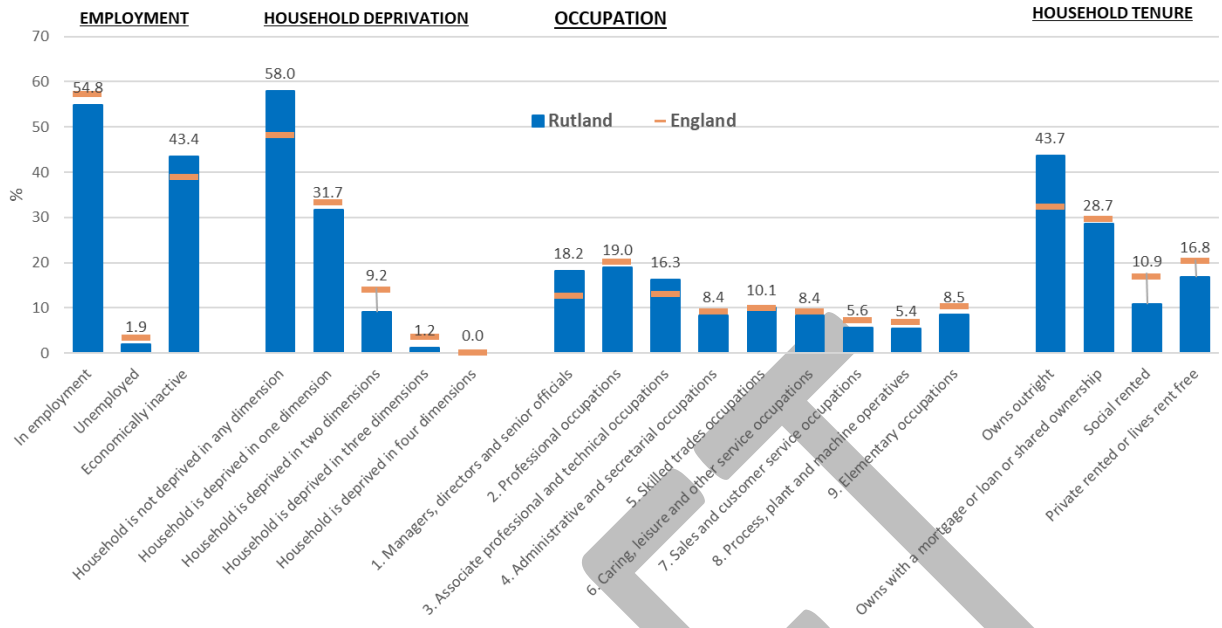
Figure 2. General health profile of Rutland resident population, Census 2021



(Source: ONS, Census 2021)

A broad socio-economic profile of Rutland's population, based on Census 2021, shows a larger proportion of households as not deprived in any dimension (58.0% vs 48.4% nationally), and a smaller proportion as deprived in one or more dimensions (household deprivation). Further, a larger proportion of Rutland households are owned outright than nationally (household tenure). Rutland residents aged 16 and over in employment are more likely to be managers, directors and senior officials or work in associate professional and technical occupations than the national average (occupation). Other indicators show a broadly similar pattern to the national average (Figure 3).

Figure 3. Summary of socio-economic indicators for Rutland and England, Census 2021

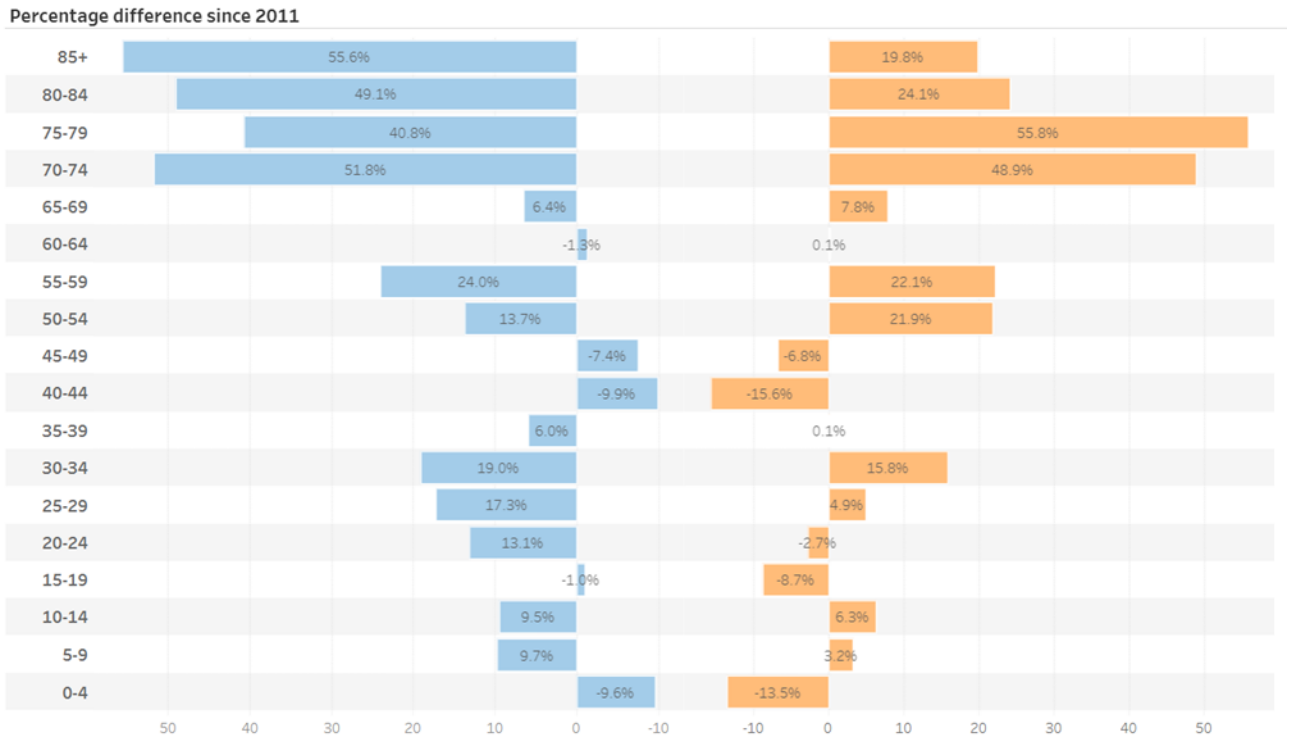


(Source: ONS, Census 2021)

Although Rutland can be described as an affluent county that performs well in terms of socio-economic and health outcomes, this average view can mask pockets of deprivation, particularly in areas where social isolation, poor access and older-age economic deprivation combine to significantly affect health in general, and mental health in particular. While socio-economic factors can contribute as much as 40% to health outcome[46], precise estimation of that impact is difficult for different populations. The general constructs such as the English Indices of Deprivation (IoD 2019[47]) are heavily skewed towards urban type of deprivation, with varied weights applied to domains such as income, employment, education/skills/training, health, crime, barriers (housing/services) and living environment. While Rutland performs well on the overall IoD 2019 score (placing within 6% least deprived local authority areas in England), and within health deprivation and disability domain (inside 5% least deprived areas), when barriers to housing and services are considered separately, Rutland places within 40% most disadvantaged local authorities across England. A much more comprehensive and nuanced description of socio-economic and health inequalities in Rutland is presented in the following JSNA chapter: https://www.lsr-online.org/uploads/rutland-health-inequalities-jsna.pdf?v=1666863138

The recent and projected changes in population age structure are likely to have significant impact on the burden of morbidity, including mental health. The population of Rutland increased by 9.8% between the 2011 and 2021 Census; this rate of increase is above the national increase of 6.6% and the East Midlands increase of 7.7%. Male population is rising at a faster rate (11.4%) compared to the female population (8.3%) since 2011. In Rutland there has been a 24.5% increase in the older population (aged 65 and over) since 2011 (Figure 4).

Figure 4. Population change in Rutland between Census 2011 and Census 2021 by five year age band and sex.

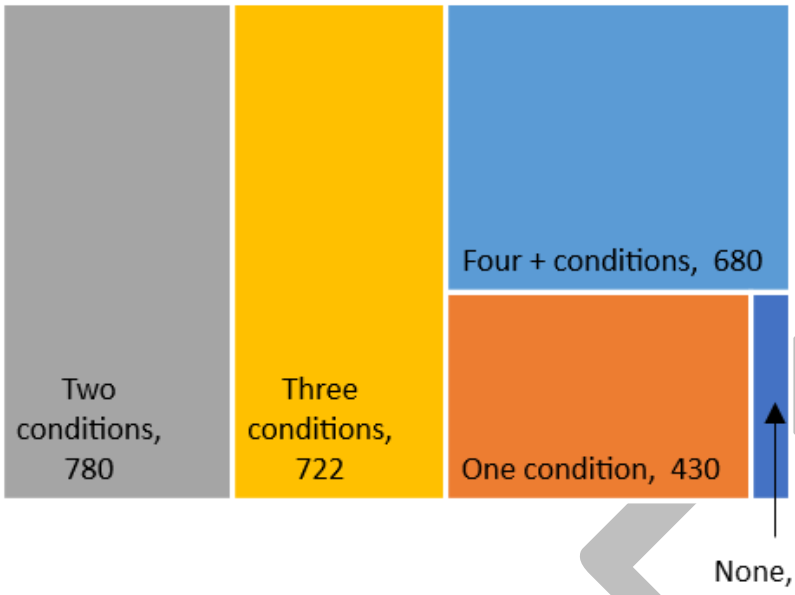


(Source: ONS, Census 2011 and Census 2021)

The population of Rutland is projected to increase by 7% in the next decade, by approximately 2,920 people (to around 44,430); this includes an increase of around 2,675 (25%) in the older population (65 and over) by 2033; the number of people aged 80 and above is projected to rise by around 1,430 (45%) by 2033. This is in comparison to the projected increase of 4% in England's population in the next decade, with a projected increase of 21% in those aged 65+ and a 35% projected increase in those aged 80+. A steeper projected rise in the older age groups in Rutland than nationally.

The population projections and current morbidity trends point toward a rise in the numbers of people with several chronic conditions (both mental and physical) in the near future[48]. This is important for planning purposes, for both health services and community care. An important factor is the increasing role of multi-morbidity – Rutland is expected to experience a rise of almost 2,200 in the older population with at least two chronic conditions (a rise of approximately 30% from current estimates) and a rise of around 680 with four or more conditions (a rise of over 40% from current estimates), within a decade (Figure 5).

Figure 5. Estimated increase (number of residents) in morbidity and multimorbidity, Rutland 2023-2033



Source: Health in 2040: projected patterns of illness in England. The Health Foundation; 2023

It is important to note that the assumptions underlying the population projections are based on current and past demographic behaviours (births, deaths and migration) and trends; with a wide level of uncertainty, they are not forecasts. International migration was at unprecedented levels in recent years and is a prime factor for that uncertainty[49] .

Further details on the demographic and economic picture of Rutland's population are available in the Rutland JSNA 2022-25 Demography and Growth chapter.

3.2. Protected Characteristics

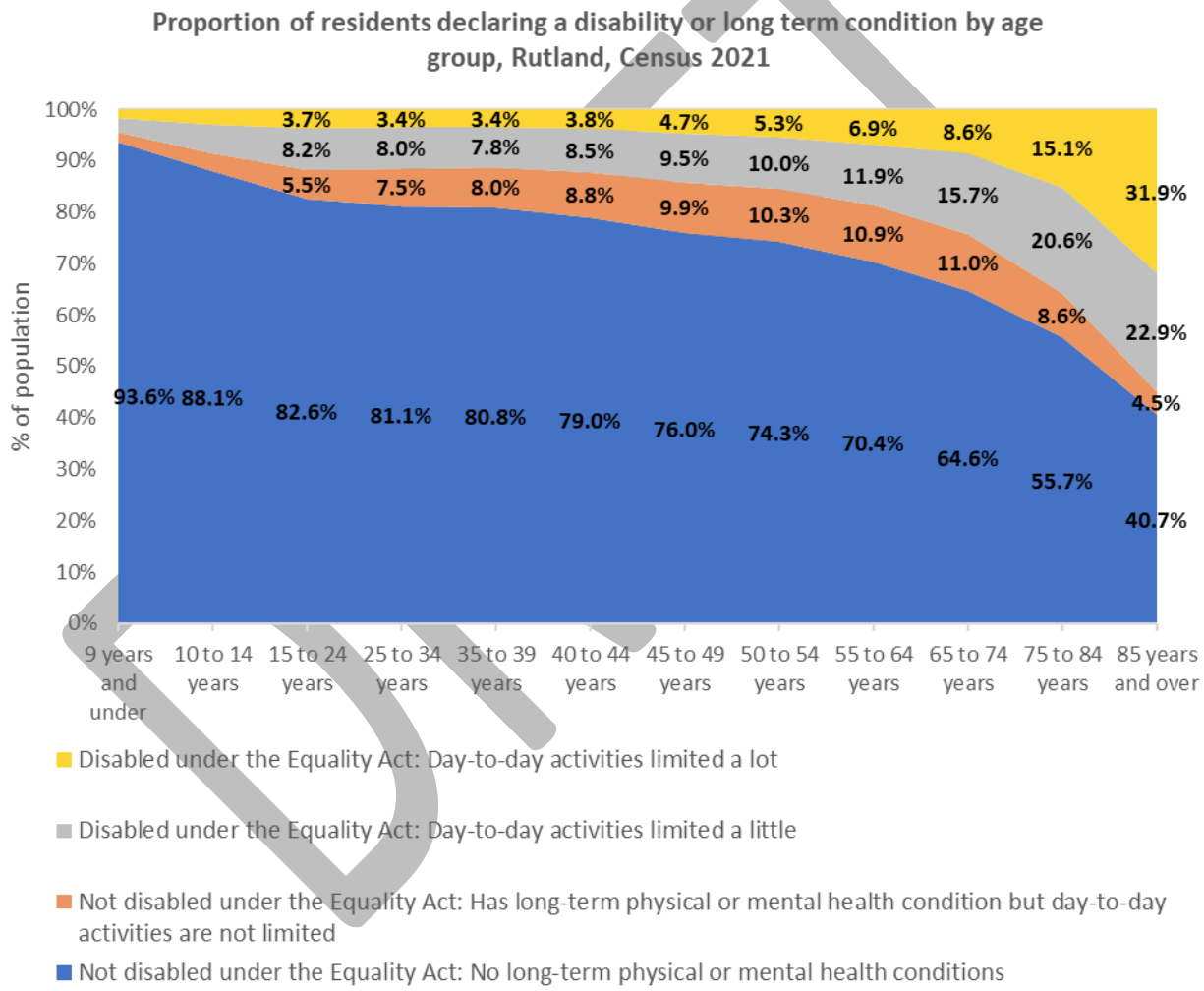
In the context of equality and discrimination law, 'populations with protected characteristics' refers to groups of individuals who are legally protected from discrimination and harassment based on specific characteristics or attributes. Equality Act 2010[50], which provides the legal framework for addressing discrimination and promoting equality in various areas of society identifies nine protected characteristics – age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation.

The Equality Act 2010 places legal obligations on individuals, employers, service providers, educational institutions, and other organizations to promote equality and prevent discrimination based on these protected characteristics. It also establishes legal mechanisms for addressing complaints of discrimination, harassment, and victimization. By protecting individuals with these characteristics, the law aims to create a more inclusive and equitable society where everyone has the opportunity to participate fully and without discrimination in all aspects of public life.

3.2.1. Disability and chronic ill-health

In Census 2021, 15.5% of Rutland's population (N=5,808) declared that they were disabled under the Equality Act, with 5.3% (N=1,972) reporting that they are limited a lot in their daily activities. As comparison, for England these proportions were 16.9% and 7.0%. In addition, 8.9% (N=3,328) of Rutland's population, although not disabled, had a long-term physical or mental health condition, which is higher than the national average of 6.9%. These proportions are highly dependent on age, with rates of disability and chronic disease rising steeply in the older population. More than half of the over 85s are disabled in Rutland (Figure 6).

Figure 6. Disability and long-term conditions (LTC), Census 2021



(Source: ONS, Census 2021)

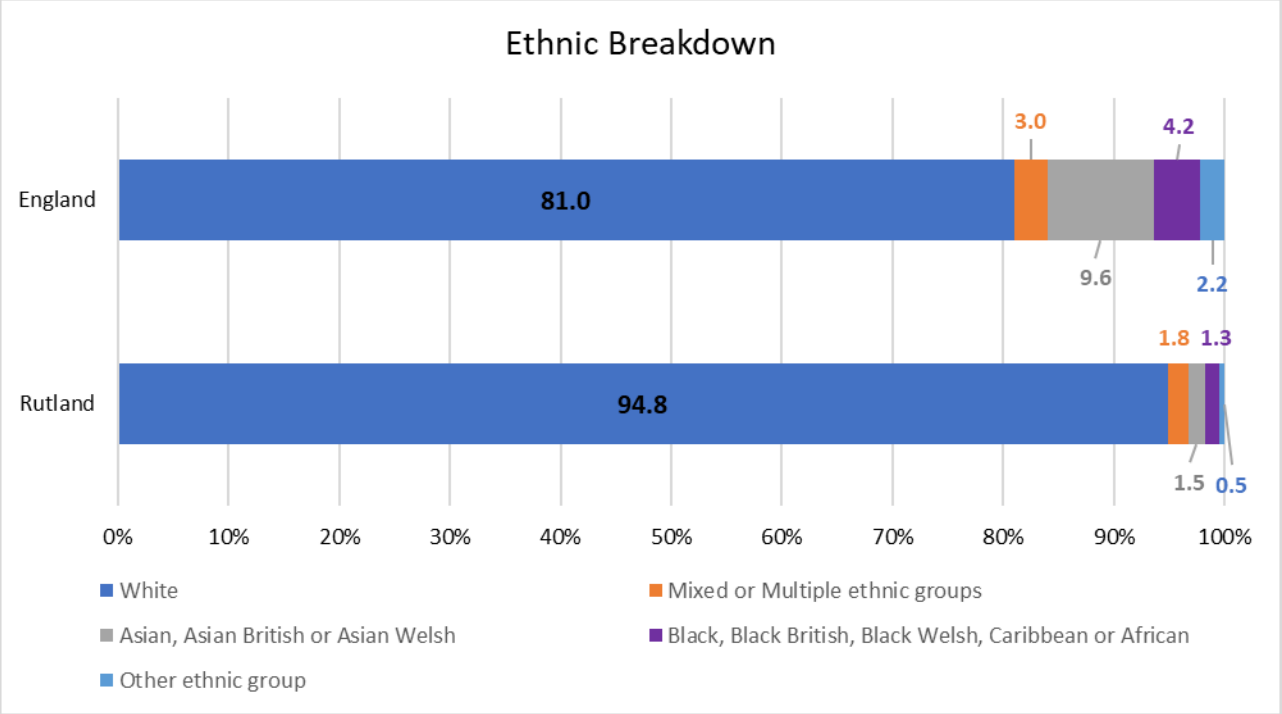
3.2.2. Ethnicity, national identity, and religion

There is evidence for higher prevalence of mental health issues in some minority ethnic groups, for example rates of schizophrenia could be 5-6 time higher in the black population and 2.5 times higher

in Asian groups[51]. Ethnic minority groups can experience barriers in access to mental health care and could remain undiagnosed.

Rutland population was in the majority of white ethnicity (94.8% vs. 81.0% nationally), the proportion of the population in Rutland which identifies with an ethnic minority group is significantly smaller than in England (5.1% vs. 19.0%). The proportion of the Rutland population which identify as white ethnicity is significantly larger than the proportion in England. The largest ethnic minority population in Rutland is Mixed or Multiple Ethnic Groups, which constitutes 1.8% of Rutland's population, followed by those of Asian descent (1.5%), the proportion of black minority (1.3%) and those identifying with other ethnic groups (0.5%) (Figure 7).

Figure 7. Ethnic profile of the population in Rutland and England, Census 2021



(Source: ONS, Census 2021)

In addition to ethnicity, religion and national identity can also play a part in mental health and wellbeing. Research indicates that there is a positive correlation between religion and mental health, possibly through positive cognitive appraisals, increased social support, healthier lifestyles and meditative practices. However, negative impacts (e.g., guilt or dependency) are also possible and such research is often criticised for biased recruitment of subjects and lack of reliable comparators from non-religious groups[52].

Christian denominations are the most predominant religion in Rutland (55.4%) as well as nationally (46.3%), a significantly larger proportion of Rutland's population report being Christian than nationally. 37.1% of Census 2021 respondents in Rutland declared themselves as having no religion,

which is not significantly different to the national average of 36.7%. The proportion of people identifying themselves as each of Muslim, Buddhist, Hindu, Sikh or Jewish is significantly lower in Rutland than nationally (Table 1).

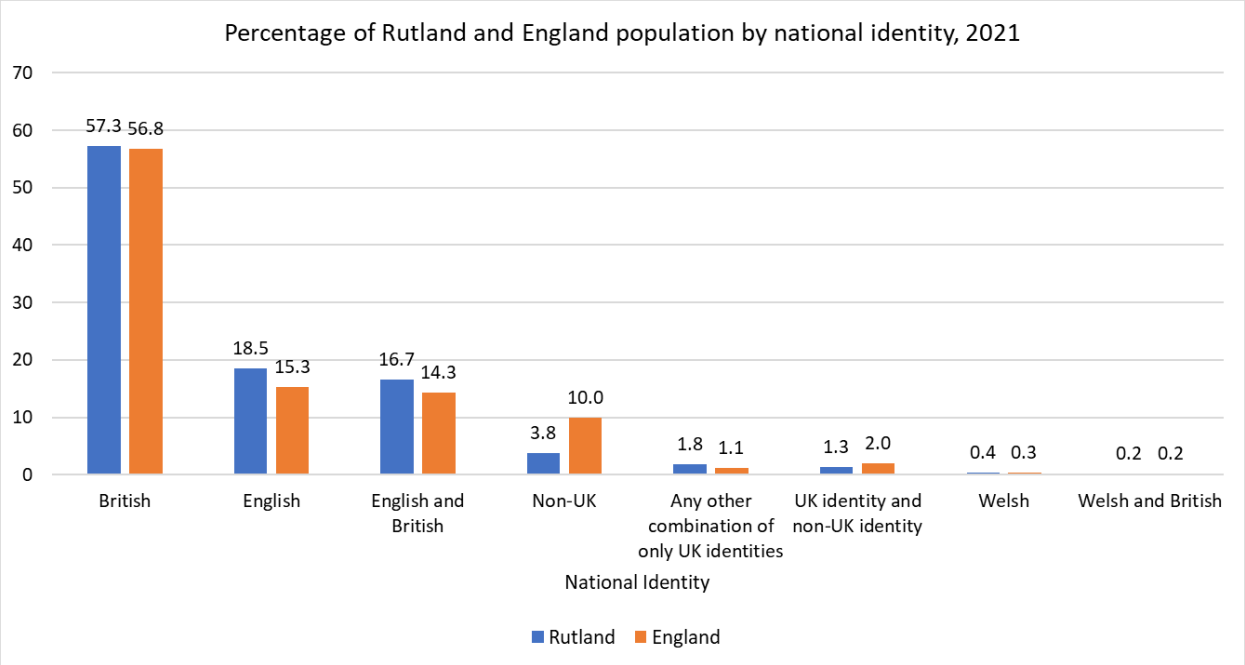
Rutland has a significantly larger proportion of the population identifying as British, English or both (92.4%) when compared to England as a whole (86.3%). Those with Non-UK identities in Rutland constitute just 3.8% of the population, a significantly smaller proportion than nationally (10.0%) (Figure 8).

Table 1. Religious breakdown of Rutland and England population, Census 2021

	Rutland		England
	Value	Percent	Percent
Total: All usual residents	41,052	100.0	100.0
Christian	22,728	55.4	46.3
No religion	15,239	37.1	36.7
Not answered	2,231	5.4	6.0
Muslim	258	0.6	6.7
Other religion	201	0.5	0.6
Buddhist	150	0.4	0.5
Hindu	125	0.3	1.8
Sikh	67	0.2	0.9
Jewish	53	0.1	0.5

(Source: ONS, Census 2021)

Figure 8. National identity of Rutland and England population



(Source: ONS, Census 2021)

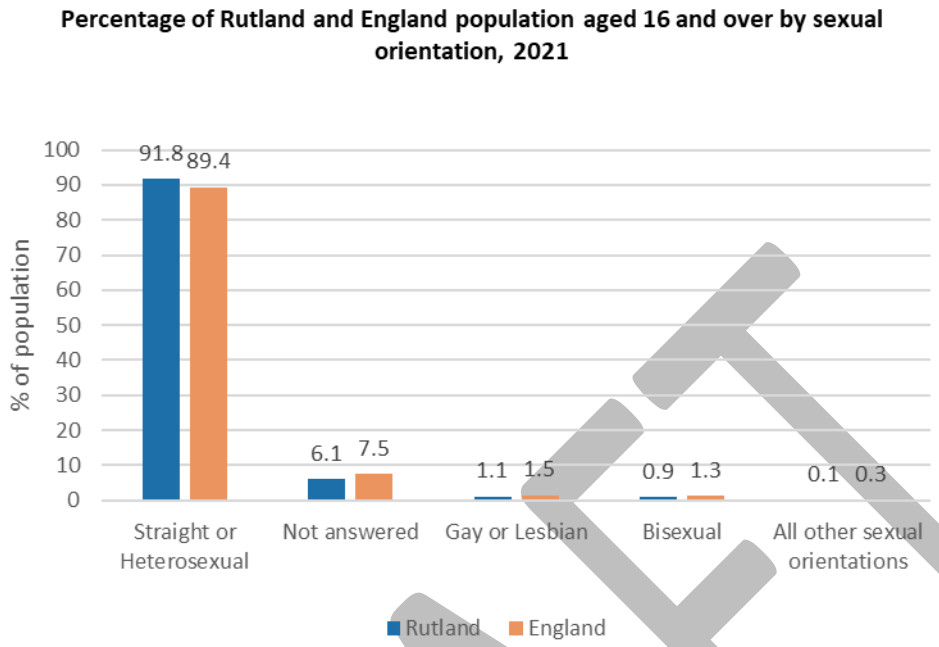
3.2.3. Sexual orientation and gender reassignment

Research shows higher risk of depression, anxiety, self-harm and suicide in LGBT+ population. Gay men have been shown to have a four-times higher risk of attempted suicide, with women more prone to suicidal thoughts and self-harm when compared to the general population[53]. The relative proportion of LGB is rising in the UK - the Annual Population Survey (2022), estimated 3.1% of the UK adult population as lesbian, gay or bisexual (LGB) in 2020, almost double the figure from 2014 (1.6%), with a similar pattern estimated for the East Midlands.

In Census 2021 a significantly smaller proportion of those aged 16 and over in Rutland declared themselves to be gay/lesbian or bisexual when compared to the national average. Of note is a significantly better response rate (only 6.1% not answered, compared to 7.5% in England) (Figure 9).

Of those aged 16 and over there was a total of around 380 gay/lesbian and 290 bisexual Rutland residents and overall 2.1% of residents aged 16 and over reported sexual orientation other than heterosexual (3.1% nationally).

Figure 9. LGBTQ population in Rutland and England



(Source: ONS, Census 2021)

In Census 2021 a total of 80* Rutland residents aged 16 and over declared that their gender was different to their sex at birth (0.2% of those aged 16 and over, compared to the 0.5% national average). This number includes 15 trans women and 20 trans men.
Other categories include 10 non-binary residents aged 16 and over and 5 in other gender identity groups.

3.2.4. Pregnancy and maternity

Pregnancy and the postpartum period can be times of significant emotional and psychological changes for women, and common mental health problems can arise during this period. Transient mood changes that occur in the days following childbirth are common and typically resolve within a few weeks. More serious and common mental health problems may include:

- Perinatal depression, a term specifically referring to depression that occurs during pregnancy or in the first year after childbirth with symptoms such as persistent sadness, low energy, changes in appetite and sleep patterns, feelings of worthlessness or guilt, and difficulty bonding with the baby.
- Perinatal anxiety disorders, such as generalized anxiety disorder (GAD) and panic disorder,

* All numbers rounded to nearest 5

which can occur in that period, involving excessive worry, restlessness, irritability, trembling or palpitations.

Personal history of mental illness, experiencing stressful life events, lack of social support, lifetime history of abuse, marital conflicts, childcare stress, chronic physical illness, preeclampsia, gestational diabetes mellitus, being exposed to second-hand smoke and sleep disturbance are among the major contributing factors to perinatal depression[54].

Other less common mental health problems include post-traumatic stress disorder (PTSD) which can follow a traumatic childbirth experience, such as a complicated delivery or medical emergency, perinatal obsessive-compulsive disorder (OCD), with obsessions often related to the baby's safety or cleanliness, leading to compulsive behaviours like excessive checking or cleaning, relatively rare but severe postpartum psychosis, characterized by hallucinations, delusions, confusion, and rapid mood swings. There is evidence that women who are forced migrants are at a particular risk of PTSD [55].

Importantly, any pre-existing severe mental illness tends to relapse in the postpartum period. Early recognition, support, and appropriate treatment are essential for managing these mental health problems during pregnancy and maternity as problems may go unrecognised and untreated due to stigma. Healthcare providers play a crucial role in assessment, diagnosis, and treatment planning, but support from family and friends, as well as community resources, are equally important in addressing mental health challenges and promoting maternal well-being.

Estimates suggest that 12% of pregnant women experience depression and 13% anxiety, rising, respectively, to 15% and 20% postpartum. Often pregnant and postpartum women experience both conditions. 1-2 per 1,000 women may develop psychosis postpartum. The mental health of mothers in the perinatal period affects foetal well-being, obstetric outcomes and the development of the child, and there are risks to using psychotropic medication[56].

Estimates presented in this section have potential caveats and were derived in 2019 from 2017/18 data by applying national estimates to local birth data.

In 2017/18 in Rutland, less than 10 women were estimated to have severe depression or PTSD in the perinatal period. Estimates suggest that in 2017/18 in Rutland there were up to 40 women with mild-moderate depression and anxiety and twice as many with adjustment disorders and distress in the perinatal period (Table 2).

Table 2. Estimated prevalence of mental health disorders in the perinatal period in Rutland, 2017/18

Indicator	Time Period	Rutland Value	CIPFA range*
Severe depressive illness in perinatal period: Estimated number of women	2017/18	8	8-118
Mild-moderate depressive illness and anxiety in perinatal period (lower and upper estimate): Estimated number of women	2017/18	27 – 40	Lower estimate: 27-393 Upper estimate: 40-589
PTSD in perinatal period: Estimated number of women	2017/18	8	8-118
Adjustment disorders and distress in perinatal period (lower and upper estimate): Estimated number of women	2017/18	40– 80	Lower estimate: 40-589 Upper estimate: 80-1,178

*Range of values for Rutland's CIPFA comparators

(Source: Office for Health Improvement and Disparities, Fingertips)

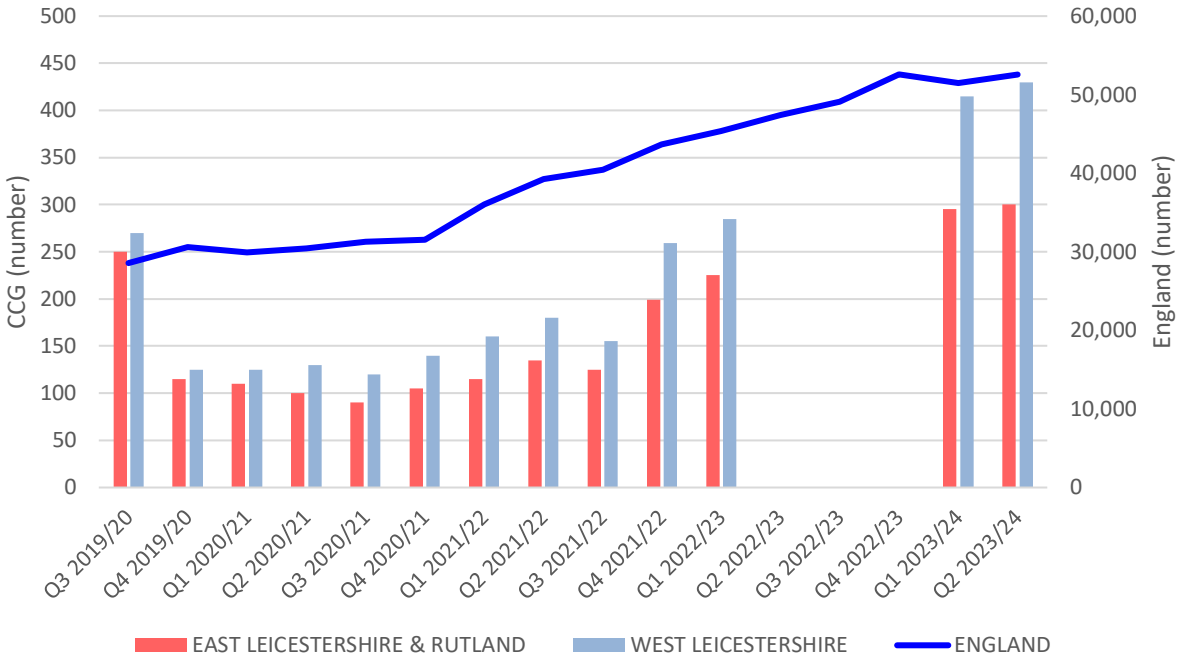
Perinatal Mental Health Services

The trends in the numbers of women accessing community perinatal mental health services have been increasing in Leicestershire and Rutland. 730 women across Leicestershire and Rutland were recorded as accessing community perinatal mental health services in quarter 2 of 2023/24 financial year - 300 in East Leicestershire and Rutland and 430 in West Leicestershire. The observed growth was similar to that observed nationally (Figure 10).

In 2022/23 the spend on this service across Leicester, Leicestershire and Rutland was over £2.55 million, with over £2.7 million planned for 2023/24 across LLR[†].

[†] *NHS England NHSMH Dashboard Q2 2023/24 (February 2024 – no financial data for sub-STP areas provided)*

Figure 10. Women accessing specialist community perinatal mental health services (trend – rolling 12 months) – Leicestershire, Rutland and England



Source: NHS Mental Health Dashboard (February 2024)

3.2.5. Marriage and partnerships

The interaction between being in a relationship (whether marriage or civil partnership) and mental wellbeing is complex, with people in poor quality relationships having worse mental health outcomes than those who are single, while good relationships are strongly linked to higher levels of mental wellbeing. The positive side includes higher level of social and emotional support, reduction in feelings of loneliness, social integration with a partner's family and their social network, lower stress levels and better mental well-being.

However, marital or partnership conflict or communication issues, can lead to increased stress, anxiety, and depression. Being in an unsatisfying or unhappy marriage or partnership can negatively impact mental health, particularly unresolved conflicts, past traumas, or unaddressed issues within the relationship can contribute to mental health challenges. Other issues impacting mental health may involve overdependence on a partner, isolation from wider social networks and loss of autonomy[57].

All of these are highly individualised, and the quality and dynamics of the relationship play a significant role in determining whether the impact is positive or negative.

In 2021, 52.2% of those aged 16 and over in Rutland were either married or in a civil partnership, significantly higher than the national average of 44.7% (Table 3). There were around 4,790 people

living alone in Rutland in 2021 - 28.7% of households were one-person households, significantly below the national average of 30.1% of households. Over half of those living alone (2,589 people) were over the age of 65.

As these are crude rates, a variety of factors are involved, such as demographics, mainly age, and deprivation.

Table 3. Population aged 16 and over by legal partnership status in Rutland and England, Census 2021

	Rutland		England	
	Count	**Percent**	**Count**	**Percent**
Total: All usual residents aged 16 and over	34,300	100.0	46,006,957	100.0
Never married and never registered a civil partnership	10,140	29.6	17,450,122	37.9
Married or in a registered civil partnership	17,891	52.2	20,561,642	44.7
Separated, but still legally married or still legally in a civil partnership	746	2.2	1,033,518	2.2
Divorced or civil partnership dissolved	3,157	9.2	4,171,639	9.1
Widowed or surviving civil partnership partner	2,366	6.9	2,790,036	6.1

(Source: ONS, Census 2021)

3.3. Education, Learning and Development

Level of education achieved can have a significant impact on mental health, and this relationship is complex and multifaceted[58]. Educational attainment is often associated with various social, economic, and psychological factors that can influence an individual's mental well-being. Higher levels of education are generally associated with greater access to financial resources through employment opportunities, healthcare, and social support. Education can open doors to a wider range of employment opportunities and higher-paying jobs. Having stable employment and financial security can reduce the stress and anxiety related to economic stability, which is a significant factor in mental health. Education can enhance cognitive skills, problem-solving abilities, and coping strategies as well as improve health literacy, enabling individuals to better understand and manage their physical and mental health.

Individuals with higher educational attainments are more likely to have better social networks, including friendships and professional relationships. These social connections can provide emotional support and reduce feelings of loneliness and isolation, which are important for mental well-being. Education can also promote greater awareness and reduce stigma surrounding mental health issues. Individuals with higher levels of education may be more open to seeking help and discussing mental health concerns. Education is associated with healthier lifestyle choices, including regular exercise, a balanced diet, and reduced rates of tobacco and alcohol use. These factors can have a positive impact on mental health. Education is considered one of the social determinants of health, including mental health[59].

Rutland's population has a higher level of educational attainment than nationally. The 2021 Census showed that 13.1% of Rutland's population aged 16 and over had no qualifications and 8.6% had level 1 and entry level qualifications, both values are significantly lower than the England average (18.1% and 9.7% respectively). The proportion of Rutland's population that had level 2 qualifications (15.4%), an apprenticeship (5.6%) and level 4 qualifications or above (37.9%) was significantly larger than the proportion of England's population (13.3%, 5.3% and 33.9% respectively). The proportion of Rutland's population that had level 3 qualifications (17.0%) was not significantly different to the national figure (16.9%).

3.4. Social Media

Social media can also have various effects on mental health, both positive and negative - effects that can vary widely from person to person and depend on individual usage patterns and experiences. The positive effects may include enabling social connections, information and awareness regarding mental health issues or reduction of stigma, providing a platform for self-expression and creativity, and support groups on social media platforms where individuals with shared experiences can connect, share advice, and provide mutual support[60].

However, there are several potential negative effects, such as online harassment and cyberbullying, negative social comparison, or addiction-like behaviours which interfere with daily life activities.

The resulting problems may include feelings of inadequacy, low self-esteem, procrastination, reduced productivity, all the way to severe psychological consequences, including anxiety, depression, and feelings of isolation.

Concerns about privacy, data security, and the potential for information to be misused on social media platforms can lead to anxiety and mistrust. Seeing updates and activities of others can lead to a fear of missing out (FOMO) on experiences, which can induce stress and anxiety.

Social media algorithms can create echo chambers where individuals are exposed to information and opinions that align with their existing beliefs, potentially leading to polarization and reinforcing biased views[61].

Exposure to negative news in the standard media can also lead to increased anxiety and stress, particularly in times of political change, economic downturn, or global adversities. Sensational or graphic reporting in particular can lead to distorted perception of risk and safety, while repeated reporting of distressing news can lead to 'compassion fatigue'. Although less of a problem than in social media, standard news outlets can also contribute to the polarisation or radicalisation of opinions. On the positive side, media can provide useful educational content, lead to a sense of engagement with community and the wider society[62].

3.5. Lifestyle

Lifestyle plays a crucial role in mental health, and the choices individuals make in their daily lives can significantly impact their psychological well-being. While positive lifestyle choices can promote good mental health, unhealthy behaviours can contribute to mental health challenges. Positive behaviours include regular physical activity, healthy diet, adequate sleep, stress management, maintaining healthy social relationships and a strong support network, and engaging in meaningful activities that provide a sense of purpose can boost self-esteem, promote happiness, and reduce the risk of depression.

Conversely, unhealthy lifestyle choices that have been shown to effect poor mental health include sedentary lifestyles (lack of physical activity and prolonged periods of sedentary behaviour have been associated with an increased risk of depression and anxiety), poor diet, high in processed foods, chronic sleep deprivation or poor sleep quality can impair cognitive function, mood regulation, and overall mental well-being, prolonged exposure to chronic stress without effective coping mechanisms can lead to the development of anxiety and depression. Lack of social connections and feelings of loneliness can have a detrimental impact on mental health and increase the risk of depression and anxiety, substance misuse, including excessive alcohol consumption and drug addiction, can worsen existing mental health issues and increase the risk of developing new ones. Engaging in negative coping strategies, such as avoidance, self-medicating with substances, or engaging in risky behaviours, can exacerbate mental health problems[63].

It is important to recognize that mental health is influenced by a combination of genetic, environmental, and lifestyle factors. While lifestyle choices can significantly impact mental well-being, mental health disorders are complex, and individuals may require professional help and support to address their mental health needs.

3.6. Employment

Employment provides not only financial security but also a sense of purpose, social connections, and opportunities for personal growth, while involuntary unemployment is likely to have significant negative impacts on an individual's mental health.

Various aspects of the work environment can influence mental well-being positively or negatively. Employment generally provides a source of income, which can reduce financial stress, and often a sense of purpose and meaning in life. It can enable the development of social connections, enhancing emotional support and reducing feelings of isolation. It can provide routine and structure to daily activities, leading to a sense of stability and predictability. Employment can also offer opportunities for skill development and personal growth, contributing to a positive self-concept and mental well-being.

However, the negative impacts may include work-related stress, which can lead to mental health

issues such as anxiety, depression, and burnout. Workplace bullying, harassment, discrimination, or toxic work environments can have a detrimental impact on mental health and well-being. Imbalanced work-life schedule or excessive overtime can both contribute to exhaustion, stress, and mental health problems. Job insecurity, such as temporary employment or frequent layoffs, can lead to anxiety and uncertainty about the future. Lack of autonomy or control of one's job can be stressful and negatively affect mental health. Jobs that are unfulfilling or do not align with an individual's interests and values can lead to dissatisfaction and unhappiness. Irregular or rotating shift work can disrupt sleep patterns and contribute to sleep disorders, which can negatively impact mental health.

The impact of employment on mental health varies from person to person and is influenced by individual factors, job characteristics, and work environments. Employers can play a significant role in promoting mental well-being by creating supportive work environments, offering employee assistance programs, and addressing issues related to workplace stress and mental health stigma.

Further discussion of employment is provided in section 5.2 which notes the impact of wider economic factors on mental health in Rutland.

3.7. Rurality

Living in rural areas, can have a significant impact on mental health. Whether these effects are predominantly positive or negative can vary depending on individual factors, such as access to resources, and the specific challenges and opportunities that rural living presents.

Potentially positive effects include strong communities with supportive social networks, access to natural settings and outdoor activities, resulting in reduced stress, improved mood, and enhanced well-being, and a more relaxed pace of life compared to urban areas.

However, there are also significant risks to mental health resulting from limited access to healthcare facilities, including mental health services. This can result in delayed or inadequate mental health care. Smaller communities can sometimes lead to concerns about privacy and stigma surrounding mental health issues. At an individual level, the experience of social isolation can a be a significant contributory factor to feelings of loneliness and depression, especially among older adults.

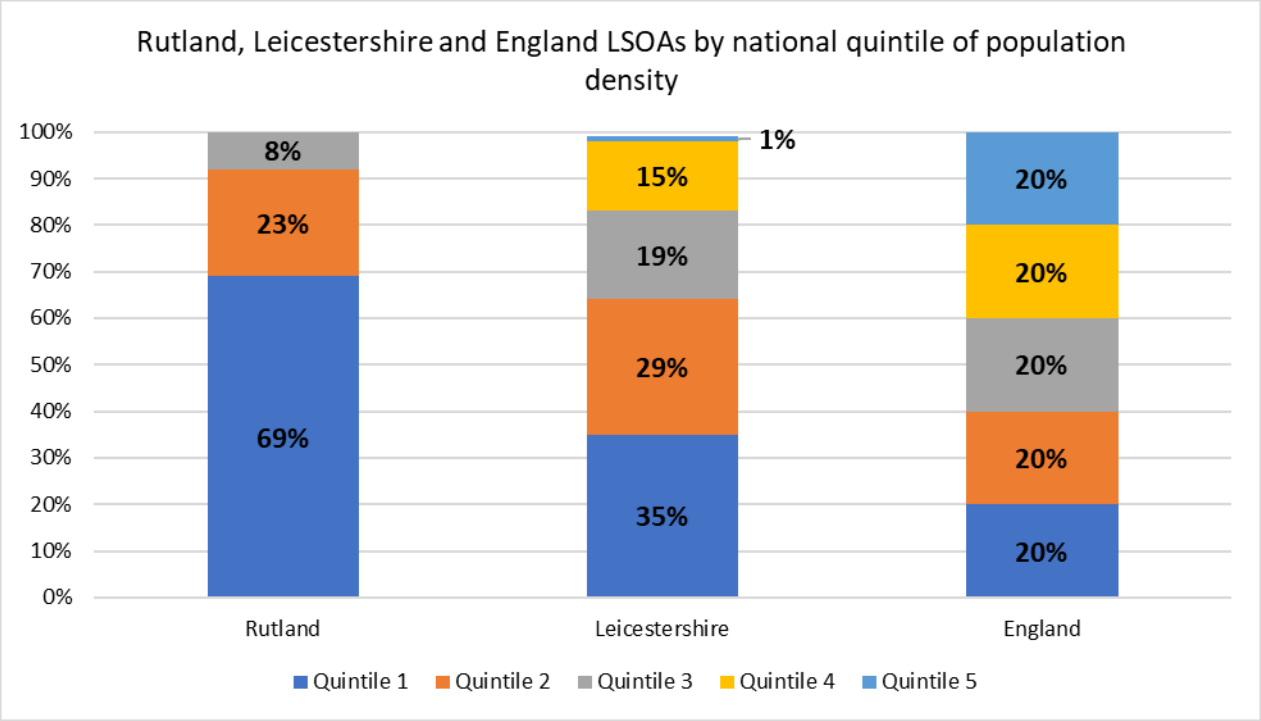
For the younger adults, rural areas may have fewer job opportunities, lower wages, and limited career options, impacting negatively on mental health, compounded by poor public transport and long travel distances to essential services. Rural areas may have limited access to high-speed internet and digital technologies. This can affect individuals' ability to access online mental health resources and telehealth services.

It is important to note that the impact of rurality on mental health is not uniform and can vary widely based on individual circumstances and the specific rural community in question. Addressing the mental health needs of rural communities requires a comprehensive, multidisciplinary approach

that considers the unique challenges and strengths of rural living.

As currently available urban-rural classification is based on Census 2011, population density from Census 2021 is presented here as a more recent proxy (Figure 11). Over two thirds of Rutland's Lower Layer Super Output Areas (LSOAs) (69%) are in the lowest national quintile by population density (less than 872 usual residents per square kilometre), with no LSOAs in Rutland in the second highest or the highest quintile.

Figure 11. Rutland, Leicestershire and England LSOAs by national quintile of population density, Census 2021



Quintile 1: lowest national quintile of population density (less than 872 usual residents per square kilometre) to quintile 5: highest national quintile of population density (over 6,658 usual residents per square kilometre)

Source: ONS, Census 2021

A comprehensive assessment of rural health inequalities in Rutland is provided in the following JSNA chapter: https://www.lsr-online.org/uploads/rutland-health-inequalities-jsna.pdf?v=1666863138

3.8. Loneliness

Loneliness is a complex emotional state that arises when individuals perceive a gap between their desired and actual social connections. It can affect people of all ages and backgrounds, and is closely associated with symptoms of depression, anxiety, and low self-esteem. Individuals who are lonely may be more prone to developing clinical depression, generalized anxiety disorder and social

anxiety.

Chronic loneliness can contribute to elevated stress levels. The stress response, when activated over extended periods, can negatively impact physical and mental health, potentially leading to conditions such as cardiovascular disease and immune system dysfunction. Loneliness has been associated with inflammation, compromised immune function, cardiovascular problems, a higher risk of chronic diseases, cognitive decline and impairments in attention, memory, and problem-solving. It can disrupt sleep patterns, leading to difficulties falling asleep or staying asleep, with further consequences on individual's mental health.

Some individuals may turn to alcohol or drugs as a way to cope with the emotional pain of loneliness, leading to substance use disorders and addiction.

Loneliness is a known risk factor for the development or exacerbation of various mental health disorders, including mood disorders (depression and bipolar disorder), anxiety disorders, and psychotic disorders. Persistent loneliness can be a significant risk factor for suicidal thoughts and behaviours.

Addressing loneliness and nurturing social connections is essential for maintaining good mental health and overall well-being.

According to the Active Lives Adult Survey (Sport England), in 2019/20 24.77% of adults (aged 16 and over) responded 'Always or often' or 'Some of the time' to the question 'How often do you feel lonely'. This was not significantly different to the national figure of 22.26%.

3.9. Other Groups at Risk

This section describes other groups potentially at higher risk of mental ill health.

Many sub-groups of the population are missed in the general statistics but can be at a much higher risk of mental ill-health with specific vulnerabilities and combinations of common or group-specific risk factors. A substantial proportion of people in prison experience depression, anxiety, self-harm or attempt suicide. Victims of crime also have higher risk of developing mental health problems. Other groups include the homeless, migrants, adult social care users, armed forces personnel and their families.

3.9.1. Prison population

The experience of being in prison, along with the factors leading up to incarceration, can affect individuals in various ways, both psychologically and emotionally. Individuals with pre-existing mental health conditions may find it challenging to access the necessary treatment and support within prison.

Prisoners have an increased risk of mental health conditions including depression, due to the harsh and restrictive environment of prisons, loss of freedom and separation, and anxiety as result of the

stress of incarceration, concerns about safety, violence, and the uncertainty of the future. This includes acute anxiety or panic attacks. Other common problems include post-traumatic stress disorder (PTSD) and substance misuse; both drug and alcohol abuse are prevalent in prison populations and incarceration may exacerbate pre-existing substance use disorders or lead to their development[64].

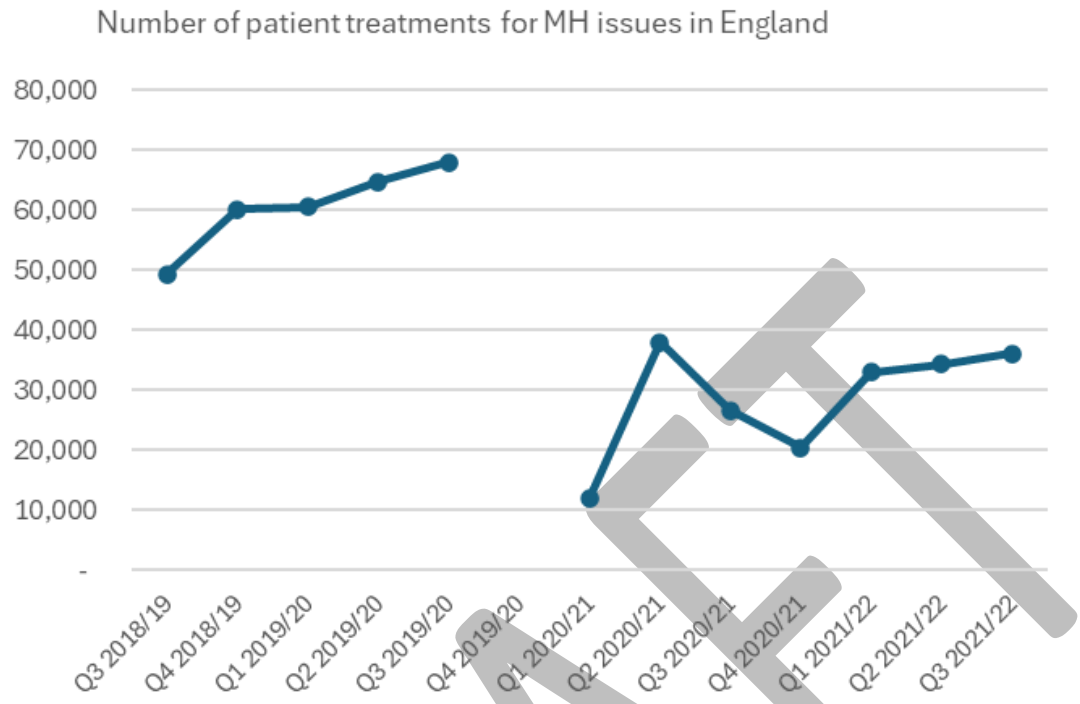
Imprisonment often results in social isolation and separation, loneliness and feelings of abandonment, stigma associated with being in prison, feelings of shame and low self-esteem, loss of personal freedom and autonomy and the resulting distress. In some prison environments, violence and victimization can be common, leading to increased stress, fear, and trauma among inmates. After release, individuals may face difficulties reintegrating into society. Some prisons offer limited access to mental health care[65].

It is important to note that the impact of imprisonment on mental health can vary widely based on individual factors, the conditions of incarceration, and the availability of mental health support within the prison system. Efforts to improve mental health care within the prison system and support for individuals both during and after their incarceration are critical steps in mitigating the negative effects of imprisonment on mental health.

The recent (2023) *Survey of Prison Mental Health Services in England*[66], based on a sample of over 7,700 people representing 14% of the prison and Youth Offender Institution (YOI) population offers some estimates of the prevalence of mental health problems in that population. The most common diagnoses were anxiety and/or depression, and talking therapies were the most commonly offered main intervention. A diagnosis of personality disorder was the third most commonly presented problem (over 17% nationally). Attention deficit hyperactivity disorder accounted for nearly 9% of primary presented problems nationally, and post-traumatic stress disorder and other trauma diagnoses accounted for 8%.

In England in 2021 there were nearly 124 thousand treatment episodes for mental health issues for the adult prison population (excluding assessments), although rates were much higher prior to the COVID-19 pandemic (Figure 12).

Figure 12. Quarterly figures for mental health treatment in the prison population in England before and after the COVID-19 pandemic



(Source: NHS England NHSMH Dashboard Q3 2022/23)

There are four prisons for men within Leicester, Leicestershire and Rutland. Leicester prison has an in-use uncrowded capacity (or Certified Normal Accommodation, CNA) of 212 and had a population of 324 in June 2023 (153% of the in-use CNA). Gartree prison in Market Harborough in Leicestershire has an in-use CNA of 621 and a population of 593 in June 2023 (95% of the in-use CNA). Stocken prison in Stretton in Rutland has an in-use CNA of 964 and a population of 1,055 in June 2023 (109% of the in-use CNA). In addition, HMP Fosse Way, a new Category C prison in Leicester received its first prisoners on 29 of May 2023. Fosse Way has a planned capacity of 1,930 male inmates. In June 2023 it had an in-use CNA of 301 and a population of 123 (41% of the in-use CNA).[67] Female prisoners are generally sent to Peterborough prison.

The report on an unannounced inspection of HMP Stocken Prison by HM Chief Inspector of Prisons 16-27 January 2023 suggested that around 85 prisoners were referred for mental health assessment each month[68].

3.9.2. Migrant population and traveller communities

Migrant populations, including refugees, asylum seekers, immigrants, and displaced individuals, often face unique mental health challenges due to the complex and stressful nature of migration. These challenges can result from pre-migration experiences, the migration journey itself, and post-

migration settlement conditions. Mental health issues in migrant populations can manifest in various ways and may include trauma and post-traumatic stress disorder (PTSD) as a result of events in their home countries, such as conflict, violence, persecution, or natural disasters. Migrant populations are at higher risk of depression and/or anxiety due to the stressors associated with migration, language barriers, cultural adjustment, discrimination, and uncertainty about legal status[69].

The process of adapting to a new culture and society can be stressful. Migrants may grapple with issues related to identity, discrimination, and navigating unfamiliar social norms and systems, they may experience social isolation and loneliness due to language barriers, limited social networks, and the absence of familiar support systems. The challenges of finding housing, employment, and access to healthcare in the host country can be overwhelming for migrants, contributing to stress and mental health difficulties. Limited proficiency in the host country's language can hinder communication, access to services, and social integration, which may exacerbate mental health issues. Experiences of discrimination and racism can negatively impact mental health, leading to feelings of injustice, anger, and reduced self-esteem[70]. However, it is essential to recognize that not all migrants will experience mental health issues.

International migration is an important driver of population change. The usual resident population in England and Wales grew by more than 2.0 million because of positive net migration since 2011.

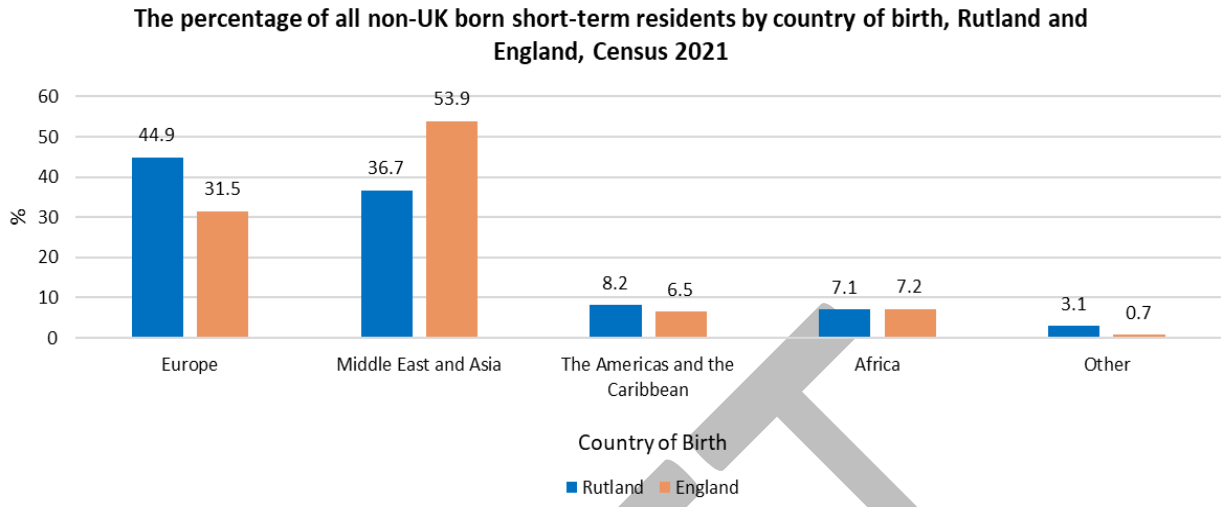
Subgroups regarded as vulnerable include asylum seekers, refugees, and those trafficked for forced labour or sexual exploitation, although these may be a minority in terms of numbers.

There were 98 non-UK born short-term residents across Rutland recorded in Census 2021.

In Rutland almost half (44.9%, N=44) of non-UK born short-term residents were of European descent, 32.7% from countries which were part of the EU in 2001 – including 24.5% from Germany. In Rutland 36.7% of non-UK born short-term residents were born in the Middle East and Asia, almost a third (29.6%) recorded Eastern Asia as their place of birth - including 19.4% from China and 8.2% from Hong Kong.

According to the 2021 Census, the proportion of non-UK born short-term residents in Rutland that were born in the Middle East and Asia was significantly smaller than the proportion in England (36.7% and 53.9% respectively), whilst the proportion born in Europe was significantly larger in Rutland than in England (44.9% and 31.5% respectively) (Figure 13).

Figure 13. Non-UK born short-term residents by country of birth



(Source: ONS, Census 2021)

Traveller communities are identified as a vulnerable population for a number of socioeconomic and health reasons such as barriers to employment and high levels of unemployment[71], which is recorded for almost a third of all adults in those communities (women are at particular risk of unemployment), lower that national average educational attainment, lower level of homeownership, with a quarter of accommodation being caravans or other mobile homes (vs 0.3% nationally), high levels of perceived discrimination (community and service providers), barriers to accessing healthcare and other services, delayed healthcare seeking and poorer health outcomes.

Census 2021 data shows that a total of 55 Rutland residents identify as Gypsy or Irish Traveller and 18 identify as Roma. The proportion of Rutland residents identifying as Gypsy or Irish Traveller at the time of the 2021 Census (0.13%) was significantly larger than the proportion in the East Midlands (0.09%). The proportion of Rutland residents identifying as Roma at the time of the 2021 Census (0.04%) was significantly smaller than the proportion in the East Midlands (0.15%) and the proportion in England (0.18%) (Table 4).

Table 4. Traveller population of Rutland, Census 2021

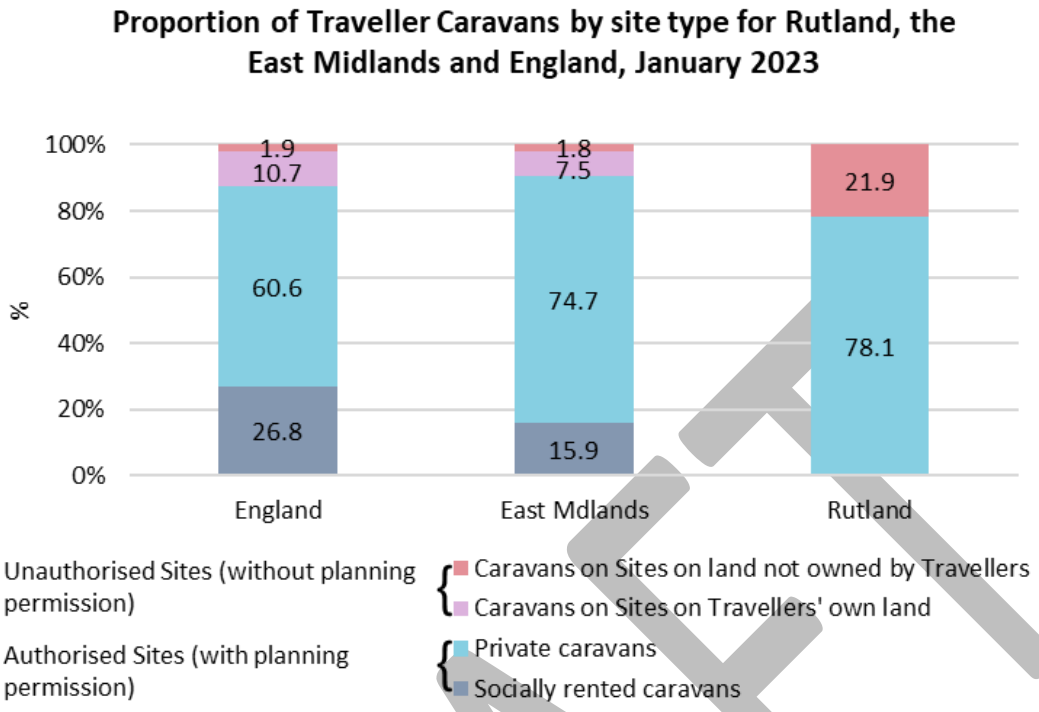
Area	Total	Gypsy or Irish Traveller		Roma	
	Population	Number	%	Number	%
England	56,490,070	60,073	0.11	99,138	0.18
East Midlands	4,880,047	4,160	0.09	7,196	0.15
Rutland	41,048	55	0.13	18	0.04

(Source: ONS, Census 2021)

The latest biannual count of traveller caravans in England (January 2023) reports 32 traveller caravans across Rutland.

Compared to the national average, a significantly larger proportion of traveller caravans were private caravans on authorised sites in Rutland (78.1% vs 60.6% nationally). The proportion of traveller caravans which were private caravans on authorised sites in Rutland was not significantly different to the regional average of 74.7%. In Rutland there were no socially rented caravans on authorised sites. A significantly larger proportion of traveller caravans in Rutland (21.9%), than nationally (1.9%) or regionally (1.8%), were caravans on unauthorised sites on land not owned by travellers (Figure 14).

Figure 14. Traveller caravans by site type for Rutland, the East Midlands and England, January 2023



(Source: Department for Levelling Up, Housing and Communities 2023)

3.9.3. Crime

The relationship between crime rates and mental health of individuals is complex, multifactorial and bidirectional. On one hand, mental health of an individual can have an impact on their possible criminal behaviour, on the other, exposure to levels of local crime can affect the mental health of individuals[72].

Effects of crime on mental health vary depending on factors such as the type of crime, the frequency of crime in a community, individual vulnerabilities, and the availability of support systems. Some of the important factors, at individual and population levels include victimisation, fear and anxiety, community-level trauma, disruption of social networks or stigmatisation, leading to a sense of injustice, anger, and negative impacts on mental health. Homicides and other violent crimes can lead to profound grief and loss within communities. Communities with high crime rates may also experience higher rates of drug and alcohol abuse, which can exacerbate mental health issues[73].

Police officers, emergency responders, and healthcare professionals who frequently deal with crime scenes and victims can experience significant psychological stress, leading to conditions like PTSD and depression[74].

It is important to note that individuals diagnosed with a mental health disorder are accountable for a fraction of violent offenders (1%) and are responsible for only a small percentage of societal violence and criminal behaviour (5%), on the contrary, they are more likely to be the victims of

crime, being more vulnerable through impaired judgement, coping skills or social isolation. Exception are individuals with severe mental illness, namely schizophrenia and bipolar disorder, particularly people with triple morbidity (severe mental illness, substance use disorder and antisocial personality disorder) who are substantially more likely to be violent than people with severe mental illness alone[75]. Despite this, persistent stereotypes continue to exist which often associates mental health disorders with criminal and violent behaviour; an image that is frequently reinforced through mass media outlets. Important factors include socio-economic, poverty, lack of education or employment opportunities, homelessness, substance misuse, rates of incarceration and access to mental health care.

The indirect costs of crime are likely to be much higher than the direct costs, although any intangible impacts (including anxiety and mental distress) are particularly difficult to measure or estimate. A 2012 study based on English survey data (British Household Survey Panel, BHPS, and English Longitudinal Study of Ageing, ELSA) found that crime caused considerable mental distress of residents, mainly driven by property crime, but also, at an individual level, by violent crime. Local crime appeared to create more distress for females and is mainly related to depression and anxiety[76].

It is important to monitor local rates as crime is not randomly distributed and is most commonly linked to high levels of deprivation and social disorganisation[77].

National and Police Force Area crime rates

There are two primary offence groups: victim-based crimes and other crimes against society. Victim-based crimes are those with a specific identifiable victim. All Crime Survey for England and Wales (CSEW) crime is victim based, as it is derived from a survey of people's experiences of crime and must have a victim for it to be recorded.

Police recorded crime includes both victim-based and other crimes that do not normally have a direct victim, referred to as "other crimes against society". Victim-based crimes include violence against the person (VAP), sexual offences, including rape, robbery, theft offences, and criminal damage and arson. Other crimes against society include drug offences, possession of weapon offences, public order offences and miscellaneous crimes against society.

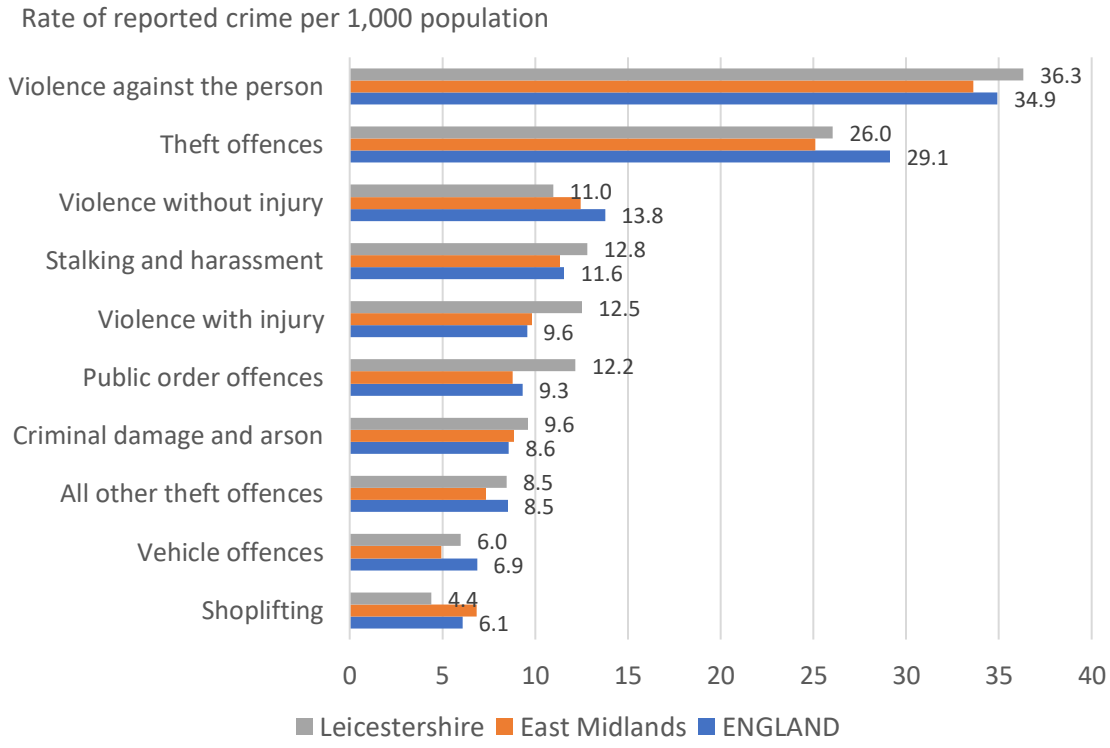
It is important to stress that these are not additive, as some events can be reported under more than one category.

Figure 15 presents the published comparative crime rates for police areas for year ending June 2023 for Leicestershire, East Midlands and England[78].

In the latest nationally reported year, the total crime rate for Leicestershire police force area (including Leicester, Leicestershire and Rutland) was 94.4 per 1,000 residents, compared to

England's 92.5 per 1,000 residents and 86.4 per 1,000 residents for the East Midlands. The most common type of crime in England was violence against the person (VAP, 35 per 1,000 residents), closely followed by theft offences (29 per 1,000 residents). Violence without injury constituted 14 per 1,000 residents, stalking and harassment nearly 12 per 1,000 residents and violence with injury nearly 10 per 1,000 residents. While the local (LLR) rates of theft offences (26 per 1,000 residents) and violence without injury (11 per 1,000 residents) were lower than national, the VAP rate was slightly higher (36 per 1,000 residents), as were stalking and harassment and violence with injury (both at 13 per 1,000 residents). It is important to stress that these are not additive, as some events can be reported under more than one category.

Figure 15. Police force area crime rates for Leicestershire, East Midlands and England- year ending June 2023



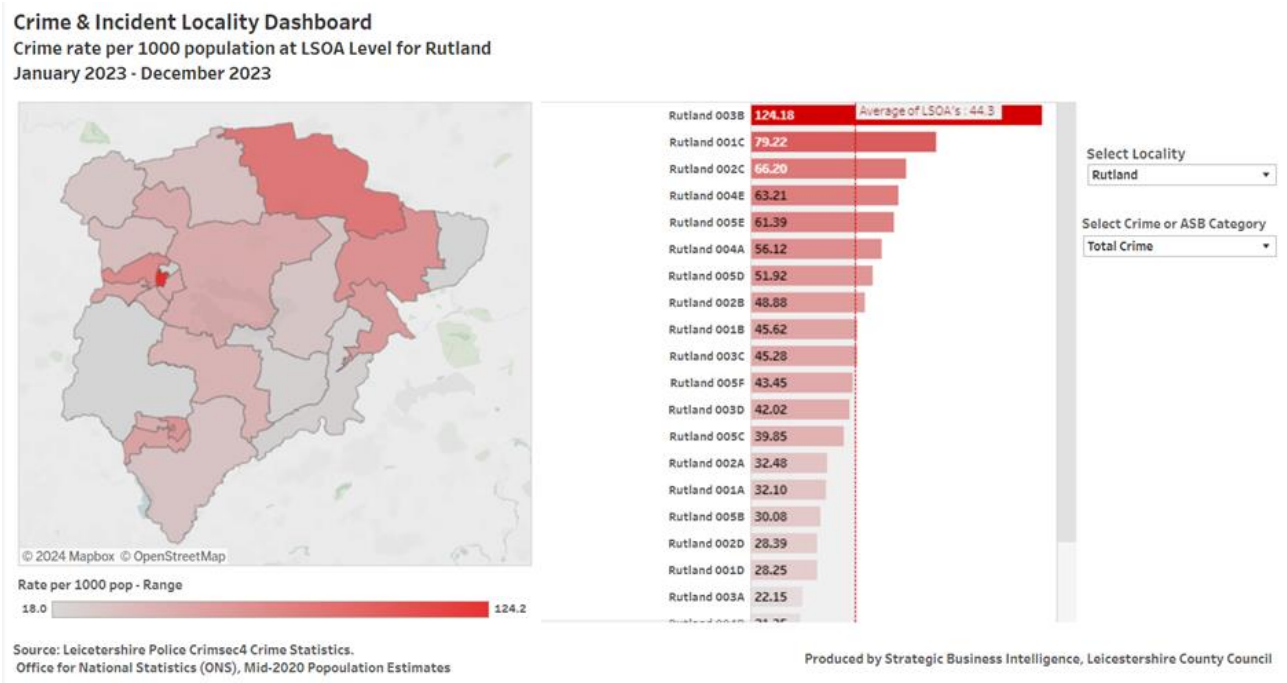
(Source: ONS 2023)

Crime rates in Rutland

Territorial police forces of England and Wales report crime and outcomes data on a monthly basis as a cumulative year-to-date aggregate (*Crimsec4* form). This system allows for a more up-to-date and granular look at the local rates. It is important to stress that this system records the outcome rather than where and when the original offence occurred, and as such the rates reflect police activity rather than the actual crime rate. Furthermore, all figures can be subject to revisions and, particularly for drug offences, time trends have to be treated with caution.

In Rutland in the year between January 2023 and December 2023 there were approximately 1,800 incidents of crime or anti-social behaviour (ASB) recorded (a rise from around 1,445 four years ago in January 2020 to December 2020). This equates to around 44.5 incidents per 1,000 residents in 2023, however local LSOA rates vary, between 124.18 (Rutland 003B - Oakham North East) and 18.02 (Rutland 004D - Ryhall and Casterton) per 1,000 (Figure 16).

Figure 16. Variation in reported crime rate across Rutland by LSOA, January to December 2023



(Source: Leicestershire County Council Crime Dashboard, 2023 – Leicestershire Police Crimsec4 Statistics, ONS Mid-2020 population estimates)

Table 5 presents the rates across Rutland using categories best matched to the national and regional averages presented in the previous section. This was derived to provide some comparison to the national data from the ONS data (presented in Figure 15). It shows that VAP rates for Rutland County (rather than LLR total) were lower than national (17 per 1,000 vs 35 per 1,000), as was the rate of public order offences (5.2 per 1,000 residents vs 9.3 per 1,000 residents) and the rate of violence with injury (6.1 per 1,000 residents vs 9.6 per 1,000 residents).

It is important to note that the categories can be overlapping and are non-additive.

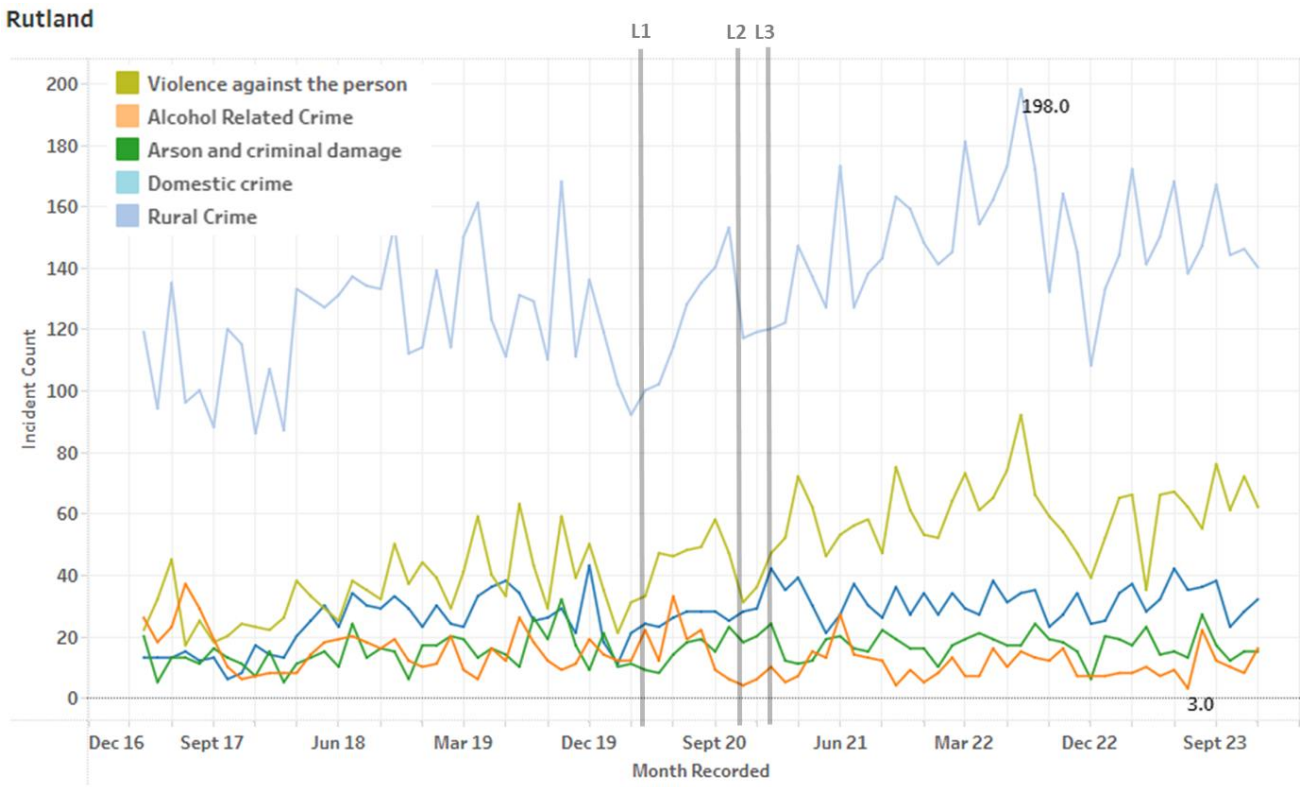
Table 5. Most common categories of reported crime in Rutland in 2023

	Number	Rate per 1,000
Rural Crime	1788	44.2
Violence against the person (VAP)	690	17.1
Violence without injury	442	10.9
Domestic crime	270	6.7
Domestic crime & incidents	270	6.7
Violence with injury	248	6.1
Theft	226	5.6
Public Order	209	5.2
Alcohol Related Crime	205	5.1

(Source: Leicestershire County Council Crime Dashboard, 2023 – Leicestershire Police Crimsec4 Statistics, ONS Mid-2020 population estimates)

Figure 17 presents the time trends in the most commonly reported crime categories with the inclusion of L1-L3, indicating approximate COVID-19 lockdown dates. Although the counts of incidents vary over time, the graph suggests an increase in violence against person and, to a smaller extent, of rural crime since 2017.

Figure 17. Recent trends in reported crime in Rutland. L1–L3 COVID-19 lockdowns (approximate placement) – July 2016 to December 20238



(Source: Leicestershire County Council Crime Dashboard, 2023 – Leicestershire Police Crimsec4 Crime Statistics)

3.9.4. Disrupted social ties

Disrupted social ties, such as the loss of social connections or the breakdown of relationships, can have a significant and negative impact on mental health. Individuals may experience a range of mental health challenges, including loneliness and isolation, depression, anxiety, loss of self-esteem and increased stress. Unresolved grief as result of a loss of close relations can lead to mental health issues such as complicated grief or depression. Substance abuse may become an unhealthy coping mechanism, as can overeating, or self-harm. Disrupted social ties can also have physical health consequences, as they are linked to higher levels of stress hormones, immune system dysfunction, and a higher risk of certain health conditions.

Mental health challenges resulting from disrupted social ties can interfere with daily functioning, including work, relationships, and overall quality of life[79].

3.9.5. Social care

Looking after a family member with a health problem, particularly a mental health issue, can significantly affect carers' mental health. Mental health problems of carers include emotional stress,

depressive symptoms and, in some cases, clinical depression [80]. More than two-thirds (71%) of carers have poor physical or mental health[81].

The results of the 2021 Census showed that 15.9% of Rutland's population were disabled under the Equality Act, significantly below the national average of 17.3%. 3.5% of Rutland's population declared themselves as having bad or very bad health which was significantly smaller than the percentage in England (5.2%).

As of the 2021 Census 8.0% of the Rutland population aged 5 and over reported providing unpaid care, this was a smaller proportion than the national figure (8.8%).

3.9.6. Students

The mental health of students can be impacted by various factors, leading to increased risks of developing mental health problems, such as high academic expectations, workload, performance pressure and fear of failure can all contribute to stress and anxiety. Many students face financial challenges, including tuition fees, living expenses, and student loan debt. Financial strain can lead to anxiety, depression, and difficulty accessing basic needs, such as food and housing. Transitioning to university or college can be socially isolating for some students, particularly if they are away from home or have difficulty making friends. Students who move away from home may have difficulty adjusting to a new environment. Relationship problems, breakups, social conflicts, and feelings of loneliness can exacerbate existing mental health issues. Some students may engage in substance use, such as alcohol, drugs, or prescription medications, as a coping mechanism for stress or to socialize. Perfectionistic tendencies, self-criticism and fear of failure can contribute to anxiety, depression, and burnout among students. Some students may face barriers to accessing mental health services, such as long wait times, limited availability of resources, or stigma surrounding help-seeking behaviour.

In 2021/22, 119,500 of UK students said they had a mental health condition, which represents 5.5% of all home students. The number saying they had a mental health condition was three and a half times as high as in 2014/15, and five times higher than in 2010. Higher rates of mental health conditions were reported among women, undergraduates, full-time students and those in their second or later years[82].

According to the 2021 Census 18.0% of Rutland's population aged five or over were classified as 'schoolchildren and full-time students', significantly below the national average of 20.4%. The 2021 Census suggests that 2.3% of Rutland's population aged 18 and over (763 adults) are full-time students, significantly below the national average of 5.2%.

3.9.7. Armed forces personnel and veterans

There are many risks to the mental health of armed forces personnel. Exposure to combat situations can lead to post-traumatic stress disorder (PTSD), anxiety, depression, and other mental health

conditions. Deployments, whether in combat zones or other operational environments, can be stressful and disruptive, leading to feelings of isolation, separation from family, and adjustment difficulties upon return. The demands of military operations, including long hours, frequent deployments, and high-pressure environments, can contribute to chronic stress, exhaustion, and burnout among personnel. Physical injuries sustained during military service, such as traumatic brain injuries, amputations, and chronic pain, can have significant psychological impacts, including depression, anxiety, and PTSD[83].

There may be an increased risk of substance abuse, including alcohol and prescription drug misuse, as a coping mechanism for stress, trauma, or adjustment difficulties. Deployments and frequent moves can place strain on relationships and family dynamics, leading to increased stress, conflict, and challenges in maintaining social support networks. Some individuals may enter military service with pre-existing mental health conditions, such as depression, anxiety, or PTSD, which may be exacerbated by the demands and stressors of military life.

Stigma surrounding mental health issues within the military culture may prevent personnel from seeking help for mental health concerns, leading to delays in diagnosis and treatment, while logistical barriers, concerns about career repercussions, and limited access to mental health services may further hinder help-seeking behaviours[84].

Transitioning from military to civilian life can be challenging, as personnel may face difficulties adjusting to civilian roles, finding employment, accessing healthcare, and reintegrating into their communities.

In 2021 (Census), a total of 2,015 residents aged 16 and over in Rutland reported to have served in the UK regular armed forces, with a further 283 having served in UK reserve armed forces and 83 having served in both regular and reserve UK armed forces.

The proportion of Rutland's population aged 16 and over that reported previously serving in the UK armed forces (6.9%) was significantly higher than the proportion in England (3.8%). This information was collected in the 2021 census after consultation with a range of stakeholders, including the Ministry of Defence. Uses of the information include ensuring adequate careers provision for ex-armed forces personnel, statutory responsibilities to provide housing for up to 5 years after leaving the forces and commissioning health services which may differ from the wider population, for example counselling services[85].

Two British Army barracks are located in Rutland, Kendrew Barracks in Cottesmore and St George's Barracks in North Luffenham. The data presented below examines summary statistics on the number of serving UK Armed Forces personnel and entitled civilian personnel with a Defence Medical Services (DMS) registration. UK armed forces includes Regulars, Gurkhas, Officer Designates and Full Time Reserve Service (FTRS) personnel. Entitled civilian personnel include contractors, service personnel family dependents and Ministry of Defence (MOD) employed civilian personnel

who are entitled to care at MOD primary care facilities. Personnel with a DMS registration have their primary care (GP services) provided by the MOD rather than the NHS.

This data suggests that in April 2022, the armed forces personnel accounted for 5.1% of the resident population in the county. The military population is younger and has a higher proportion of males compared to the resident population of Rutland. In April 2022, there were 2,110 Armed Forces personnel and entitled civilian personnel registered in Rutland. 1,550 individuals (73%) were in the Armed Forces and 560 individuals (27%) were entitled civilian personnel. Of the total, 1,530 were male and 580 female, with 1,330 males in the UK Armed forces and 220 females.[86] Since this data was collated, the 1st Battalion of the Royal Anglian Regiment has arrived from Cyprus to Kendrew Barracks in Rutland, potentially marking a significant demographic change for personnel and families.

Rutland Armed Forces Health and Wellbeing Survey 2023

Rutland Armed Forces Health and Wellbeing Survey was live between 12 April 2023 and 2nd June 2023. The target population of the survey was personnel, families and veterans located in Rutland and 1st Battalion in Cyprus due to move to Rutland at the time (this move has since occurred). In total, 69 participants completed the online survey, 65% of whom were females and 93% were white. Only 13% (N=9) of the surveyed sample were serving members of the armed forces, with 57% family members and 28% veterans. Due to small numbers, conclusions have to be treated with caution, but the results suggest that a larger proportion of veterans or family members (both 79%) felt their mental health was negatively influenced than among the small group of members of the armed forces (33%).

Conclusions drawn from the survey around mental health were that the relatives of service members endure challenges which should not be overlooked. While many respondents reported that life in the Armed Forces negatively impacts mental health, only 22% accessed mental health services in Rutland, and just 10% reported they would feel comfortable doing so. This suggests that mental health services should be linked into other channels that they would feel comfortable accessing. 6% of participants would like to see counselling available directly at Kendrew and St George's. Results also suggested that respondents do not feel very involved in the Rutland community and there is demand from serving members, families and veterans for different social and exercise groups. For all support services, including mental health, respondents would like to access them face-to-face at the barracks or in Rutland.

3.9.8. Homelessness

Homelessness is strongly associated with increased risks to mental health. Common mental health conditions among the homeless population include depression, anxiety disorders, post-traumatic stress disorder (PTSD), schizophrenia, and substance use disorders. Many homeless individuals have experienced significant trauma and adverse life experiences, such as childhood abuse, neglect,

domestic violence, or traumatic events while living on the streets. These experiences can contribute to the development of mental health disorders and exacerbate existing symptoms[87].

Substance abuse is prevalent among homeless individuals, and there is a high rate of co-occurring mental health and substance use disorders (dual diagnosis). Substance abuse can exacerbate mental health symptoms and make it more challenging for individuals to access and engage with mental health services. Homelessness is often accompanied by physical health challenges, including inadequate access to healthcare, poor nutrition, exposure to harsh weather conditions, and an increased risk of infectious diseases.

Homeless individuals often face social isolation, stigma, and discrimination, and the stigma surrounding mental illness and negative past experiences with healthcare providers may deter individuals from seeking help.

In addition, there is an increased risk of experiencing violence, victimization, and exploitation. These traumatic experiences can have profound effects on mental health and contribute to the development of PTSD and other mental health disorders.

Homelessness and mental illness often form a vicious cycle, where mental health issues can contribute to homelessness, and homelessness can exacerbate mental health challenges. Breaking this cycle requires comprehensive support services addressing housing, healthcare, employment, and social integration.

The *Annual Rough Sleeping Snapshot in England*[88], reported on the numbers of people sleeping rough[‡] on one night in autumn in 2023. Across England there were nearly 3,898, which has risen for the second year in a row (by 27%) but remains lower than the peak in 2017, and 9% lower than pre-pandemic (2019) figures. The general national trend showed an increase up to 2017 with some reduction in 2018 and 2019. The East Midlands region followed a similar trend, with total or rough sleepers counted in 2020 at 187.

In Rutland there were 0 people rough sleeping on the snapshot night.

The *Statutory Homelessness Statistics* for 2022/23 (Department of Levelling Up, Housing and Communities) show that across Rutland there were an estimated 54 homeless households (owed a relief duty) and 80 households threatened with homelessness (owed a prevention duty). Overall, this equates to 134 households owed a duty under the Homelessness Reduction Act which is a rate of 7.6 per 1,000 households which is significantly better (lower) than the rate in England (12.4 per 1,000 population).

[‡] The snapshot records only those people seen, or thought to be, sleeping rough on a single night and may exclude many groups, such as those in shelters.

Looking at their composition, homeless households (those owed a relief duty) were most commonly single adult male's (35%), followed by single adult females' (28%) and single female parents with dependent children (24%).

For households threatened by homelessness (those owed a prevention duty), the most common household compositions were that of single female parents with dependent children (28%), followed by single female households (25%) and single male households (21%).

3.9.9. Multiple disadvantage

Multiple Disadvantage or Severe and Multiple Disadvantage (SMD) refers to people facing two or more of the following issues – mental health issues, homelessness, offending and substance misuse. SMD can include other sources of disadvantage, for instance poor physical health, domestic/sexual abuse, community isolation, undiagnosed brain injuries, autism and learning disabilities. In England, 2.3 million adults (5.2% of the population) face two or more of these primary domains in a single year[89].

A closely related term is that of multiple complex needs (MCN), a broad definition including severe and multiple disadvantage and multiple exclusion in a population experiencing co-occurring issues of homelessness, substance use, crime and mental health problems; overlapping vulnerabilities associated with extreme health inequalities[90]

SMD has a higher degree of stigma and dislocation from societal norms when compared to other social inequalities. People affected by SMD are predominantly young white men, aged 25–44, often with long-term histories of economic and social issues and, in most cases, childhood trauma of various kinds, very poor family relationships and/or educational experience[91]

Despite having very high levels of morbidity and mortality, people with SMD encounter significant barriers to accessing healthcare and have lower patient enablement and they are more likely to have negative experiences of healthcare, including stigma and discrimination. GP appointment systems are often incompatible with their help seeking behaviours and the majority of general practice does not effectively include them[92]

An analysis, published by Lankelly Chase Foundation in 2015[93] and based on data for 2010 and 2011, estimated that an 'average' local authority might expect to have about 1,470 SMD (as defined by involvement in two out of the three relevant service systems) cases per year, however this would vary across the country. Specific rates were calculated for all local authority areas using data on homelessness (Supporting People), drug misuse (NDTMS) and offender data (Offended Assessment System). Rutland (and Leicestershire) were both placed among the 20 lowest prevalence areas, with a score of 47 (against the national average of 100), ranging from 21 (Wokingham) to 306 (Blackpool). Based on this one can broadly estimate the number of adults with SMD at 140 for Rutland.

4. Mental Health Needs

4.1. Mental Well-being and Mental Health Conditions

Mental well-being, also referred to as mental health and emotional well-being, encompasses a person's emotional, psychological, and social state of being. It reflects an individual's overall mental and emotional health and their ability to cope with life's challenges. While there is no universally agreed-upon definition, mental well-being is often characterized by emotional resilience, positive emotions, self-acceptance, autonomy and self-determination, positive relationships, personal growth and development, mental and emotional stability, quality of life and respect for others[94].

The World Health Organisation states that "mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes". It also defines mental health conditions as "mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning, or risk of self-harm" [95].

It is important to note that mental well-being is not a fixed state but a dynamic and evolving aspect of a person's life. It can be influenced by various factors, including genetics, environment, life experiences, and personal choices. Additionally, mental well-being is not the absence of all negative emotions or challenges but the ability to navigate and overcome them in a healthy and adaptive way. Although people with mental health conditions are more likely to experience lower levels of mental well-being, this is not always or necessarily the case.

4.2. Common Mental Health Disorders (CMD)

Common mental health conditions include a variety of, often overlapping, disorders such as depression, anxiety, phobias, obsessive-compulsive disorder (OCD) and panic disorder. Although they do not affect cognition, they may cause a significant level of distress and disability. They are relatively common and often undiagnosed, hence the importance of population-based estimates[96].

4.2.1. Wider determinants

Common mental disorders are influenced by a wide range of factors, including both individual and wider determinants. The wider determinants of mental disorders refer to the broader social, economic, environmental, and cultural factors that can affect an individual's mental health and well-being. These determinants often interact with individual-level factors to shape mental health outcomes.

The socioeconomic factors play a significant role in mental health. Unemployment, income inequality, and lack of access to basic resources (e.g., housing, healthcare, education) can contribute

to stress and increase the risk of mental disorders. The nature of employment, job security, and workplace stress can impact mental health. High-stress jobs, job insecurity, and workplace discrimination can contribute to mental disorders. Strong social support systems and positive social relationships are protective factors for mental health. Loneliness, social isolation, and lack of social connections can increase the risk of common mental disorders [97].

Adverse childhood experiences, including trauma, abuse, neglect, and household dysfunction, can have long-lasting effects on mental health and increase the risk of mental disorders in adulthood. Education and literacy levels are associated with mental health outcomes. Higher levels of education are often linked to better mental health, as they can provide greater access to resources and opportunities.

Access to safe and stable housing, as well as the quality of the neighbourhood environment, can influence mental health. Unsafe or unstable housing and exposure to neighbourhood violence can be detrimental. Access to mental healthcare services, as well as general healthcare, is crucial. Barriers to accessing healthcare, including stigma, cost, and availability, can hinder early intervention and treatment.

Cultural factors, social norms, and stigma related to mental health can affect individuals' willingness to seek help and access services. Experiences of discrimination, racism, homophobia, or other forms of marginalization can contribute to stress, depression, and anxiety among affected individuals. Health behaviours, such as diet, physical activity, substance use, and sleep patterns, can impact mental health. Unhealthy behaviours may increase the risk of mental disorders. Availability and accessibility of social services, including social welfare, housing support, and community programs, can provide important resources for individuals facing mental health challenges.

Communities with high levels of social capital, characterized by trust, social cohesion, and civic engagement, tend to have better mental health outcomes for their residents [98]. Environmental factors, such as exposure to pollution, natural disasters, or extreme weather events, can contribute to stress and affect mental health.

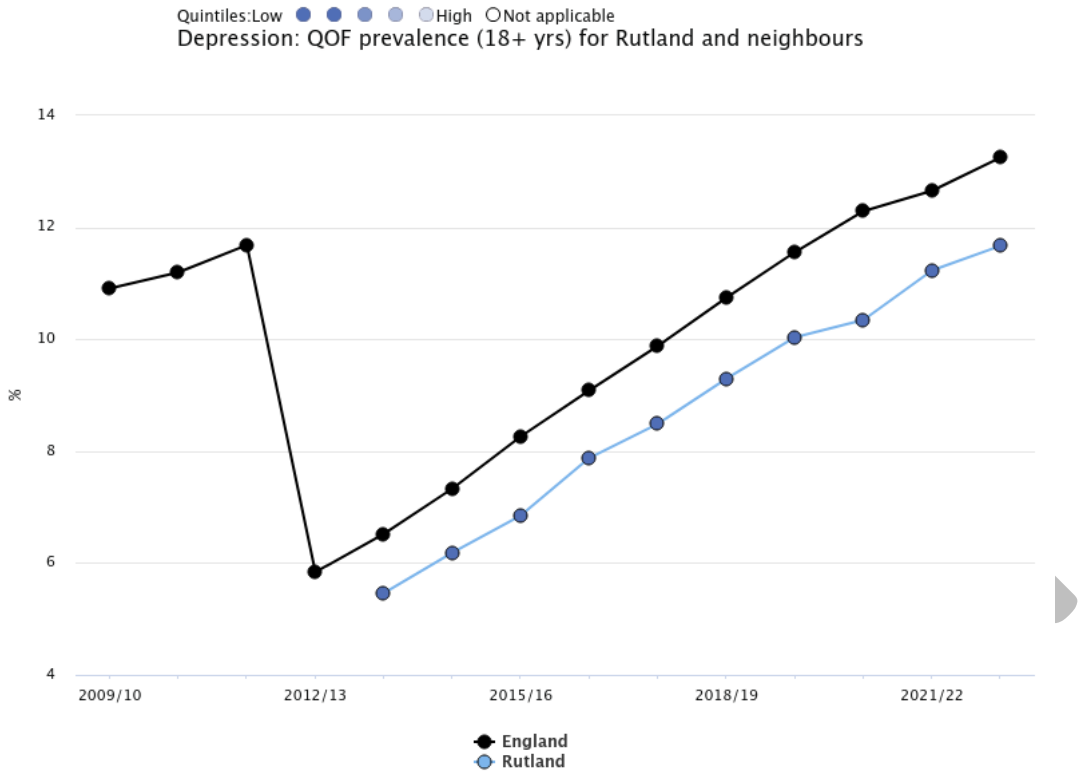
Addressing the wider determinants of common mental disorders requires a comprehensive, multisectoral approach involving government policies, social programs, community support, and individual interventions. Efforts to reduce social and economic inequalities, improve access to healthcare, promote positive social relationships, and reduce stigma can all contribute to better mental health outcomes for individuals and communities [99].

4.2.2. Prevalence

In 2022/23 the prevalence of depression among adults registered at GP practices across Rutland was 11.7%, which is significantly lower than the national average of 13.2%. In 2022/23 Rutland had the second lowest prevalence when compared to its 14 CIPFA comparators. The prevalence of depression among adults registered at GP practices across Rutland and England has shown a

significant and increasing trend over the most recent five time periods (Figure 18).

Figure 18. Trend in the prevalence of depression (GP registered population) in Rutland and England 2009/10 – 2022/23



(Source: Office for Health Improvement and Disparities, Fingertips)

The incidence of depression in 2021/22 in adults registered with GP practices in Rutland (1.2%) was significantly lower than the national value of 1.5%. Rutland had the fourth lowest prevalence when compared to its 14 CIPFA comparators in 2021/22.

The estimated prevalence of common mental conditions for those aged 16 and over in 2017 in Rutland is 3,925 cases, with around 750 cases among those aged 65 and above. In 2017, the estimated prevalence of common mental disorders in those aged 16 and over and 65 and over in Rutland was significantly better (lower) than the value for England.

In Rutland in 2019/20 the rates of attended contacts with community and outpatient mental health services and new referrals to secondary mental health services were significantly below the national average. There were over 19 thousand attended contacts with community and outpatient mental health services per 100,000 population in Rutland in 2019/20 (N=7,755) and there were around 2,220 new referrals to secondary mental health services in the same time period.

The rate of inpatient stays in secondary mental health services in Rutland in 2019/20 (102 per 100,000 population, 40 stays) was significantly lower than the national average (241 per 100,000 population) and the lowest of Rutland's CIPFA comparators (Table 6).

Expressed as comparative rates, the measured prevalence indicators were below the national

averages and low when compared with Rutland's CIPFA comparators.

Table 6. Common mental health conditions in Rutland– estimated prevalence, incidence and rates of contact with services

Indicator	Time Period	Rutland		CIPFA value range	England value
		Value	Count		
Depression: QOF Prevalence (18+ years)	2022/23	11.7% ↑	3,944	11.2% - 15.7%	13.2%
Depression: QOF incidence (18+ years) – new diagnosis	2021/22	1.2% →	401	0.9% - 2.2%	1.5%
Estimated prevalence of common mental disorders: % of population aged 16 and over	2017	11.9	3,925	11.9-17.5	16.9
Estimated prevalence of common mental disorders: % of population aged 65 and over	2017	7.8	754	7.8-11.4	10.2
Attended contacts with community and outpatient mental health services, per 100,000 (All Ages)	2019/20	19,238	7,755	16,928-34,554	30,674
New referrals to secondary mental health services, per 100,000 (All Ages)	2019/20	5,477	2,220	4,321-9,262	6,897
Inpatient Stays in secondary mental health services, per 100,000 (All Ages)	2019/20	102	40	102-291	241

Recent trend over most recent five time periods:
↑ Increasing
→ No significant change

Significantly better than the national average	
Significantly below the national average	

(Source: Office for Health Improvement and Disparities, Fingertips)

Prevalence modelling using APMS data and current population estimates

The *Adult Psychiatric Morbidity Survey (APMS)* aims to provide information and analyses on both treated and untreated psychiatric disorders in the population aged 16 and over in England, as well as provide trend data through comparison with earlier surveys in the series. It is run every seven years, with the last published survey data from 2014. Because of the COVID-19 pandemic, the current survey edition was earmarked for 2022/23, this data has not been published yet.

APMS 2014 surveyed the symptoms of depression and anxiety, to estimate the prevalence of depression, generalised anxiety disorder (GAD), phobias, panic disorders, obsessive-compulsive disorder (OCD) as well as symptoms not otherwise specified (CMD-NOS), which mixed anxiety and depression and cannot by classified within any of the specific types mentioned. The revised Clinical Interview Schedule (CIS-R) was used - an interviewer assessed 14 non-psychotic symptoms of CMD, scoring them according to their severity. A CIS-R score of 12 and above was the threshold applied

to indicate that a level of CMD symptoms was present such that primary care recognition is warranted.

The Survey indicated a sex difference, CMD being more common in women (21%) rather than men (14%), significant socioeconomic differences (CMD three times more common in people out of work or in receipt of financial support), the role of social isolation (a third of all adults under 60 living alone vs 17% overall rate) and ethnicity - prevalence higher among black or mixed groups (22%).

Applying the Survey results to the ONS 2022 Rutland Mid-Year Population Estimates, around 5,480 people could be suffering from any CMD, with approximate estimates for specific conditions as follows: GAD 1,910, depression 1,080, phobias 720, OCD 400, panic disorder 200, with other (not specified conditions) accounting for additional 2,530 cases.

APMS also surveyed for PTSD and trauma. Trauma was defined as experience that either put a person or someone close to them at risk of serious harm or death. The results suggested that in England over a third of adults aged 16 and over (31%) have had a traumatic event in their lifetime and may go on to develop PTSD. Overall, just over 4% of adults screened positive for PTSD in the past month, with similar rates for men and women, the rate was highest among younger women (16–24-year-olds - 13%), declining sharply with age. The risk was higher in people under 60 living alone, those not in work and among benefit recipients. Only 13% of those screening positive for PTSD had already been diagnosed by a health professional. These findings can indicate about 1,190 people with possible PTSD across Rutland.

Of course, these estimates need to be treated with caution.

4.2.3. People Accessing NHS Talking Therapies

Formerly known as IAPT (Improving Access to Psychological Therapies), NHS Taking Therapies are NHS-funded, evidence based, psychological therapies for depression and anxiety. In 2022, nearly 1.22 million people accessed the service in England and 1.9 million should be able to access it in 2023/24.

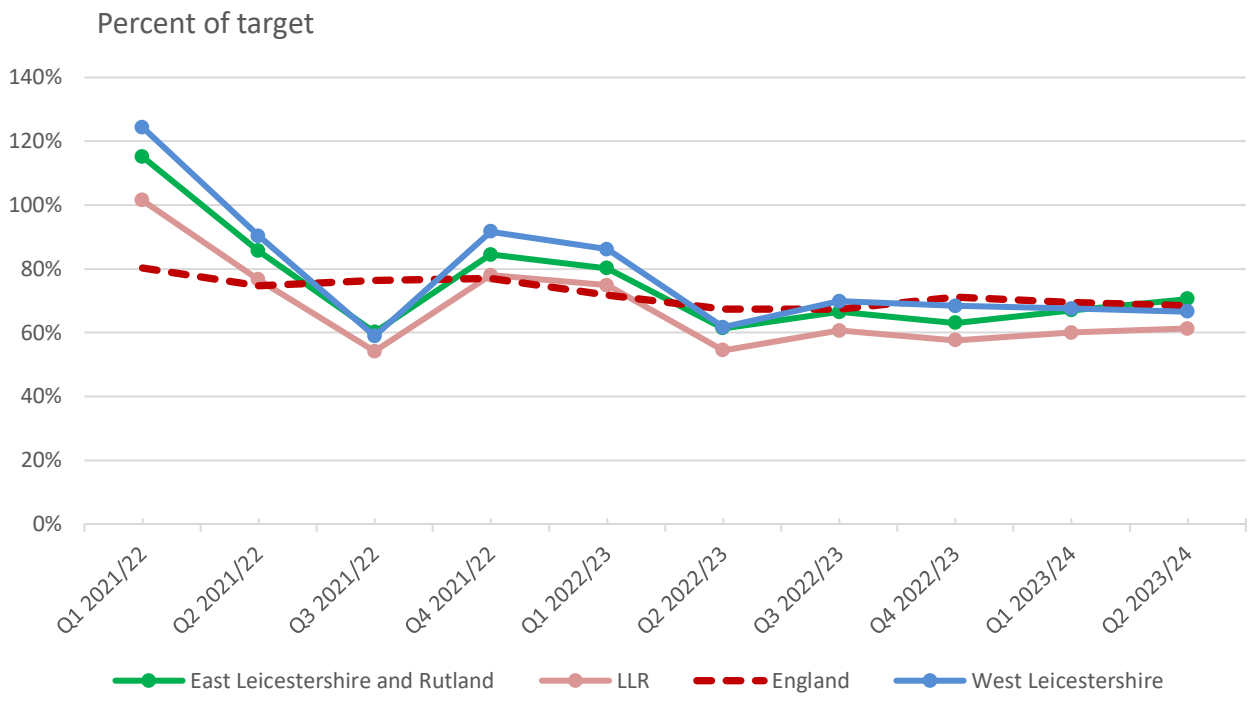
Published data indicate that in 2022/23 12,950 people accessed these services in Leicestershire and Rutland. Although the access rates to this service are similar to the national average for both East Leicestershire and Rutland and West Leicestershire, they are below the target set for these services, at 68% and 67%, respectively (Figure 19).

In quarter 2 of 2023/24 just over six percent (6.5%) of all referrals were for patients aged 65 and above in West Leicestershire and 8.9% in East Leicestershire and Rutland, against the 6.9% national average, which can be explained by age structure differential.

There are no financial sub-ICB data for 2022/23, but in 2021/22 the total spend on NHS Talking Therapies was over £5.6 million in two Leicestershire and Rutland CCGs, an increase from £4.3

million in 2017/18. As a percentage of planned spend, the rate for the whole of LLR was just 82% of the target 2022/23, compared to 90% in the previous year (Figure 20).

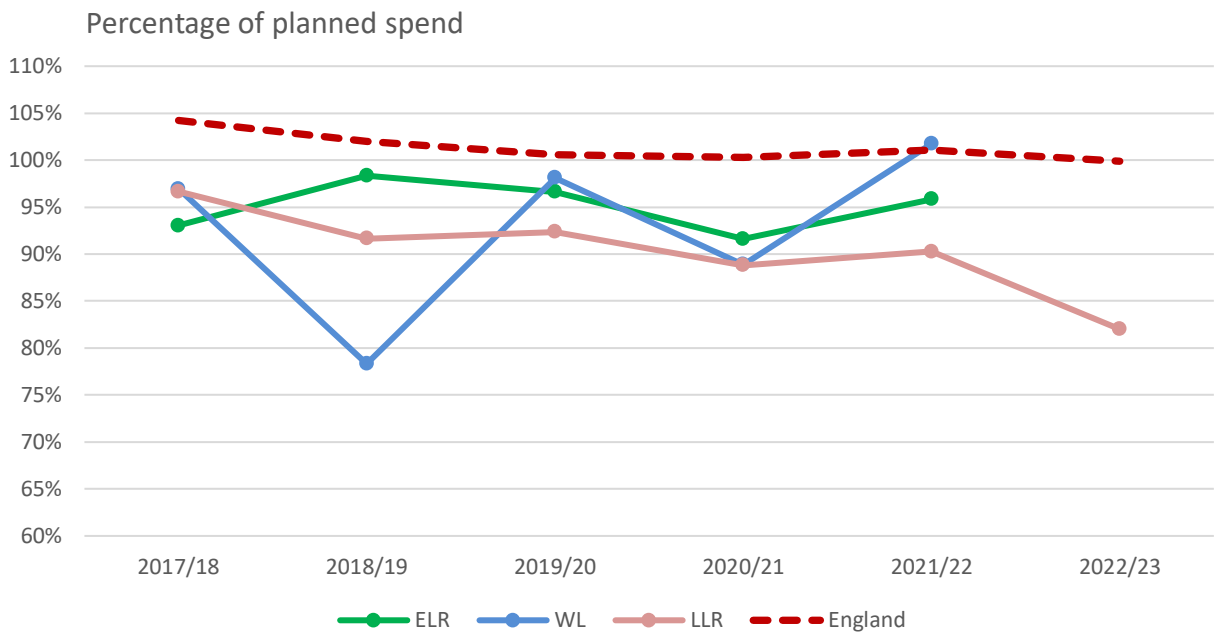
Figure 19. Talking Therapies – quarterly access rate as a percentage of target between April 2021/22 and September 2023/24



Note: rates for Q1 2023/24 were not available and are imputed.

(Source: NHS Mental Health Dashboard - February 2024)

Figure 20. Talking Therapies – actual against planned annual spend since 2017/18 (note: no sub-ICB financial data after 2021/22)

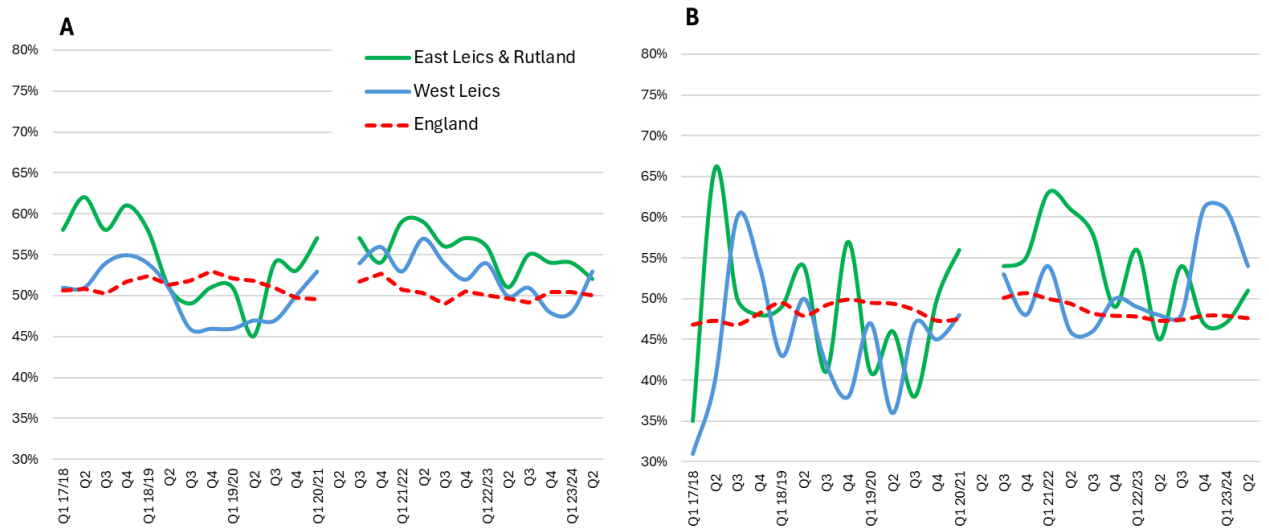


(Source: NHS Mental Health Dashboard - February 2024)

Recovery rates

Nationally, the Talking Therapies recovery rates were consistently around 50%, including those for ethnic minority populations. On a background of substantial variation, particularly for ethnic minorities, from 2020/21 the local recovery rates seemed to be somewhat higher than the national average (Figure 21).

Figure 21. Recovery rates (proportion of people who attended at least two treatments contacts and are moving to recovery. A = all groups, B = ethnic minority groups (Black, Asian or other)

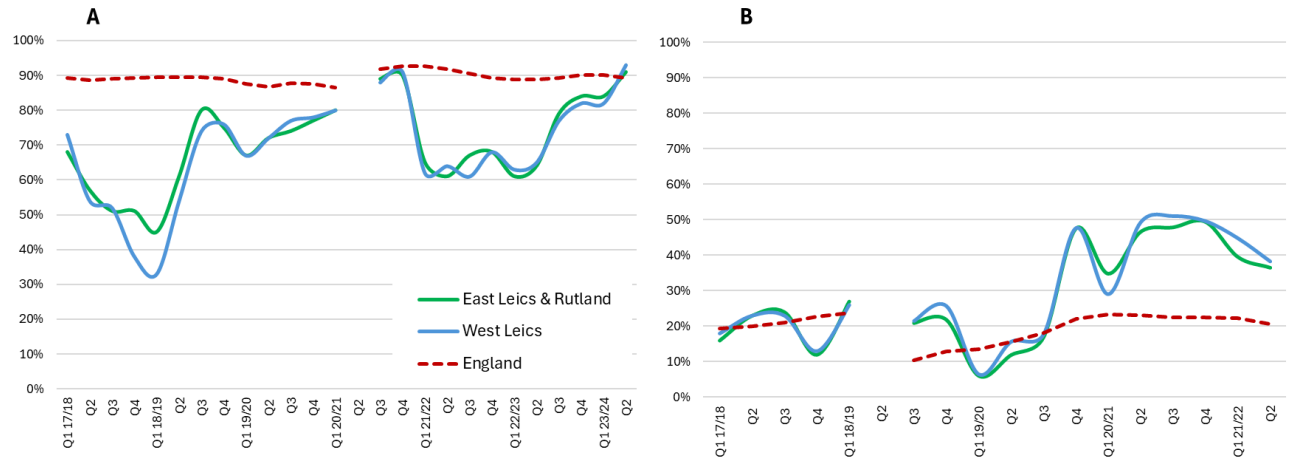


(Source: NHS England, NHS Mental Health Dashboard, February 2024)

Waiting times

Over the last five years, people tended to wait longer for their first appointment locally. For those waiting for their first appointment, the latest figures (for period July-September 2023) for East Leicestershire and Rutland show that the waits improved, with 91% accessing services within 6 weeks (national average 89%) and 100% within 18 weeks (vs 98% across England). Recently more than a third (36% in July-September 2023) of those in treatment were waiting more than 90 days between their first and second appointment, against the national average of 21%, although this rate is decreasing (Figure 22).

Figure 22. Talking Therapies waiting times. A = Proportion of people receiving their first treatment appointment within 6 weeks of referral (denominator: those who finished treatment in reporting period). B = In-treatment pathway waits over 90 days.



(Source: NHS England, NHS Mental Health Dashboard, February 2024)

4.2.4. Depression

Depression is a highly prevalent mental health condition globally. In 2019, an estimated 280 million people, including 5% of all adults and more than 10% of women in the perinatal period, experienced depression. Depression is a major contributor to loss of productivity, together with anxiety it is estimated that nearly 1 trillion US dollars are lost each year due to lost productivity worldwide[100].

Around one in five people (20%) across the world will experience depression at some point in their lives and the annual prevalence is somewhere between 5 and 10%. Depression is a major risk factor for suicide.

Although depression can affect both men and women it is more common among females, and there is evidence to suggest that the rates are higher among adolescents and young adults.

The prevalence of depression varies across regions, a variety of cultural, socio-economic and health care access factors can influence these patterns. The COVID-19 pandemic had a negative impact on the prevalence of depression - apart from the psycho-social effects of the pandemic on the whole society, infection with COVID-19 was shown to lead to increased rates of major depression and anxiety in those infected by the virus[101].

Data on the prevalence of depression in Rutland is summarised in Table 6, section 4.2.2.

4.2.5. Dementia

This section presents data for groups at risk, risk factors, prevalence (estimated and diagnosed), outcomes and mental health services, specifically for dementia. It is important to stress that dementia shares many underlying factors and treatment pathways with other common mental conditions, the discussion below concentrates on those which were investigated specially for dementia.

Background

The term dementia refers to several diseases that affect thought, memory, and the ability to perform daily activities. The illness mainly affects older people and gets worse over time. Dementia is caused by many different diseases or injuries that directly and indirectly damage the brain. Alzheimer's disease is the most common form and may contribute to 60–70% of cases, other forms include vascular dementia, dementia with Lewy bodies, and a group of diseases that contribute to frontotemporal dementia. Dementia may also develop after a stroke or in the context of certain infections such as HIV, as a result of harmful use of alcohol, repetitive physical injuries to the brain (chronic traumatic encephalopathy) or nutritional deficiencies. The boundaries between different forms of dementia are indistinct and mixed forms often co-exist.

Dementia is currently the seventh leading cause of death worldwide and is a major cause of disability and dependency among older people. Women are disproportionately affected, directly and indirectly, by the social and economic costs from dementia, because they provide 70% of care hours for people living with dementia and experience more disability-adjusted life-years and mortality caused by it[102].

Alzheimer's disease primarily affects older adults, the majority of cases are diagnosed in individuals over 65 years old (known as late-onset Alzheimer's disease). Although less common, the early onset cases (under the age of 65 at diagnosis) are often linked to genetic factors. Alzheimer's disease tends to affect women more than men, partly because women tend to live longer. Some research suggests that hormonal and genetic factors may also play a role[103]. The prevalence can vary by region and country. Some regions, like North America and Western Europe, have higher rates compared to others. These variations may be due to differences in lifestyle, genetics, and healthcare access.
Several risk factors have been identified, including genetics (family history), age, cardiovascular health, and lifestyle factors such as diet, exercise, and cognitive stimulation.
With the aging population worldwide, the number of people affected by Alzheimer's disease is projected to increase significantly in the coming decades. This will pose substantial challenges to healthcare systems and caregivers. Alzheimer's disease has a substantial economic impact due to the costs associated with healthcare, long-term care, and lost productivity. It places a significant burden on individuals, families, and societies[104].

The symptoms of Alzheimer's disease can vary in severity and typically worsen over time. Memory

loss is one of the earliest and most noticeable signs, including trouble remembering recent events, names, and appointments. Other common symptoms include difficulty with problem solving, difficulty concentrating and taking longer to do tasks, confusion with time or place, difficulty with familiar tasks, misplacing items and being unable to retrace steps to find them. These are usually followed by language problems, decreased judgement, loss of initiative, behavioural changes such as mood swings, irritability, or withdrawal from social activities. Patients have difficulty recognizing familiar faces and problems with spatial awareness, as well as often finding it challenging to learn or remember new information or tasks[105].

Risk factors and prevention

Particular demographic groups are more at risk of developing dementia, the demographic breakdown of Rutland's population is discussed above in section 3.1. Dementia is known to affect more women than men. Black, Asian and Minority Ethnic communities are also at greater risk of developing dementia, as are those with learning disabilities, particularly those with Down's syndrome[106,107,108]. Dementia is a growing problem within prisons. A study by Sutin in 2018 also found that loneliness is associated with increased risk[109]. The increased risk of dementia with increases in age is of most note for Rutland. As discussed previously in section 3.1, a larger proportion of Rutland's population are in the older age groups than nationally. This, alongside the projected rise in Rutland's older population highlights the importance of considering the future needs of Rutland's population with regards to dementia.

Behavioural factors such as alcohol misuse, obesity and high body mass index (BMI), physical inactivity and smoking are all linked to increased risk of developing dementia[110,111,112]. Other risk factors associated with increased risk of dementia include hypertension, diabetes, depression, coronary heart disease (CHD) and stroke[113,114,115]. Publicly available data on alcohol misuse in Rutland is limited, often suppression is applied due to small counts.

The population of Rutland overall demonstrate a relatively low prevalence of the range of health behaviour risk factors for dementia in comparison to England. In 2021/22, the percentage of adults aged 18 and over classified as obese was significantly lower (20.2%) than the national average (25.9%); also, in 2022/23 the percentage of patients aged 18 or over with a BMI over 30 recorded on GP disease registers was significantly lower (10.2%) than the national average (11.4%). The percentage of physically inactive adults was not significantly different to the national average of 22%. The percentage of patients recorded as current smokers on GP registers in Rutland in 2022/23 was significantly below the national percentage, with a significant decreasing trend.

For other risk factors, the prevalence of hypertension, as recorded on GP registers, was significantly higher was than the national figure (18.5% vs. 14.4%), with a significant increasing trend over the most recent five years. A systematic review identified midlife hypertension as a significant risk factor

for the later development of both Alzheimer's disease and vascular dementia[116]. The prevalence of diagnosed CHD in Rutland was significantly higher than the prevalence in England in 2022/23 (3.4% vs. 3.0%). The proposed mechanism is that pathological changes in CHD reduce blood flow to the brain along with the formation of blood clots which may damage brain cells may increase the risk of vascular dementia. Furthermore, the prevalence of diagnosed stroke was 2.3%, significantly higher than the prevalence in England (1.8%). Strokes and transient ischaemic attacks (TIAs) are two known causes for vascular dementia[117]. However, the diagnosed prevalence of diabetes mellitus in Rutland was 6.7%, significantly lower than the national prevalence of 7.5%.

In summary, the prevalence of many of the health conditions which can increase the risk of dementia is higher than the national average, while lifestyle risk factors are generally lower.

Table 7. Prevalence of risk factors for dementia in Rutland

Indicator	Time period	Rutland			CIPFA value range	England value
		Value	Count	Recent Trend		
Health behaviours						
Obesity: QOF prevalence (18+years)	2022/23	10.2%	3,464	→	10.1%-13.4%	11.4%
Percentage of adults (aged 18+) classified as obese	2021/22	20.2%	-	-	20.2%-32.0%	25.9%
Percentage of physically inactive adults	2021/22	20.8%	-	-	13.7%-24.3%	22.3%
Smoking: QOF prevalence (15+ years)	2022/23	10.0%	3,606	↓	10.0%-15.1%	14.7%
Other risk factors						
Hypertension: QOF prevalence (all ages)	2022/23	18.5%	7,808	↑	13.1%-19.3%	14.4%
Diabetes: QOF prevalence (17+ years)	2022/23	6.7%	2,316	→	5.6%-8.4%	7.5%
Coronary Heart Disease (CHD): QOF prevalence (all ages)	2022/23	3.4%	1,453	-	2.6%-4.8%	3.0%
Stroke: QOF prevalence (all ages)	2022/23	2.3%	986	-	1.7%-2.8%	1.8%

Significantly lower than the national average	
Not significantly different to the national average	
Significantly higher than the national average	
Significantly better than the national average	

Recent trend over most recent five time periods:
→ No significant change
↑ Increasing
↓ Decreasing
\- Cannot be calculated

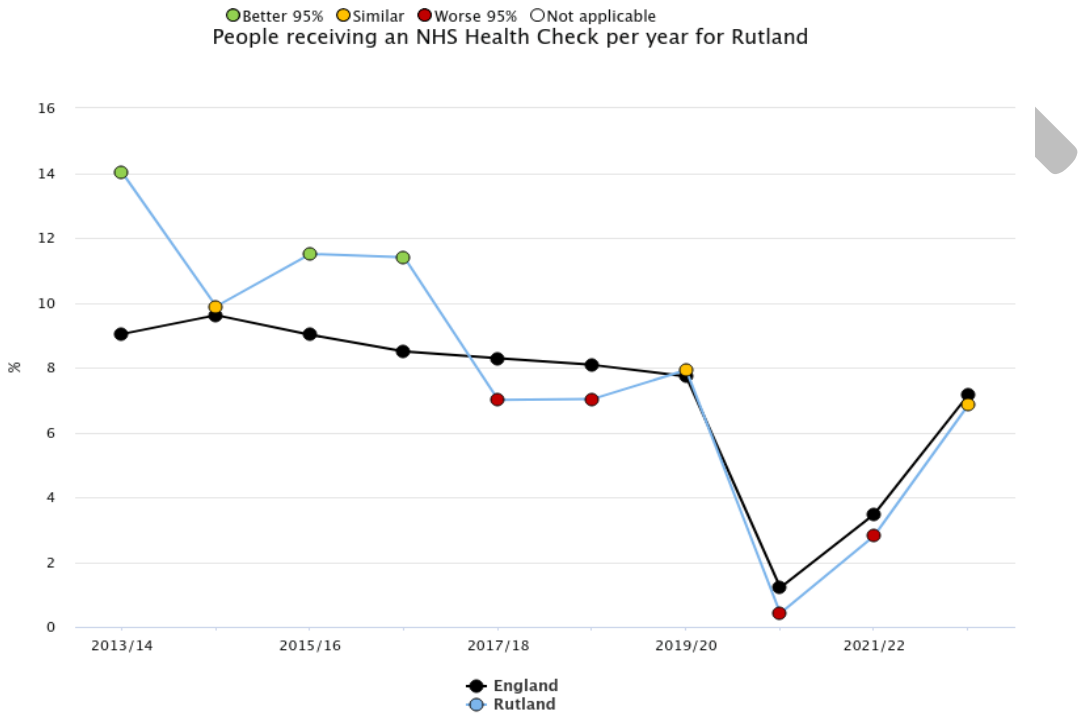
(Source: Office of Health Improvement and Disparities, Fingertips)

One way to help prevention of dementia is early diagnosis and treatment of the contributing conditions described above. The NHS Health Check Programme aims to help prevent heart disease,

stroke, diabetes and kidney disease. A high take up of NHS Health Check is important to identify early signs of poor health leading to opportunities for early interventions. The NHS Health Check is also used to promote opportunities in mid-life to reduce the behavioural risk factors for dementia by providing advice on dementia to the relevant age group[118].

In 2022/23, 6.8% of people (aged 40 to 74) in Rutland who were eligible for an NHS Health Check, received a health check. This coverage rate is not significantly different to the national average of 7.2%. In the pre-pandemic years, the performance of the programme was variable, with relatively high coverage up to 2016/17, followed by two low-uptake years and an expected trough due to COVID-19 pandemic (Figure 23).

Figure 23. Percentage of people receiving an NHS Health Check per year for Rutland and England, 2013/14 to 2022/23



(Source: Office for Health Improvement and Disparities, Fingertips)

Prevalence

In 2019, it was estimated that 55 million people were living with dementia worldwide (with 10 million new cases every year), a number that is expected to increase to 78 million by 2030 and 139 million by 2050[119]. Dementia puts a substantial burden on the healthcare system; in 2018 the cost of dementia was estimated at US $1 trillion and is estimated to surpass US $2 trillion by 2030[120], about half of these costs are attributable to care provided informally.

The recorded dementia prevalence provides an indication of the concentration, within a population,

of the number of people who have been diagnosed and who are living with the condition. This indicator can be used to inform local service planning as to the scale of services required to provide treatment, care and support as needed, so that those with dementia can live well with the condition[121].

The Quality Outcomes Framework (QOF) data published by OHID (Table 8) are only available up to 2021/22. The diagnosed prevalence of dementia in Rutland in 2021/22 was 0.9% (358 individuals) which was significantly higher than the national average of 0.7%. There was no significant change in this prevalence across the five most recent time periods (Figure 24). The more recent data available through NHS Digital shows that in 2022/23 the prevalence of dementia in patients registered with GP practices in Rutland was 0.8% (352 patients), this was significantly higher than the national average of 0.7%. This could be explained by the older population profile of Rutland - as there are more older people in Rutland and the prevalence of dementia increases with age, Rutland has a higher prevalence of dementia than England which has a smaller proportion of older people than Rutland.

However, the percentage of patients aged 65+ with dementia recorded on GP practice disease registers in Rutland in 2020 was 3.4%, this was significantly lower than the national average of 4.0%.

In Rutland, less than half (48.5%) of those aged 65 years and above estimated to have dementia are on the GP register with a diagnosis, indicating that another 370 patients could be without a diagnosis or access to treatment. Not only is this significantly below the benchmark of 66.7%, but it is also below the national average of 63% and it is the lowest figure across Rutland's CIPFA comparators.

Dementia is considered 'young onset' when it affects people under 65 years of age, this is also referred to as 'early onset' or 'working age' dementia[122]. The crude recorded prevalence of dementia in those aged under 65 years registered at GP practices in Rutland in 2020 (2.37 per 10,000 population) was not significantly different to the prevalence in England (3.05 per 10,000 population). The proportion of people aged under 65 years with dementia registered at GP practices in Rutland in 2020 was 2.0%, this was not significantly different to the value of 3.5% for England - Rutland had the lowest proportion of its CIPFA neighbours (Table 8).

Table 8. Dementia prevalence and diagnosis for Rutland and England, 2020-2023

Indicator	Time Period	Rutland			CIPFA range	England value
		Value	Count	Recent Trend		
Dementia: QOF prevalence (all ages) (%)	2021/22	0.9%	358	→	0.7% - 1.1%	0.7%
Dementia: Recorded prevalence (aged 65 years and over) (%)	2020	3.38%	348	-	3.38% - 4.33%	3.97%
Dementia: Crude Recorded Prevalence (aged under 65 years) per 10,000 population	2020	2.37	7	-	1.99 - 4.91	3.05
Dementia (aged under 65 years) as a proportion of total dementia (all ages) (%)	2020	2.0%	7	-	2.0% - 4.0%	3.5%
Estimated dementia diagnosis rate (aged 65 and older) (%)	2023	48.5%[1]	346	→	48.5% - 67.9%	63.0%

Significantly below the national average	
Not significantly different to the national average	
Significantly worse than the benchmark goal	

1 Benchmarking against goal: > 66.7% (significantly) | similar to 66.7% | < 66.7% (significantly)

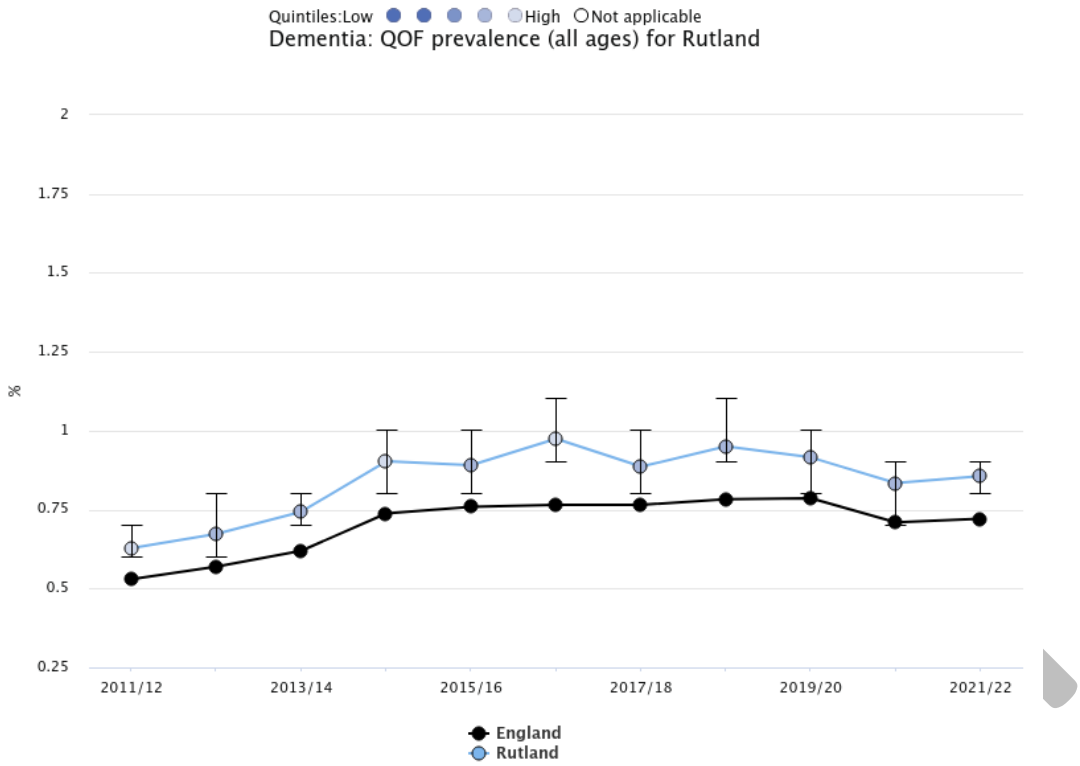
Recent trend over most recent five time periods:

→ No significant change

\- Could not be calculated

(Source: Office for Health Improvement and Disparities, Fingertips)

Figure 24. Dementia QOF prevalence (all ages) for Rutland and England (%), 2011/12 – 2021/22



(Source: Office for Health Improvement and Disparities, Fingertips)

Projected prevalence

As age is a major unmodifiable risk factor for dementia and the older population is expected to increase in size, so is the number of people living with dementia. Overall, between 2023 and 2040 the number of people aged 65 and over in Rutland with dementia is estimated to increase from 830 to 1,233, an increase of 48.6%. While in persons aged 85 years and over, the increase is expected to be 70.3% (from 370 to 630). The largest increase is predicted to be in males aged 85 years and over which is projected to increase by 86.9% from 107 to 200 people with dementia (Table 9).

Table 9. Current and projected estimates of dementia in Rutland population aged over 65 years and over 85 years for males, females and persons, 2023-2040

	2023	2025	2030	2035	2040	% change 2023 to 2040
Males 65 and over	313	327	382	438	475	51.8%
Males 85 and over	107	107	138	192	200	86.9%
Females 65 and over	516	536	573	690	758	46.9%
Females 85 and over	263	263	283	394	430	63.5%
Persons 65 and over	830	864	955	1,129	1,233	48.6%
Person 85 and over	370	370	421	586	630	70.3%

Source: Projecting Older Peoples Populations Information, (POPPI), 2023

In Rutland the estimated numbers of early onset dementia in each of the males aged 30-39, 40-49, 50-59, 60-64 and the females of the same age groups were below 5 for all of the 2023, 2025, 2030, 2035 and 2040 predictions. The total number of males aged 30-64 predicted to have early onset dementia in Rutland 2023 was 7, the prediction for 2040 was also 7. The total number of females aged 30-64 predicted to have early onset dementia in Rutland in 2023 was 5, the prediction for 2040 was also 5[123].

Primary Care

This section outlines data about people with dementia in East Leicestershire and Rutland Sub-ICB, including ethnicity, sex and age breakdown. Data at county/district level are not available[124].

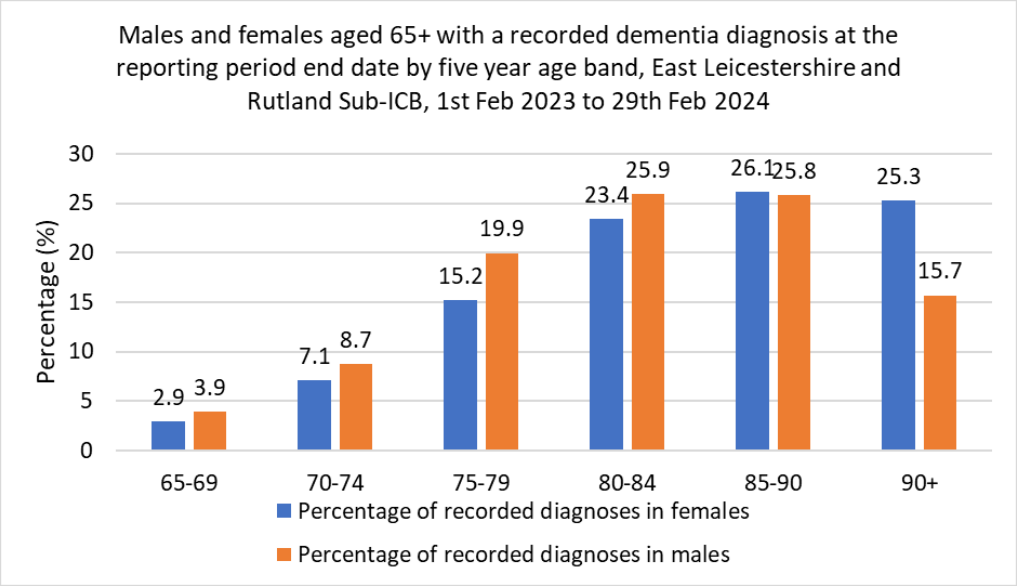
Data for February 2023 to February 2024 show that in East Leicestershire and Rutland out of 3,385 patients with a recorded diagnosis of dementia, 72% had their latest ethnicity recorded as in the white, 3% as in the Asian or Asian British, 0.3% as other, 0.3% as 'mixed or multiple' and 0.1% as black/African or Caribbean/black British. The remaining 21% of patients did not have their ethnicity recorded. Of patients aged 65 or over in that period, almost half (47.6%) were aged 85+ and a further 41.4% were aged 75 to 84 years, 61% were females and 39% were males. A detailed age/sex breakdown is given in Figure 25.

Based on data for April 2023 to February 2024, the recent type of dementia recorded was most commonly Alzheimer's disease (41%), 16% of cases were vascular dementia and 8% mixed dementia (diagnosed as having more than one type of dementia), with the remaining 35% classified as 'other' dementia[§]. [**]

[§] Any other dementia types than Alzheimer's disease, vascular dementia or mixed dementia.

[**] Dementia type data was rounded to the nearest 5.

Figure 25. Age breakdown of males and females aged 65+ with a recorded dementia diagnosis in February 2024, East Leicestershire and Rutland



Source: NHS England

Caution should be taken when interpreting this data as it has not been standardised against the demographic profile of the population.

Memory Services

Community based memory services teams assess people who have memory and other cognitive difficulties that might indicate a form of dementia, aiming to ensure early diagnosis and access to treatment.

In Rutland there were 270 open referrals to these services in 2022/23, and 740 contacts, of which 77% were attended. This related to 210 individuals in that year; expressed as a rate this equates to 2.0 individuals per 1,000 among older population (65 and above). This rate is slightly higher than the national rate of 1.9/1,000 or that across Leicestershire (1.7/1,000)[††].

Living with dementia

This section presents a selection of comparative indicators collected in primary and secondary care, summarising the use and quality of care for people with dementia. Unfortunately, the data have a significant time lag and are heavily affected by COVID-19 pandemic.

The percentage of patients diagnosed with dementia whose care plan had been reviewed in a face-

[††] NHS Mental Health Bulletin 2022/23

to-face review in the preceding 12 months in Rutland in 2020/21 was 27.7%, this was significantly below the percentage of 39.7% in England. This is an important measure in place to help improve the quality of life for the patient and/or carer. This indicator was likely heavily affected by the pandemic as the figure for 2019/20 was 84.6% and significantly above the national average.

The rate of emergency hospital admissions for people aged 65 and over with a mention of dementia or Alzheimer's in any of the diagnosis code positions in Rutland in 2019/20 (2,311 per 100,000 population) was significantly lower than the rate in England (3,517 per 100,000 population). In 2020, the percentage of assessed residential care and nursing home beds suitable for those aged 65 years and over with dementia in Rutland (79.9%) was significantly worse than the national figure (96.2%). In Rutland in 2020, this equated to 60 beds that were not assessed. Non-assessed beds can occur when new residential care homes and nursing homes are registered in the area or it may indicate a localised assessment issue[125]. The percentage of residential care home and nursing home beds, suitable for a person aged 65 and over with dementia, which were rated as 'good' or 'outstanding' by the Care Quality Commission (CQC) in Rutland in 2020 was 79.9%, this was significantly higher (better) than the percentage of 74.1% in England.

The percentage of assessed residential care and nursing home beds suitable for those aged 65 and over with dementia, indicates that each bed that was assessed in Rutland in 2020 received a 'good' or 'outstanding rating by the CQC (Table 10).

Table 10. Living with Dementia indicators for Rutland and England 2019-2021

Indicator	Time Period	Rutland			CIPFA range	England value
		Value	Count	Recent Trend		
Dementia care plan has been reviewed in the last 12 months (denominator includes Personalised Care Adjustments) (%)	2020/21	27.7%	93	-	23.0% - 48.9%	39.7%
Dementia: Direct standardised rate of emergency admissions (aged 65 years and over) – per 100,000 population	2019/20	2,311	245	-	2,138 – 3,602	3,517
Dementia: Quality rating of residential care and nursing home beds (aged 65 years and over) (%)	2020	79.9%	239	-	53.1% - 85.7%	74.1%
Dementia: Percentage of assessed residential care and nursing home beds (aged 65 years and over) (%)	2020	79.9%	239	-	79.9% - 99.9%	96.2%
Dementia: Residential care and nursing home bed capacity (aged 65+) (%)	2020	85.9%	299	-	59.0% - 121.6%	75.3%

Significantly below the national average	
Significantly better than the national average	
Significantly worse than the national average	

Recent trend over most recent five time periods:

- Cannot be calculated

(Source: Office for Health Improvement and Disparities, Fingertips)

Mortality

In 2019 in the UK, mortality from Alzheimer's and other dementias was the most common cause of death for females and the second most common cause for males (preceded only by IHD), with rates for women almost twice as high as for men[126]. In 2022, there were 62,118 deaths due to dementia and Alzheimer's disease in England, almost two-thirds of these were in women. Over two-thirds of Rutland's deaths due to dementia and Alzheimer's disease in 2022 were in females - there were 71 deaths in total, 23 of these were in males and 48 were in females. In Rutland in 2022 the mortality rates from dementia and Alzheimer's disease in persons, males and females were not significantly different to the national rates. In Rutland in 2019 the rate of mortality in people aged 65 and over with a recorded mention of dementia or Alzheimer's (747 per 100,000 population) was not significantly different to the rate in England (849 per 100,000 population). The proportion of all dementia and Alzheimer deaths which took place in the individuals usual place of residence in Rutland in 2019 was 75.3%, this was not significantly different to the proportion in their usual place of residence in England (70.3%) (Table 11).

Table 11. Dementia mortality in Rutland and England, 2019 and 2022

Indicator	Sex	Time Period	Rutland			CIPFA range	England value
			Value	Count	Recent Trend		
Mortality rate from dementia and Alzheimer's disease, all ages – directly standardised rate, per 100,000 population	Persons	2022	123.7	71	⇨		111.7
	Male	2022	91.2	23	⇨		100.2
	Female	2022	144.6	48	⇨		118.1
Direct standardised rate of mortality: People with dementia (aged 65 years and over) – per 100,000 population	Persons	2019	747	79	-	674-905	849
Deaths in Usual Place of Residence: People with dementia (aged 65 years and over) (%)	Persons	2019	75.3%	58	-	68.2% – 83.7%	70.3%

Not significantly different to the national average

Recent trend over most recent five time periods: ⇨ No significant change

\- Could not be calculated

(Source: Office for Health Improvement and Disparities, Fingertips)

4.2.6. Neurodevelopmental Disorders

Autism Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) are neurodevelopmental disorders which can coexist, particularly in children. Although adults can have both ADHD and ASD, the combination is less common. While ASD is considered a lifelong disorder, long-term studies have shown that in one-third to two-thirds of children with ADHD, symptoms last into adulthood.

ASD is characterised by impaired social interaction and communication, severely restricted interests, and highly repetitive behaviours, while ADHD, classically considered a disorder of childhood, is characterized by core symptoms of attention, impulsivity, and hyperactivity[127]. These symptoms persist into adulthood in about 40–60% of cases and even persist into later life, with around 3% of adults aged 50 and older reporting clinically significant ADHD symptoms[128].

Estimated prevalence

The *Adult Psychiatric Morbidity Survey (APMS)* in 2014 screened for ASD and ADHD. The prevalence of ASD in the English adult (aged 16 and over) population was estimated to be around 0.8%, (0.5% and 1.3%, 95% confidence interval); higher in men (1.5%) than women (0.2%) and higher among people with no qualifications.

Nearly 10% of adults in England screened positive for ADHD, with higher rates in younger adults, those living alone, people without educational qualifications, the unemployed and those who are economically inactive. Only 2.3% of those screened positive had been diagnosed by a professional.

For Rutland this is equivalent to an estimated 290 adults with ASD (between 120 and 730, 95% confidence interval) and 3,090 adults with ADHD (2,840 to 3,370, 95% confidence interval). Please note the high level of uncertainty in the autism estimate in particular.

Access to services

The national data[129] show a significant rise in the number of referrals for autism assessment – the number waiting in April 2019 was just over 17,400 in England, compared to 172,000 in December 2023 (almost a ten-fold rise).

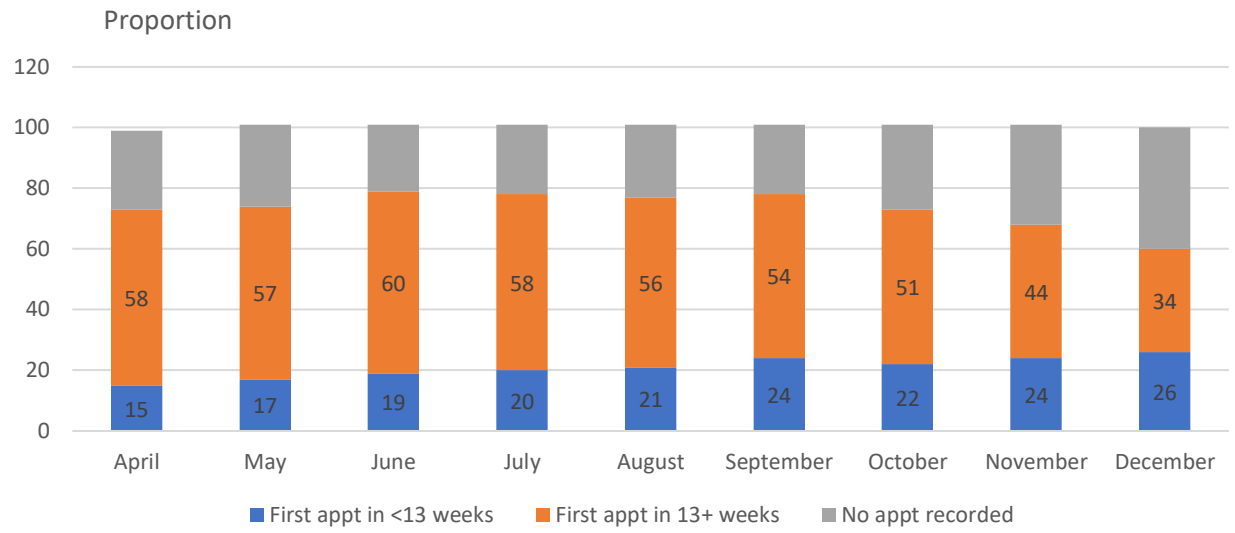
The available data at the sub-ICB level show that in December 2023 there were 165[‡‡] adults from East Leicestershire and Rutland with an open referral for suspected autism. Among those, 90 (55%) were waiting for more than 13 weeks. This proportion is lower than the national 87% average.

In 2023, there were on average 35 new and 31 closed autism referrals for adults across East Leicestershire and Rutland.

While nationally only 5.2% of adults waiting had their first appointment within the recommended 13 weeks in December of 2023, this indicator is higher in East Leicestershire and Rutland at 26% (N=25). The monthly progress since April 2023 is shown on Figure 26.

[‡‡] All numbers rounded to nearest 5

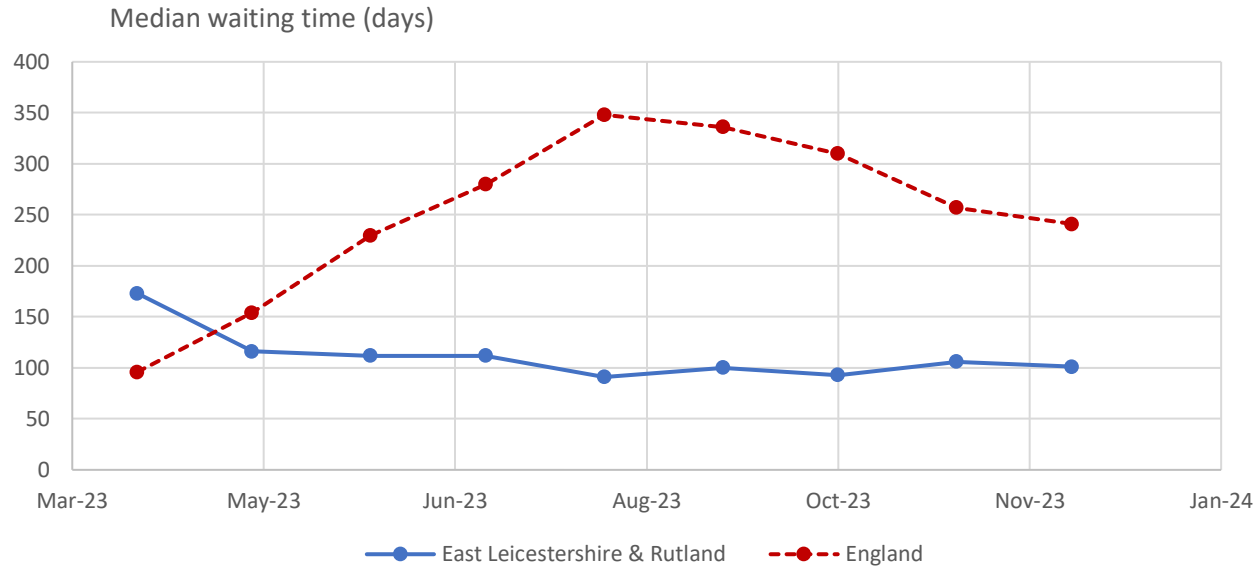
Figure 26. Adults with open autism referral in East Leicestershire and Rutland receiving their first appointment between April and December of 2023



(Source: NHS Digital, Autism Waiting Time Statistics)

Nationally, the median waiting time for children and adults has risen from 92 days in April 2019 to 281 days in December 2023. In 2023, the local waiting times for adults seemed to be significantly shorter than the national average, more similar to national pre-pandemic figures (Figure 27).

Figure 27. Median waiting time for a first appointment (adults only) for suspected autism, April-December 2023



(Source: NHS Digital, Autism Waiting Time Statistics)

It is important to stress that the NHS Autism Waiting Time Statistics are classified as experimental and have to be treated with some caution. It does not, for example, include data collected by the community services, where mental health diagnosis also happens. The data rely on Mental Health Services Dataset (MHSDS) only; the number of providers submitting data to MHSDS has increased over time which can affect the published time trends.

4.2.7. Medically unexplained symptoms (MUS)

The term 'Medically Unexplained Symptoms' (MUS) is used for 'persistent bodily complaints for which adequate examination does not reveal sufficiently explanatory structural or other specified pathology'. Other terms used for physical or bodily symptoms that cause distress or impairment but do not have a clear medical or organic cause are 'functional symptoms', 'somatoform disorders', or 'somatic symptom disorders'. For a proportion of patients with MUS, the symptoms may be part of a poorly understood syndrome, such as chronic fatigue syndrome (CFS), also known as ME, irritable bowel syndrome (IBS) or fibromyalgia (pain all over the body)[130].

Common examples of medically unexplained symptoms include chronic pain, fatigue (often profound tiredness and exhaustion), digestive symptoms such as abdominal pain, bloating, or diarrhoea, neurological (dizziness, headaches, weakness, or sensory disturbances), cardiovascular symptoms (palpitations, chest pain, or shortness of breath) or non-epileptic seizure (seizure-like episodes that are not associated with the abnormal electrical brain activity seen in epilepsy). While these symptoms are real and experienced by the individual, they cannot be attributed to a specific medical condition or disease through standard medical examinations or tests.

Medically unexplained symptoms can be challenging to diagnose and manage because they often lack clear physiological markers or abnormalities that can be identified through medical tests or imaging. However, it is important to note that individuals experiencing these symptoms are genuinely suffering, and their symptoms can have a significant impact on their quality of life and daily functioning.

Some individuals with MUS may receive a diagnosis of a somatic symptom disorder (excessive focus on and distress about physical symptoms) or a related condition, such as illness anxiety disorder (hypochondriasis) or conversion disorder (functional neurological symptom disorder).

Treatment for individuals with MUS often involves a multidisciplinary approach, including psychological interventions (counselling, cognitive behavioural therapy or psychotherapy), medication (particularly for co-occurring depression or anxiety), education and supportive care[131].

It is important to approach individuals with medically unexplained symptoms with empathy, understanding, and a collaborative approach to care. A thorough evaluation is needed to rule out any underlying medical conditions before arriving at a diagnosis of MUS or a related disorder.

4.3. Severe Mental Illness (SMI)

People with severe mental illness are more likely to be in treatment, thus the prevalence recorded through GP registers is more likely to be a true representation of the numbers in the population.

4.3.1. Risk factors

Potential risk factors for SMI may be genetic (certain genetic variations or predispositions may make individuals more susceptible to conditions such as schizophrenia, bipolar disorder, or major depressive disorder), biological (e.g., abnormalities in dopamine and serotonin levels have been implicated in schizophrenia and depression, respectively), adverse childhood experiences, environmental (e.g., high levels of stress, exposure to traumatic events, chronic illness, substance abuse, or environmental toxins), substance abuse, and socioeconomic factors[132].

Cultural factors, including stigma surrounding mental illness, can also impact help-seeking behaviours and treatment outcomes. Certain chronic medical conditions, such as neurological disorders, autoimmune diseases, or endocrine disorders, may increase the risk of developing serious mental illnesses or exacerbate existing symptoms.

Certain personality traits, such as high levels of neuroticism, introversion, or impulsivity, may increase the risk of developing serious mental illnesses. However, personality traits alone are unlikely to cause mental illness but may interact with other risk factors.

It is essential to note that the development of serious mental illnesses is often multifactorial, with interactions between genetic, biological, psychological, and environmental factors playing a role. Additionally, having one or more risk factors does not necessarily mean that an individual will develop a serious mental illness, as protective factors and resilience can also influence outcomes. Early identification, intervention, and support can help mitigate the impact of risk factors and improve outcomes for individuals with serious mental illnesses.

4.3.2. Prevention

Prevention can be primary (preventing a disease from occurring), secondary or tertiary, after the onset of disease, providing earlier diagnosis and treatment, or reducing adverse symptoms, complications or long-term disability.

Factors that promote positive wellbeing and resilience are key in preventing mental illness and improving outcomes in those with mental illness[133]. Childhood and adolescence are the critical periods for setting growth and wellbeing for the adult life; empowering youth with life skills and opportunities to reach their full potential in adult life has been shown to have a positive effect on both physical and mental health outcomes. For severe mental disease, early identification and interventions are of key importance and have been shown to be highly cost-effective.

Although prevention of severe mental illness may not be possible, particularly in those with genetic

predisposition, there are many strategies to help manage risk factors, such as early intervention (e.g. treatment of symptoms, cognitive behavioural therapy), providing supportive environments, healthy nutrition and maintenance of good physical health, and stress reduction. Avoidance of substance misuse, particularly drugs like cannabis or hallucinogens, which have been linked to the development of SMI is also important.

4.3.3. Prevalence

WHO estimates a global prevalence of all mental disorders at 12.5% of the population[134].

There are different clinical criteria and diagnostic practices for SMI across various countries, thus local estimates may not be comparable, particularly between more or less developed countries. Rates will also vary depending on various socio-economic and cultural factors.

In the Unites States, for example, the published estimate for 2020 (Substance Abuse and Mental Health Services Administration, SAMHSA) is 5.6% of all adults aged 18 or over. The estimated prevalence of psychotic disorders (a subset within SMI) is around 0.7%, bipolar disorder 2% and 4.4% screen positive for symptoms of PTSD [135].

Estimated prevalence

The *Adult Psychiatric Morbidity Survey (APMS)* in 2014 found that 2% of the surveyed English adult population (aged 16 and over) screened positive for bipolar disorder; which was more common in younger age-groups (3.4% of 16–24-year-olds), in those not in employment or living alone. Over 3% of adults under 65 screened positive for ASPD, which was more common in men than women with 2.4% positive for BPD. The Survey also screened for 'any personality disorder', and found 14% of adults as positive, with similar rates in men and women. Screening positive on all three measures of personality disorder was more common among younger people, those living alone, and those not in employment or in receipt of benefits. Over 6% of people screening positive for ASPD and 13% for BPD believed that they have had a personality disorder (vs 1% of the screen-negative cohort); in the majority this group also had a diagnosis of personality disorder from a professional.

In addition, APMS attempted to screen for *probable psychotic disorder* in the surveyed English adult population (aged 16 and over). The overall prevalence was low (0.7%); however, the rate was higher in black men (3.2%) and the socioeconomic factors are strongly linked – people who were economically inactive or on benefits (in these groups prevalence could reach 13%), or those in social isolation. Around four-fifths of people identified with psychotic disorder were in receipt of treatment.

Applying APMS rates to Rutland's population (ONS Mid-Year Estimates 2022) one can broadly estimate about 570 (95% confidence interval 460 to 710) people with bipolar disorder and 4,330 (95% confidence interval 4,030 to 4,650) with any personality disorder. It is also estimated that there could be around 220 people with psychotic disorder in Rutland.

These estimates have to be treated with caution, as they are based on the 2014 survey and not fully adjusted for important socio-economic factors.

Diagnosed prevalence

In 2022/23 the number of people on practice disease registers across Rutland with a diagnosis of schizophrenia, bipolar disorder and other psychoses is just over 310 (0.74% of the total practice list size). This is significantly lower than the national average of 1.00%. The prevalence in Rutland is the second lowest of its CIPFA comparators in 2022/23. There has been no significant change in the prevalence of severe mental illness in Rutland over the most recent five years.

The registered total of around 312 is also below the estimated 790 (bipolar disorder plus other probable psychotic disorders) from APMS (see above).

Despite the caveats relating to APMS estimates described above, there could still be a substantial gap in the diagnosis of SMI in primary care in Rutland.

4.3.4. People accessing community mental health services

Across England, the rates of access to community mental health services for adults with SMI are strongly correlated to deprivation, with the rate under 560 per 100,000 population in the most affluent decile compared to 1,460 per 100,000 population in the most deprived one, equivalent to 2.6 ratio. The average rate in England was 900 per 100,000 population, with higher rates for males (1,029 per 100,000 population) than females (719 per 100,000 population) in 2022/23. The highest rates were among those aged 85 and over (over 1,600 per 100,000 population). National rates were highest among those of mixed or multiple ethnicity (over 1,000 per 100,000 population) and black ethnicities (980 per 100,000 population) compared to just over 570 per 100,000 population in the Asian or Asian British population, and under 790 per 100,000 population in white residents.

Rates of contact in Leicestershire and Rutland were slightly higher than the England average (Table 12), with total of 7,630 adults with serious mental illness accessing those services in 2022/23.

Table 12. People accessing community mental health services (adults or older adults only) with serious mental illness who received 2 or more contacts within 2022/23.

	Number	Rate per 100,000 population
East Leicestershire and Rutland	3,235	937
West Leicestershire	4,395	1,077
England	508,214	900

(Source: NHS Digital MHB 2022/23)

4.3.5. Outcomes

People with SMI are more likely to have adverse physical outcomes, with higher rates of premature mortality.

In the three years between 2018 and 2020, premature mortality in adults with SMI in Rutland (55.9 per 100,000 population) was significantly better (lower) than the national average (103.6 per 100,000 population) - with Rutland having the lowest rate of its CIPFA neighbours.

In Rutland in 2018-20, the risk of premature mortality in adults with SMI was almost 4.5 times higher than in adults without SMI, the excess risk in Rutland was not significantly different to the national value of almost 4 times higher. Premature mortality due to cancer in adults with severe mental illness contributes to this higher risk, with around 15 premature deaths between 2018-20 and a 1.5 times higher risk of premature mortality due to cancer than adults without SMI (Table 13). Mortality from other common causes (cardiovascular, liver and respiratory disease) in those with SMI in Rutland is too low to report a value.

Table 13. Mortality among those with severe mental illness in Rutland and England (2018-20)

Indicator	Time Period	Rutland			CIPFA range	England value
		Value	Count	Recent Trend		
Premature mortality in adults (18-74 years) with severe mental illness (SMI) – directly standardised rate, per 100,000 population	2018-20	55.9	55	-	55.9-111.0	103.6
Excess under 75 mortality rate in adults with severe mental illness (SMI) – excess risk (%)	2018-20	445.8%	-	-	269.2-615.1	389.9%
Premature mortality due to cancer in adults with severe mental illness (SMI) – directly standardised rate, per 100,000 population	2018-20	13.9	15	-	11.1-23.4	20.2
Excess under 75 mortality rate due to cancer in adults with severe mental illness (SMI) – excess risk (%)	2018-20	157.1%	-	-	51.0-241.6	125.8%

Not significantly different to the national average	
Significantly better than the national average	

Recent trend over most recent five time periods:

- Cannot be calculated

(Source: Office for Health Improvement and Disparities, Fingertips)

4.3.6. SMI and physical health

People with SMI are at higher risk of poor physical health, with higher levels of obesity, asthma, diabetes, COPD and CVD. Smoking prevalence is twice as high in those experiencing SMI when compared to the general population [136]. Improving the coverage of physical health checks was part of the NHS Long Term Plan, with a 390,000 minimum target to be achieved by 2023/24. The six health checks include alcohol, blood glucose levels, blood lipids, blood pressure, BMI and weight, and smoking. Nationally, the rate of health checks in people with SMI has increased since 2018/19 from 25% to over 50% in 2023/24. The rates were lowest during the COVID-19 pandemic.

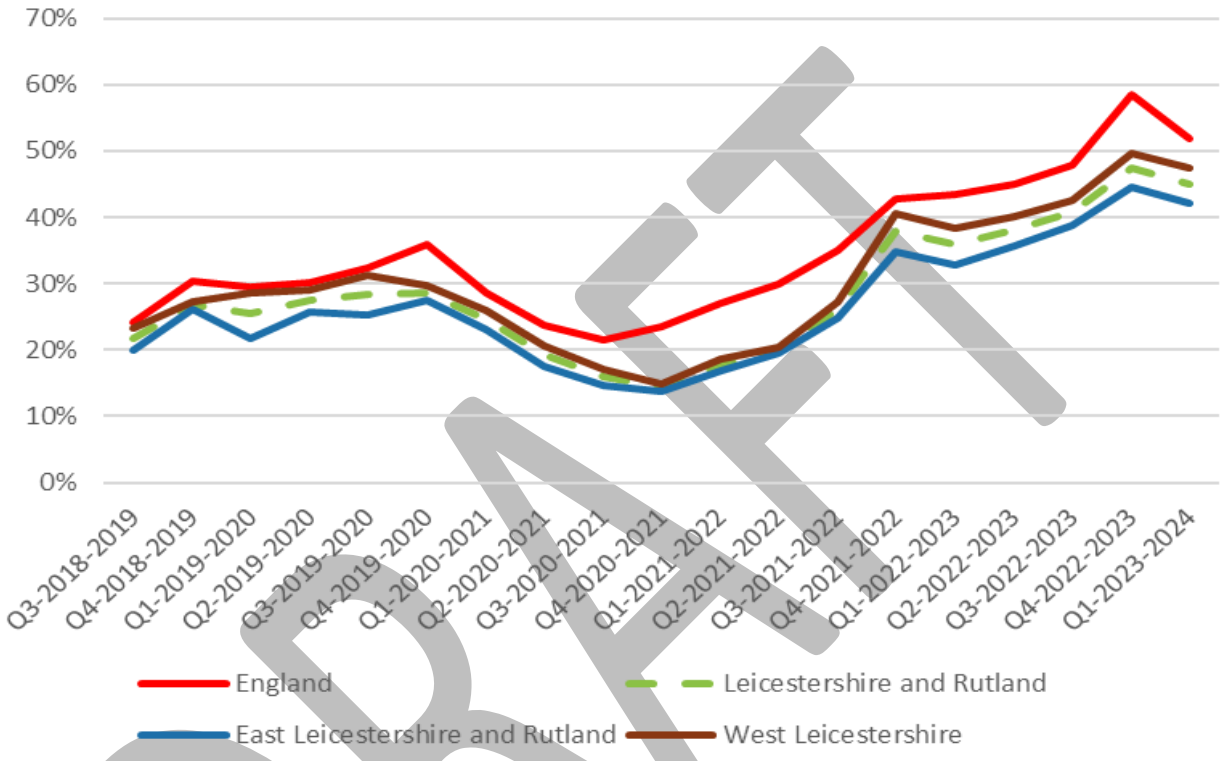
Although the rates in Leicestershire and Rutland have been lower than in England, the trends have been similar (Figure 28).

Caveats include completeness of trend data (2018/19 included only checks done in primary care and are more comprehensive since then) and its coverage across England.

Latest data for June 2023 (Q1 of 2023/24) indicates that 45% of people registered with SMI across

Leicestershire and Rutland had a full check in the previous 12 months (2,897 of 6,424 registered on 30th of June). This is lower than the 62% in Leicester, 52% nationally and 55% across the Midlands region.

Figure 28. Trends in health checks coverage for people with SMI (% of people registered with SMI getting all six checks in the previous 12 months), Q3 2019/2019 to Q1 2023/2024



(Source: NHS England NHSMH Dashboard)

4.3.7. SMI and cancer screening

Cancer screening programmes are designed to help early diagnosis and to improve the likelihood of successful treatment. Currently there are three NHS programmes - cervical screening, breast and bowel screening. The latest comparative screening coverage figures quoted here are for year 2022/23[§§].

Cervical screening – all women aged 25 to 49 are invited for screening every 3 years, and those aged 50 to 64 every 5 years. In 2022/23, the overall coverage in England for the younger and older age groups was 67% and 75%, respectively, with the corresponding rates in East Leicestershire and Rutland (ELR) significantly higher than the national average, 73% and 78%, respectively.

Breast screening through a mammogram is offered to women from the age of 50 to their 71st

[§§] Source: OHID 2024 (Fingertips: Cancer Services)

birthday, or at earlier age for those at higher risk of breast cancer. The coverage of the breast screening programme in England was 65% in 2022/23, with a significantly higher rate in ELR (70%).

Bowel screening aims for an early diagnosis of bowel cancer, as 90% of cases can be treated successfully when discovered early. It is offered to people aged 60 to 74 years of age. In 2022/23, the coverage for this screening programme across England was 72%, with significantly higher levels locally – 76% in ELR.

The most recent (end of December 2023) data for cancer screening coverage for people with SMI in East Leicestershire and Rutland indicate that the cervical screening rate is lower than in the general population locally (70% vs. 73-78%), while bowel screening coverage is higher in this group (over 87% vs. 76%).

However, breast cancer screening coverage for women with SMI is low, approximately half of the previous national or local rates in the general population (34% vs 72%) (Table 14).

Table 14. Cancer screening coverage for people with SMI – Q3 2023/24

	Period	Number Screened	Total Eligible	% Screened	ELR uptake (general population)
East Leicestershire and Rutland					
Cervical screening (women 25-64)	60 months	794	1135	70.0%	73 - 78%
Breast screening (women 50-70)	36 months	386	1129	34.2%	72%
Bowel screening (men & women 60-74)	24 months	664	757	87.7%	76%

(Source: Leicestershire Health Informatics Service 2024)

4.4. Suicide and Self-Harm

Suicide is a global public health issue. According to the World Health Organization (WHO), approximately 700,000 people die by suicide each year worldwide[137]. This number represents a significant but preventable loss of life. Understanding the distribution, causes, risk factors, and trends related to suicidal behaviours within populations is crucial for developing effective prevention and intervention strategies.

Suicide rates vary by age and gender. In many countries, suicide rates are higher among males than females. However, suicide attempts are more common among females. The highest suicide rates tend to occur in older adults (especially in males) and young individuals (especially in females) [138].

The choice of suicide method varies by region and culture. Common methods include hanging, poisoning, firearms, and jumping from heights. Access to lethal means, such as firearms, can significantly increase the risk of fatal suicide attempts [139].

Suicide rates vary widely by country and region. Factors contributing to these variations include

cultural norms, access to healthcare, social support systems, and economic conditions.

A significant proportion of individuals who die by suicide have a diagnosable mental health condition, such as depression, bipolar disorder, or substance use disorders. However, not all individuals who die by suicide have a known mental health diagnosis.

Suicide attempts are far more common than completed suicides. Many individuals who attempt suicide do not go on to complete it. Non-fatal suicide attempts are often a strong predictor of future suicide risk.

In addition to a history of previous suicide attempts, risk factors include family history of suicide, access to lethal means, social isolation, chronic illness, exposure to trauma or abuse, and stigma associated with seeking help. Conversely, protective factors against suicide include access to mental healthcare, strong social support networks, coping skills, and a sense of belonging and purpose.

Suicide prevention efforts involve a combination of public health initiatives, mental health promotion, crisis helplines, gatekeeper training, and access to mental healthcare services. Reducing access to lethal means, such as restricting firearm access, can be an effective suicide prevention strategy.

Ongoing surveillance and data collection are essential for monitoring trends in suicide rates and evaluating the effectiveness of prevention efforts.

It is important to note that suicide is a complex issue with multiple contributing factors, and it often involves the interplay of individual, societal, and cultural elements. Prevention efforts should encompass a holistic approach, addressing both the immediate risk factors and the broader social determinants of suicide. Increased awareness, education, and the destigmatisation of mental health issues are crucial components of suicide prevention strategies.

Rates of self-harm, suicide and undetermined injury are a broad indicator of the underlying mental health of the population. Because of the relatively small numbers of suicides, it is often difficult to show significant differences between areas or establish the significance of trends over time.

4.4.1. Rates of self-harm and suicide in Rutland

There were 45 emergency hospital admissions due to intentional self-harm in Rutland in 2021/22. This equates to a rate of 106.4 per 100,000 population which was significantly better (lower) than the national figure of 163.9 per 100,000 population. Rutland had the second lowest rate out of its CIPFA comparators. Of the 45 emergency hospital admissions due to intentional self-harm in Rutland in 2021/22, 25 were in those aged 10 to 24 years – of these, 10 were in those aged 10-14 years and 10 were in those aged 15-19 years.

In 2022/23, the rate of hospital admissions as a result of self-harm in those aged 10-24 years in Rutland (241.9 per 100,000 population) was not significantly different to the national figure of 319.0 per 100,000 population (Table 15). The Rutland rate equates to 15 admissions.

Between 2020 and 2022 there were 7 suicides in Rutland.

Table 15. Hospital admissions for Intentional Self-Harm in Rutland and England, 2021/22 and 2022/23

Indicator	Time Period	Rutland			CIPFA range	England value
		Value	Count	Recent trend		
Emergency hospital admissions for intentional self-harm, directly standardised rate per 100,000 population	2021/22	106.4	45	-	102.9 – 279.3	163.9
Hospital admissions as a result of self-harm (10-24 years), directly standardised rate per 100,000 population	2022/23	241.9	15	⇨	216.4 – 662.3	319.0

Not significantly different to the national average	
Significantly better than the national average	

Recent trend over most recent five time periods:

⇨ No significant change

\- Could not be calculated

(Source: Office for Health Improvement and Disparities, Fingertips)

The *2014 APMS* assessed the prevalence of suicidal thoughts, attempted suicide and self-harm through both the face to face and self-completion of a survey in a population sample of adults aged 16 and over in England. Younger women (16-24) were more likely to self-harm (26%) than men of the same age (10%), or older women; the gap between young men and young women has grown over time.

Over 5% of adults reported suicidal thoughts in the past year, a significant increase on the 3.8% reporting this in 2000. Groups more likely to report these thoughts and behaviours included those who lived alone or were out of work (either unemployed or economically inactive). The survey found that two-thirds of Employment and Support Allowance (ESA) recipients had suicidal thoughts (66.4%) and approaching half (43.2%) had made a suicide attempt at some point.

For Rutland, these findings can be translated into estimates of around 6,590 people with suicidal thoughts, 2,100 of suicidal attempts and 2,100 people self-harming. These are broad estimates and need to be treated with caution.

This data demonstrates that it is important to acknowledge that there may be more people in need of mental health services and support in Rutland than the number of suicides and hospital admissions suggests, with many more people estimated to be experiencing suicidal attempts and self-harming.

4.4.2. Suspected Suicide Surveillance

A near to real time suspected suicide surveillance system (nRTSSS) was launched on 30 November 2023[140]. It is designed to act as an early warning system for changes in patterns of deaths by suicide to enable appropriate intervention.

It collects data on all suspected suicides, where cause of death was not yet confirmed by coroners' inquest. In all cases of 'sudden and unexpected' deaths, a suspected cause is assigned by the attending police officer, which is followed by a review based on the NPCC (National Police Chiefs' Council) guidance. Any suspected suicide assignation is provisional. The whole of England is not yet covered - not all PFA (police force areas) are participating. Overall, a coverage of 75% of the population of England aged 10 and above is currently covered.

The national report (based on nearly 5,000 deaths, around 75% of which were men) presents statistics for the most recent 15-month period (June 2022-August 2023). It describes monthly suspected suicide rates by age group and sex to show any variations, and 3-month aggregated data to describe suspected suicide methods.

Generally, the rates were three times higher for men than for women, except for the month of October within which the rate for men was four times higher. The rate was highest in June (13.1 per 100,000 population) and lowest in February (10.1 per 100,000 population), although monthly variations were not statistically significant. Rates were highest among 45–64-year-olds (14 per 100,000 population) and lowest for those 65 and above (6.5 per 100,000 population). The most common method of suicide was hanging, strangulation and suffocation (more than half of all deaths), followed by poisoning (20%).

Some detailed results indicate higher rates of suicide in the summer, for both men and women, with seasonal variation among younger adults (those aged 25-44). In the older group (65 years of age and above) the rates are increasing, with a recommendation to be monitored. There is also an indication of changes in the method of suicide, with an increase in jumping/lying in front of moving objects, as well as in drowning.

Sub-national data have not been published.

4.5. Substance misuse and smoking

It is estimated that 86% of people who access alcohol services experience mental health problems and 70% of those accessing drug misuse treatment have a mental illness. A 30-year-old concept of 'dual diagnosis'.

More than a third of people with mental health problems and more than two-thirds of people in psychiatric units smoke tobacco[141].

Both substance misuse and smoking contribute to morbidity and mortality among those with mental

health issues but there are problems with access to appropriate services as substance misuse and mental health services are provided separately.

In 2021-22 in Rutland, 68% of adults who entered drug, and 62% of those entering alcohol-only treatment were identified as having a mental health need, for reasons other than substance misuse. The local numbers are too low for robust comparison to the national rate, but they are in the same ballpark (70% for both groups nationally). The rates were higher for women than men (86% vs 61% and 67% vs 59%, for drugs and alcohol, respectively). In the alcohol-only group, over three-quarters were receiving treatment for their mental health, mainly through their GP or CMHT (Community Mental Health Team)[142].

In Rutland in 2021/22 the rates of admission episodes for mental and behavioural disorders due to the use of alcohol, according to the broad definition, were significantly better (lower) than the national figures for persons, males and females.

According to the GP Patient Survey, in 2022/23 8.3% of the adult population in Rutland classify themselves as current smokers (either occasional or regular smokers). Data from the same survey shows that of adults reporting a diagnosed long term mental health condition, 25.7% classify themselves as current smokers. The percentage of adults classifying themselves as current smokers in Rutland is significantly higher in those reporting a diagnosed long term mental health condition, with those reporting a mental health condition three times as likely to be current smokers. The smoking prevalence in adults with a long-term mental health condition in Rutland according to the GP Patient Survey (25.7%) is not significantly different to the national average (25.1%) (Table 16).

Table 16. Substance misuse and smoking in those with mental health conditions in Rutland and England

Indicator	Time Period	Rutland			CIPFA range	England
		Value	Count	Recent Trend		
Admission episodes for mental and behavioural disorders due to use of alcohol (Broad) (Persons) – per 100,000 population	2021/22	142	59	-	142-467	404
Admission episodes for mental and behavioural disorders due to use of alcohol (Broad) (Male) - per 100,000 population	2021/22	202	43	-	202-626	587
Admission episodes for mental and behavioural disorders due to use of alcohol (Broad) (Female) -per 100,000 population	2021/22	86	16	-	86-371	233
Smoking prevalence in adults with a long-term mental health condition (18+) – current smokers (GPPS) (%)	2022/23	25.7%	-	-	17.1-33.0	25.1%
Smoking prevalence in adults (18+) – current smokers (GPPS) (%)	2022/23	8.3%	-	-	8.3-13.7	13.6%

Not significantly different to the national average	
Significantly better than the national average	

Recent trend over most recent five time periods:

- Cannot be calculated

(Source: Office for Health Improvement and Disparities, Fingertips)

4.6. Eating Disorders

Eating disorders are relatively common mental health conditions, with estimates suggesting that they affect millions of individuals worldwide. The most prevalent eating disorders include anorexia nervosa, bulimia nervosa, and binge-eating disorder [143].

Eating disorders disproportionately affect females compared to males, with rates typically higher among women and girls. However, it is important to recognize that males also experience eating disorders, though they may be less likely to seek treatment or receive a diagnosis. Eating disorders can develop at any age, but they often emerge during adolescence or young adulthood.

Various risk factors contribute to the development of eating disorders, including genetic predisposition, psychological factors (e.g., low self-esteem, perfectionism), sociocultural influences (e.g., media portrayals of body image), interpersonal factors (e.g., history of trauma or abuse), and biological factors (e.g., alterations in brain chemistry) [144].

Eating disorders frequently co-occur with other mental health conditions, such as mood disorders (e.g., depression, anxiety), substance use disorders, and personality disorders. Individuals with eating disorders may also experience medical complications related to their disordered eating behaviours. Eating disorders can have serious consequences for physical health, including

nutritional deficiencies, electrolyte imbalances, gastrointestinal problems, cardiovascular complications, and bone density loss. They also impact psychological well-being and quality of life.

Due to the stigma surrounding eating disorders and barriers to accessing care, many individuals may not seek treatment or receive a formal diagnosis. As a result, the true prevalence of eating disorders may be underestimated. While eating disorders are recognized as a global health concern, prevalence rates may vary between countries and cultures due to differences in sociocultural norms, access to healthcare, and awareness of eating disorders [145].

4.7. NHS Secondary Mental Health Service Use

Although health service use data are not a direct representation of mental health needs in a population, being representative of demand for care rather than of need, they do contribute to the understanding, prevention and control of diseases. Under careful analysis, they can provide crucial information on prevalence, incidence, patterns of disease, inequalities, health care utilisation, risk factors and populations at risk, health care costs and effectiveness, and patient behaviour and preference, among others.

Published annually, the NHS England *Mental Health Bulletin* (MHB) provides the most detailed picture available of people who used NHS funded secondary mental health, learning disabilities and autism services in England[146]. At the time of writing, the latest data are for financial year 2022/23 (April 2022 to March 2023).

While some of the MHB data are available at a local level, there is also a wealth of contemporary national-level intelligence providing useful insights into the current trends and inequalities in access to mental health services (some selected ethnic and deprivation examples are presented below) and, as proxy, in the prevalence of mental health conditions in the population. It is important to stress that the subset of the population in contact with specialist mental health services are already at a health disadvantage, nationally their mortality rate that is 3.6 times higher than the general population [147].

This section aims to report on the recent local trends and broader, national, patterns of inequality in access to specialist mental health services.

4.7.1. Contact and admission rates

Broadly, the 2022/23 data show rising rates with 6.3% of people (5.2% of all males and 6.1% of females) in England in contact with secondary mental health, learning disabilities and autism services in 2022/23, compared to 5.8% in 2021/22 and 5.0% in 2020/21– a 16% year on year rise.

3.6% of adults (aged 18 and above) in contact with services spend time in a hospital, less than in the previous (2021/22) year (4.2%). Prior to 2021/22, this proportion fluctuated between 4.2% and 5.1%. The year on year rise across England was 10% between 2021/22 and 2022/23, less than the

16.2% between 2020/21 and 2021/22. Across Rutland the trend was higher (14.2%) (Table 17).

Table 17. Number of people in contact with NHS funded secondary mental health, learning disabilities and autism services for residents in Rutland and England (all ages)

	In contact 2022/23 *	Admitted 2022/23 **	% of contacts admitted 2022/23	In contact 2021/22	Trend (%) ***
Rutland	2,055	40	1.9	1,800	14.2
England	3,582,864	91,945	2.6	3,256,659	10.0

* Number of people in contact with NHS funded secondary mental health, learning disabilities and autism services

** Number of people admitted as an inpatient while in contact with NHS funded secondary mental health, learning disabilities and autism services

*** Proportional increase in the number between 2021/22 and 2022/23

(Source: NHS Digital MHB 2022/23)

The Mental Health Bulletin provides demographic data down to sub-ICB (previously CCG) level, where people are classified using their GP registration status rather than their residence. Data presented here are for East Leicestershire and Rutland (03W, ELR).

Table 18. Number of people in contact with mental health services, access and admission rates for GP registered population in East Leicestershire and Rutland, by population group, 2022/23

	East Leicestershire & Rutland			
	In contact	**Contact rate (% of population)***	**Admitted****	**% Admitted**
All	19,515	5.7	450	2.3
Age:				
<18	3,915	5.6	10	0.3
18+	15,600	5.7	440	2.8
Sex:				
Male	8,100	4.6	250	3.1
Female	11,240	6.6	195	1.7
Ethnicity:				
Asian or Asian British	935	2.9	40	4.3
Black or Black British	150	3.5	5	3.3
Mixed	350	4.3	10	2.9
White	14,850	5.0	340	2.3
Other Ethnic Groups	145	2.5	10	6.9
Not Stated	2,510	-	35	1.4
Not Known	320	-	5	1.6
Unknown	260	-	0	0.0
Deprivation:				
01 Most deprived	220	3.5	10	4.5
02	2,205	8.8	70	3.2
03	3,695	6.7	80	2.2
04	5,895	5.9	105	1.8
05 Least deprived	7,430	5.2	160	2.2

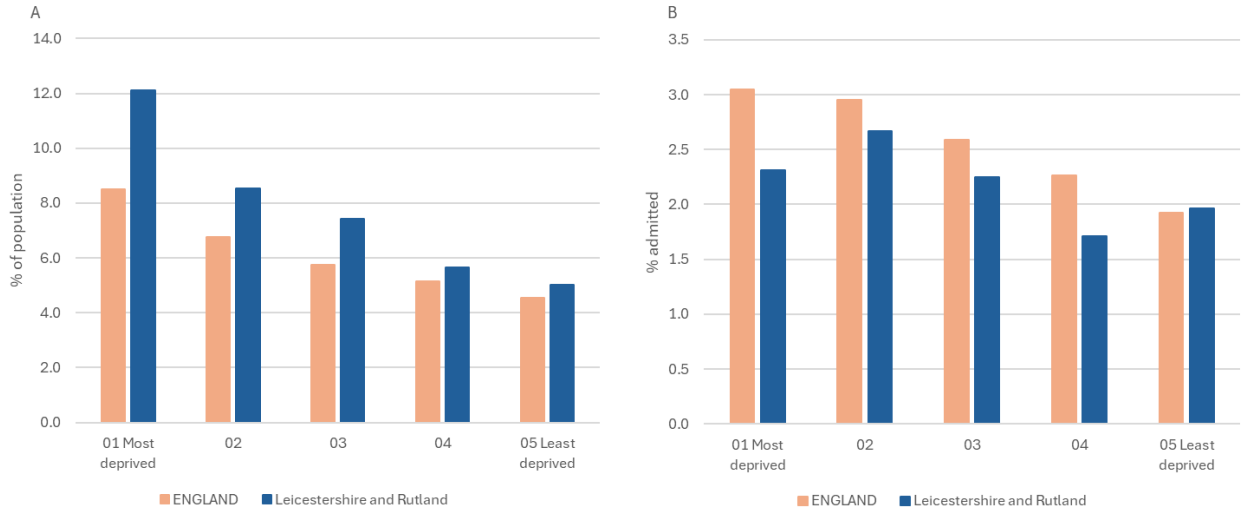
* Calculation for ethnicity excludes 'not stated', 'not known' or 'unknown' – rates to be treated with caution as for 15% of people in contact ethnicity was not known

** Number of people admitted as an inpatient while in contact with NHS funded secondary mental health, learning disabilities and autism services

(Source: NHS Digital MHB 2022/23)

Across East Leicestershire and Rutland in 2022/23, women were 39% more likely to be in contact with secondary mental health services than men, although also 45% less likely to be admitted as in-patients. Although there is some evidence of gradient across social deprivation categories, this is not consistent. The rates of contact were highest among white and mixed ethnicity population groups (Table 18 and Figure 29).

Figure 29. Rates of access to secondary mental health service (A) and proportion of admitted to hospital (B) across Leicestershire and Rutland in 2022/23, by deprivation quintiles

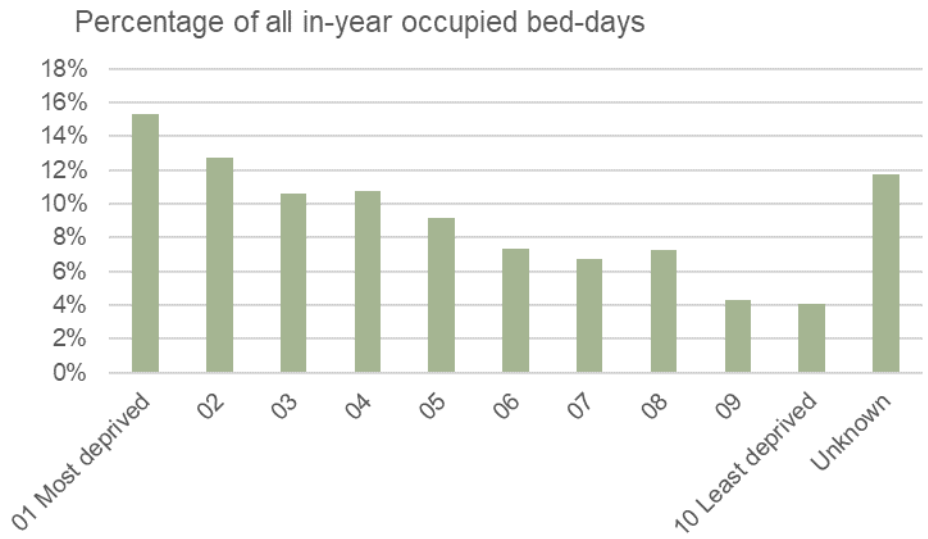


(Source: NHS Digital MHB 2022/23)

4.7.2. Bed Occupancy

Bed occupancy in mental services is strongly linked to socio-economic deprivation. Across England, the most deprived quintile of deprivation contributed 28% of all occupied bed-days, while the least deprived just 8% (Figure 30).

Figure 30. Bed occupancy by Indices of Multiple Deprivation, England 2022/23



(Source: NHS Digital MHB 2022/23)

The Leicestershire rate of bed occupancy, expressed as the number of in-year bed days in NHS funded secondary mental health service per 1,000 population (all ages) was about 38% lower than

the national average (105 vs 168 per 1,000) and was even lower in Rutland (65 per 1,000).

For comparison, the registered population East Leicestershire and Rutland CCG had a relatively high rate of 162/1,000, with a clear, three-fold difference between the most deprived and affluent areas.

Table 19. In-year occupied bed days in 2022/23 across Leicestershire, Rutland and England

	Number of in year bed days	Rate (per 1,000)	Rate Q1 (most deprived)	Rate Q5 (least deprived)
East Leicestershire and Rutland*	53,425	161.7	367.5	125.9
West Leicestershire *	42,210	109.6	288.4	72.0
Rutland	2,660	64.6	-	-
Leicestershire	75,750	104.9	-	-
England	9,512,771	168.4	269.2	75.4

(Source: NHS Digital MHB 2022/23)

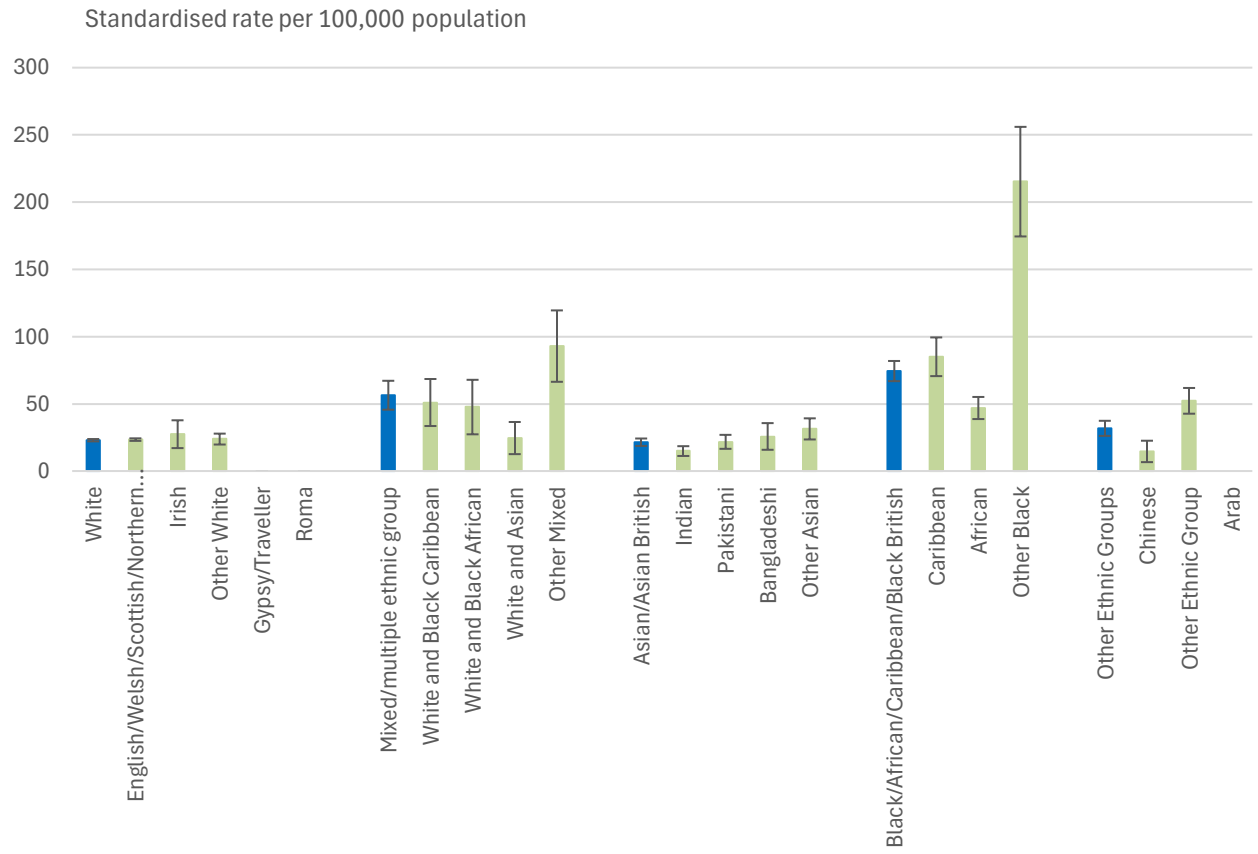
4.7.3. Inequalities at the national level

This section presents some of the more notable examples of ethnic differentials for adult patients in the NHS secondary mental health services in England in 2023. Although local data were not available, the national picture can give a useful indication of potential groups at higher risk. The underlying data were sourced from the 2022/23 NHS Digital Mental Health Bulletin.

For example, for adults aged 18-64 the highest rates of *long hospital stays* (60 days or more) in 2022/23 were for the 'other black' ethnic category (331/100,000 population) and 'other mixed' category (92/100,000), compared to the overall 32/100,000 and 25/100,000 in white population. It follows that these groups can be at significantly higher risk of long-term hospital stays. It has to be stressed that for 14% of cases in the national set ethnicity was poorly recorded ('not known', 'not stated' or 'other ethnic group') and these figures need to be treated with some caution.

The rates of *restrictive intervention* also varied significantly across ethnic groups with highest rates among those classified as 'other black' with over 200 interventions per 100,000 population compared to just over 21/100,000 in those from Asian or Asian British background, differing almost ten-fold. 'Other mixed' group and those of Caribbean descent also had relatively high rates (a five-fold differential with Asian groups) (Figure 31).

Figure 31. Rates of people subject to a restrictive intervention per 100,000 population, England 2022/23



(Source: NHS Digital MHB 2022/23)

Although the link between long hospital stays and restrictive interventions to deprivation was less pronounced, there were twice as many restrictive interventions in the most deprived quintile than in the most affluent one. And a three-fold gradient in the rates of long stays (60+ days) for adults in England in 2022/23.

4.7.4. Outpatients

Across England, the main groups of people in contact with services, but not admitted as inpatients, were with Core Community Mental Health (38%), followed by activity in general hospitals (11%) and Crisis & Acute Mental Health Activity in Community Settings. Notably a large proportion (over a half) of activity is described as 'other services', a further 8% were not classified.

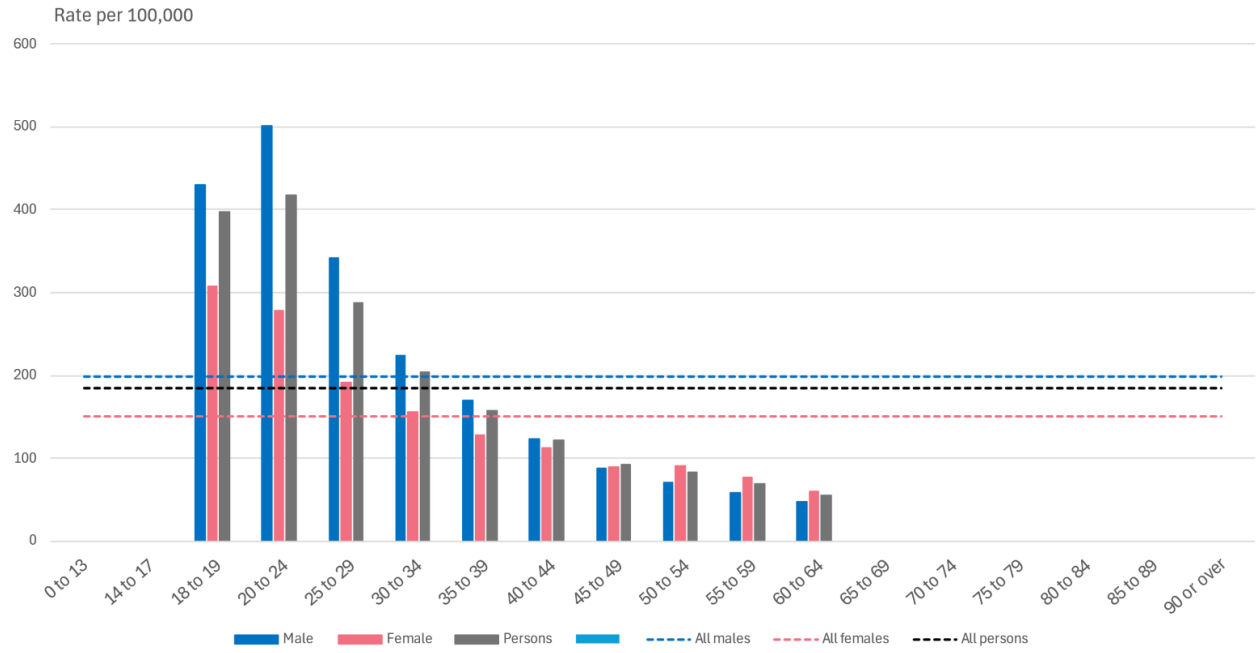
4.7.5. Early Intervention for Psychosis (EIP) pathway

Evidence suggests that early intervention for psychosis can lead to better long-term outcomes, including reduced hospitalisation rates, improved symptom control, higher rates of employment

and educational engagement[148]. Individuals experiencing psychosis for the first time have multifaceted needs, which necessitates rapid access to treatment, integrated service delivery (across psychiatric treatment, psychological therapies and work-based and family support), psychoeducation and support, medical management and psychological therapies, e.g. cognitive-behavioural therapy (CBT).

The national data show that the majority of all active referrals are for younger adults 18 and 34, with higher rates for men (by about a third) and with very few referrals among those aged 65 or above; the difference between men and women reduces with age (Figure 32).

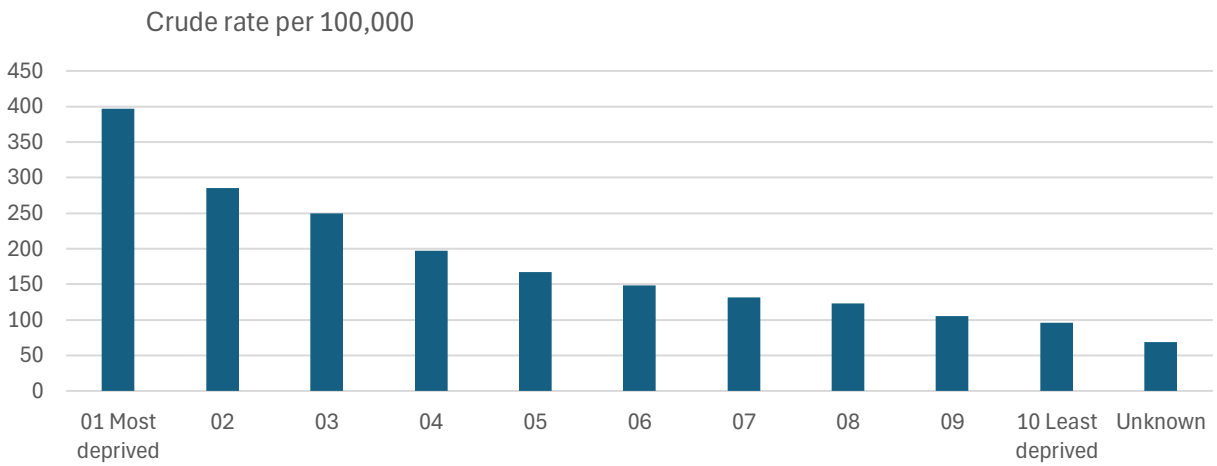
Figure 32. Referrals on EIP pathway in England in 2022/23 by age and sex (Source: NHS Digital MHB)



(Source: NHS Digital MHB 2022/23)

In England, there is a strong correlation between the rates of referral and deprivation, with rates over four times higher in the most deprived quintile of the population when compared to the most affluent quintile in England (Figure 33).

Figure 33. Referrals on EIP in England in 2022/23 by deprivation



(Source: NHS Digital MHB 2022/23)

Specialist Perinatal Mental Health Community Services

Are described in section 3.2.4, page 23 (Pregnancy and Maternity)

Memory Services for People with Dementia

Are described in section 4.2.5, page 58 (Dementia)

5. Impacts

5.1. COVID-19 Pandemic

The COVID-19 pandemic has had a significant impact on mental health worldwide, affecting individuals of all ages and backgrounds. Some of the mechanisms include increased stress and anxiety (through fear of contracting the virus, financial concerns, and social isolation), depression and loneliness (distancing measures, lockdowns, and restrictions on gatherings) and in some cases grief and loss, due to the loss of loved ones due to COVID-19, as well as disruptions to important life events such as weddings, graduations, and funerals, leading to feelings of grief and bereavement[149].

The economic impact of the pandemic, including job losses, reduced income, and financial insecurity, has contributed to stress, anxiety, and depression for many individuals and families. The disruption to daily routines, including work, school, and leisure activities, has led to feelings of uncertainty and a loss of purpose for some individuals, which can impact mental well-being.

The prolonged nature of the pandemic, combined with ongoing uncertainty and stress, has contributed to feelings of fatigue and burnout for many people, impacting their mental well-being.

Certain populations, including healthcare workers, older adults, people with pre-existing mental health conditions, and marginalized communities, may be disproportionately affected by the mental health impacts of the pandemic due to various factors such as increased exposure to stressors and barriers to accessing support. There is evidence of widening inequalities as result of the pandemic. In England, COVID-19 mortality rates were higher in the more deprived parts of the country[150], although the same evidence emerged from other parts of the world, the Americas, Europe, Africa and the Western Pacific[151].

Although in the main an overwhelmingly negative experience for most, it should be acknowledged that for some the pandemic had positive impacts on their mental health. For example, more time away from commuting and office work opened up time for mindfulness, family time and getting exercise and exposure to community outdoor spaces which can have positive impacts for physical and mental health[152].

5.1.1. The workplace

The COVID-19 pandemic has had a significant impact on the mental health of people in employment and those on furlough, at its worst in November 2020 to January 2021, with some improvement reported since then. The level of this improvement depends on the type of industry, particularly how fast a sector has bounced back after the pandemic.

It is estimated that the total estimated cost of mental ill-health has increased by 25% since 2019 and – reaching £53-56 billion in 2020/21, contributed to by presenteeism (attending work while ill), higher turnover of staff, and, to a lesser degree by absenteeism. Mental health of younger workers

and those from ethnic minorities was more affected by the pandemic, while the key workers were under more pressure than non-key workers, due to an increased risk of infection, pressure at work and wider pandemic-related stresses[153].

5.2. Employment and economy

Work is generally good for both physical and mental health and wellbeing and is a key part of the recovery process. There is a complex, two-way relationship between mental health and employment, with poor mental health decreasing the likelihood of meaningful employment and unemployment affecting mental health negatively. Getting back into employment increases the likelihood of improved health (from poor to good) almost threefold, and boosts quality of life almost twofold. People living with mental illness have employment rates of just 16% to 35%, a significant gap to general population [154].

One of the forms of support for people with disability or health conditions affecting their ability to work is ESA (Employment and Support Allowance). At the national level, the rates of claiming ESA for mental or behavioural disorders are strongly linked to deprivation, with rates in the most deprived decile 2.5 times higher than in the least deprived.

In 2022/23 in Rutland, the percentage of the population with a physical or mental long term health condition that was in employment (aged 16 to 64) was 73.8%, this was not significantly different to the national figure of 65.3%. In 2022/23 there was a 10.4% gap in employment between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate in England. The gap in Rutland (3.3%) was not significantly different to the national figure. The rate of Employment and Support Allowance (ESA) claimants for mental and behavioural disorders in 2018 in Rutland (12.0 per 1,000 population) was significantly better (lower) than the national average (27.3 per 1,000 population). Rutland had the lowest rate of claimants of its CIPFA comparators. The rate in Rutland has shown a significant increasing and worsening trend over the most recent five time periods.

In 2021/22 in Rutland, the percentage of the population who were in contact with secondary mental health services that were in paid employment (18-69 years) was not significantly different to the national figure (4.0% vs. 6.0%). The gap in the employment rate for those who were in contact with secondary mental health services and the overall employment rate in Rutland in 2021/22 (71.9 percentage points) was not significantly different to the national figure (69.4 percentage points).

The proportion of adults in contact with secondary mental health services who lived in stable and appropriate accommodation in Rutland in 2020/21 was not significantly different to the national average (34.0% vs. 58.0%) (Table 20).

Table 20. Differentials in employment and economic factors for those with mental health conditions in Rutland

Indicator	Time Period	Rutland			CIPFA range	England
		Value	Count	Recent Trend		
The percentage of the population with a physical or mental long term health condition in employment (aged 16 to 64)	2022/23	73.8%	-	-	50.8 – 76.0	65.3%
Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate (Gap-percentage points)	2022/23	3.3	-	-	3.0 – 16.7	10.4
ESA claimants for mental and behavioural disorders: rate per 1,000 working age population	2018	12.0*	270	↑	12.0-37.1	27.3
The percentage of the population who are in contact with secondary mental health services that are in paid employment (18-69 years)	2021/22	4.0%	13	-	1.0%-14.0%	6.0%
Gap in the employment rate for those who are in contact with secondary mental health services and the overall employment rate (Gap – percentage points)	2021/22	71.9	-	-	66.2-76.4	69.4
Adults in contact with secondary mental health services who live in stable and appropriate accommodation (Proportion - %)	2020/21	34.0%	-	-	34.0%-84.0%	58.0%

Significantly better than the national average	
Not significantly different to the national average	

Recent trend over most recent five time periods:
↑ Increasing and getting worse

(Source: Office for Health Improvement and Disparities, Fingertips)

5.3. Return on Investment

In 2019 mental health conditions are estimated to have accounted for 7% of all ill-health with the cost to the UK's economy estimated at nearly £118 billion per year (5% of UK GDP), with the majority of this cost falling outside of the health care system – through lost employment and informal care costs [155].

Of the total, £101 billion is attributed to England. More than half of the estimate (56%) is for ages 15-49, with 27% for those aged 50-69. The largest components by condition are for depression (23%), anxiety (18%) and bipolar disorder (17%). Thus, prevention of depression and anxiety would have the most significant impact.

Evidence indicates that there is a positive return of around £5.30 on every £1 spent on mental health interventions in the workplace [156] [157].

Although important, and easier to quantify, the workplace is not the only setting where prevention is likely to have economic impact, others include[158]:

- Perinatal depression prevention (health visiting)
- Parenting programmes
- School and education – antibullying programmes, exercise and physical activity
- Early identification in young adults
- Psychological interventions in those living with long-term conditions
- Prevention in older people – measures to reduce social isolation, increase physical activity, for example

As with other public health interventions, these are likely to have long-term effects, often difficult to quantify through, typically shorter-term, research.

5.4. Dementia

Dementia is progressive in nature with patient's needs changing over time, which has implications for service planning at an individual and at population level. It has significant impact on the life of the patient, with loss of independence and mental capacity, but also on wider circle of family and friends, who often provide care. These carers may experience negative effects including increased mental health issues, physical ill health, social isolation and financial hardship. It is therefore important they are considered as 'second patients' who require support alongside the person with dementia[159]. It was estimated in 2019 that dementia sufferers and their families in the UK spend around an estimated £8.3 billion pound on paid for care, whilst also contributing around £13.9 billion in unpaid care[160].

Dementia not only affects someone's mental health but also their emotional wellbeing. Dementia diagnosis can cause a range of emotional responses and can cause the person to be treated differently by others. It can also contribute to the person feeling isolated or lonely which in itself has health consequences. Diagnosis can also trigger other mental health conditions in particular anxiety and depression. These additional conditions can negatively affect the patient's health even further than the original dementia[161]. These additional mental and emotional health issues add to the burden placed on the person with dementia but also those caring for them, the wider community they live in and the services they access.

Up to a quarter of hospital inpatients at one time in the UK may have a diagnosis of dementia, contributing a large amount to the burden on our acute hospitals. In 2014 the NHS spent around £4.9 billion on dementia care. Whilst social care spent around £15.7 billion on care for people with dementia, with £4.5 billion of this coming from local authorities and the remaining cost coming from families paying for state funded care. With these costs expected to rise[162].

6. Current Services

6.1. Summary of Adult Mental Health Services in England

Mental health services for adults in England are provided through the National Health Service (NHS) and other community organizations. The NHS services are traditionally grouped as primary, secondary, and tertiary care, but under the NHS Long Term Plan, transformation is ongoing to create integrated community mental health services.

- General practitioners (GPs) are often the first point of contact for individuals seeking mental health support. They can provide assessments, referrals to specialist services, and prescribe medication.
- Talking Therapies (previously Improving Access to Psychological Therapies, IAPT) program offers therapies like cognitive behavioural therapy (CBT) for common mental health issues such as depression and anxiety. It aims to provide timely and evidence-based interventions.
- Community Mental Health Teams (CMHTs) consist of various professionals, including psychiatrists, psychologists, social workers, and community psychiatric nurses. They provide comprehensive support to individuals with severe and enduring mental health problems.
- Crisis Resolution and Home Treatment Teams (CRHT) offer intensive support to individuals experiencing a mental health crisis, aiming to prevent hospital admissions and support individuals in their homes.
- Inpatient Services are offered to individuals requiring more intensive support, there are psychiatric hospitals and units available across England. These provide care and treatment for acute mental health conditions.

In addition, there are specialized services for specific mental health needs, such as eating disorders, personality disorders, and psychosis. These services offer tailored interventions and support.

Increasing emphasis is placed on recovery-oriented approaches, promoting individuals' independence, resilience, and social inclusion. Many organizations offer peer support and self-help groups where individuals with lived experience of mental health problems can connect, share experiences, and support each other's recovery. There's a growing emphasis on digital mental health services, including online therapy platforms, apps, and helplines, providing accessible support options for those who may not access traditional services. Efforts are made to integrate mental health services with social care and other support services to provide holistic support for individuals with complex needs.

Most services are commissioned locally by Integrated Care Boards (ICBs); however, some specialist services are commissioned by NHS England. NHS England is in the process of delegating responsibility for commissioning specialised mental health, learning disability and autism services

to NHS-Led Provider Collaboratives[163].

6.2. Local Mental Health Services for Adults

Most of mental health services for adults in Rutland are commissioned and operate across Leicester, Leicestershire and Rutland (LLR).

This section provides only a summary of current local services – for a more comprehensive description please see the separate **Appendix.**

For urgent mental health support, people may contact the **Mental Health Central Access Point**, a 24/7 freephone, operated by Leicestershire Partnership Trust and Turning Point, **NHS111 service** or a **Crisis Café**.

6.2.1. Mental Health Central Access Point

The phone line is staffed by recovery workers from Turning Point, who, after an assessment, can transfer callers to an appropriate staff member at Leicester Partnership NHS Trust (LPT).

6.2.2. Neighbourhood Mental Health Cafés

(https://www.leicspart.nhs.uk/service/neighbourhood-mh-cafes/

The cafes are drop-in centres operated by supportive, trained staff.

For non-urgent mental health support people can contact their general practice or the **NHS Talking Therapies**, a self-referral, free confidential service provided by Vita Minds (Vita Health part of Spire Healthcare).

6.2.3. NHS Talking Therapies

Formerly known as IAPT (Improving Access to Psychological Therapies), NHS Taking Therapies are NHS-funded, evidence based, psychological therapies for depression and anxiety. It is provided by Vita Health Group (VitaMinds) for all adults who live and are registered with a GP in Leicester, Leicestershire and Rutland (https://www.vitahealthgroup.co.uk/nhs-services/nhs-mental-health/leicester-leicestershire-rutland .

6.3. Leicestershire Partnership NHS Trust

LPT provides the following inpatient, outpatient and community services:

6.3.1. The Bradgate Mental Health Unit

The Bradgate Mental Health Unit (Glenfield Hospital, Leicester) is an acute mental health admissions unit with six recovery-focused general psychiatry wards, two psychiatric intensive care wards and one low-secure ward.

6.3.2. Adult Community Mental Health Teams

There are eight community multidisciplinary mental health teams providing a secondary care, planned assessment and treatment service. This might involve psycho-social interventions, medical prescribing or, if eligibility criteria are met, social care commissioning of services. They aim to provide support with mental health needs, all aspects of daily life such as self-care, well-being and health promotion.

6.3.3. Forensic Mental Health Services

This is both an inpatient and a community service for people with a history of offending who also suffer from mental ill health. It operates from the Herschel Prins Centre, Glenfield Hospital in Leicestershire.

6.3.4. Perinatal Mental Health Service

A team of health professionals at Bradgate Mental Health Unit, Glenfield Hospital, providing personalised and specialist care to people with moderate to severe mental health problems relating to pregnancy, childbirth and the first year following a child's birth (also known as the perinatal period).

6.3.5. Maternal Mental Health Service

Based at Prince Philip House, St Matthews Health & Community Centre, Malabar Road, Leicester this is a psychology-led, trauma-informed service, helping women and birthing people with moderate to severe difficulties related to birth trauma, baby loss, and tokophobia.

6.3.6. Psychosis Intervention & Early Recovery (PIER) Team

Based at Merlyn Vaz Health and Social Care Centre, Leicester, the team offers support to people recovering from a psychotic episode. The service offers help to people aged 14 – 64 years who are experiencing first symptoms of psychosis, as well as providing help to their families.

6.3.7. Mental Health Liaison

This is a multidisciplinary team of liaison professionals providing assessment and treatment for people who experience mental health problems as a result of physical illness. The service provides a specialist *Chronic Fatigue Syndrome (CFS) service*.

6.3.8. Mental Health Services for Older People (MHSOP)

MHSOP provides inpatient, outpatient and memory services for older people. *MHSOP Inpatients* operates across two sites, The Evington Centre and the Bennion Centre, with three wards. Working closely with community intensive teams, community mental health teams and outreach services for older people with functional and organic mental health problems. *MHSOP Memory Service*

operating from Evington Centre, provides diagnostic assessment and treatment for people with dementia within a clinic setting, care home or their own home. People of all ages with possible dementia can be referred, while the *MHSOP Outpatient Service* provides assessment and treatment for people over 65 years with moderate/complex functional mental health issues in clinics held across Leicester, Leicestershire and Rutland.

There is also an *MHSOP In-reach Team,* based at Neville Centre*,* Leicester General Hospital Site, helping patients who live in a care, residential or nursing home, and are experiencing difficulties due to their dementia and require specialist support and advice.

6.3.9. Mental Health Wellbeing and Recovery Support Service (MHWRSS)

This service is aimed at providing a first point of access for people who need mental health support. P3 (https://www.p3charity.org) provides this service for Rutland and Leicester City.

6.3.10. Crisis Resolution and Home Treatment Team

This team provides a rapid assessment of people who are experiencing a mental health crisis and would otherwise require a hospital admission to an acute mental health ward, due to mental health crisis which impacts on the person's ability to cope with day-to-day activities.

6.3.11. Adult Eating Disorders Service

Is an outpatient service for patients from LLR and a regional inpatient service for the East Midlands for adults aged 18 and over who have eating disorders such as anorexia nervosa, bulimia nervosa, binge eating disorder and other diagnosable eating disorders.

6.3.12. Therapy Services for People with Personality Disorder (TSPPD)

The service provides psychotherapy programmes drawn from a number of different models of psychotherapy for people age 18+ who have been assessed for the group therapy service and discussed it with their referrer.

6.3.13. Severe and Enduring Mental Illness Rehabilitation

These are rehabilitation inpatient units providing multidisciplinary care for patients who have severe and enduring mental illness.

6.3.14. Acute Recovery Team

Is providing specialist care, including an ECT clinic and Clozapine clinic, blood tests and monitoring.

6.3.15. Clinical Neuropsychology

Based at the Leicester General Hospital, the team serves both inpatients and outpatients who are having cognitive difficulties as a result of a neurological condition, providing neuropsychological

assessment and advice, intervention, rehabilitation, and training.

6.3.16. Leicestershire Psycho-oncology Service (LPOS)

Helping those with emotional and mental difficulties following a diagnosis of cancer, providing a range of interventions in hospital or in patient's home.

6.3.17. Huntington's Disease Inpatient and Community Service

Is a community inpatient unit for people with Huntington's disease for patients with severe and enduring mental health needs and require complex care due to physical, psychiatric, behavioural and psychological needs or rehabilitation. The community team is also based there.

6.3.18. Assertive Outreach (AO) Service

The service is provided within a multidisciplinary team approach, predominantly delivered within people's homes. The service offers a range of therapeutic interventions. It has been specifically set up to work in partnership with people with long-standing mental health needs which are 'psychotic' in nature.

6.3.19. Central Referral Hub/Unscheduled Care service

All referrals into Mental Health Services for Older People from across Leicester, Leicestershire and Rutland are received by the Central Referral Hub. People of all ages with probable dementia and adults over the age of 65 with depression, anxiety or psychotic illnesses.

6.3.20. Criminal Justice and Liaison Diversion

The service assesses people's mental health needs who have had any contact with the criminal justice system or police for any reason, victim, suspect, defendant, witness or bystander, who it is felt would benefit from mental health intervention.

6.3.21. Employment Support Service

The service is delivered to adult patients (17 and above) open to community mental health teams, psychosis intervention and early recovery (PIER) and assertive outreach, providing information, advice, guidance and support to find paid work, as part of an individualised recovery plan. Currently operates employment clinics in nine locations across Leicester, Leicestershire and Rutland (LLR).

6.3.22. Homeless Mental Health Service

The Homeless Mental Health Service is a multi-disciplinary team offering engagement, mental health assessment and referral to mainstream mental health and support services – for people age 16 and over, who are homeless or staying in temporary accommodation. The team is made up of three full-time mental health practitioners, a part-time psychiatrist, part-time clinical psychologist

and a part-time secretary.

6.3.23. Leicestershire Recovery College

Based at the Mett Centre, Leicester, this is an NHS college offering a range of recovery-focused educational courses and resources for people aged 18 and over who have lived experience of mental health challenges, along with their friends, family and LPT staff.

6.3.24. Medical Psychology

A service for adults who are having difficulties with managing the impact of medical/physical health problems on their psychological well-being or are finding that their mental health is having a direct impact on their physical health. The service can offer assessment and treatment to adult patients from all medical specialities. Referrals only from University Hospitals of Leicester (UHL) Consultants (or a member of their team).

6.3.25. Mental Health Urgent Care Hub

A team of mental health practitioners with the expertise to treat people of all ages; this includes mental health nurses, support workers, and consultants. It is specifically for people with mental health needs that don't need any physical health support from an emergency department.

People are referred to the hub by emergency services, social care or health professionals.

6.3.26. Op Community

Op Community is a telephone line for the armed forces community (including veterans, reservists, serving personnel, families and the wider armed forces community) to offer support and guidance around navigating NHS services and advice regarding other services that can support with issues.

6.3.27. Outreach Team for Adult Learning Disabilities Service

The Outreach Team works with adults aged 18 years + with a diagnosed learning disability and their carers where the person with a learning disability has challenging behaviours that might mean they cannot continue to be supported in the community/at home.

6.3.28. Psychological Awareness of Unusual Sensory Experiences (PAUSE)/At Risk Mental State (ARMS)

Planned to launch in Autumn 2023, initially in a targeted geographical area rather than across Leicester, Leicestershire and Rutland. To offer NICE-recommended psychological and psychosocial interventions to people aged 14 – 35 years who may be experiencing the early signs of psychosis.

6.3.29. Reconnect

The service offers care to those aged 18 and above with identified vulnerabilities after a custody

service. Provides up to 12 weeks pre-release and six months post-release person centred support, including assertive outreach, digital guidance, system navigation, signposting to support from wider health and wellbeing services.

6.3.30. The Involvement Centre and Café

The Involvement Centre is an information, IT and social resource, open to inpatients, outpatients, service users, carers and visitors.

6.3.31. Arts in Mental Health

The team delivers a range of artistic projects for mental health service users whilst supporting service users.

6.3.32. The Mett Centre

A mental health day resource centre in Leicester city centre, offering recovery-focused support, through individualised programmes of meaningful activities, physical and mental health promotion, social inclusion and therapeutic interventions.

6.4. PAVE Team (Pro-Active Vulnerability Engagement)

This is a partnership between police, mental health practitioners, and substance misuse practitioners providing targeted support for people who intensively use health and police services. The aim is to reduce the number of people with mental ill health being held inappropriately in police cells. The multi-disciplinary team includes police officers, mental health practitioners, and substance misuse Recovery Workers. In addition clinical support is available as required from a Consultant Psychiatrist.

6.5. Voluntary and Community Sector Services

In Rutland, voluntary and community based services include:

Norton Housing Support (http://nortonhousingandsupport.org.uk/) provides support and accommodation to adults with ongoing mental health needs and/or learning disabilities.

Leicestershire Action for Mental Health Project (LAMP) (https://www.lampadvocacy.co.uk/) provides independent mental health advocacy (IMHA).

The Singing Café (https://thesingingcafe.co.uk) is a charity initiative run by Without Walls to address the needs of vulnerable members of Leicestershire population, seeking to address loneliness and mental health conditions. Can be found in Melton and Wigston.

The Carers Centre (https://www.claspthecarerscentre.org.uk/) aims to support unpaid carers across the diverse communities of Leicester, Leicestershire and Rutland.

Living Without Abuse (https://lwa.org.uk/) offers information and advice to anyone experiencing

domestic abuse and/or sexual violence.

Voluntary Action Leicester (VAL https://valonline.org.uk/) is an active part of the local voluntary, community and social enterprise (VCSE) sector, providing advice, support and training to charities and community groups across Leicestershire. They are a source of information on other voluntary initiatives for people with mental health across LLR.

6.6. Local Authority and Other Mental Health Services

The working age adults mental health care pathway supports recovery and reablement, aimed at maximising people's independence, and their ability to self-manage. Service provision includes;

6.6.1. Mental Health Reablement Teams

The service provides the first offer to the majority of people who are eligible for support for their mental health problems (excluding safeguarding, and urgent crisis/complex work). These teams provide short term solution focused support to promote recovery and increase independence. These teams are staffed by Mental Health Social Workers.

6.6.2. Community Mental Health Teams

The teams include Social Workers, and Mental Health Social Workers, and most also include an Approved Mental Health Professional (AMHP). The teams provide a service to all service users in their locality. In addition to the locality based teams there are countywide services providing more specialised support and interventions.

6.6.3. Mental Health Wellbeing and Recovery Service

Commissioned jointly between, Leicestershire County Council, Leicester City Council, Rutland County Council, and the three CCG's and currently provided by three different providers, the service offers support networks focused on wellness and recovery, encouraging independence and developing own personal support networks.

6.6.4. Specialist Substance Misuse Treatment Services

Specialist substance misuse services for Leicestershire and Leicester City are jointly commissioned by Leicestershire County Council (Public Health) and Leicester City Council (Adult Social Care) with additional funding by the Office of Police + Crime Commissioner (OPCC) and NHS England. It is currently provided by the Turning Point. There are close working arrangements with inpatient psychiatric wards, and weekly clinics/drop-ins attended by the Dual Diagnosis Senior Recovery Worker. In addition there is a weekly mental health drop-in session at the main service hub in the city centre, but available for any service user.

6.6.5. Local Authority Public Health Services

The Public Health Department approach involves finding ways to improve the mental wellbeing of the population in Leicestershire, through assessing health needs, assessing evidence base for interventions, direct commissioning/contracting of services, and working with other departments and partners. The department leads the Leicestershire, Leicester City and Rutland wide Suicide Audit and Prevention Group. In addition to the suicide prevention work, currently the department commissions and/or contributes to a number of local initiatives aimed at improving mental wellbeing and supporting recovery:

First Contact + offers access to a range of low level preventative services through a single point of contact. This is an online service ensuring that people can access information, advice and support across a range of issues.

Local Area Co-ordinators (LAC's) is a community based intervention delivered in specific areas by Local Area Co-ordinators. The team work on an asset-based model to increase individual and community capacity, preventing people reaching crisis, and thereby reducing demand on public services. Whilst not a specific mental health service, much of the work undertaken supports improving people's mental wellbeing and addresses issues that impact on individual mental health.

Other services include:

6.6.6. Getting Help in Neighbourhoods

This service is commissioned by the ICB and in partnership with Leicestershire County Council this service offers drop-in sessions offering a listening ear and short-term support based on the needs of the individual. It is available to anybody aged 18, the sessions are running across Leicester, Leicestershire and Rutland

6.6.7. Student Mental Health

The ICB is leading on a workstream focussing on the needs of the student population across the universities in Leicester and Leicestershire in conjunction with the university health and wellbeing services.

6.6.8. Mental Health Practitioner/Facilitators

Is a Primary Care based service for patients with more severe and enduring mental illness such as schizophrenia and bipolar disorder.

6.6.9. Mental Health central Access Point

Is a 24/7 self-referral service for people in need of mental health support for themselves or others, commissioned by the ICB and staffed currently by Turning Point , this is an all-age service that provides signposting, assessment and intervention.

6.6.10. Place of Safety

This is the Section 136 (S136) suite at the Bradgate Mental Health Unit. This suite is used for emergency psychiatric assessment by an AMHP detained by police, under S136 of the MHA. S136 is used on an exceptional basis, although when it is appropriate to be used, it is preferable for the individual to be detained in a healthcare setting rather than a criminal justice setting.

6.6.11. Triage Car

Leicestershire Police and a mental health nurse from LPT respond to people with mental health problems in public places

6.6.12. Transition work

The ICB is leading on services and pathways for those aged 18-25.

6.6.13. Upcoming service to Rutland: Women's Hub

Rutland are in the process of mobilising a women's hub to provide social, emotional and health support including sexual health, menopause and social prescribing.

6.7. Additional Dementia Services

Admiral Dementia Nurse Service – includes specialist dementia nurses who give practical and emotional support to family carers, as well as the person with dementia. The service is available to people living in Rutland and will work with family carers as their prime focus, promote best practice in person centred dementia care, pre diagnostic support, support through transitions in care and bereavement support.

Rutland Dementia Support Service, LeicesterShire & Rutland Age UK – Supports people who are living in Rutland and who are awaiting or living with an early diagnosis of dementia. The service offers, personalised information and advice, emotional support as well as access to a range of group activities that promote wellbeing.

Dementia Friendly Leicestershire, Care Choices – A practical guide to living with dementia in Leicester, Leicestershire and Rutland which explores all aspects of living with dementia. The guide is available here: https://www.carechoices.co.uk/publication/leicestershire-dementia-guide/

The Hub of Hope, Chasing the Stigma – This mental health support signposting tool brings local, national, peer, community, charity, private and NHS mental health support and services together into one place.

Dementia carers Support Age UK - Dementia advisors support friends and family of those with dementia with information and advice about navigating local services and applying for benefits.

7. Identified Needs and Gaps in Provision

- Rutland has a faster than national demographic growth among older adults which has direct implications for future health needs, levels of morbidity and multimorbidity, including mental health conditions.
- The numbers of women accessing community perinatal mental health services in Leicestershire and Rutland are increasing, following the national trend.
- There is some evidence of rising local crime rates, including rural crime and violence against the person, and further analysis of the impacts on mental health would be recommended.
- Although some work to understand the health and wellbeing needs of Rutland's armed forces population has been undertaken recently, the small numbers of respondents make it difficult to draw conclusions on the wider needs of this population, particularly that this population has recently changed.
- The proportion of people waiting for NHS Talking Therapies for a long time was higher than expected in previous years but shows improvement recently (91% seen within 6 weeks across East Leicestershire and Rutland).
- The prevalence of dementia in patients registered with GP practices in Rutland has been consistently higher than the national average, however the proportion of patients with their care plan reviewed in the last 12 months was relatively low in 2020/21. This could be the result of the COVID-19 pandemic, as in prior years this indicator was above the national average; when available, the later data could show post-pandemic recovery.
- The estimated prevalence of severe mental illness (SMI) in Rutland is 790, whilst there were just 312 patients registered with SMI on GP registers. This suggests that a substantial number of patients are not accessing treatment.
- Comparative data show higher rates of premature mortality among people with SMI, with a suggestion this is largely due to cancer mortality in Rutland, although the numbers are too low to draw a statistically valid conclusion.
- Only half of people with severe mental illness receive full physical health checks (45% in Leicestershire and Rutland), against the current 60% performance target – a preventative measure that could be improved.
- Due to the small numbers of suicides in Rutland we are unable to report details on these figures within this report. However broad estimates suggest that there are around 4,000 people self-harming and/or attempting suicide in Rutland. Surveillance of suspected suicide is on-going.
- Dementia prevalence is projected to increase – between 2023 and 2040 the number of

people aged 65 and over in Rutland with dementia is estimated to increase by 48.6%, while in persons aged 85 years the increase is expected to be 70.3%. Plans will need to take the projected growth into account to ensure that the capacity of dementia services is increased to meet this level of need in the future.

- People with personality disorders (PD), estimated to account for at least 4,000 in Rutland, experience considerable stigma, and, as was previously assumed, less chances of effective recovery. However, there is evidence that treatment for PD can be effective; a trauma-informed understanding of PD would consider it as complex trauma. Currently, care for PD is fragmented with gaps in service provision offering a compassionate understanding about PD and treatment.
- There is a lack of flexible mental health outreach for people who sleep rough and may have dual diagnosis with substance misuse.
- It is recognised that 50% of mental health problems are established by age 14 and 75% by age 25, and although one in ten children and young people aged 5-16 have a clinically diagnosable condition, 70% have not had appropriate interventions at a sufficiently early age (MH Foundation 2024).
- There are gaps in the continuity of care for people self-harming, attending Emergency Department and returning back to locality Primary care and local services, particularly for those at university who may be at a part-time address.

8. Recommendations

- To seek opportunities for prevention and early detection of mental health conditions, including raising awareness of the risk factors of dementia and prevention measures for these.
- To monitor and improve uptake of physical health checks, particularly among those with serious mental illness or dementia.
- As Rutland is predominantly rural, issues of access to services and hidden pockets of deprivation should be recognised and addressed at a local level, through improved joint working. Needs of some at risk groups such as prisoners, travellers and armed forces personnel should assessed at a local level.
- To improve the transition from children's services such as CAMHS into adult services, with a focus on prevention. The ICB is leading on this piece of work and the system plays a key part in shifting the focus from separate children and adult services into considering children's mental health as part of the adult preventative offer across the life course. A comprehensive offer for 0-25 year olds that reaches across mental health services for children, young people and adults could deliver an integrated approach across health, social care, education and the voluntary sector, and offer person-centred and age-appropriate care for mental and physical health needs, rather than an arbitrary transition to adult services based on age not need.
- To develop prevention services for carers of people with mental health difficulties to provide support before that person reaches a crisis.
- To improve access to mental health services particularly in communities where there may be a stigma attached to living with a mental health problem.
- To develop flexible mental health outreach for people who sleep rough and may have dual diagnosis with substance misuse (primarily Leicestershire and Leicester).
- To enhance continuity of care for self-harm, including emergency services, primary and social care and other local services.
- To develop a local Prevention Concordat with a prevention-focused approach (primarily Leicestershire).
- To improve access to effective treatments for personality disorders (PD).
- To implement the recommendations of the on-going gambling-related harm workstream for suicide prevention alongside the work on cost of living pressures.
- To enhance engagement with the voluntary and community sector.
- To enhance local data collection on mental health inequalities, prevention and services, including mapping of services and patient pathways, particularly for vulnerable groups such as pregnant women and armed forces populations.

- The effectiveness of the Rutland Women's Hub service currently being mobilised should be assessed and monitored to ensure that this service is meeting the needs of women in Rutland.
- Further modelling of the impact of current demographic trends on future mental health needs and demand for health care would be recommended, particularly for dementia.

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RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2024

MENTAL HEALTH AND DEMENTIA – ADULTS

APPENDIX

March 2024

Business Intelligence Team
Leicestershire County Council

Public Health Intelligence

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Produced by the Business Intelligence Service at Leicestershire County Council.

1. Current Mental Health Services (Adults)

Mental health services for adults in Rutland operate mostly across Leicester, Leicestershire and Rutland (LLR).

1.1. First point of contact

For ***urgent mental health support***, people should contact the Mental Health Central Access Point, a 24/7 freephone, operated by Leicestershire Partnership Trust and Turning Point, NHS111 service or a Crisis Café.

1.1.1. Mental Health Central Access Point

Introduced in April 2020, a new contact point in Leicester, Leicestershire and Rutland to help people who want support with their mental health. The phone line is staffed by recovery workers from Turning Point, who explore a caller's needs and transfer them to an appropriate staff member from *Leicester Partnership NHS Trust (LPT*); this could be a direct transfer or a call back. People should be called back within four hours for urgent care. As well as assessments and early interventions where needed, the service aims to reduce the pressure on other services, particularly emergency services.

1.1.2. Neighbourhood Mental Health Cafés

Mental Health Cafés are part of Leicestershire Partnership NHS Trust's local support for people who need immediate help with their mental health. The cafes are drop-in centres operated by supportive, trained staff (https://www.leicspart.nhs.uk/service/neighbourhood-mh-cafes/).

There are 12 cafes operating across LLR, the following ones are in Rutland and East Leicestershire:

- Rutland Neighbourhood Mental Health Café – provided by Pepper's – A Safe Place
- Melton Neighbourhood Mental Health Café – provided by Sunny Skies CIC
- Market Harborough Neighbourhood Mental Health Café – provided by Turning Point
- Syston Neighbourhood Mental Health Café – provided by Rural Community Council
- Enderby Neighbourhood Mental Health Café – provided by Beacon Care and Advice
- Lutterworth Neighbourhood Mental Health Café – provided by Beacon Care and Advice CIC

For ***non-urgent mental health support*** patients can contact their general practice or NHS Talking Therapies, a self-referral, free confidential service provided by Vita Minds (Vita Health part of Spire Healthcare).

1.1.3. NHS Talking Therapies

Formerly known as IAPT (Improving Access to Psychological Services), NHS Taking Therapies are NHS-funded, evidence based, psychological therapies for depression and anxiety. It is commissioned and delivered at the local level, locally Vita Health Group provides this service to all adults (16-years

and over) who live and are registered with a GP in Leicester, Leicestershire and Rutland (https://www.vitahealthgroup.co.uk/nhs-services/nhs-mental-health/leicester-leicestershire-rutland . These services are free and confidential, after an assessment, may be face to face, online or in a group.

1.2. Leicestershire Partnership NHS Trust

LPT provides the following inpatient, outpatient and community services:

1.2.1. The Bradgate Mental Health Unit

(Glenfield Hospital Site, Groby Road, Leicester)

The Bradgate Mental Health Unit is an **acute mental health admissions unit** with seven acute admission wards and a ten-bedded male Psychiatric Intensive Care Unit (PICU). There is also a six-bedded female PICU, Griffin Ward, nearby at Herschel Prins Centre. Its multi-disciplinary care team, include consultant psychiatrists, psychology, occupational therapy, social care, and they will undertake a full assessment of patient's mental, physical and social needs.

The recovery-focused general psychiatry wards include:

- Ashby Ward – assessment and care for men in the acute stage of their illness.
- Aston Ward – female acute needs ward
- Beaumont Ward – acute inpatient assessment and care
- Bosworth Ward – male acute needs ward
- Heather Ward – female acute needs ward
- Thornton – male acute needs ward

The psychiatric intensive care wards include:

- Belvoir Ward – male ward
- Griffin Ward – female ward

The low-secure environment care is provided at the Phoenix Ward.

1.2.2. Adult Community Mental Health Teams

The responsibilities of our community mental health teams (CMHTs) and the assertive outreach service are to meet the needs of service users who require the intervention of a specialist mental health team.

There are eight community mental health teams providing a secondary care planned assessment and treatment service. This might involve psycho-social interventions, medical prescribing or, if eligibility criteria are met, social care commissioning of services.

The multi-disciplinary team (MDT) is made up of nursing and medical staff, occupational therapists,

psychologists and administration staff. The aim is to support with mental health needs, all aspects of daily life such as self-care, well-being and health promotion.

1.2.3. Forensic Mental Health Services

(Herschel Prins Centre, Glenfield Hospital Site, Groby Road, Leicester)

This is both an inpatient and a community service for people with a history of offending who also suffer from mental ill health. Care is provided by a multidisciplinary team and the ward provides qualified and unqualified nursing cover on all shifts. The ward has input from occupational therapists, and a therapeutic liaison worker who will be on duty to enable activities, groups and therapeutic interventions to take place, alongside psychology input.

1.2.4. Perinatal Mental Health Service

(Bradgate Mental Health Unit, Glenfield Hospital site)

A team of health professionals that provide personalised and specialist care to people living in Leicester, Leicestershire and Rutland who have moderate to severe mental health problems relating to pregnancy, childbirth and the first year following a child's birth (also known as the perinatal period). Offers various treatments either in homes, community locations, clinics or via video calls, including pre-conception advice and counselling, home visits, group therapy sessions, support clinics, nursery nurse sessions, counselling and talking therapies, and advice and support on medications. Patients need a referral for a GP or other healthcare professionals, referral criteria include:

- moderate to severe mental health conditions such severe anxiety or depression
- history of serious mental health difficulties and who are planning a pregnancy or are pregnant
- family history of serious mental health difficulties such as bipolar disorder or postpartum psychosis.

Patients with moderate to severe difficulties related to birth trauma, baby loss, and tokophobia are referred to *Maternal MHS*.

1.2.5. Maternal Mental Health Service

(Prince Philip House, St Matthews Health & Community Centre, Malabar Road, Leicester)

Is a psychology-led, trauma-informed service, comprising a small multi-disciplinary team helping women and birthing people with moderate to severe difficulties related to birth trauma, baby loss, and tokophobia. This service is for those experiencing difficulties following a traumatic birth experience or baby loss, or if they are struggling with severe anxiety about their pregnancy or upcoming birth and would like additional support. Those with complex or severe mental health problems relating to pregnancy, childbirth and the first year following a child's birth, are referred to

the *Perinatal Mental Health Service*.

1.2.6. Psychosis Intervention & Early Recovery (PIER) Team

(PIER Team, Merlyn Vaz Health and Social Care Centre, Leicester)

The team offers support to people recovering from a psychotic episode. It can also help reduce the likelihood of experiencing further psychotic episodes in the future. The service is made up of a team of experienced professionals, including nurses, psychologists, psychiatrists, occupational therapists, and support workers. The service offers help to people aged 14 – 64 years who are experiencing first symptoms of psychosis, as well as providing help to their families.

1.2.7. Mental Health Liaison

(Farm Lodge, The Bradgate Unit, Glenfield Hospital)

The Liaison Psychiatry Service is a multidisciplinary team of liaison professionals providing assessment and treatment for people who experience mental health problems as a result of physical illness. The service is for the adult population of Leicester, Leicestershire and Rutland who are aged between 16 years and 65, including inpatient wards at UHL hospitals or as outpatients. The service provides a specialist **Chronic Fatigue Syndrome (CFS) service**.

1.2.8. Mental Health Services for Older People (MHSOP)

MHSOP provides inpatient, outpatient and memory services.

MHSOP Inpatients

Mental health services for older people inpatient service operating across two sites, The Evington Centre (*Leicester General Hospital site*) and the Bennion Centre (*Glenfield Hospital site*). The Evington Centre has two single sex wards and caters for patients with organic mental health problems (decreased mental function due to a medical or physical condition). The Bennion Centre has a female only ward and a mixed sex ward and caters for patients with a functional illness (decreased mental function which is not due to a medical or physical condition). Working closely with community intensive teams, community mental health teams and outreach services for older people with functional and organic mental health problems.

MHSOP Memory Service

The Memory Service for East Leicester, Rutland and East Leicestershire is based in Evington Centre, Leicester General Hospital site. The service provides diagnostic assessment and treatment for people with dementia within a clinic setting, care home or their own home. People of all ages with possible dementia can be referred.

The memory service provides assessment, diagnosis and treatment for people who are experiencing memory difficulties. The team includes psychiatrists and specialist memory service nurses.

MHSOP Outpatient Service

(The Neville Centre, Leicester General Hospital Site)

The MHSOP Outpatient Service provides assessment and treatment for people over 65 years with moderate/complex functional mental health issues, Clinics are held across Leicester, Leicestershire and Rutland. We support people over 65 years of age with depression, anxiety or psychotic illness.

MHSOP In-reach Team

(The Neville Centre, Leicester General Hospital Site)

The team sees patients who live in a care, residential or nursing home, and are experiencing difficulties due to their dementia and require specialist support and advice. The team also provide mental health assessment and specialist support to older patients with mental health problems who are current inpatients in one of our community hospitals, including:

- Patients demonstrating behaviour and psychological symptoms of dementia (BPSD) where there is concern that, without support, their behaviour could lead to hospital admission. This could be due to a risk of harm to self and/or others or the behaviour impacting on the ability of the care home to meet the patient's needs.
- Patients requiring intensive assessment and intervention to maintain placement in a care home.
- Management of withdrawal of anti-psychotic medication giving rise to behavioural changes which could impact on placement in care homes.
- Patients in a community hospital who need a mental health assessment.

1.2.9. Mental Health Wellbeing and Recovery Support Service (MHWRSS)

This service is aimed at providing a first point of access for people who need mental health support. It is designed to be easy to access – people can contact the service direct without the need of seeing their GP – and it provides more than medical support, recognising that mental health issues are often caused by other stresses. This service is open to anyone aged 18+ living in Leicester, Leicestershire or Rutland who is experiencing emotional and mental health problems, as well as their carers.

There are four providers, and each one is covering a part of the city and/or county:

- LifeLinks (http://www.rflifelinks.co.uk/contact) - Blaby, Oadby & Wigston, Harborough
- NCHA (Care and Support http://www.ncha.org.uk/talk-to-us) – Melton and Charnwood
- MHM (Mental Health Matters http://www.mhm.org.uk/leicestershire-and-rutland-mental-health-wellbeing-and-recovery-service) – North West Leicestershire, Hinckley and Bosworth
- P3 (https://www.p3charity.org) – Rutland and Leicester City

1.2.10. Crisis Resolution and Home Treatment Team

(Bradgate Mental Health Unit, Glenfield Hospital Site)

The Crisis Resolution and Home Treatment Team provides a rapid assessment of people who are experiencing a mental health crisis. The service is for adults aged 18 and over who, without this service, would require hospital admission to an acute mental health ward, due to mental health crisis which impacts on the person's ability to cope with day-to-day activities.

1.2.11. Adult Eating Disorders Service

(The Bennion Centre, Glenfield Hospital Site, Groby Road)

Is an outpatient service for patients from Leicester, Leicestershire and Rutland and a regional inpatient service for the East Midlands for adults aged 18 and over who have eating disorders such as anorexia nervosa, bulimia nervosa, binge eating disorder and other diagnosable eating disorders.

1.2.12. Therapy Services for People with Personality Disorder (TSPPD)

(Gwendolen House, Leicester General Hospital Site)

The service provides psychotherapy programmes drawn from a number of different models of psychotherapy for people age 18+ who have been assessed for the group therapy service and discussed it with their referrer.

1.2.13. Severe and Enduring Mental Illness Rehabilitation

(Stewart House and The Willows Inpatient Units)

These are rehabilitation inpatient units providing care for patients who have severe and enduring mental illness. Stewart House has 30 beds, and the Willows has 38 beds on four wards. The multi-disciplinary team (MDT) is made up of nursing and medical staff, occupational therapists, psychologists, speech and language therapists, physiotherapists and administration and housekeeping staff.

1.2.14. Acute Recovery Team

Providing specialist care, including an ECT clinic and Clozapine clinic, blood tests and monitoring.

1.2.15. Clinical Neuropsychology

The Department of Clinical Neuropsychology is based at the Leicester General Hospital and serves both inpatients and outpatient who are having cognitive difficulties as a result of a neurological condition. Providing expert neuropsychological assessment and advice, intervention, rehabilitation, and training.

1.2.16. Leicestershire Psycho-oncology Service (LPOS)

(Hadley House, Leicester General Hospital)

The service aims to help with emotional difficulties people face following a diagnosis of cancer, including depression, persistent distress, severe anxiety, anger, suicidal thoughts, communication problems, adapting to lifestyle change, body image worries and low self-esteem. The service offers a range of treatments including, emotional support, face to face talking therapy, graded activity planning, cognitive behavioural therapy (CBT), antidepressants, group therapy, tailored information, relaxation programmes and telephone support. Patients are seen in hospital or in their own home.

1.2.17. Huntington's Disease Inpatient and Community Service

(Mill Lodge, The Rise, Narborough, Leicestershire)

A community inpatient unit for people with Huntington's disease for patients with severe and enduring mental health needs and require complex care due to physical, psychiatric, behavioural and psychological needs or rehabilitation. The community team is also based there.

1.2.18. Assertive Outreach (AO) Service

Assertive Outreach is a model of care which has proved effective for people with a serious mental illness. The service is provided within a multidisciplinary team approach (including nurses, occupational therapists, social workers, psychologists, doctors and support workers) where all staff can be involved in a person's care package. The service is predominantly delivered within people's homes. There is occasional contact via outpatient clinics and the service maintains contact with people during any hospital admission. The service offers a range of therapeutic interventions. It has been specifically set up to work in partnership with people with long-standing mental health needs which are 'psychotic' in nature.

1.2.19. Central Referral Hub/Unscheduled Care service

(The Neville Centre on the Leicester General Hospital site)

All referrals into Mental Health Services for Older People from across Leicester, Leicestershire and Rutland are received by the Central Referral Hub. People of all ages with probable dementia and adults over the age of 65 with depression, anxiety or psychotic illnesses.

1.2.20. Criminal Justice and Liaison Diversion

The service assesses people's mental health needs who have had any contact with the police or are involved in the criminal justice system whether they are a suspect or a witness. Patients are referred to the service by professionals in the criminal justice service or the police, and may include people who have had any contact with the criminal justice system or police for any reason, victim, suspect, defendant, witness or bystander, who it is felt would benefit from mental health intervention.

1.2.21. Employment Support Service

The service is delivered to adult patients (17 and above) open to community mental health teams, psychosis intervention and early recovery (PIER) and assertive outreach. Its aim is to provide information, advice, guidance and support to find paid work, as part of an individualised recovery plan. Help to find and maintain paid work using the Individual Placement and Support (IPS) model, proven to succeed with people with a lived experience of mental ill health. The Employment Support Service team have more than nine years' experience as the provision was delivered by *Aspiro*, on behalf of LPT, for eight of those years.

Currently operates employment clinics in nine locations across Leicester, Leicestershire and Rutland (LLR).

1.2.22. Homeless Mental Health Service

The Homeless Mental Health Service is a multi-disciplinary team offering engagement, mental health assessment and referral to mainstream mental health and support services – for people age 16 and over, who are homeless or staying in temporary accommodation. The team is made up of three full-time mental health practitioners, a part-time psychiatrist, part-time clinical psychologist and a part-time secretary.

1.2.23. Leicestershire Recovery College

(Mett Centre in Leicester City Centre)

Leicestershire Recovery College is an NHS college offering a range of recovery-focused educational courses and resources for people aged 18 and over who have lived experience of mental health challenges, along with their friends, family and Leicestershire Partnership NHS Trust staff. The Recovery College is based at the Mett Centre in Leicester City Centre, offering online courses, and classroom courses at venues across Leicestershire and Rutland. The courses are designed to contribute to wellbeing and recovery, supporting people to recognise their own resourcefulness and skills in order to become experts in their own self-care and achieve the things they want to in life.

1.2.24. Medical Psychology

(Leicester General Hospital, Gwendolen Road, Leicester)

The Medical Psychology Department is a service for adults who are having difficulties with managing the impact of medical/physical health problems on their psychological well-being or are finding that their mental health is having a direct impact on their physical health. The team of clinical psychologists offers specialist assessment and interventions to individuals to help manage their emotional stress of living with an acute or long-term physical health condition.

The service can offer assessment and treatment to adult patients from all medical specialities. Referrals can only be accepted from University Hospitals of Leicester (UHL) Consultants (or a

member of their team).

1.2.25. Mental Health Urgent Care Hub

(Bradgate Unit, Glenfield Hospital site)

A team of mental health practitioners with the expertise to treat people of all ages; this includes mental health nurses, support workers, and consultants. It is specifically for people with mental health needs that don't need any physical health support from an emergency department.

People are referred to the hub by emergency services, social care or health professionals.

1.2.26. Op Community

Op Community is a telephone line for the armed forces community (including veterans, reservists, serving personnel, families and the wider armed forces community) to offer support and guidance around navigating NHS services and advice regarding other services that can support with issues.

1.2.27. Outreach Team for Adult Learning Disabilities Service

(The Agnes Unit, Anstey Lane, Leicester)

The Outreach Team works with adults aged 18 years + with a diagnosed learning disability and their carers where the person with a learning disability has challenging behaviours that might mean they cannot continue to be supported in the community/at home. The team currently consists of eight qualified nurses, five healthcare support workers, an occupational therapist and a speech and language therapist, with support from psychiatry.

1.2.28. Psychological Awareness of Unusual Sensory Experiences (PAUSE)/At Risk Mental State (ARMS)

Planned to launch in Autumn 2023, initially in a targeted geographical area rather than across Leicester, Leicestershire and Rutland. The service will offer NICE-recommended psychological and psychosocial interventions to people aged 14 – 35 years who may be experiencing the early signs of psychosis. ARMS will support people for up to two years. Assessments and interventions will be provided within a multidisciplinary team approach and include NICE recommended Family and CBT interventions; social inclusion; education and peer interventions which aim to: reduce stigma; focus on helping people maintain their education, work and social links and goals to improve functioning and long terms outcomes; tailored to, and based in the local community; reducing the number of people who meet the threshold for diagnosis and need secondary care services and improving transition to PIER to facilitate early intervention where needed.

1.2.29. Reconnect

The service offers care to those aged 18 and above with identified vulnerabilities after a custody

service. It seeks to improve the continuity of care of vulnerable people leaving prisons or Immigration Removal Centres (IRC); it supports service users' transition to community-based services and safeguards health gains made whilst in prison/IRC, offers liaison, advocacy, signposting, and engagement with community-based health and support services. It helps to support a safe transition from prisons/IRC to community-based healthcare and support services.

The Reconnect service provides up to 12 weeks pre-release and six months post-release person centred support, including assertive outreach, digital guidance, system navigation, signposting to support from wider health and wellbeing services.

1.2.30. The Involvement Centre and Café

(Bradgate Mental Health Unit, Glenfield Hospital site)

The Involvement Centre is an information, IT and social resource, open to inpatients, outpatients, service users, carers and visitors.

1.2.31. Arts in Mental Health

The arts in mental health team deliver a range of artistic projects for mental health service users whilst supporting service users. Managing a range of arts in mental health projects on an open referral basis, including arts, music, comedy, literature and spoken word sessions. Serving people with severe and enduring mental health problems and particularly vulnerable or socially isolated service users. We are however open to all people with mental health problems.

1.2.32. The Mett Centre

(The Mett Centre, Unit 2, 20 Lee Street, Leicester)

The Mett Centre is a mental health day resource centre in Leicester city centre, offering recovery-focused support, through individualised programmes of meaningful activities, physical and mental health promotion, social inclusion and therapeutic interventions. The service is available to adults with complex and enduring mental health difficulties who have a Consultant Psychiatrist at Leicestershire Partnership NHS Trust and is particularly suitable for individuals who are isolated socially and may currently find it difficult accessing mainstream services.

1.3. PAVE Team (Pro-Active Vulnerability Engagement)

This is a partnership between police, mental health practitioners, and substance misuse practitioners providing targeted support for people who intensively use health and police services. The aim is to reduce the number of people with mental ill health being held inappropriately in police cells. The multi-disciplinary team includes police officers, mental health practitioners, and substance misuse Recovery Workers. In addition clinical support is available as required from a Consultant Psychiatrist.

1.4. Voluntary and Community Sector Services

In Rutland, voluntary and community based services include:

Norton Housing Support (http://nortonhousingandsupport.org.uk/) provides support and accommodation to adults with ongoing mental health needs and/or learning disabilities. Personal support includes assistance with budgeting, social inclusion, support to better manage and physical mental health, develop daily living skills, building confidence and self-esteem, emotional support and support in accessing other services.

The service partners with other local mental health services, including GPs CPNs, Crisis team, Remploy and other.

Leicestershire Action for Mental Health Project (LAMP) (https://www.lampadvocacy.co.uk/) provides independent mental health advocacy (IMHA). It involves supporting people at critical appointments, such as with GP, Mental Health Team or other consultations, where necessary challenging professionals on their behalf, if they are unable to do this alone, and supporting people in finding the right service for the circumstances, as well as referring to them. The service is for people with mental health problems and for carers of people with mental illness.

The Singing Café (https://thesingingcafe.co.uk) is a charity initiative run by Without Walls to address the needs of vulnerable members of Leicestershire population, seeking to address loneliness and mental health conditions. Can be found in Melton and Wigston.

The Carers Centre (https://www.claspthecarerscentre.org.uk/) aims to support unpaid carers across the diverse communities of Leicester, Leicestershire and Rutland. These include providing advice and information for those who provide unpaid care, group social activities, training and financial advice.

Living Without Abuse (https://lwa.org.uk/) offers information and advice to anyone experiencing domestic abuse and/or sexual violence. They provide support services to population of Leicester, Leicestershire or Rutland. The organisation is committed raising awareness of domestic abuse and sexual violence, working towards its prevention and eradication, and assisting those affected by this crime to determine their own lives.

Voluntary Action Leicester (VAL https://valonline.org.uk/) is an active part of the local voluntary, community and social enterprise (VCSE) sector, providing advice, support and training to charities and community groups across Leicestershire. They are a source of information on other voluntary initiatives for people with mental health across LLR.

1.5. Local Authority and Other Mental Health Services

The working age adults mental health care pathway supports recovery and reablement, aimed at maximising people's independence, and their ability to self-manage. Service provision includes;

1.5.1. Mental Health Reablement Teams

There are two teams covering Leicestershire; West Team and East Team. The service provides the first offer to the majority of people who are eligible for support for their mental health problems (excluding safeguarding, and urgent crisis/complex work). These teams provide short term solution focused support to promote recovery and increase independence. These teams are staffed by Mental Health Social Workers.

1.5.2. Community Mental Health Teams

There are six locality teams across the county, Blaby/Oadby & Wigston, Melton, Hinckley, North West Leicestershire, Charnwood, and Harborough. All teams include Social Workers, and Mental Health Social Workers, and most also include an Approved Mental Health Professional (AMHP). The teams provide a service to all service users in their locality. In addition to the locality based teams there are countywide services providing more specialised support and interventions.

1.5.3. Mental Health Wellbeing and Recovery Service

The mental health wellbeing and recovery service is commissioned jointly between, Leicestershire County Council, Leicester City Council, Rutland County Council, and the three CCG's. The service is currently provided by 3 different providers, providing coverage across all districts in the county (and Leicester City and Rutland); Richmond Fellowship (operating as Life Links), Mental Health Matters, and Voluntary Action South Leicestershire (VASL).

The service offers support networks focused on wellness and recovery, encouraging independence and developing own personal support networks. It offers flexibility to choose support based on own personal need. This can be face to face, providing information, advice and navigation services, one to one sessions, and group support sessions; online support including a directory of services, and a 24/7 chat feature allowing questions to be asked/answered; and community recovery support.

1.5.4. Specialist Substance Misuse Treatment Services

Specialist substance misuse services for Leicestershire and Leicester City are jointly commissioned by Leicestershire County Council (Public Health) and Leicester City Council (Adult Social Care). Additional funding for this service is provided by the Office of Police + Crime Commissioner (OPCC) and NHS England. The integrated substance misuse treatment service is currently provided by Turning Point. In addition to Senior Recovery Workers, Recovery Workers, and Support Workers, the service includes a Consultant Psychiatrist, and a Counselling Psychologist, and a Dual Diagnosis Senior Recovery Worker. There are close working arrangements with inpatient psychiatric wards, with fortnightly clinics run by the Turning Point Consultant Psychiatrist, and weekly clinics/drop-ins attended by the Dual Diagnosis Senior Recovery Worker. In addition there is a weekly Mental Health Drop-in session at the main service hub in the city centre, but available for any service user. Turning Point are commissioned separately to provide 1.2wte Recovery Workers to the Pro-Active

Vulnerability Engagement (PAVE) Team.

1.5.5. Local Authority Public Health Services

The Public Health Department approach involves finding ways to improve the mental wellbeing of the population in Leicestershire. The department does this in a number of ways; assessing population needs, and the supporting evidence base for interventions, direct commissioning/contracting of services, and working with other departments and partners to develop joint initiatives. The department leads the Leicestershire, Leicester City and Rutland wide Suicide Audit and Prevention Group. The role of the group is to lead on and co-ordinate strategies and actions to reduce the risks and burden of suicide locally. In addition to the suicide prevention work, currently the department commissions and/or contributes to a number of local initiatives aimed at improving mental wellbeing and supporting recovery;

First Contact + offers access to a range of low level preventative services through a single point of contact. This is an online service ensuring that people can access information, advice and support across a range of issues. This includes a range of health and wellbeing topics including mental health, and advice and support on topics that have the potential to impact on mental wellbeing, such as debt and benefits, and families and relationships. The service provides early identification of needs and brief opportunistic interventions, support for self-help, or referral to a service provider. As well as providing advice pages, and signposting to useful resources, there is an option to self-refer for further contact.

Local Area Co-ordinators (LAC's) is a community based intervention delivered in specific areas by Local Area Co-ordinators. Whist the team work with other agencies such as GP surgeries, adult social care, and the police they are independent of these services and work directly with individuals and in communities to improve health and wellbeing. The team work on an asset-based model to increase individual and community capacity, preventing people reaching crisis, and thereby reducing demand on public services. Whilst not a specific mental health service, much of the work undertaken supports improving people's mental wellbeing and addresses issues that impact on individual mental health.

1.5.6. Getting Help in Neighbourhoods

This service is commissioned by the ICB and in partnership with Leicestershire County Council this service offers drop-in sessions offering a listening ear and short-term support based on the needs of the individual. It is available to anybody aged 18, the sessions are running across Leicester, Leicestershire and Rutland

1.5.7. Student Mental Health

The ICB is leading on a workstream focussing on the needs of the student population across the universities in Leicester and Leicestershire in conjunction with the university health and wellbeing

services.

1.5.8. Mental Health Practitioner/Facilitators

Is a Primary Care based service for patients with more severe and enduring mental illness such as schizophrenia and bipolar disorder.

1.5.9. Mental Health central Access Point

Is a 24/7 self-referral service for people in need of mental health support for themselves or others, commissioned by the ICB and staffed currently by Turning Point, this is an all-age service that provides signposting, assessment and intervention.

1.5.10. Place of Safety

This is the Section 136 (S136) suite at the Bradgate Mental Health Unit. This suite is used for emergency psychiatric assessment by an AMHP detained by police, under S136 of the MHA. S136 is used on an exceptional basis, although when it is appropriate to be used, it is preferable for the individual to be detained in a healthcare setting rather than a criminal justice setting.

1.5.11. Triage Car

Leicestershire Police and a mental health nurse from LPT respond to people with mental health problems in public places

1.5.12. Transition work

The ICB is leading on services and pathways for those aged 18-25

1.5.13. Upcoming service to Rutland: Women's Hub

Rutland are in the process of mobilising a women's hub to provide social, emotional and health support including sexual health, menopause and social prescribing.

1.6. Additional Dementia Services

Admiral Dementia Nurse Service – includes specialist dementia nurses who give practical and emotional support to family carers, as well as the person with dementia. Users of the service will be given the knowledge to understand dementia and its effects, the skills and tools to improve communication and emotional and psychological support to help carers carrying on in their caring roles. The service is available to people living in Rutland who have dementia, their carers, family members and friends. The service will work with family carers as their prime focus, promote best practice in person centred dementia care, pre diagnostic support, support through transitions in care and bereavement support.

Rutland Dementia Support Service, LeicesterShire & Rutland Age UK – Supports people who are

living in Rutland and who are awaiting or living with an early diagnosis with dementia. The service is available to all residents aged 18 and over in Rutland who have a suspected or formal diagnosis of dementia and who live within the Rutland County Council boundaries. The support is designed to enable people who are living with dementia and informal carers to live well, maintain their independence, and enable them to focus on their personal strengths and make the most of the support that is available in their local community. The service offers, personalised information and advice, emotional support as well as access to a range of group activities that promote wellbeing in an inclusive and welcoming social environment such as a monthly memory cage, a monthly coffee and chat, time in nature, a walk in the park and maintenance cognitive stimulation therapy.

Dementia Friendly Leicestershire, Care Choices – A practical guide to living with dementia in Leicester, Leicestershire and Rutland. The Dementia Friendly Leicestershire guide explores all aspects of living with dementia. The guide outlines Dementia support available locally in addition to providing a better understanding of the condition and how best to support those affected. The guide is available here: https://www.carechoices.co.uk/publication/leicestershire-dementia-guide/

The Hub of Hope, Chasing the Stigma – This mental health support signposting tool brings local, national, peer, community, charity, private and NHS mental health support and services together into one place.

Dementia carers Support Age UK - Dementia advisors support friends and family of those with dementia with information and advice about navigating local services and applying for benefits.

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Report No: 58/2024
PUBLIC REPORT

HEALTH AND WELLBEING BOARD

23 April 2024

JOINT HEALTH AND WELLBEING STRATEGY UPDATE

Report of the Portfolio Holder for Adults and Health

Corporate Priorities:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Diane Ellison: Portfolio Holder for Adults and Health	
Contact Officer(s):	Kim Sorsky, Director of Adult Services and Health, RCC	Telephone: 01572 758352 Email: ksorsky@rutland.gov.uk
	Mike Sandys, Director of Public Health for Leicestershire and Rutland, LCC	Telephone: 0116 3054259 Email: mike.sandys@leics.gov.uk
	Debra Mitchell, Deputy Chief Operating Officer, LLR ICB	Telephone: 07969910333 Email: debra.mitchell3@nhs.net
	Katherine Willison, Health and Wellbeing Integration Lead, RCC	Telephone: 01572 758341 Email: kwillison@rutland.gov.uk
Ward Councillors	N/A	

DECISION RECOMMENDATIONS
That the Committee: 1. Notes the further development of the JHWS Delivery Plan. 2. Notes the Public Health Outcomes Framework: Update for Rutland Reports

1 PURPOSE OF THE REPORT

1.1 The Joint Health and Wellbeing Strategy (JHWS) is a statutory responsibility of the health and Wellbeing Board (HWB) and falls under its governance.

1.2 The purpose of this report is to update the HWB on progress of the JHWS Delivery Plan.

1.3 The report also highlights elements of the Public Health Outcomes Framework: Update for Rutland

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The overall aim of the joint strategy is 'people living well in active communities.' It aims to 'nurture safe, healthy and caring communities in which people start well and thrive together throughout their lives'. In order to achieve its objectives, the Strategy is structured into seven priorities following a life course.

2.2 Appendix A provides a high-level summary of progress across the JHWS's priorities. This includes the aims and activities to achieve all elements of the strategy, the stage of the project, start and completion dates and milestones, measures of success, progress updates and risks and mitigations. This is an evolving plan and will be updated and amended as required. This is a newly designed plan which has been created to so that information is easier to identify, and reporting is more efficient. Work is required to complete some sections of the plan, particularly on dates, measures of success and milestones. This will be completed during the next quarter.

2.3 A 12-month review of the JHWS is currently being completed and will be available for the next HWB. The review will demonstrate that many schemes have evolved to work that is now 'Business as Usual', reflecting progressing implementation of the Strategy's priorities.

2.4 The following are some highlights of progress of the JHWS over the last quarter:

2.4.1 Learning disability annual health checks are being offered across Rutland to all people aged 14+ who are on their GP surgeries' learning disability register.

2.4.2 For those aged that have not attended or are very complex, GPs can refer to the Learning Disability Annual Health Check Pilot. Rutland has been utilising this service, whereby visits are provided to complete the health check, in an environment in which people can feel more relaxed such as their home or school.

2.4.3 The LPT Learning Disability Primary Care Liaison Nurse has good links with the GP surgeries in Rutland and has visited each surgery to discuss annual health checks and offer training as needed. There is a process in place by which RCC Children's Services can raise concerns regarding anyone they are working with who has not received a health check.

2.4.4 HH from the Oral Health Team has attended Early Years sessions at the Family Hub to promote good oral health. She has trained five members of staff to deliver these messages on a regular basis. The training covered activities, health messages and the ability to answer basic questions. HH will be asked to continue to visit so parents are hearing the messages from an expert.

2.4.5 The Oral Health Team also attended an Early Years event on 7th February 2024, which showcased services available to young children in Rutland, providing information to 18 parents. The Rutland Family Hub promotes oral health bimonthly, on social media. (**Supporting Priority 1 Best start to life**)

2.4.6 An Armed Forces community health and wellbeing plan with specific actions to support the community has been developed. This follows a workshop in February with partners and the MoD. Delivery of the plan has now commenced.

2.4.7 MECC (Making Every Contact Count) training has been delivered to RCC Adult

Social Care. Additional trainers are being identified to support wider delivery across departments and partners. (**Supporting Priority 2 Prevention**)

2.4.8 GP surgeries have implemented a priority phoneline to improve access for the most vulnerable patients or those at a high risk, including palliative care patients, those who are housebound, those who are dependent on carers.

2.4.9 The Acute Respiratory Illness Hub based at Uppingham Surgery, has provided over 300 appointments between December 2023 and February 2024. (**Supporting Priority 4 Equitable Access**)

2.4.10 Levelling Up is progressing with a Governance Board and a delivery team established. Medi-Tech facilities will be at Oakham Enterprise Park and indicative Mobi Hub routes have been identified.

2.4.11 Some outpatients' services are being delivered from Rutland Memorial Hospital and X-Ray and Ultrasound occur 2 days per week. (**Supporting Priority 5 Growth and Change**)

2.4.12 The first Dying Well Steering Group was held in January with good attendance from partners. 3-, 6- and 9-month priorities agreed including exploring engagement and developing and End of Life Population Health Management Approach.

2.4.13 A productive Pathway Mapping workshop was held in March identifying processes, resources and gaps. (**Supporting Priority 6 Dying Well**)

2.5 Appendix B is the 'Public Health Outcomes Framework (PHOF): Update for Rutland' – November 2023. This highlights the learning achieved from evaluation of the most recent quarterly PHOF update. The report demonstrates how Rutland is performing using data available for Public Health Outcomes indicators, whether these are improving or worsening, how significant the change in performance is and importantly how this compares to the national data.

2.6 Of note over the last quarter, reflecting progress in the delivery of the JHWS is the following:

2.6.1 **Priority 7a Mental Health:** self-reported wellbeing measure of low happiness is significantly better than the national average. The percentage of respondents scoring low for how happy they felt yesterday has decreased from 4.7% in 2021/22 to 3.5% in 2022/23. This is significantly better than the national average of 8.9%. This can be seen to be a reflection of the work which has been driven by the Rutland Neighbourhood Mental Health Group

2.6.2 **Priority 2 Staying healthy and independent: Prevention:** the percentage reporting a long term Musculoskeletal (MSK) problem is significantly worse than the national average. The percentage of people aged 16+ reporting a long-term musculoskeletal problem increase from 21.0% in 2022 to 23.3% in 2023. In 2023 Rutland performed significantly worse than the national figure of 18.4% for the first time since 2019. One scheme seeking to improve this situation is the Healthy Workplaces Project which is in its early stages. It is known that anxiety and depression can lead to physical problems including MSK issues.

3 ALTERNATIVE OPTIONS

3.1 The JHWS is a statutory responsibility and has been consulted on publicly.

4 FINANCIAL IMPLICATIONS

4.1 In common with previous JHWS, the strategy brings together and influences the spending plans of its constituent partners or programmes (including the Better Care Fund), and will enhance the ability to bid for national, regional or ICS funding to drive forward change.

5 LEGAL AND GOVERNANCE CONSIDERATIONS

5.1 The JHWS meets the HWB's statutory duty to produce a JHWS, and the ICS duty for there to be a Place Led Plan for the local population.

5.2 JHWS actions will be delivered on behalf of the HWB via the Children and Young People's Partnership, the Integrated Delivery Group, the Staying Healthy Partnership and the Neighbourhood Mental Health Group.

6 DATA PROTECTION IMPLICATIONS

6.1 Data Protection Impact Assessments (DPIA) will be undertaken for individual projects as and when required to ensure that any risks to the rights and freedoms of natural persons through proposed changes to the processing of personal data are appropriately managed and mitigated.

7 EQUALITY IMPACT ASSESSMENT

7.1 Equality and human rights are key themes in embedding an equitable approach to the development and implementation of the Plan. An RCC high level Equality Impact Assessment (EqIA) has been completed and approved.

7.2 The initial Equality Impact Assessment sets out how the Strategy, successfully implemented, could help to reduce a wide range of inequalities. It is acknowledged that the strategy and delivery plan are high level and therefore additional equality impact assessments will be completed as appropriate as services are redesigned or recommissioned within the life of the strategy.

8 COMMUNITY SAFETY IMPLICATIONS

8.1 Having a safe and resilient environment has a positive impact on health and wellbeing. National evidence has also shown that more equal societies experience less crime and higher levels of feeing safe than unequal communities. The JHWS has no specific community safety implications but will work to build relationships across the Community Safety Partnership and to build strong resilient communities across Rutland.

9 HEALTH AND WELLBEING IMPLICATIONS

9.1 The JHWS is a central tool in supporting local partners to work together effectively with the Rutland population to enhance and maintain health and wellbeing.

10 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

10.1 The JHWS provides a clear, single vision for health and care with purpose of driving change and improving health and wellbeing outcomes for Rutland residents and patients. The progress against the plan set out in this paper supports the HWB in tracking and steering delivery.

11 BACKGROUND PAPERS

11.1 There are no additional background papers

12 APPENDICES

12.1 Appendix A: JHWS Delivery Plan March 2024

12.2 Appendix B: Public Health Outcomes Framework (PHOF): Update for Rutland – February 2024

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.

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Rutland Joint Health and Wellbeing Strategy Delivey Plan 2022 - 2027

1. Purpose of this Document

This Delivery Plan document shares the Joint Health and Wellbeing Strategy delivery plan and corresponding actions that will be collectively focussed on for 2022 - 2027. This plan has been informed by the views of Rutland people, local staff, partnership groups and health and care commissioners.

This document aims to give stakeholder visibility around the key priority actions identified during the development of the Rutland Joint Health & Wellbeing Strategy. It provides a single focused strategic partnership overview with detail of the local actions we will deliver to make or influence Place level improvement. It also includes key measures to enable us to check if we are seeing improvement through our collective efforts and includes information to help us to keep track of progress in one place. The document will also help with keeping track of key issues and points for influence at a Place level that will make improvement in Rutland.

2. Guiding Principles for Delivery

- Improve health equity/support reduction of health inequalties inc, the needs of the veteran community, issues caused by rurality, mental health needs.
- Strengthen self care and prevention services.
- Consider the wider determinants of health.
- Improve local access to, and integration of, health and care services
- Support collboration at a local level where this is potential for greater impact/improvement
- Make the Rutland population aware of the services offered locally - ensuring an adaptable set of communication approaches for different groups

3. Partnership Delivery Governance

It is anticipated that groups such as the Health & Wellbeing Board will be a key recipient user of the detailed information contained within this document. This action plan will be a key partnership tool to enable all partners to see which activities are the highest priorities for the Health and Wellbeing Board and the Integrated Delivert Group, how these are progressing and support local discussions for implementation. The tool will also provide ongoing opportunity for stakeholders/partners to reflect, using the guiding principles, on where their contributions can help deliver the aims of the group.

It is important to note that some of the actions within this tool have direct links to longer term major NHS strategic priorities for Leicester, Leicestershire and Rutland (LLR) Integrated Care System (ICS). It has dependencies on other complex organisational partners and/or national programmes requiring closer working with local and national partners at all levels and our communities to ensure we successfully deliver this plan for the people of Rutland.

4. Key Focus Priorities

1. Better Start in Life
2. Prevention
3. Living with Ill Health
4. Equitable Access
5. Growth and Change
6. Dying Well

7a. Mental Health
7b. Inequalities

8. Comms & Engagement

5. Guidance on Delivery Stage for Melton Partnership Delivery Leads:

Not Started - The work described in the plan is yet to commence
Feasibility - The work to support decisions/approvals around delivery are taking place
Delivery - The work described in the plan is being delivered
Evaluation - The work described in the plan is being evaluated against improvement aims
Completion - The work described in the plan has been completed

6. Guidance on RAG Status for Rutland Priority Leads:

Overall	What is overall status of Action / Project to deliver as per plan?
	Progressing as Planned nothing to escalate
	Progressing as planned but some challenges with risks or issues/Timeline / Finance that can or are being resolved
	Challenges / risks or issues that cant be resolved and require escalation as will not deliver as planned

7. Workbook Guidance

Leads please follow the below process for updating the workbook:

- Click on the JHWS Delivery Plan tab.
- Use "Priority" column (col. B) filter by priority you which to update.
- If you need to add or close activities, please discuss with Katherine Willison

8. Lead Names and Contact details

Priority	Lead	Contact Details
Better Start in Life	Bernadette Caffrey	bcaffrey@rutland.gov.uk
Prevention	Adrian Allen	adrian.allen@leics.gov.uk
Living with Ill Health	Emmajane Hollands	ehollands@rutland.gov.uk
Equitable Access	Charlie Summers	charlotte.summers7@nhs.net
Growth and Change	Adhvait Sheth	adhvait.sheth1@nhs.net
Dying Well	Sammi Le Corre	sammi.le-corre1@nhs.net
Mental Health	Mark Young	myoung@rutland.gov.uk
Inequalities	Mitch Harper	mitchell.harper@leics.gov.uk
Comms & Engagement	Alexandra Chamberlain	achamberlain@rutland.gov.uk

Count of Project Stage	Column Labels				
Row Labels	**(blank)**	**Delivery**	**Not started**	**Feasibility**	**Grand Total**
Best Start in Life					
Dying Well		5	2	7	14
Equitable Access					
Growth & Change					
Living with Ill Health Prevention					
Comms & Engagement		7	1		8
Mental Health Inequalties		6			6
Grand Total		**18**	**3**	**7**	**28**

Count of Montly RAG	Column Labels			
Row Labels	**(blank)**	**Green**	**Grey**	**Grand Total**
Best Start in Life				
Dying Well		7	8	15
Equitable Access				
Growth & Change		1		1
Living with Ill Health Prevention				
Comms & Engagement		8	2	10
Mental Health Inequalties		6		6
Grand Total		**22**	**10**	**32**

Row Labels	**Count of High Level Actions**
Best Start in Life	3
Dying Well	11
Equitable Access	
Growth & Change	1
Living with Ill Health Prevention	9
Comms & Engagement	8
Mental Health Inequalties	9
Grand Total	**48**

JHWB Strategy Ref:	Priority	Aim	High Level Actions	Lead Organisation	Lead	Project Stage	Health Inequalities Considered	Start Date	Expected End Date	Actual End Date	Milesones for 24/25	Measures of Success	Progress Updates March 2024	Progress Updates April 2024	Progress Updates May 2024	Key Risks	Mitigations	Montly RAG
1.1	**Best Start in Life**	**Healthy Child Development in the 1001 critical days (conception to 2 years old)**			**Bernadette Caffrey**													
1.1.1	**Best Start in Life**	Expand Family Hub locations	Increase the number of Family Hub venues	RCC	**Bernadette Caffrey**			Jan-24										
1.1.2	**Best Start in Life**	Local implementation of the Maternity Transformation Programme		LPT	**Bernadette Caffrey**				Mar-23			•Reduction in low birth weight term babies. •Reduction in infant mortality						
1.2	**Best Start in Life**	**Confident Families and Young People**			**Bernadette Caffrey**													
1.2.1	**Best Start in Life**	Transitions improvement project for our LD community (0-25yrs)		RCC	**Bernadette Caffrey**		Y	Sep-22										
1.2.2	**Best Start in Life**	Improve school readiness in pupils receiving free school meals		RCC	**Bernadette Caffrey**		Y					Improve the percentage of pupils who are receiving free school meals who have a good school readiness score						
1.3	**Best Start in Life**	**Acess to Health Services**			**Bernadette Caffrey**													
1.3.1	**Best Start in Life**	Increase health checks for children with SEND aged 14+	Ensure that children with SEND are receiving their health check and that this health check is holistic, considering the wider determinants of health.	LPT	**Bernadette Caffrey**		Y		Mar-23			•Increase the number of health checks being completed for children 14+ with SEND.						
1.3.2	**Best Start in Life**	Improve the quality of EHCPs for children with SEND		RCC	**Bernadette Caffrey**		Y	Jan-24										
1.3.3	**Best Start in Life**	Increase immunisation take-up for children and young people where this is low	Identify sub-groups where take up is low and understand why.	LPT	**Bernadette Caffrey**				Mar-23			•Increase in the number of children receiving immunisations						
2.1	**Prevention**	**Supporting People to Take an Active Part in Their Communities**			**Adrian Allen**													
2.1.1	**Prevention**	Increase the levels of volunteering across the county	Use the Citizens Advice Rutland (CAR) volunteering marketplace to improve the availability of volunteers.	CAR	**Adrian Allen**				Sep-23			Number of volunteers in Rutland						
2.1.2	**Prevention**	Feasibility study of potential community models in Rutland	Explore the potential application of innovative models to empower individuals and communities.	CAR	**Adrian Allen**				Mar-24									
2.2	**Prevention**	**Looking after Yourself and Staying Well in Mind and Body**			**Adrian Allen**													
2.2.1	**Prevention**	Support our residents to increase their activity levels	Increase referrals into excersise and activity programmes	Active Rutland	**Adrian Allen**				Mar-24		•Implement Healthy Conversations Training (Making every							
2.2.2	**Prevention**	Improve residents health education/awareness and increase confidence to self-care			**Adrian Allen**				Mar-24									
2.2.3	**Prevention**	Ensure our workforce are trained and empowered to have healthy conversations	Implement Health Conversations training (Make Every Contact Count MECC+). Include professionals working with housebound individuals		**Adrian Allen**				Jun-23									
2.2.4	**Prevention**	Promote and support residents to achieve or maintain a healthy weight.	• Develop a whole systems approach to healthy weight, factoring in actions across different strands including the food environment, school setting, workplaces and physical activity. • Map gaps and opportunities across the strands to inform priorities and specific actions to be delivered.		**Adrian Allen**		Y		Mar-26									
2.2.5	**Prevention**	Support the wellbeing of the armed forces community through the wider Rutland service offer.	• Review and support all parts of the armed forces community to improve their health and wellbeing outside of MoD support, with specific actions delivered within the Staying Healthy Partnership • Align with healthcare actions already progressing within the Rutland Health Plan.		**Adrian Allen**		Y		Mar-25									
2.3	**Prevention**	**Encourage and Enable up take of Preventative Health Services**			**Adrian Allen**													
2.3.1	**Prevention**	Increase uptake of immunisation and screening programmes	Completion of health equity audits on uptake of immunisation and screening programmes across Rutland.		**Adrian Allen**		Y		Mar-23									
2.4	**Prevention**	**Maintaining and Developing the Enrivonmental, Economic and Social Conditions to Encourage Healthy Living for All**			**Adrian Allen**													
2.4.1	**Prevention**	Ensure there is a health and equity focus in all policies	Obtain commitment of relevant organisations in Rutland to building in consideration of health and equity in their day to day.		**Adrian Allen**		Y		Mar-24									
			Health Impact Assessments (HIAs) or Integrated Assessments for decision making and policy development		**Adrian Allen**													
			Support decision makers with trainng and development on Health in all Policies and the wider determinants of health.		**Adrian Allen**													
3.1	**Living with Ill Health**	**Healthy Ageing - Living Well with Long-Term Conditions, Reducing Frailty and Falls Prevention**			**Emmajane Hollands**													
3.1.1	**Living with Ill Health**	Ensure patients are at optimum pre-operative fitness, including an holistic assessment of needs and enviroment requirements.	Initiate Below the Waist Pre-Hab pilot in Rutland		**Emmajane Hollands**					Jun-23	•Requires evaluation							
3.1.2	**Living with Ill Health**	Monitor deterioration of residents' health.	Use NEWS2/Restore Mini and Whzan to monitor the health and possible deterioration of a cohort of residents, to identify deterioration early, initiate appropriate treatment and reduce avoidable hospital admissions	RCC	**Emmajane Hollands**						•Requires evaluation							
3.1.2	**Living with Ill Health**	Ensuring people in rural communities have access to peer support	Initiate a befriending service for isolated individuals, delivered by Age UK	Age UK	**Emmajane Hollands**													
3.2	**Living with Ill Health**	**Support, Advice and Community Involvement for Carers**			**Emmajane Hollands**													
3.2.1	**Living with Ill Health**	Improve the identification of unpaid carers within our communities.	Increase the number of unpaid carers identified.	RCC	**Emmajane Hollands**		Y					•Numbers of carers registered in practice systems.						
			RCC and PCN staff to use the LLR Care Record to integrate carer		**Emmajane Hollands**													
3.2.2	**Living with Ill Health**	Integrate information processes and pathways with local partners, ensuring carers have access to the right information	Creation of a leaflet that can be given to carers on patient discharge.	RCC	**Emmajane Hollands**													
3.3	**Living with Ill Health**	**Healthy, fulfilled lives for people living with Learning or Cognitive Disabilities and Dementia**			**Emmajane Hollands**													
3.3.1	**Living with Ill Health**	Ensure that residents with LD are regularly monitored and support is provided early to enable them to live healthy lives.	Increase the number of LD health checks being completed		**Emmajane Hollands**		Y					•Number of LD health checks completed						
3.3.2	**Living with Ill Health**	Provide care and supprot for people with LD closer to home. Enabling them to stay in Rutland with access to friends and family.	Scope what is needed and potential resource requried.	RCC	**Emmajane Hollands**		Y					•Number of out of area placements for Rutland residents with LD.						
3.3.3	**Living with Ill Health**	Support people with LD and/or Autism to access volunteering, work and/or education oppurtunities	Scope current position and if there is a target to meet. This will inform next steps.	RCC	**Emmajane Hollands**		Y					Increase the % of our LD and Autistc community in employment						
3.3.4	**Living with Ill Health**	Increase Dementia diagnosis rates in Rutland and improve the dementia pathway experience for patients and their family/carers.	Pilot a Proactive Care Dementia Project to support diagnosis closer to home.	ICB	**Emmajane Hollands**		Y					•Increase in dementia diagnosis rates in Rutland •Increase in patients and carers offered follow-up support.						
		Increase Dementia diagnosis rates in Rutland and improve the dementia pathway experience for patients and their family/carers.	Reinstigate the Memory Clinic at Rutland Memorial Hospital	RCC	**Emmajane Hollands**		Y											
		Increase Dementia diagnosis rates in Rutland and improve the dementia pathway experience for patients and their family/carers.	As part of the pilot, trial a wrap-around clinic for Rutland patients attending the Memory Clinic.	RISE	**Emmajane Hollands**		Y											
4.1	**Equitable Access**	**Increase the Availabilty of Diagnostic and Elective Health Services Closer to Home**			**Charlie Summers**													
5.1	**Growth & Change**	**Planning and Developing "Fit for the Future" Health and Care Infrastructure**			**Adhvait Sheth**													

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5.1.1	Growth & Change	Work with local/neighbouring Integrated Care Systems (ICSs) partners to share information to ensure in border and cross border population impacts are consistantly understood	•LLR CCGs PCES Population Model that shows impact on health infrastructure as a result of growth in the Rutland border • Documented population health impact of Stamford North Housing Developments outside of the border shared with partners • Routine joint dialogue between partners •Initial baseline of Non Local plan impact by Rutland LSOA • Ongoing 6 monthly reviews and updates of latest LSOA level impact vs initial baseline position •RCC and Neighbouring LPA approach to prioritisation and CIL allocation plans is in place and visible to partners •Agreed population model with robust methodology that can be used to support dynamic impact modelling by LSOA •Work with Rutland County Council to facilitate development of a set of options for a Health Campus /Medi-tech trials facility	ICB	**Adhwait Sheth**			Sep-22	Apr-24			•Aligned fit for the future plans with neighbouring ICS's • Healthcare is confirmed as priority for infrastructure funding and recieved adequate support in line with growth and impact • Understanding of current CIL funding including trajectory of allocations and any unallocated funding • Understand where Healthcare sits in wider prioritisation of infrastructure support • Agreed updated Information requirements and timely sharing with health partners to inform dynamic modelling •RCC to undertake a Community Infrastructure Levy (CIL) policy review with due consideration of enabling greater support for local healthcare infrastructure to ensure this is a key priority area of support going forward •Health Strategic Partners Involvement in CIL review process and receipt of report on new policy implications				•Risk that RCC does not approve the RMH Enhanced Procedure Suite Business Case at Full Council Meeting in September 2023 meaning that plans to bring care closed to residents may not be delivered. •Prioritisation of CIL due to limited funding against number of schemes may result in some not being supported	•None identified with no NHS Capital available. •Continue strategic dialogue around priorities for CIL/look at economies fo scale/alternative funding sources.	Green
6.1	Dying Well	**We want people to feel comfortable and confident in talking about, and planning for, the end of life.**			**Sammi Le Corre**													
6.1.1	Dying Well	To scope historic comms and engagement activities and develop next steps for a local approach.	•Gain access to the insight hub and share findings with Comms and Engagement lead. •Interrogate what is available and plan local approach.	RCC	**Sammi Le Corre**	Feasibility		Jan-24	Apr-24		Develop a comms and engagement programme centred around a shift in culture when it comes to talk about end of life.	A rolling rota of communications out to the Rutland public and service providers. A possible impact on end of life conversations occuring in services.						Green
6.1.2	Dying Well	Develop comms plan linking into LLR PEoLC Task Force schedule for the LLR End of Life Strategy		RCC	**Sammi Le Corre**	Feasibility		Jan-24	Jul-24		Aligning the comms and engagement work being completed by the LLR PEoLC Task Force with the programme in Rutland. Including the LLR PEoLC strategy engagement.							Green
6.2	Dying Well	**We want to make it possible for people to die in their place of choice**			**Sammi Le Corre**													
6.2.1	Dying Well	Develop a local data set to support our understanding of end of life in Rutland.	Monitor place of death data.	ICB	**Sammi Le Corre**	Not started		Apr-24			Align metrics with the LLR Task Force data work stream. Where we have metrics already, look to begin monitoring these through the IDG.							Grey
6.2.2	Dying Well	Scope if conducting an "After Death" audit is feasible considering clinicians availability and the needs of patients.	Discuss with Dying Well and LLR Task Force clinical leads to ascertain what is necessary and would this excersise add value.	ICB	**Sammi Le Corre**	Not started		Apr-24										Grey
6.3	Dying Well	**We want to ensure people are support throughout their journey**			**Sammi Le Corre**													
6.3.1	Dying Well	Develop our understanding of what the end of life/palliative care pathway looks like for Rutland patients	Hold a pathway mapping workshop	ICB	**Sammi Le Corre**	Delivery		Apr-24										Green
6.3.2	Dying Well	Increase the completion of ReSPECT planning for appropriate patients	Base line end of life care planning in Primary Care	ICB	**Sammi Le Corre**	Feasibility		Jan-24										Green
6.3.3	Dying Well	Improve identification of residents who would benefit from a conversation about end of life planning	Develop a risk stratification approach for end of life care and support for our population	ICB	**Sammi Le Corre**	Feasibility		Apr-24										Grey
6.3.4	Dying Well	Improve identification of residents who would benefit from a conversation about end of life planning	Identifty Rutland's "2%".	ICB	**Sammi Le Corre**	Feasibility		Jan-24										Grey
6.4	Dying Well	**We want to ensure that carers are fully supported in their role**			**Sammi Le Corre**													Grey
6.4.1	Dying Well	Develop our understanding of what services are available for carers of people who are towards the end of their life.	Review the service carers have access to, with a focus on carers of people who are near the end of their lives.	RCC	**Sammi Le Corre**	Feasibility												
6.5	Dying Well	**We want to make it possible for all those bereaved to have access to bereavement support, if they want it.**			**Sammi Le Corre**													Grey
6.5.1	Dying Well	Develop our understanding of bereavemement services	Review bereavement support services. Ensuring to consider the Veteran Communities.	RCC	**Sammi Le Corre**	Feasibility												Green
6.6	Dying Well	**We want to implement the Marie Curie (2022) recommendations**		ICB	**Sammi Le Corre**	Delivery	Y	Dec-23	Jan-27									Green
6.7	Dying Well	**We want to implement the End of Life JSNA (2022) recommendations**		ICB	**Sammi Le Corre**	Delivery	Y	Dec-23	Jan-27									Green
6.8.1	Dying Well	**We will work to the Palliative and End of Life Care Ambitions Framework**	Review our maturity against the ambitions maturity matrix	ICB	**Sammi Le Corre**	Delivery	Y	Dec-24	Jan-25									Grey
6.8.2	Dying Well	**We will work to the Palliative and End of Life Care Ambitions Framework**	Continue to add necessary actions to the detailed action plan	ICB	**Sammi Le Corre**	Delivery	Y	Jan-25	Mar-25									Grey
7a.1	Mental Health	**Supporting Good Mental Health**			**Mark Young**													
7a.1.1	Mental Health	Increase access to perinatal Mental health support services, wherever Rutland women have chosen to give birth.	•increase our understanding of the Perinatal Mental Health Service. •Develop an action plan to increase the number of people accessing this service.	LPT	**Mark Young**	Delivery						An increase in the number of people accessing perinatatl services						Green
7a.1.2	Mental Health	Understand the gaps in service reported by service users where children and young people need help with their mental health but have not reached the thresholds for mainstream mental health services, or have reached thresholds but are on waiting lists for CAMHS services, and ways to address these, including via new local services and low level/interim support offers delivered through library and wider commissioned and community services. Factor in anticipated future changes e.g. end of Resilient Rutland funding for children and young people's counselling in 2023.	•Align priorities and actions with the Rutland Children and Young People's Strategy 2022/25 •Analyse recent surveys, such as the Family Hub consultation to inform next steps.	LPT/PH	**Mark Young**	Delivery	Y	Mar-23	Apr-25			Gaps identified and solutions put in place.						Green
7a.1.3	Mental Health	Increasing local resource to respond to children and young people's mental health need through implementation of Key Worker role, Mental Health support workers support in Schools, contribution of Resilient Rutland programme (funding ending Jan 23). Support to families on waiting lists and for those requiring support but not reaching CAMHS thresholds. Parallel support for parents and carers of children and young people with mental health needs.	•Improve our understanding of the gaps and what children and young people are telling us about what support they need. •Launch of MySelfReferral service to allow CYP to self-refer or seek support for their mental health	RCC,VCS, ICB	**Mark Young**	Delivery	Y	Mar-23	Apr-25			Increased resource available for children and young people.						Green
7a.1.4	Mental Health	Transformation project for Rutland- Ensuring Mental Health services are delivered in Rutland including; a)Supporting services via funding bids: (Mental Health VCS grant scheme – crisis café - second round June 2022, Small grants - £3k - £50k - second round to open June 2022, OPCC commissioner safety fund – up to £10k) b)A clear co-designed approach to supporting farmers' and other individuals' needs linked to rurality c)A clear co-designed approach to better meeting veterans' and armed forces families' mental health needs d)A clear local plan to better coordinate care across neighbouring service areas	•Promote available grants and funding oppurtunities with all parthers and support where necessary. •Creation of MH pathway, which can be used in GP surgeries. •Engagement with the veterans and farmers communities. Exploring what we can do to support those who have access issues due to rurality.	LPT/ICB/RCC	**Mark Young**	Delivery	Y					•Funding bids are best suited to the current needs of our population and are able to demonstrate effective results. •The MH pathway is used within the GP surgeries and is recognised as the pathway to follow when there is a mental health support need. •The farming and veteran communities are working more closely with us to better understand their needs.						Green

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7a.1.5	Mental Health	Increased response for low level mental health issues. Promotion of recognised self-service self-help tools and frameworks notably Five ways to wellbeing. Expansion of capacity in local low level mental health services and closer working between involved local agencies and services, including in the voluntary and community sector and peer support, so more people access help sooner in their journey. Opportunities to develop resilience skills, e.g. through the Recovery College.	•Increase capacity in local low-level mental health services. •Establish closer working between involved agences/services, including the voluntary and community sector and peer support.	PCN/LPT/RCC/VCS	Mark Young	Delivery						Closer working relationships bettwen agencies/services. Resulting in people receiving the correct time at first contact. Reducing their need to repeat their stories.				Increase in referals to the RISE team for MH support. Concerns over capacity and staff burn-out.	There are ongoing talks to look at allocation of the BCF funding to recruit a new social prescriber/low level mental health support worker to help support those experiencing low-level mental health support needs.	Green
7a.1.6	Mental Health	Deliver on the Long-term plan objectives for mental health for the people of Rutland: a)Move towards an integrated neighbourhood based approach to meeting mental health needs in Rutland b)Annually assessing the physical health needs of people with Serious Mental Illness (SMI) in Rutland c)Aiding people with serious mental illness into employment d)Delivering psychological therapies (IAPT - VitaMinds) for individuals as locally as possible to Rutland	•Establish a neighbourhood mental health group. •Introduce a new MDT specifically for community based MH support. •LPT MH Facilitator role to support people within Rutland diagnosied with an SMI (includes an annual health check). •LPT Employment Support Service Individiaul Placement and Support Lead, to support people with SMI into employment. •Work more closely with NHS LLR Talking Therapies to ensure our local population are accessing their services.	LPT/PCN/RCC/VitaMinds	Mark Young	Delivery	Y					•Improved relationships and integrated wokring within Rutland's neighbourhood approach. •Increase in numbers of people diagnosied with an SMI receiving physical health checks. - National Target - 60% •Increase the numbers of people with SMI into employment. •Improved understanding of Rutland residents accessing NHS LLR Talking Therapies services.						Green
7b.1	Inequalties	Ensure addressing health inequalities is considered across planning and delivery of actions within the core priorities.	•Priority leads consider opportunities to address health inequalities within all action areas. •Insight from the health inequalities needs assessment is used to ensure population groups experiencing inequalities are supported. The needs assessment will inform new projects across the core priorities.		Mitch Harper	Delivery	Y											
8.1	Comms & Engagement	**Readiness to Deliver the Plan**			Alexandra Chamberlain													
8.1.1	Comms & Engagement	Ensure coordination of communications activity and mechanisms across partners	•Define & agree scope and coordinate with key priority leads system level communications activity and mechanisms – e.g. access to citizen panels. •Ensure linkage with other communication & engagement teams: RCC Communications team (Matt Waik), Sue Veneables (insights team)	RCC	Alexandra Chamberlain	Delivery		Mar-23				•Clarity regarding remit for the communications work programme. •Regular, productive, communication meetings.						Green
8.1.2	Comms & Engagement	Identify SMART goals and objectives for specific pieces of work	•Appoint leads to ensure delivery, measurement and review.		Alexandra Chamberlain	Delivery											Pending high level audit.	Green
8.2	Comms & Engagement	**Ensuring People have Access to the Information they need to Maintain their Health & Wellbeing and to Navigate Change Successfully**			Alexandra Chamberlain													
8.2.1	Comms & Engagement	Create a visual health and wellbeing brand for Rutland	•Coordinate with the ICB and places on what this brand is to be.		Alexandra Chamberlain	Delivery						Agreement on the brand.						Green
8.2.2	Comms & Engagement	Ensure residents are fully aware of the community and health and well-being offer in Rutland and understand how to access it.	•Develop and implement a multi-channel communication plan to enhance information for signposters and the public. Including distinct groups. Aligning with the work of the HWB and cater for those that are digitally exlucded or use cross-boarder services.	RCC/RIS	Alexandra Chamberlain	Delivery	Y		Jun-23			•Completed Health and Wellbeing Communication plan aligned with the HWB. •Expanded reach of communication campaigns, including social media followers, posts and shares. •RIS montly visitor figures. •Qualitative feedback on awareness of and access to services across Rutland.						Green
8.2.3	Comms & Engagement	Coordinate engagement mechanisms for Rutland's population.	•Improve Learning Disability Partnership Board •Rolling engagement events - Carers Week •Launch of self-referral portal. •Analysis of the Adult Social Care annual feedback survey •Update personalisation survey.	RCC	Alexandra Chamberlain	Delivery	Y		May-23			Agree to a coordinated approach at place.						Green
8.2.4	Comms & Engagement	Improve training oppurtunties, including behavioural insights and social media.	•Promote the digital inclusion network via the Rutland libraries. •Promote digital champions training, their resources (Learn my way) and the national data bank - https://www.onlinecentresnetwork.org/resources/health	RCC	Alexandra Chamberlain	Delivery	Y		Mar-24			Number of digital champions (waiting training to be rolled out.)						Green
8.2.5	Comms & Engagement	Build digital confidence in Rutland	•Coordinate with digital champions in the community to design and promote the self service portal. •Link to local actions and consult with leads	RCC	Alexandra Chamberlain	Delivery												Green
8.2.6	Comms & Engagement	Enhance the Rutland Information Service (RIS)	•Develop RIS social media presence - bringing content to the online places people visit. •Website technical code refresh for accessibility and ease of use via mobile phone. •Initiate website usability testing to increase the effectiveness of RIS content. •Enhance the reach and scope of the Rutland Information Service (RIS) via multiple channels (web, social media, print). •Update RIS online plaftorm to meet accessibility standards and improve mobile device operability (most users access RIS via mobile device). •Enhance online functionality of RIS for clearer routes into preventative services. -Map digital confidence, to consult.		Alexandra Chamberlain	Not started	Y										Grey
8.3	Comms & Engagement	**Involving the Public and Professional Stakeholders in Service Design and Change**			Alexandra Chamberlain													
8.3.1	Comms & Engagement	Develop a local engagement approach	•Create an enagement toolkit for partners to use, drawn from wider best practice. To include: •Approach to compensation where required. •Existing groups who could be engaged. •How to reach less often heard groups and groups facing inequalities.		Alexandra Chamberlain		Y											Green
8.3.2	Comms & Engagement	Engagement Training			Alexandra Chamberlain													Grey
8.3.3	Comms & Engagement	Promote commitement to the Think Local Act Personal, Making it Real framework			Alexandra Chamberlain													Green
8.4	Comms & Engagement	**Communication Activities to Support Access and Navigation of Local Services**			Alexandra Chamberlain													
8.4.1	Comms & Engagement	Training and education for the general public on the use of the NHS app for booking appointment and ordering medication			Alexandra Chamberlain													
8.4.2	Comms & Engagement	Create a how to guide/video for practice websites to show patients how to download and use the NHS app			Alexandra Chamberlain													
8.4.3	Comms & Engagement	Promotion of the changing structure of local primary care and the new roles available through the additional roles reimbursement scheme.			Alexandra Chamberlain													
8.4.4	Comms & Engagement	Link in with LLR ICB comms to inform and influence planned LLR campaigns in 2023/24			Alexandra Chamberlain													
8.4.5	Comms & Engagement	Recruit dedicated Digital Inclusion and Communications resources to support development, access, and navigation of e.g., Patient Online System/NHS App services/remote consultations/ practice websites (22/23)			Alexandra Chamberlain													
8.4.6	Comms & Engagement	Creation of an infographic to demonstrate the anticipated inpact of the Rutland Health and Wellbeing Strategy and what that will mean to patients.			Alexandra Chamberlain													

LLR ICB: Rutland Place Healthcare Plan (Focus Areas Delivery Tracker) Jan 2024 - Dec 2024

LLR 5YP Allignment	Rutland Focus	Healthcare Plan Action	Objective (s) (Please also include in year products and/or deliverables that will result from this Action)	ICB Lead	Start Date	End Date	Top Milestones and Critical Activities (Next 12 months - Jan 2024 - Dec 2024	Key Progress / Achievements	Key Next Steps / Actions	Top Risks & Mitigations	Overall RAG Status
3. Right Care, right time, right place	Older Peoples Health	Link Urgent Care Coordination Hub and Rutland Care Homes that are enabled to monitor health digitally (Whzan Enabled)	With the linking of care homes that were involved in the Whazan pilot it is hoped that there can be a reduction in convaynces to A&E by intervention of the Urgent Care Co-ordination hub and this can lead to more referrals to alternative pathways.	Charlie Summers/MC/JM	Apr-24	Mar-25	• Agreement from System Exec for the expansion of the urgent care co-ordination hub pathway. • Agreement from Oakham Medical Practice to participate in the pilot. • Baseline of conveyance rate from care home to emergency admission for particpating care homes. • Agreement of pathway to be followed • Commencement of pilot	• Currently awaiting proposal to go to System Exec for additional funding for the expansion of the Urgent Care Co-ordination Hub pathway. Initial scoping work with Oakham Medical Practice has been put on hold until this has been agreed	• Paper to go to System Exec at the end of January for discussion.	• Expansion of pilot is not agreed at System Exec and additional funding not identifed.	Not Started
2. Keeping People Well	Older Peoples Health	Proactive Care @ Home Frameworks for managing Cardiovascular Disease Long Term Conditions	Embedding of the proactive care @ home frameworks in primary care.	Sammi Le Corre / Jess Lucas	Jan-24	Mar-25	•Scoping the project •Working with Rutland practices to understand current use of the frameworks. •Increasing use of the frameworks	•Work not yet started	•Meet with Jess Lucas - previous lead for embedding the framsworks and identify next steps	•No risks currently	Not Started
2. Keeping People Well	Older Peoples Health	Proactive identification of Frail / Housebound patients with dedicated Care Co-ordination Support	By identiifying frail and housebound patients through the use of population health management, those that may be at increased risk of hospital admission and managing that risk by effective care planning and dedicated care co-ordination, therefore hopefully reducing risk of deterioration and /or risk of admission.	Charlie Summers	Apr-23	Mar-24	• Identification of a group of frail and housebound patients in Rutland who are at increased risk of a hospital admission through the use of population health management and risk stratication. • Baseline of number of patients without a care plan • Identification of patients within the cohort group that have a care plan in place.	• This project has been in place within Rutland Health PCN since April 2023 as a part of their inequalities plan. An update on number of patient identified and who have a care plan has been requested.	• Data to be collected at the end of 2023/24 and a decision made with to continue approach.	• Implemented as a part of the PCN DES in 2023/24.	Green
3. Right Care, right time, right place	Older Peoples Health	Priority phone lines for vulnerable patients such as Palliative care patients, carers and housebound patients in Rutland	As a part of the capacity access and improvement plan, creation of a dedicated phone line for patients identified as vulnerable ensuring they can quickly get through to the practice if required. therefore reducing potential for escalation and reduce the risk of emergency admission and improved outcomes.	James Burden / Charlie Summers	Jul-24	Jun-25	• As a part of the capacity access and improvement plan this was indetified as an area of need as well as a part of the integrated community services workshop in November 2023.	• Update with regards to progress requested from Rutland Health PCN.	• Seek clarity as to whether this element of the Capacity Access and Improvement Plan has been implemented.	The PCN has not had a PCN Manager in post since November 2023. The new PCN manager is due to commence in February 2024.	Amber
2. Keeping People Well	Older Peoples Health	Develop Population Health Management and Multi Disciplinary Team working approach within Rutland INT	Idenitfying a cohort of patients that are most of risk for a deterioration in their condition by using population health management. Case managing these patients on a regular basis via discussion at a multi-disciplinary team approach.	Emma Jayne Perkins / James Burden / Sammi Le Corre	Aug-24	Jul-25	•Developing a PHM approach. •Obtaining approval of approach from Rutland's Health and Care Collaborative. •Approval of project management resource •Project scoping and initiation	•PHM approach proposal taken to Health and Care Collaborative in December 2023 - approved and RCC want to invest in a project management role to drive the work forward.	•Waiting on recruitment of the project management resource	•Delay in recruitment	Not Started
2. Keeping People Well	Older Peoples Health	Continuation and evaluation of proactive care project that focuses on Dementia (Contributing to the increase of our lower than expected diagnosed rates of Dementia)	Rutland's was idenitfied as an outlier for the dementia diagnosis rates. As a part of the anticipatory care project, Rutland has re-established the Memory Clinic at RMH and also combines this with a wrap around service provision provided by the Admiral Nurse, PCN Care Co-ordinator and consultant.	Sammi Le Corre	Jul-23	On-going	•Write up Proactive Care Dementia Pilot evaluation with recommendations. •Agree next steps and service offer development •Gain approval for BCF monies to be used for a Social Prescriber within the RISE team to embed the programme as BAU.	•The dementia diagnosis rate in Rutland has been increasing steadily since the commencement of the project. •The Health and Wellbeing noted the progress made by the project in January 2024	•Write up complete pilot evaluation.	•BCF funding will not be approved for the Social Prescriber role	Green
8. Women's Health, including Maternity	Access to Health Services	Assess feasibility for a Women's Health Hub that covers Rutland *(Women's Health Hub - WHH)*	To meet national requirements in having a women's health hub in each ICB (nationally) as set-out in the Women's Health Strategy 2022 and NHSE deliverable.	Katie Connor/ James Burden	Mar-24	Mar-26	• Mobilsation of Rutland's Women's Health Hub • Implementation of Rutland's Women's Health Hub • Reporting schedule (including reporting into the Women's Partnership bi-monthly) • Evaluation(?) - Depends on timescale • Links into the Women's Engagement Strategy	• Rutland's Health Hub modelled and agreed through ICB sign-off routes (covering Melton) • Rutland Health Hub clinical and operational leads engaged in Women's Hubs Delivery Group with wider LLR WHHs • • •	• Await further information on timelines due to challenge sighted in column N • Opportunities for existing integration and engagement with women around hubs • Opportunities for wider workforce and public upskilling on women's health • Scope wider Women's National deliverables for Rutland •	• WHH timelines delayed by ICB. Further work ongoing to determine benefits realisation and funding models to re-present at SCG. KC and MT to meet with EMT colleagues to discuss 11/01/24. Challenge sighted in Women's risk/issue register which is flagged to ICB board and subsequent partner boards. ICB Women's Team working hard to engage and provide progress updates to partners and WHH leads to ensure expctations are managed as well as good working relationships.	Amber
4. Integrated Community Health and Wellbeing Hubs	Access to Health Services	Specify requirements for a local Health and Wellbeing Hub	A priority of the Rutland Joint Strategic Health and Wellbeing Strategy is to expand and improve the experience of receiving care locally within Rutland so that the growing population can be better cared for nearer home, minimising the length of time spent in acute hospital settings, and where possible, avoiding acute hospital admissions in the first instance. This can be achieved through collaborative opportunities to work with partners across health and care to develop a more holistic offer in Rutland with the right mix of services through the development of a local Health and Wellbeing Hub inclusive of same day access provision at Rutland Memorial Hospital.	Debra Mitchell / Kim Sorsky /	Jan-24	Sep-25	• Develop a clear partnership understanding of local Assets / Services in scope of hub developments • Identify key service dependencies across the healthcare plan • ? • ? • ?	• Workshop took place to start documentation of all key assets and services that are in scope • ? • ? • ? • ?	• Firmer summary of the model of care and associated infrastructure requirmements • ? • ? • ? • ?	•Only certain amount of Capital is available therefore everything will not be possible, prioritisation and sequencing will be key •Political support will be key to approval for any proposals / business cases	Amber
3. Right Care, right time, right place	Access to Health Services	Primary Care Capacity and Access Plans	The Capacity Access and Improvement Plan aim is to provide the space, funding, and licence for PCNs to focus on making improvements to help manage demand and improve patient experience of access, so patients can access care more equitably and safely, prioritised on clinical need. It also supports the accurate recording of general practice activity, so that improvement work can be data-led. PCN's will be assessed against three key areas, these are patient experience, ease of access and demand management, and accuracy of recording in appointments. The PCN has implmented a number of initaitives throughout 2023/24 that have been baselined and improvements will be measured as a part of the evaluation in 2024/25.	Charlie Summers	Apr-23	Mar-24	• Design and produce a Capacity Access and Improvement plan that supports improvement to demand and capacity and patients experience of care. • Submission of plan to the ICB for approval. • Approval of submitted plan. • Baseline measures taken for all indicators in the plan. • Mid year review of plan implementation.	• Baseline measures taken for all key indicators submitted as a part of the plan. • Redesign of all four individual practices websites to support ease of use and stanardisation in line with NHSE guidance. • LLR patients survey launched on behalf of all LLR practices to ascertain patients views on accessibility and satisfaction. • Mid year review of Capaccity Access and Improvement Plan undertaken. • Final report submitted with performance indicated against all of the areas identified.	• Update from the PCN requested on progress to date with the Capacity and Access Improvement Plan • Websites updated, standardised across all four practices and re-launched. • Mid year review undertaken and assurance given with regards to progress to date.	• Rutland PCN manager left post at the end of October and the new PCN Manager will not be in post until February 2024. Concern that momentum may be lost with regards to implementation of the Capacity Access and Improvement Plan in the short term.	Green
3. Right Care, right time, right place	Access to Health Services	Expand local Elective Care / Diagnostics Provision		Jo Clinton / Deb Mitchell			• ? • ? • ? • ?	• ? • ? • ? • ?	• ? • ? • ? • ?	• ? • ? • ? • ?	Not Started
7. Mental Health	Access to Health Services	Help local people build connections through Rural Coffee Connect mobile provision delivered at local community sites		Mark Young			• ? • ? • ? • ?	• ? • ? • ? • ?	• ? • ? • ? • ?	• ? • ? • ? • ?	Not Started

LLR ICB: Rutland Place Healthcare Plan (Focus Areas Delivery Tracker) Jan 2024 - Dec 2024

LLR 5YP Allignment	Rutland Focus	Healthcare Plan Action	Objective (s) (Please also include in year products and/or deliverables that will result from this Action)	ICB Lead	Start Date	End Date	Top Milestones and Critical Activities (Next 12 months - Jan 2024 - Dec 2024	Key Progress / Achievements	Key Next Steps / Actions	Top Risks & Mitigations	Overall RAG Status
3. Right Care, right time, right place	Older Peoples Health	Link Urgent Care Coordination Hub and Rutland Care Homes that are enabled to monitor health digitally (Whzan Enabled)	With the linking of care homes that were involved in the Whazan pilot it is hoped that there can be a reduction in convaynces to A&E by intervention of the Urgent Care Co-ordination hub and this can lead to more referrals to alternative pathways.	Charlie Summers/MC/JM	Apr-24	Mar-25	• Agreement from System Exec for the expansion of the urgent care co-ordination hub pathway. • Agreement from Oakham Medical Practice to participate in the pilot. • Baseline of conveyance rate from care home to emergency admission for particpating care homes. • Agreement of pathway to be followed • Commencement of pilot	• Currently awaiting proposal to go to System Exec for additional funding for the expansion of the Urgent Care Co-ordination Hub pathway. Initial scoping work with Oakham Medical Practice has been put on hold until this has been agreed	• Paper to go to System Exec at the end of January for discussion.	• Expansion of pilot is not agreed at System Exec and additional funding not identifed.	Not Started
3. Right Care, right time, right place	Access to Health Services	Develop the clinical model for local same day access at Rutland Memorial Hospital	Local development of a model for same day access that best meets the needs of the population of Rutland. This includes a review of minor illness and minor injury needs. Once a model has been formulated this will go out to consultation in preparation for procurement and mobilisation in April 2025.	Jeremy Bennett / Charlie Summers	Apr-23	Mar-25	• Undertake a review of all current same day service provision for Rutland including GP appts, NHS 111, CPCS, urgent care and MIU including data for out of county providers. • Formulate a same day access working group and meet to go through the data. • Complete a case for change document for Rutland and get it signed off. • Request to extend current urgent care contracts to to go to SCG. • Write an options appriasal paper that outlines the key future model/s for future consideration. Go out to formal consultation on future model of care for Rutland's same day access.	• A data collation and reiew has been undertaken that brings together all the services that either support or deliver same day access to Rutland patients. • A Case for Change process was followed to identify current and future patient needs for Primary Care in rutland was developed and submitted to the ICB in September 2023. • A workshop was held with key Rutland stakeholders to assess provision and identify the need for same day services in Rutland. • Individual follow up meetings were held wiht providers (inlcuding DHU) to inform potential model development. • Current work is ongoing to produce an options appraisal document for same day access from 25/26, to be submitted for discussion at a second workshop	• Await outcome of request to extend urgent care contracts for 24/25 to enable consultation and pathway redesign to be undertaken. • Await confirmation of the consultation timescales to be advised by communications and engagement team. • Continue to further develop the various options to be included in the options appraisal. • •	• Anticpated that the liklihood of an election may bring additional delay due to purdah rules and regulations. • The timescale of the extension of the current hub provision is unknown at present • ? • ?	Amber
N/A	Armed Forces Community	Engagement with Kendrew Barracks to develop relationships with Defence Medical Services leads and to develop understanding of key areas of need		Debra Mitchell / Adhvait Sheth	Jan-24	Mar-25	• ? • ? • ? • ?	• ? • ? • ? • ?	• ? • ? • ? • ?	• ? • ? • ? • ?	Green
1. Preventing Illness	Armed Forces Community	Promote NHS Armed Forces support services (OPTIMAL Model) and referrals locally Inc. through Joy platform and local GP accredited practices	To increase identification of Veterans / AFC in local Primary Care services to improve local recording and access to services. To ensure that the full range of Optimal services including OpCommunity are available on the Joy system. Monitor referrals and their sources that are available through the Insigts available on the Joy Platform to ensure there is some activity from Rutland services. Raise awareness within the AFC of the need to self identify as a Veteran when accessing services in Rutland	Emma Jayne Perkins / Adhvait Sheth / Ian Reynolds	Jan-24	Mar-25	• To add full range of Optimal model of services as service tiles onto the Joy platform ensuring that these are visible to services in Rutland. • To review referrals and sources on a quarterly basis to inform any targeted engagement or communicatiom to drive up appropriate use • Work with local AF covenant lead and local welfare team Vterans channels to raise awareness of the benefits for Veterans to self identify upon accessing services • To share AFC e-learning guides with local INT / operational teams so that there is an awarensss of this community	• All Optimal Model services are live tiles on Joy platform • ? • ? • ? •	• Run a first quarter report to understand levels of usage and whether any patterns of access • ? • ? • • ?	• ? • ? • ? • ? • ?	Green
3. Right Care, right time, right place	Armed Forces Community	Implement LLR Armed Forces OpCOMMUNITY (SPOC) pilot for Armed Forces Families and Veterans and Communicate this across Rutland and neighboring areas.	Delivery of an ICB commissioned single point of contact for the AFC starting by Q3 2023/24, that can be accessed via email and telephone. Development of specific communication material to raise awareness of the service across LLR. Undertake a Local and regional evaluation of service during 2024/2025 to inform future ICB sustainability options for 2025/2026.	Adhvait Sheth	Sep-23	Mar-25	• Agreed funding in place and carry over of finances is accomodated by finance teams to ensure delivery upto Dec 2024 in current form. • Communication material is produced and shared across LLR stakeholders. • Local evaluation process commences and report of findings is produced (commence July 2024) • LLR ICB EMT agree by Q3 2024/25 a sustainabe route for enabling access to services for AFC, beyond national pilot funding	• OpCommunity went live in Sept 2023 • Communication material shared in Nov 2023 with local Welfare Teams, IDG stakeholders inc HW Rutland for wider dissemination aross Rutland • Finance transfers have been clarified to ensure delivery unto Dec 2024. LPT are clear that they need to ensure carry over into the 24/25 raher than the ICB.	• Local evaluation to commence not earlier than July 2024 with a view to an LLR ICB EMT paper in Sept 2024 with options and reccomendations	• Future options sustainability of local ways of working beyond NHSE funding will be important to sustained improvement for this community. Risk to continuity of care improvement and local discharge of due regard for health for this population. Mitigation for this includes local evaluation to inform benfits picture and also further increase GP accreditation and encourage as a route into Optimal service.	Green
2. Keeping People Well	Armed Forces Community	Develop Population Health Management and Risk Stratification capability around Veterans to support local Integrated Neighbourhood Teams	To enable the capability to have a distinct view of Veterans across LLR PHM and Risk Stratification Tool.	Mark Pierce / Adhvait Sheth	Jan-25	Jun-26	TBC	TBC	TBC	If Veterans status is not being recorded in Primary Care and other care settings then we will not see the benefits of this capability. Dependency on identification of Veterans in Primary Care and ensure is as close to prevelance as possible	Not Started
9.Children and Young People	Armed Forces Community	Strengthen joint working across borders to enable specialist health needs for 'service children' and those who access a general practice outside of Rutland to be assessed and met		TBC??			• ? • ? • ? • ? • ?	• ? • ? • ? • ? • ?	• ? • ? • ? • ? • ?	• ? • ? • ? • ? • ?	Not Started

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Public Health Outcomes Framework: Update for Rutland

February 2024

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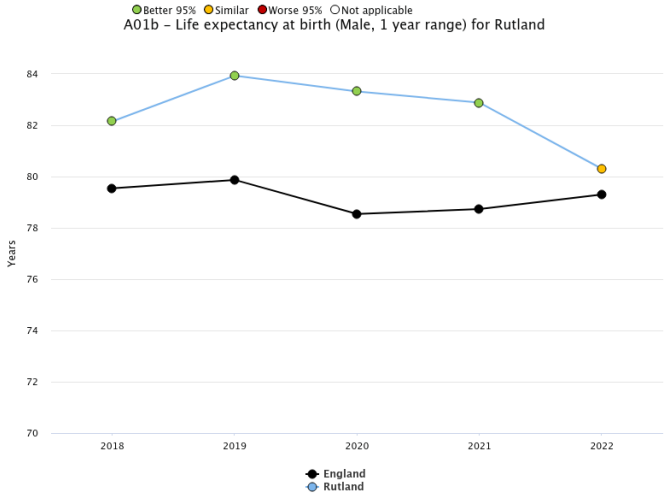
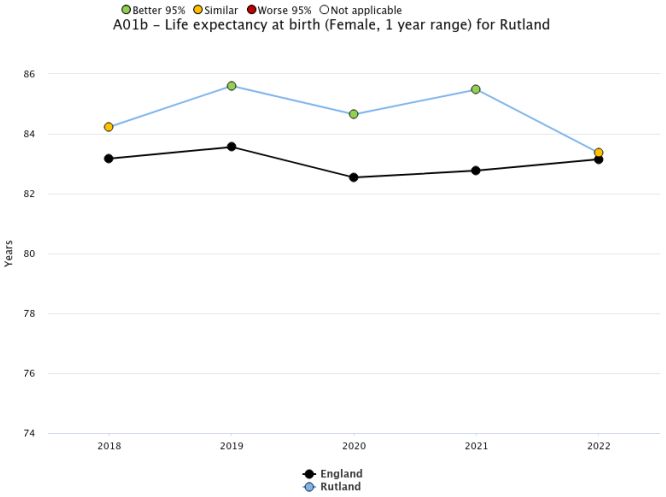
What have we learnt in the PHOF update?

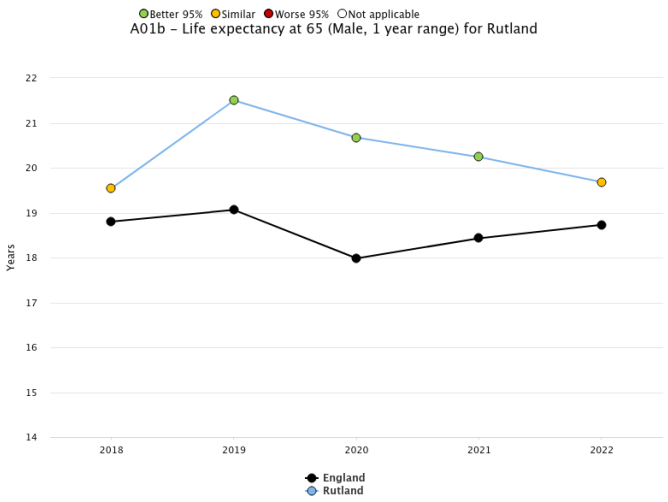
1. Life expectancy at birth has decreased in males and females, life expectancy at 65 has decreased in males and increased in females.

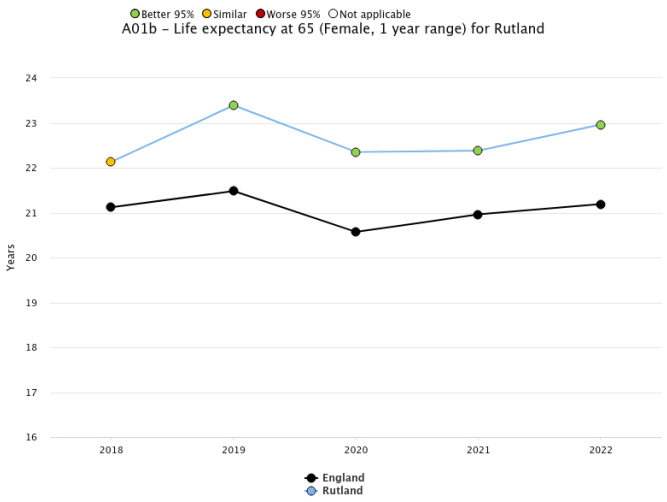
- In Rutland life expectancy at birth for males has decreased year on year since 2019. The figure decreased from 82.9 years in 2021 to 80.3 years in 2022. Rutland performed significantly better than the national figure between 2018 and 2021, in 2022 the Rutland figure is not significantly different to the national figure of 79.3 years.
- In Rutland life expectancy at birth for females has decreased from 85.5 years in 2021 to 83.4 years in 2022. Rutland performed significantly better than the national figure between 2019 and 2021, in 2022 the Rutland figure was not significantly different to the national figure of 83.2 years.





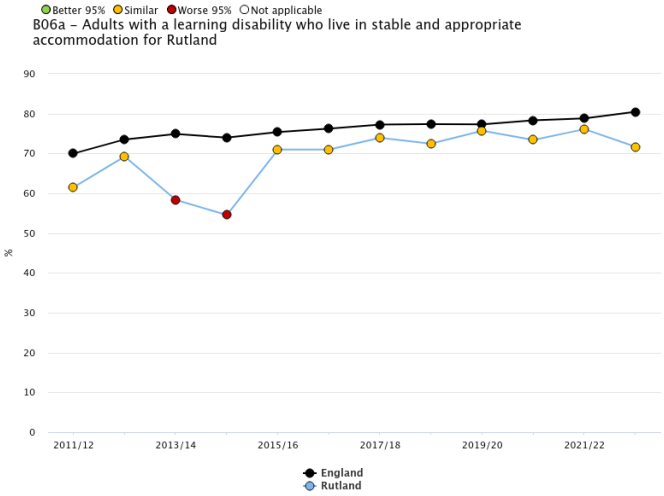
- Life expectancy at 65 for males has decreased year on year since 2019 in Rutland. The figure decreased from 20.2 years in 2021 to 19.7 years in 2022. Rutland performed significantly better than the national figure between 2019 and 2021, in 2022 the Rutland figure is not significantly different to the national figure of 18.7 years.
- Life expectancy at 65 for females has increased from 22.4 years in 2021 to 23.0 years in 2022. This continues to be significantly better than the national figure of 21.2 years. Rutland has performed significantly better than the national figure since 2019.





2. The percentage of adults with a learning disability who live in stable and appropriate accommodation continues to be similar to England.

- The proportion of adults with a learning disability who live in stable and appropriate accommodation in Rutland has decreased from 76.1% in 2021/22 to 71.7% in 2022/23. Rutland's performance continues to be similar to the national average of 80.5% for this indicator.
- Over the last five data points, the percentage of adults with a learning disability who live in stable and appropriate accommodation in Rutland has shown no significant change.



3. Overall school readiness is significantly better than the national average, while school readiness for children with free school meal status is significantly worse than the national average.

School Readiness: the percentage of children achieving a good level of development at the end of Reception

- The percentage of children achieving a good level of development at the end of Reception for Rutland has improved from 70.9% in 2021/22 to 75.5% in 2022/23. This is significantly better than the England average of 67.2%.

School Readiness: the percentage of children with free school meal status achieving a good level of development at the end of Reception

- The percentage of children with free school meal status achieving a good level of development at the end of Reception for Rutland has decreased from 55.9% in 2021/22 to 25.0% in 2022/23, this equates to a decrease of 15 children. In 2022/23 the Rutland figure is significantly worse than the England average of 51.6%.

School Readiness: the percentage of children achieving the expected level in the phonics screening check in Year 1

- The percentage of children achieving the expected level in the phonics screening check in Year 1 has increased from 79.2% in 2021/22 to 85.6% in 2022/23. For the first time since 2015/16, Rutland performed significantly better than the England average of 78.9% in 2022/23.

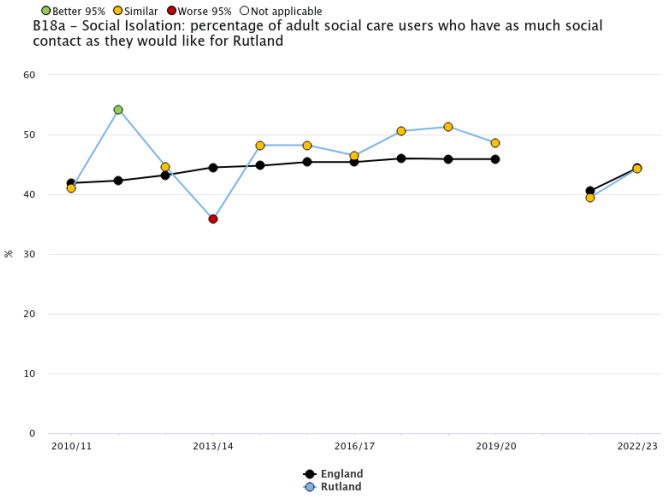
4. The rate of LARC excluding injections prescribed in Rutland is significantly above the national average.

- The total prescribed Long Acting Reversible Contraception (LARC) excluding injections rate in Rutland increased from 34.5 per 1,000 population in 2021 where performance was significantly below the national average, to 49.8 per 1,000 population in 2022 where performance was significantly above the national average.

5. Social isolation of adult social care users and adult carers in Rutland is not significantly different to the national average.

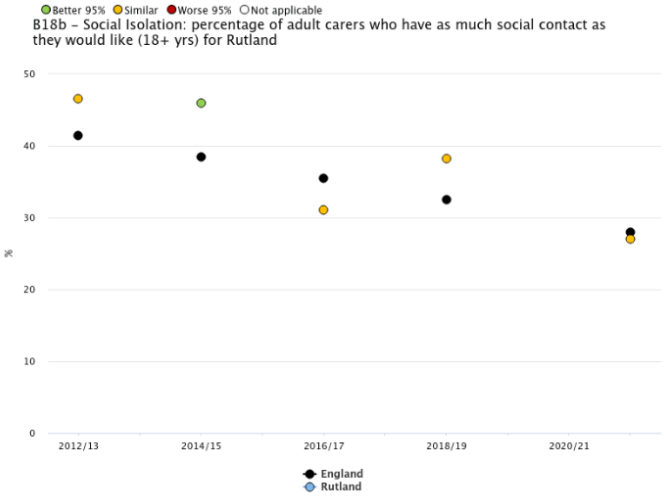
Social Isolation: percentage of adult social care users who have as much social contact as they would like

- The percentage of adult social care users who had as much social contact as they would like for Rutland increased from 39.5% in 2021/22 to 44.3% in 2022/23. The value for Rutland has not been significantly different to the national percentage since 2010/11, with the exception of 2011/12 where Rutland performed significantly better than the national average and 2013/14 where Rutland performed significantly worse than the national average.



Social Isolation: percentage of adult carers who have as much social contact as they would like (18+ years)

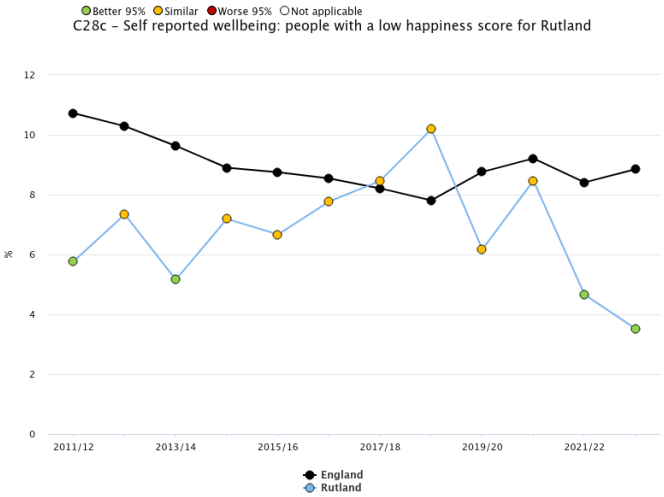
- In 2021/22, the percentage of adult carers (aged 18+) who had as much social contact as they would like for Rutland was 27.0%. This is statistically similar to the national percentage of 28.0%.



6. Self-reported wellbeing measure of low happiness is significantly better than the national average, while high anxiety is similar to the national average.

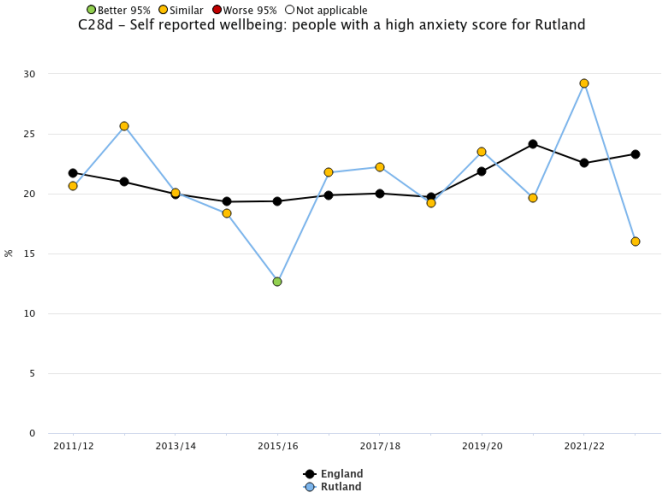
People with a low happiness score

- In Rutland, the percentage of respondents scoring 0-4 (low score) for how happy they felt yesterday has decreased from 4.7% in 2021/22 to 3.5% in 2022/23, which is significantly better than the national average of 8.9%.



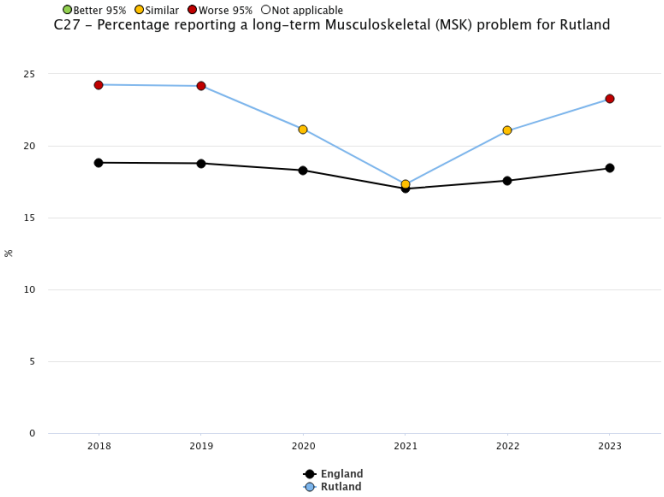
People with a high anxiety score

- In Rutland, the percentage of respondents scoring 6-10 (high score) for how anxious they felt yesterday has decreased from 29.2% in 2021/22 to 16.0% in 2022/23, which is similar to the national average of 23.3%.



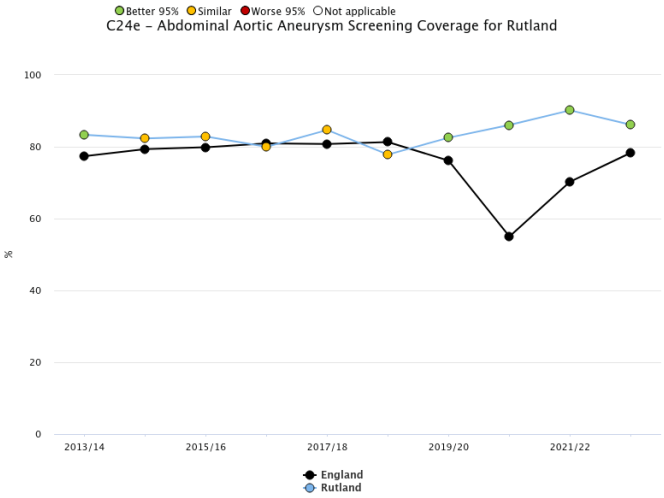
7. The percentage reporting a long-term Musculoskeletal (MSK) problem is significantly worse than the national average.

- The percentage of people aged 16+ reporting a long-term Musculoskeletal problem increased from 21.0% in 2022 to 23.3% in 2023. In 2023 Rutland performed significantly worse than the national figure of 18.4% for the first time since 2019.



8. Abdominal Aortic Aneurysm screening coverage has shown a significant increasing and improving trend.

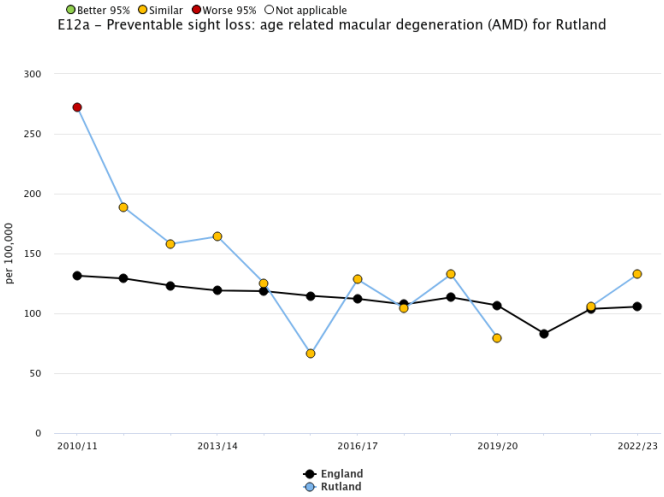
- Abdominal Aortic Aneurysm screening coverage has decreased from 90.2% in 2021/22 to 86.1% in 2022/23. Rutland continues to perform significantly better than the national average of 78.3% in 2022/23 and has been performing significantly better since 2019/20.
- Over the last five data points, Abdominal Aortic Aneurysm screening coverage in Rutland has shown a significant increasing and improving trend.



9. Age-related Macular Degeneration (AMD) and new sight loss certifications in Rutland continue to be similar to the national average.

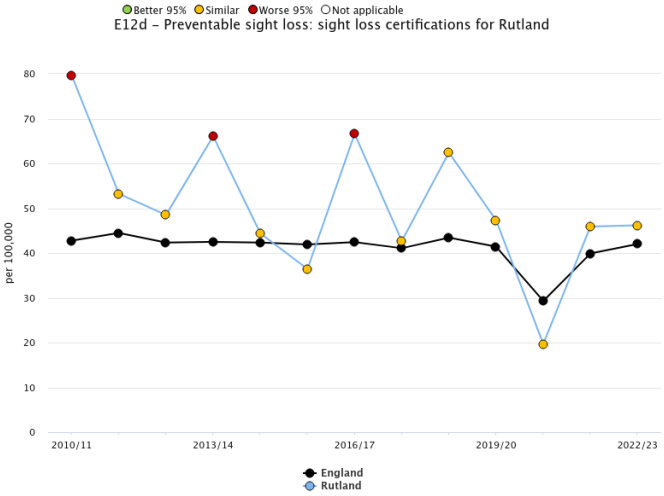
Age related Macular Degeneration (AMD)

- In 2022/23, in Rutland, 14 people over the age of 65 lost their sight due to age related macular degeneration, this equates to a rate of 132.7 per 100,000 population of people aged over 65. This is similar to the national rate of 105.6 per 100,000 population of people aged over 65.



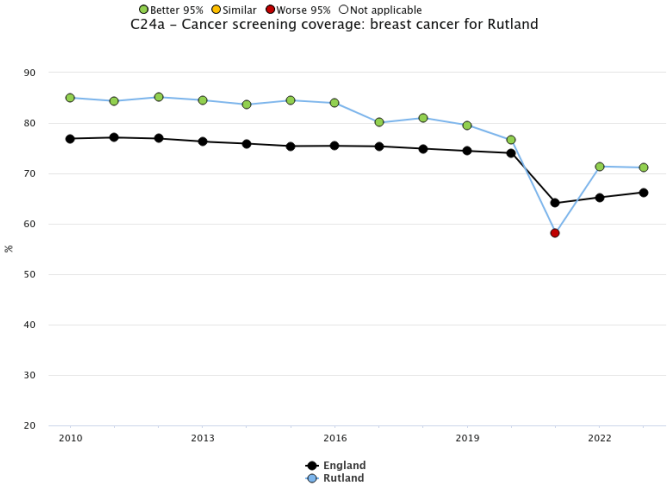
Sight loss certifications

- In 2022/23, 19 new certificates of visual impairment were received by Rutland residents. This equates to a rate of 46.2 per 100,000 population, this is similar to the national rate of 42.0 per 100,000 population.

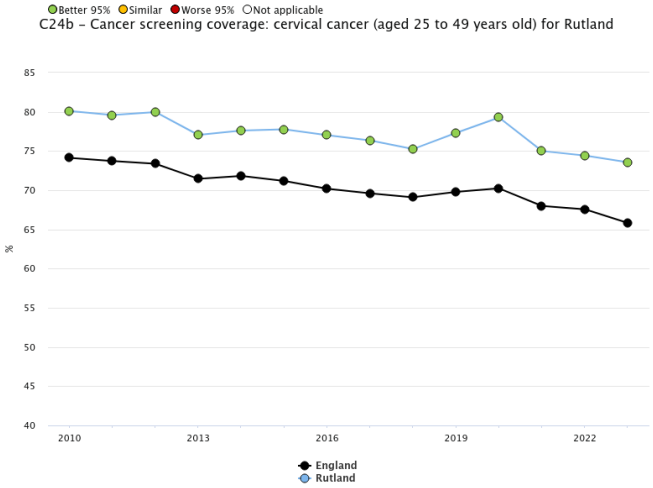


10. Cancer screening coverages have shown a mixed picture of trends.

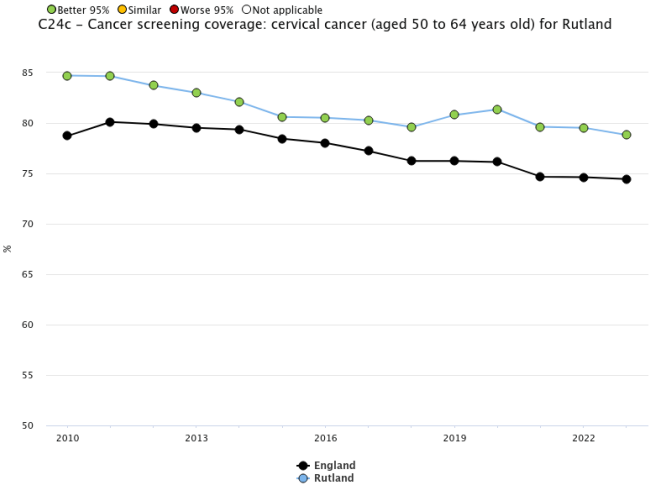
- Breast cancer screening coverage has decreased from 71.4% in 2022 to 71.2% in 2023. Rutland continues to perform significantly better than the national average of 66.2% and with the exception of 2021 has been performing significantly better since the recording of this indicator began in 2010.
- Over the last five data points, the breast cancer screening coverage in Rutland has shown a significant decreasing and worsening trend.



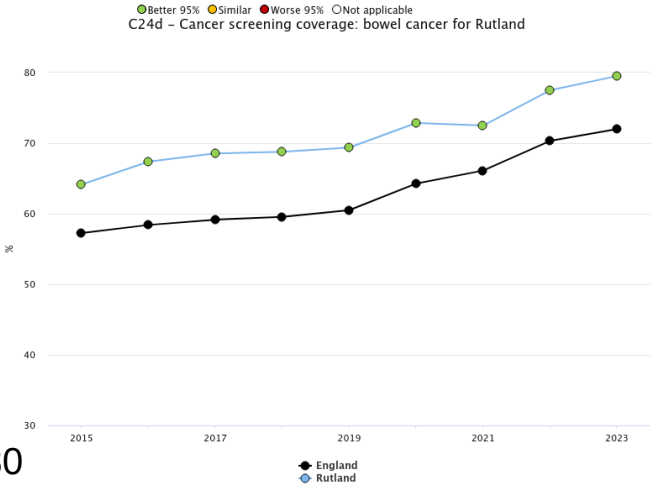
- Cervical cancer screening coverage for females aged 25 to 49 years has decreased from 74.4% in 2022 to 73.6% in 2023. Rutland continues to perform significantly better than the national average of 65.8% and has been performing significantly better since the recording of this indicator began in 2010.
- Over the last five data points, the cervical cancer screening coverage for females aged 25 to 49 years in Rutland has shown a significant decreasing and worsening trend.



- Cervical cancer screening coverage for females aged 50 to 64 years has decreased from 79.5% in 2022 to 78.8% in 2023. Rutland continues to perform significantly better than the national average of 74.4% and has been performing significantly better since the recording of this indicator began in 2010.
- Over the last five data points, the cervical cancer screening coverage for females aged 50 to 64 years in Rutland has shown no significant change.



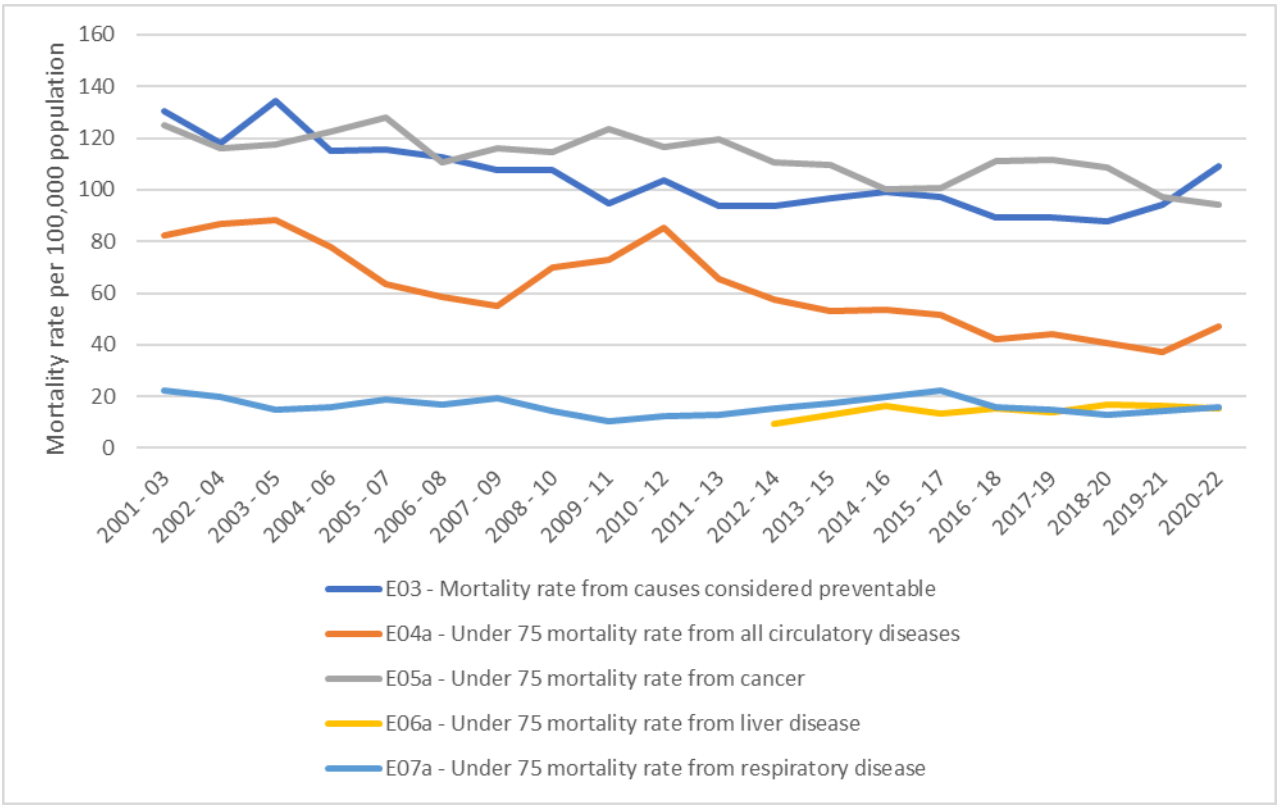
- Bowel cancer screening coverage has increased from 77.5% in 2022 to 79.5% in 2023. Rutland continues to perform significantly better than the national average of 72.0% and has been performing significantly better since the recording of this indicator began in 2015.
- Over the last five data points, the bowel cancer screening coverage in Rutland has shown a significant increasing and improving trend.



11. Changes to mortality rates by cause show a mixed picture.

- The under 75 mortality rate from causes considered preventable has increased from 94.4 per 100,000 population in 2019-21 to 109.2 per 100,000 population in 2020-22 and remains significantly lower (better) than the England rate of 170.1 per 100,000 population.
- The under 75 mortality rate from circulatory diseases has increased from 37.0 per 100,000 population in 2019-21 to 47.2 per 100,000 population in 2020-22 and remains significantly lower (better) than the England rate of 76.0 per 100,000 population.
- The under 75 mortality rate from cancer has decreased from 97.3 per 100,000 population in 2019-21 to 94.2 per 100,000 population in 2020-22 and remains significantly lower (better) than the England rate of 123.2 per 100,000 population.
- The under 75 mortality rate for liver disease has decreased from 16.4 per 100,000 population in 2019-21 to 15.5 per 100,000 population aged under 75 in 2020-22 and continues to be similar to the England rate of 21.1 per 100,000 population.
- The under 75 mortality rate from respiratory disease has increased from 14.2 per 100,000 population in 2019-21 to 15.9 per 100,000 population in 2020-22 and remains significantly lower (better) than the England rate of 28.9 per 100,000 population.

Mortality rates from preventable causes, circulatory diseases in under 75s, cancer in under 75s, liver disease in under 75s, and respiratory disease in under 75s, per 100,000 persons, Rutland, between 2001-03 and 2020-2022



Appendix 1: Performance Summary

This release of the PHOF contained 189 indicators. The overall findings are summarised below.

Overall performance across Rutland is significantly better than the England average or against a benchmarking goal for 55 of the indicators presented in the PHOF. Performance is significantly worse for 10 indicators and these indicators need to show improvement.

Table 1: Summary of RAG Ratings for Rutland, February 2024

Domain	Better	Similar	Worse	Not compared	Lower	Higher	Total
A: Overarching indicators	8	8	0	8	0	0	24
B: Wider determinants of health	13	13	1	15	0	0	42
C: Health improvement	22	17	3	13	0	1	56
D: Health protection	3	5	5	23	0	0	36
E: Healthcare & premature mortality	9	15	1	6	0	0	31
Total	**55**	**58**	**10**	**65**	**0**	**1**	**189**

1. All Indicators – Rutland's Performance Against National/Benchmark

Currently, performance is significantly worse for 10 indicators and these indicators need to show improvement.

- B02a – School readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception
- C26a – Cumulative percentage of the eligible population aged 40 to 74 offered an NHS Health Check
- C26c – Cumulative percentage of the eligible population aged 40 to 74 who received an NHS Health check
- C27 – Percentage reporting a long-term Musculoskeletal (MSK) problem
- D04f – Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 years old) (Female)
- D04f – Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 years old) (Male)
- D06c – Population vaccination coverage: Shingles vaccination coverage (71 years)
- D07 – HIV late diagnosis in people first diagnosed with HIV in the UK
- D08a – Proportion of drug sensitive TB notifications who had completed a full course of treatment by 12 months
- E15 – Estimated dementia diagnosis rate (aged 65 and older)

2. All Indicators – Rutland's Performance is Getting Worse

From August 2016, markers of significant trend were added to the PHOF. When there are at least five consecutive non-overlapping data points available for a proportion or crude rate indicator, a chi-squared statistical test for trend is carried out on the most recent five points. If there is no significant trend in the most recent five points, the test is redone, including an additional (sixth) point, and so on, going further back until the full series has been tested.

Currently, there are 5 indicators that have a significant worsening trend.

- C24a – Cancer screening coverage: breast cancer
- C24b – Cancer screening coverage: cervical cancer (aged 25 to 49 years old)
- D04e – Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old) (Female)
- D04g – Population vaccination coverage: Meningococcal ACWY conjugate vaccine (MenACWY) (14 to 15 years)
- D06b – Population vaccination coverage: PPV

A. Overarching indicators

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
A01a - Healthy life expectancy at birth	All ages	Male	2018 - 20	74.7	62.0	63.1	Years	-	→
A01a - Healthy life expectancy at birth	All ages	Female	2018 - 20	66.8	61.9	63.9	Years	-	→
A01b - Life expectancy at birth	All ages	Male	2020 - 22	82.1	78.6	78.9	Years		→
A01b - Life expectancy at birth	All ages	Male	2022	80.3	78.9	79.3	Years	-	→
A01b - Life expectancy at birth	All ages	Female	2020 - 22	84.5	82.4	82.8	Years		→
A01b - Life expectancy at birth	All ages	Female	2022	83.4	82.7	83.2	Years	-	→
A01c - Disability free life expectancy at birth	All ages	Male	2018 - 20	64.9	62.0	62.4	Years	-	→
A01c - Disability free life expectancy at birth	All ages	Female	2018 - 20	61.8	60.0	60.9	Years	-	→
A01a - Healthy life expectancy at 65	65	Male	2018 - 20	16.1	9.67	10.5	Years	-	→
A01a - Healthy life expectancy at 65	65	Female	2018 - 20	16.1	10.4	11.3	Years	-	→
A01b - Life expectancy at 65	65	Male	2020 - 22	20.2	18.2	18.4	Years		→
A01b - Life expectancy at 65	65	Male	2022	19.7	18.6	18.7	Years	-	→
A01b - Life expectancy at 65	65	Female	2020 - 22	22.6	20.6	20.9	Years		→
A01b - Life expectancy at 65	65	Female	2022	23.0	20.8	21.2	Years	-	→
A01c - Disability-free life expectancy at 65	65	Male	2018 - 20	10.5	9.43	9.84	Years	-	→
A01c - Disability-free life expectancy at 65	65	Female	2018 - 20	12.8	9.53	9.87	Years	-	→

B. Wider determinants of health

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
B01b - Children in absolute low income families (under 16s)	<16 yrs	Persons	2021/22	9.97	21.0	15.3	%	-	-
B01b - Children in relative low income families (under 16s)	<16 yrs	Persons	2021/22	11.8	25.4	19.9	%	-	-
B02a - School readiness: percentage of children achieving a good level of development at the end of Reception	5 yrs	Persons	2022/23	75.5	66.8	67.2	%	-	→
B02a - School Readiness: percentage of children with free school meal status achieving a good level of development at the end of Reception	5 yrs	Persons	2022/23	25.0	52.0	51.6	%	-	→
B02b - School readiness: percentage of children achieving the expected level in the phonics screening check in Year 1	6 yrs	Persons	2022/23	85.6	78.7	78.9	%	→	→
B02b - School readiness: percentage of children with free school meal status achieving the expected level in the phonics screening check in Year 1	6 yrs	Persons	2022/23	73.8	66.0	66.5	%	→	→
B02c - School readiness: percentage of children achieving at least the expected level in communication and language skills at the end of Reception	5 yrs	Persons	2022/23	84.7	79.3	79.7	%	-	→
B02d - School readiness: percentage of children achieving at least the expected level of development in communication, language and literacy skills at the end of Reception	5 yrs	Persons	2022/23	76.3	68.3	68.8	%	-	→
B03 - Pupil absence	5-15 yrs	Persons	2021/22	6.50	7.51	7.55	%	→	↑
B05 - 16 to 17 year olds not in education, employment or training (NEET) or whose activity is not known	16-17 yrs	Persons	2022/23	1.43	4.90	5.20	%	→	→
B06a - Adults with a learning disability who live in stable and appropriate accommodation	18-64 yrs	Persons	2022/23	71.7	81.7	80.5	%	→	→
B06b - Adults in contact with secondary mental health services who live in stable and appropriate accommodation	18-69 yrs	Persons	2020/21	34.0	53.0	58.0	%	-	→
B08a - Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate	16-64 yrs	Persons	2022/23	3.30	9.10	10.4	Percentage points	-	→
B08a - The percentage of the population with a physical or mental long term health condition in employment (aged 16 to 64)	16-64 yrs	Persons	2022/23	73.8	66.0	65.3	%	-	→
B08b - Gap in the employment rate between those who are in receipt of long term support for a learning disability (aged 18 to 64) and the overall employment rate	18-64 yrs	Persons	2021/22	66.9	71.7	70.6	Percentage points	-	→
B08b - The percentage of the population who are in receipt of long term support for a learning disability that are in paid employment (aged 18 to 64)	18-64 yrs	Persons	2021/22	9.00	3.10	4.80	%	→	→
B08d - Percentage of people in employment	16-64 yrs	Persons	2022/23	77.1	75.1	75.7	%	→	→
B09a - Sickness absence: the percentage of employees who had at least one day off in the previous week	16+ yrs	Persons	2019 - 21	1.32	1.83	1.82	%	-	→
B09b - Sickness absence: the percentage of working days lost due to sickness absence	16+ yrs	Persons	2019 - 21	0.43	1.12	1.01	%	-	→
B10 - Killed and seriously injured (KSI) casualties on England's roads	All ages	Persons	2022	36.8 &	92.1 &	94.5 &	per billion vehicle miles	→	-
B11 - Domestic abuse related incidents and crimes	16+ yrs	Persons	2022/23	26.5 ^	27.3	30.6 [b]	per 1,000	-	-

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
B12a - Violent crime - hospital admissions for violence (including sexual violence)	All ages	Persons	2018/19 - 20/21	20.8	32.9	41.9	per 100,000	-	→
B12b - Violent crime - violence offences per 1,000 population	All ages	Persons	2022/23	17.5	33.6 x	34.4	per 1,000	↑	→
B12c - Violent crime - sexual offences per 1,000 population	All ages	Persons	2022/23	2.28	3.19 x	2.95	per 1,000	↑	→
B13a - Reoffending levels: percentage of offenders who reoffend	All ages	Persons	2020/21	20.5	24.9	24.1	%	→	-
B14a - The rate of complaints about noise	All ages	Persons	2020/21	1.93	6.62 &	12.0 &	per 1,000	↓	→
B14b - The percentage of the population exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime	All ages	Persons	2016	0.87	3.49	5.50	%	-	-
B14c - The percentage of the population exposed to road, rail and air transport noise of 55 dB(A) or more during the night-time	All ages	Persons	2016	1.29	5.41	8.48	%	-	-
B15a - Homelessness: households owed a duty under the Homelessness Reduction Act	Not applicable	Not applicable	2022/23	7.60	10.8	12.4	per 1,000	-	→
B15c - Homelessness: households in temporary accommodation	Not applicable	Not applicable	2022/23	0.37	1.26	4.15	per 1,000	-	→
B17 - Fuel poverty (low income, low energy efficiency methodology)	Not applicable	Not applicable	2021	12.9	13.6	13.1	%	-	-
B18a - Social Isolation: percentage of adult social care users who have as much social contact as they would like	18+ yrs	Persons	2022/23	44.3	42.6	44.4	%	-	→
B18b - Social Isolation: percentage of adult carers who have as much social contact as they would like	18+ yrs	Persons	2021/22	27.0	26.6	28.0	%	-	→
B19 - Loneliness: Percentage of adults who feel lonely often or always or some of the time	16+ yrs	Persons	2019/20	24.8	22.7	22.3	%	-	-
1.01i - Children in low income families (all dependent children under 20)	0-19 yrs	Persons	2016	6.50	16.3	17.0	%	→	→

C. Health improvement

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
C01 - Total prescribed LARC excluding injections rate / 1,000	All ages	Female	2022	49.8	47.1	44.1	per 1,000	–	↑
C03a - Obesity in early pregnancy	All ages	Female	2018/19	20.1	24.2	22.1	%	–	–
C03c - Smoking in early pregnancy	All ages	Female	2018/19	11.9	16.4	12.8	%	–	–
C04 - Low birth weight of term babies	=37 weeks gestational age at birth	Persons	2021	2.38	2.66	2.77	%	→	→
C05a - Baby's first feed breastmilk	Newborn	Persons	2020/21	86.1	68.6	71.7	%	–	–
C05b - Breastfeeding prevalence at 6 to 8 weeks - current method	6-8 weeks	Persons	2022/23	57.0	49.5	49.2 [a]	%	–	→
C06 - Smoking status at time of delivery	All ages	Female	2022/23	7.20	11.4	8.80	%	–	→
C07 - Proportion of New Birth Visits (NBVs) completed within 14 days	<14 days	Persons	2022/23	93.1	89.6	79.9 [a]	%	↑	→
C08a - Child development: percentage of children achieving a good level of development at 2 to 2 and a half years	2-2.5 yrs	Persons	2022/23	86.1	77.4	79.2 [a]	%	→	→
C08b - Child development: percentage of children achieving the expected level in communication skills at 2 to 2 and a half years	2-2.5 yrs	Persons	2022/23	92.2	85.4	85.3 [a]	%	→	→
C08c - Child development: percentage of children achieving the expected level in personal social skills at 2 to 2 and a half years	2-2.5 yrs	Persons	2022/23	92.2	89.8	90.3 [a]	%	→	→
C09a - Reception prevalence of overweight (including obesity)	4-5 yrs	Persons	2022/23	22.6	21.0	21.3	%	→	→
C09b - Year 6 prevalence of overweight (including obesity)	10-11 yrs	Persons	2022/23	28.1	36.4	36.6	%	→	→
C10 - Percentage of physically active children and young people	5-16 yrs	Persons	2022/23	45.6	49.0	47.0	%	–	–
C11a - Hospital admissions caused by unintentional and deliberate injuries in children (aged 0 to 14 years)	<15 yrs	Persons	2021/22	49.6	63.8	84.3	per 10,000	–	–
C11b - Hospital admissions caused by unintentional and deliberate injuries in young people (aged 15 to 24 years)	15-24 yrs	Persons	2021/22	92.4	104.4	118.4	per 10,000	–	–
C14b - Emergency Hospital Admissions for Intentional Self-Harm	All ages	Persons	2021/22	106.4	161.9	163.7	per 100,000	–	–
C15 - Percentage of adults aged 16 and over meeting the '5-a-day' fruit and vegetable consumption recommendations (new method)	16+ yrs	Persons	2021/22	39.5	32.7	32.5	%	–	→
C15 - Proportion of the population meeting the recommended '5 a day' on a 'usual day' (adults) (old method)	16+ yrs	Persons	2019/20	64.9	55.0	55.4	%	–	→
C16 - Percentage of adults (aged 18 plus) classified as overweight or obese	18+ yrs	Persons	2021/22	55.5	67.0	63.8	%	–	→
C17a - Percentage of physically active adults	19+ yrs	Persons	2021/22	70.2	66.3	67.3	%	–	→
C17b - Percentage of physically inactive adults	19+ yrs	Persons	2021/22	20.8	22.9	22.3	%	–	→
C18 - Smoking Prevalence in adults (18+) - current smokers (APS)	18+ yrs	Persons	2022	9.47	14.0	12.7	%	–	→
C21 - Admission episodes for alcohol-related conditions (Narrow)	All ages	Persons	2021/22	315.3	535.5	493.9	per 100,000	–	–
C21 - Admission episodes for alcohol-related conditions (Narrow)	All ages	Male	2021/22	358.7	688.9	663.5	per 100,000	–	–
C21 - Admission episodes for alcohol-related conditions (Narrow)	All ages	Female	2021/22	277.8	395.6	341.1	per 100,000	–	–
C22 - Estimated diabetes diagnosis rate	17+ yrs	Persons	2018	73.8	84.6	78.0	%	–	→
C23 - Percentage of cancers diagnosed at stages 1 and 2	All ages	Persons	2021	47.8	52.9	54.4	%	→	→
C24a - Cancer screening coverage: breast cancer	53-70 yrs	Female	2023	71.2	68.5 x	66.2 x	%	↓	→
C24b - Cancer screening coverage: cervical cancer (aged 25 to 49 years old)	25-49 yrs	Female	2023	73.6	68.3 x	65.8 x	%	↓	→
C24c - Cancer screening coverage: cervical cancer (aged 50 to 64 years old)	50-64 yrs	Female	2023	78.8	76.2 x	74.4 x	%	→	→
C24d - Cancer screening coverage: bowel cancer	60-74 yrs	Persons	2023	79.5	73.5 x	72.0 x	%	↑	↑

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
C24e - Abdominal Aortic Aneurysm Screening Coverage	65	Male	2022/23	86.1	85.2 x	78.3 x	%	↑	→
C24m - Newborn Hearing Screening: Coverage	<1 yr	Persons	2022/23	98.9	98.9 x	98.5 x	%	-	→
C24n - Newborn and Infant Physical Examination Screening Coverage	<1 yr	Persons	2022/23	96.6	95.5 x	96.2 x	%	-	→
C26a - Cumulative percentage of the eligible population aged 40 to 74 offered an NHS Health Check	40-74 yrs	Persons	2018/19 - 22/23	53.5	53.3	64.7	%	-	↓
C26b - Cumulative percentage of the eligible population aged 40 to 74 offered an NHS Health Check who received an NHS Health Check	40-74 yrs	Persons	2018/19 - 22/23	46.1	51.5	42.3	%	-	↑
C26c - Cumulative percentage of the eligible population aged 40 to 74 who received an NHS Health check	40-74 yrs	Persons	2018/19 - 22/23	24.6	27.5	27.4	%	-	→
C27 - Percentage reporting a long-term Musculoskeletal (MSK) problem	16+ yrs	Persons	2023	23.3	20.0	18.4	%	-	→
C28c - Self reported wellbeing: people with a low happiness score	16+ yrs	Persons	2022/23	3.52	9.26	8.85	%	-	→
C28d - Self reported wellbeing: people with a high anxiety score	16+ yrs	Persons	2022/23	16.0	21.5	23.3	%	-	→
C29 - Emergency hospital admissions due to falls in people aged 65 and over	65+ yrs	Persons	2021/22	1565	2009	2100	per 100,000	-	-
C29 - Emergency hospital admissions due to falls in people aged 65 to 79	65-79 yrs	Persons	2021/22	687.5	926.3	992.6	per 100,000	-	-
C29 - Emergency hospital admissions due to falls in people aged 80 plus	80+ yrs	Persons	2021/22	4111	5148	5311	per 100,000	-	-

D. Health protection

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
D01 - Fraction of mortality attributable to particulate air pollution (new method)	30+ yrs	Persons	2022	5.61	6.13	5.82	%	–	–
D02a - Chlamydia detection rate per 100,000 aged 15 to 24	15-24 yrs	Female	2022	2452 *	2483 *	2110 *	per 100,000	–	↑
D02a - Chlamydia detection rate per 100,000 aged 15 to 24	15-24 yrs	Male	2022	777.4	1243	1112	per 100,000	–	→
D02a - Chlamydia detection rate per 100,000 aged 15 to 24	15-24 yrs	Persons	2022	1520	1922	1680	per 100,000	–	↑
D02b - New STI diagnoses (excluding chlamydia aged under 25) per 100,000	All ages	Persons	2022	246.5	339.1 @	495.8	per 100,000	–	→
D04e - Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old)	12-13 yrs	Female	2021/22	81.7 *	67.8 *	69.6 *	%	↓	↑
D04e - Population vaccination coverage: HPV vaccination coverage for one dose (12 to 13 year old)	12-13 yrs	Male	2021/22	81.7 *	60.4 *	62.4 *	%	–	↑
D04f - Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 years old)	13-14 yrs	Female	2021/22	66.5 *	69.1 *	67.3 *	%	→	↓
D04f - Population vaccination coverage: HPV vaccination coverage for two doses (13 to 14 years old)	13-14 yrs	Male	2021/22	69.5 *	64.1 *	62.4 *	%	–	↓
D04g - Population vaccination coverage: Meningococcal ACWY conjugate vaccine (MenACWY) (14 to 15 years)	14-15 yrs	Persons	2021/22	91.6 *	78.1 *	79.6 *	%	↓	→
D06b - Population vaccination coverage: PPV	65+ yrs	Persons	2020/21	68.0 *	71.4 *	70.6 *	%	↓	↓
D06c - Population vaccination coverage: Shingles vaccination coverage (71 years)	71	Persons	2021/22	32.2 *	46.0 *	44.0 *	%	–	↑
D07 - HIV late diagnosis in people first diagnosed with HIV in the UK	15+ yrs	Persons	2020 - 22	100.0 *	47.9 *	43.3 *	%	–	→
D08a - Proportion of drug sensitive TB notifications who had completed a full course of treatment by 12 months	All ages	Persons	2020	0.00 ~	85.4	84.2	%	–	–
D09 - NHS organisations with a board approved sustainable development management plan	Not applicable	Not applicable	2015/16	40.0	60.0	66.2	%	→	→
D10 - Adjusted antibiotic prescribing in primary care by the NHS	All ages	Persons	2022	0.80 *	0.90 *	0.87 *	per STAR-PU	–	↑

E. Healthcare and premature mortality

Indicator	Age	Sex	Period	Value	Value (Region)	Value (England)	Unit	Recent trend	Change from previous
E01 - Infant mortality rate	<1 yr	Persons	2020 - 22	5.32 $	4.41	4.03	per 1,000	-	-
E02 - Percentage of 5 year olds with experience of visually obvious dental decay	5 yrs	Persons	2021/22	15.1	22.3	23.7	%	-	→
E03 - Under 75 mortality rate from causes considered preventable	<75 yrs	Persons	2020 - 22	109.2	173.5	170.1	per 100,000	-	→
E03 - Under 75 mortality rate from causes considered preventable	<75 yrs	Persons	2022	131.4	159.5	153.7	per 100,000		→
E04a - Under 75 mortality rate from all circulatory diseases	<75 yrs	Persons	2020 - 22	47.2	79.2	76.0	per 100,000	-	→
E04a - Under 75 mortality rate from all circulatory diseases	<75 yrs	Persons	2022	75.0	79.5	77.8	per 100,000		→
E04b - Under 75 mortality rate from circulatory diseases considered preventable	<75 yrs	Persons	2020 - 22	21.0	31.8	30.1	per 100,000	-	→
E05a - Under 75 mortality rate from cancer	<75 yrs	Persons	2020 - 22	94.2	126.9	123.2	per 100,000	-	→
E05a - Under 75 mortality rate from cancer	<75 yrs	Persons	2022	88.8	125.5	122.4	per 100,000		→
E05b - Under 75 mortality rate from cancer considered preventable	<75 yrs	Persons	2020 - 22	32.7	51.3	50.5	per 100,000	-	→
E06a - Under 75 mortality rate from liver disease	<75 yrs	Persons	2020 - 22	15.5	21.2	21.1	per 100,000	-	→
E06b - Under 75 mortality rate from liver disease considered preventable	<75 yrs	Persons	2020 - 22	14.6	19.0	18.7	per 100,000	-	→
E07a - Under 75 mortality rate from respiratory disease	<75 yrs	Persons	2020 - 22	15.9	28.3	28.9	per 100,000	-	→
E07b - Under 75 mortality rate from respiratory disease considered preventable	<75 yrs	Persons	2020 - 22	8.86	16.7	17.0	per 100,000	-	-
E09a - Premature mortality in adults with severe mental illness (SMI)	18-74 yrs	Persons	2018 - 20	55.9	108.2	103.6	per 100,000	-	→
E09b - Excess under 75 mortality rate in adults with severe mental illness (SMI)	18-74 yrs	Persons	2018 - 20	445.8	435.7	389.9	%	-	→
E11 - Emergency readmissions within 30 days of discharge from hospital	All ages	Persons	2020/21	14.4	15.1	15.5	%	-	→
E12a - Preventable sight loss: age related macular degeneration (AMD)	65+ yrs	Persons	2022/23	132.7	126.8 x	105.6	per 100,000	→	→
E12c - Preventable sight loss: diabetic eye disease	12+ yrs	Persons	2022/23	0.00	3.11 x	2.87	per 100,000	→	→
E12d - Preventable sight loss: sight loss certifications	All ages	Persons	2022/23	46.2	47.7 x	42.0	per 100,000	→	→
E13 - Hip fractures in people aged 65 and over	65+ yrs	Persons	2022/23	484.1	577.0	558.0	per 100,000	→	→
E13 - Hip fractures in people aged 65 to 79	65-79 yrs	Persons	2022/23	177.3	254.3	243.8	per 100,000	→	→
E13 - Hip fractures in people aged 80 and over	80+ yrs	Persons	2022/23	1374	1513	1469	per 100,000	→	→
E14 - Winter mortality index	All ages	Persons	Aug 2021 - Jul 2022	7.20	6.50	8.10	%	-	→
E14 - Winter mortality index (age 85 plus)	85+ yrs	Persons	Aug 2021 - Jul 2022	11.8	8.50	11.3	%	-	→
E15 - Estimated dementia diagnosis rate (aged 65 and older)	65+ yrs	Persons	2023	48.5 *	65.2 *	63.0 *	%	→	→

If you require information contained in this leaflet in another version e.g. large print, Braille, tape or alternative language please telephone: 0116 305 6803, Fax: 0116 305 7271 or Minicom: 0116 305 6160.

જો આપ આ માહિતી આપની ભાષામાં સમજવામાં થોડી મદદ ઇચ્છતાં હો તો 0116 305 6803 નંબર પર ફોન કરશો અને અમે આપને મદદ કરવા વ્યવસ્થા કરીશું.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਵਿਚ ਕੁਝ ਮਦਦ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 0116 305 6803 ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਅਸੀਂ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਦਵਾਂਗੇ।

এই তথ্য নিজের ভাষায় বুঝার জন্য আপনার যদি কোন সাহায্যের প্রয়োজন হয়, তবে 0116 305 6803 এই নম্বরে ফোন করলে আমরা উপযুক্ত ব্যক্তির ব্যবস্থা করবো।

اگر آپ کو یہ معلومات سمجھنے میں کچھ مدد درکار ہے تو براہ مہربانی اس نمبر پر کال کریں 0116 305 6803 اور ہم آپ کی مدد کے لئے کسی کا انتظام کر دیں گے۔

假如閣下需要幫助，用你的語言去明白這些資訊，請致電 0116 305 6803，我們會安排有關人員為你提供幫助。

Jeżeli potrzebujesz pomocy w zrozumieniu tej informacji w Twoim języku, zadzwoń pod numer 0116 305 6803, a my Ci dopomożemy.

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Report No: 61/2024
PUBLIC REPORT

HEALTH AND WELLBEING BOARD

23 April 2024

BETTER CARE FUND (BCF): QUARTER THREE REPORT 2023-24

Report of the Portfolio Holder for Adults and Health

Corporate Priorities:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Diane Ellison, Portfolio Holder for Adults and Health	
Contact Officer(s):	Kim Sorsky, Director of Adult Services and Health	01572 758352 ksorsky@rutland.gov.uk
	Katherine Willison, Health and Wellbeing Integration Lead	01572 758409 kwillison@rutland.gov.uk
Ward Councillors	N/A	

DECISION RECOMMENDATIONS
That the Committee: 1. Notes the content of the report. 2. Notes that the Rutland 2023-25 Quarter 3 Report of the Better Care Fund (BCF) gained approval from the Chair of the Health and Wellbeing Board and from the ICB Executive team, and was submitted to the National BCF Team on 31 January 2024

1 PURPOSE OF THE REPORT

1.1 To brief the Health and Wellbeing Board (HWB) on the 2023-25 Quarter 3 Report of the BCF.

1.2 Update the HWB on the work of the Rutland BCF Partnership Board.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The Rutland BCF Plan for 2023-23 was submitted to the national BCF team in June 2023. This included a plan which set out the ambitions for the 5 BCF Metrics and intermediate care capacity and demand proposals for reablement for community and hospital discharge.

2.2 The BCF Quarter 3 Report includes updates on Metrics data and whether performance is on track against the targets set in the 2023-25 Plan. The Report also includes an update on spend and activity for certain schemes within the plan.

3 METRICS

3.1 There are 5 metrics to report against for 2023-24:

i. **Avoidable admissions**
Unplanned admissions for Chronic Care Sensitive Ambulatory Conditions. Indirectly standardised rate of admissions per 100,000 population.

ii. **Discharge to usual place of residence**
The percentage of people discharged from acute hospital to their normal place of residence.

iii. **Falls**
Emergency hospital admissions due to falls in people aged 65 and over directly aged standardised rate per 100,000.

iv. **Residential admissions**
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population.

v. **Reablement**
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into Reablement/ rehabilitation services.

3.2 Targets and Performance

Ambitious targets for the Metrics were agreed for 2023-24 which formed part of the 2023-25 Rutland BCF Plan. The targets were required to be high reaching to demonstrate intention of making further progress and improvements to outcomes which would be demonstrated by these metrics. For quarter 2 (as per HWB Report January 2024), the data showed that we were on track to meet the reablement target but not on track to meet the targets in the other metrics. The data for quarter 3 shows that in addition to being on track to meet the reablement target, we are also on track to meet the target for discharge to usual place of residence. We are still not on track to meet the remaining 3 targets. See table below for further details.

Metric	Planned Performance	Actual Performance	Assessment of progress
Avoidable admissions (number)	Quarter 2 117.0	Quarter 2 161	Not on track
Discharge Usual Place of Residence (percentage)	Quarter 2 90.9%	Quarter 2 91.5%	On track
Falls (standardised rate per 100,000	Quarter 2	Quarter 2	Not on track

Metric	Planned Performance	Actual Performance	Assessment of progress
population)	288.6	390.1	
Residential admissions (per 100,000 population)	193	317 as of December 2023	Not on track
Reablement (percentage)	95.7%	91% as of December 2023	On track

3.3 The number of **avoidable admissions** is not on track to meet the target. The number has increased in quarter 2 from quarter 1 and is 43 above the target.

3.4 The percentage of **discharges to usual place of residence** is now on track to meet the target.

3.5 The **falls** rate is calculated per 100,000 of the population so that data is comparable with different sized populations nationally. Therefore, the gap between the planned and actual performance is relatively small.

3.6 The **residential admissions** data is also calculated per 100,000 of the population. This performance shows we are not on track for the planned target. However, this target was particularly ambitious based on unusually good records in the last 2 years. The actual number as at December 2023 was 19, the target having been set at 20 for the year.

3.7 The **reablement** target was missed but is very close. This is based on a snapshot figure for December 2023. The performance has improved since the previous report. Local performance reports show that reablement consistently achieves good results in the 90+% and so this target has been considered to be on track.

3.8 Included in the report was the following narrative regarding **avoidable admissions**: It continues to be a challenge to prevent such hospital admissions, with a high proportion of older adults and higher risk of comorbidities.

3.9 A new Health and Care Collaboration project is due to start. Part of this will be implementing a Risk Stratification model for the PCN. People with multiple co-morbidities will trigger a response/intervention for prevention purposes. The introduction of the Whzan clinical boxes should begin to have an impact in reducing hospital admissions for care home residents.

4 SPEND AND ACTIVITY

4.1 An update on the expenditure and outputs for certain schemes within the BCF plan for quarters 1 and 2 was included in the report. There were no issues with expenditure or outputs.

4.2 Schemes requiring updates were:

- Carers Services, including Admiral Nursing and Respite

- Assistive Technologies, including Telecare and Disabled Facilities Grant
- Home and Bed Based Intermediate Care Services

5 RUTLAND BCF PARTNERSHIP BOARD

5.1 The aim of the Board is to ensure that the BCF plan achieves its aims and outcomes within the financial contributions agreed by the partners. It provides governance to ensure the rules and processes of the Rutland BCF are embedded as standard.

5.2 Reports for quarters 3 and 4 are currently being completed by the Budget Holders of the schemes within the plan. These include information on progress made, how the schemes align with the BCF objectives and priorities and financial updates and viability. This information will be used for evaluation by the Board.

5.3 BCF monies were agreed by the BCF Board in February, to be released for the following schemes:

- Community Inclusion Officer
- Customer Feedback Contract

6 CONSULTATION

6.1 Not applicable currently.

7 ALTERNATIVE OPTIONS

7.1 Not applicable currently

8 FINANCIAL IMPLICATIONS

8.1 Local partners have proceeded to deliver the BCF programme ‘on trust’, based on consensus across the Council and ICB.

9 LEGAL AND GOVERNANCE CONSIDERATIONS

9.1 The plan received sign off from Executive Team at the ICB.

10 DATA PROTECTION IMPLICATIONS

10.1 There are no new Data Protection implications. Reports contain only anonymised data.

11 EQUALITY IMPACT ASSESSMENT

11.1 Not applicable

12 COMMUNITY SAFETY IMPLICATIONS

12.1 There are no identified community safety implications from this report.

13 HEALTH AND WELLBEING IMPLICATIONS

13.1 The Better Care Fund programme is an important element of Rutland’s response to enhancing the health and wellbeing of its population, representing more than £3m of ICB and LA funding to be used for integrated health and social care interventions.

This report sets out that Rutland continues to be committed to improving the outcomes of the population.

14 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

14.1 The committee is recommended to note the Rutland BCF 2023-25 Quarter 3 Report, submission of which to the BCF national team on 31 January was signed off by the Chair.

15 BACKGROUND PAPERS

15.1 There are no additional background papers

16 APPENDICES

16.1 Appendix A: Rutland BCF Quarter 3 Report

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577.

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Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

1. Guidance for Quarter 3

Overview

The Better Care Fund (BCF) reporting requirements are set out in the BCF Planning Requirements document for 2023-25, which supports the aims of the BCF Policy Framework and the BCF programme; jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities (DLUHC), NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

The key purposes of BCF reporting are:
1) To confirm the status of continued compliance against the requirements of the fund (BCF)
2) In Quarter 2 to refresh capacity and demand plans, and in Quarter 3 to confirm activity to date, where BCF funded schemes include output estimates, and at the End of Year actual income and expenditure in BCF plans
3) To provide information from local areas on challenges, achievements and support needs in progressing the delivery of BCF plans, including performance metrics
4) To enable the use of this information for national partners to inform future direction and for local areas to inform improvements

BCF reporting is likely to be used by local areas, alongside any other information to help inform Health and Wellbeing Boards (HWBs) on progress on integration and the BCF. It is also intended to inform BCF national partners as well as those responsible for delivering the BCF plans at a local level (including ICBs, local authorities and service providers) for the purposes noted above.

BCF reports submitted by local areas are required to be signed off by HWBs, including through delegated arrangements as appropriate, as the accountable governance body for the BCF locally. Aggregated reporting information will be published on the NHS England website.

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background and those that are not for completion are in grey, as below:

Data needs inputting in the cell

Pre-populated cells

Not applicable - cells where data cannot be added

Note on viewing the sheets optimally

To more optimally view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%.
Most drop downs are also available to view as lists within the relevant sheet or in the guidance tab for readability if required.
The row heights and column widths can be adjusted to fit and view text more comfortably for the cells that require narrative information.

Please DO NOT directly copy/cut & paste to populate the fields when completing the template as this can cause issues during the aggregation process. If you must 'copy & paste', please use the 'Paste Special' operation and paste 'Values' only.

The details of each sheet within the template are outlined below.

Checklist (2. Cover)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be complete before sending to the BCF team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.

5. Please ensure that all boxes on the checklist are green before submitting to england.bettercarefundteam@nhs.net and copying in your Better Care Manager.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off. Once you select your HWB from the drop down list, relevant data on metric ambitions and capacity and demand from your BCF plans for 2023-24 will prepopulate in the relevant worksheets.
2. HWB sign off will be subject to your own governance arrangements which may include a delegated authority.
4. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer needed.

3. National Conditions

This section requires the HWB to confirm whether the four national conditions detailed in the Better Care Fund planning requirements for 2023-25 (link below) continue to be met through the delivery of your plan. Please confirm as at the time of completion.
https://www.england.nhs.uk/wp-content/uploads/2023/04/PRN00315-better-care-fund-planning-requirements-2023-25.pdf

This sheet sets out the four conditions and requires the HWB to confirm 'Yes' or 'No' that these continue to be met. Should 'No' be selected, please provide an explanation as to why the condition was not met for the year and how this is being addressed. Please note that where a National Condition is not being met, the HWB is expected to contact their Better Care Manager in the first instance.

In summary, the four national conditions are as below:
National condition 1: Plans to be jointly agreed
National condition 2: Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer
National condition 3: Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time
National condition 4: Maintaining NHS contribution to adult social care and investment in NHS commissioned out of hospital services

4. Metrics

The BCF plan includes the following metrics:
- Unplanned hospitalisations for chronic ambulatory care sensitive conditions,
- Proportion of hospital discharges to a person's usual place of residence,
- Admissions to long term residential or nursing care for people over 65,
- Reablement outcomes (people aged over 65 still at home 91 days after discharge from hospital to reablement or rehabilitation at home), and;
- Emergency hospital admissions for people over 65 following a fall.

Plans for these metrics were agreed as part of the BCF planning process.
This section captures a confidence assessment on achieving the locally set ambitions for each of the BCF metrics.
A brief commentary is requested for each metric outlining the challenges faced in achieving the metric plans, any support needs and successes in the first six months of the financial year.
Data from the Secondary Uses Service (SUS) dataset on outcomes for the discharge to usual place of residence, falls, and avoidable admissions for the first quarter of 2023-24 has been pre populated, along with ambitions for quarters 1-4, to assist systems in understanding performance at HWB level.

The metrics worksheet seeks a best estimate of confidence on progress against the achievement of BCF metric ambitions. The options are:

- on track to meet the ambition
- not on track to meet the ambition
- data not available to assess progress

You should also include narratives for each metric on challenges and support needs, as well as achievements.
- In making the confidence assessment on progress, please utilise the available metric data along with any available proxy data.

Please note that the metrics themselves will be referenced (and reported as required) as per the standard national published datasets.

No actual performance is available for the ASCOF metrics - Residential Admissions and Reablement - so the 2022-23 outcome has been included to aid with understanding. These outcomes are not available for Hackney (due to a data breach issue) and Westmorland and Cumbria (due to a change in footprint).

5. Spend and Activity

The spend and activity worksheet will collect cumulative spend and outputs in the year to date for schemes in your BCF plan for 2023-24 where the scheme type entered required you to include the number of output/deliverables that would be delivered.

Once a Health and Wellbeing Board is selected in the cover sheet, the spend and activity sheet in the template will prepopulate data from the expenditure tab of the 23-25 BCF plans for all 2023-24 schemes that required an output estimate.

You should complete the remaining fields (highlighted yellow) with incurred expenditure and actual numbers of outputs delivered to the end of the third quarter (1 April to 31 December).

The collection only relates to scheme types that require a plan to include estimated outputs. These are shown below:

Scheme Type	**Units**
Assistive technologies and equipment	Number of beneficiaries
Home care and domiciliary care	Hours of care (unless short-term in which case packages)
Bed based intermediate care services	Number of placements
Home based intermediate care services	Packages
DFG related schemes	Number of adaptations funded/people supported
Residential Placements	Number of beds/placements
Workforce recruitment and retention	Whole Time Equivalents gained/retained
Carers services	Number of Beneficiaries

The sheet will pre-populate data from relevant schemes from final 2023-24 spending plans, including planned spend and outputs. You should enter the following information:
- **Actual expenditure to date in column I.** Enter the amount of spend from 1 April to 31 December on the scheme. This should be spend incurred up to the end of December, rather than actual payments made to providers.

- **Outputs delivered to date in column K**. Enter the number of outputs delivered from 1 April to 31 December. For example, for a reablement and/or rehabilitation service, the number of packages commenced. The template will pre-populate the expected outputs for the year and the standard units for that service type. For long term services (e.g. long term residential care placements) you should count the number of placements that have either commenced this year or were being funded at the start of the year.
- **Implementation issues in columns M and N.** If there have been challenges in delivering or starting a particular service (for instance staff shortages, or procurement delays) please answer yes in column M and briefly describe the issue and planned actions to address the issue in column N. If you answer no in column M, you do not need to enter a narrative in column N.

More information can be found in the additional guidance document for tab 5, which is published alongside this template on the Better Care Exchange.

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

2. Cover

Version 2.0

Please Note:

- The BCF quarterly reports are categorised as 'Management Information' and data from them will published in an aggregated form on the NHSE website. This will include any narrative section. Also a reminder that as is usually the case with public body information, all BCF information collected here is subject to Freedom of Information requests.

- At a local level it is for the HWB to decide what information it needs to publish as part of wider local government reporting and transparency requirements. Until BCF information is published, recipients of BCF reporting information (including recipients who access any information placed on the Better Care Exchange) are prohibited from making this information available on any public domain or providing this information for the purposes of journalism or research without prior consent from the HWB (where it concerns a single HWB) or the BCF national partners for the aggregated information.

- All information will be supplied to BCF partners to inform policy development.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Rutland
Completed by:	Katherine Willison
Email:	kwillison@rutland.gov.uk
Contact number:	01572 758409
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Checklist

Complete:
Yes
Yes
Yes
Yes
Yes
Yes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. This does not apply to the ASC Discharge Fund tab.

Complete

	Complete:
2. Cover	Yes
3. National Conditions	Yes
4. Metrics	Yes
5. Spend and activity	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

3. National Conditions

Selected Health and Wellbeing Board: Rutland

		Checklist Complete:
Has the section 75 agreement for your BCF plan been finalised and signed off?	No	Yes
If it has not been signed off, please provide the date the section 75 agreement is expected to be signed off	01/03/24	Yes

Confirmation of National Conditions			
National Conditions	**Confirmation**	**If the answer is "No" please provide an explanation as to why the condition was not met in the quarter:**	
1) Jointly agreed plan	Yes		Yes
2) Implementing BCF Policy Objective 1: Enabling people to stay well, safe and independent at home for longer	Yes		Yes
3) Implementing BCF Policy Objective 2: Providing the right care in the right place at the right time	Yes		Yes
4) Maintaining NHS's contribution to adult social care and investment in NHS commissioned out of hospital services	Yes		Yes

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

4. Metrics

Selected Health and Wellbeing Board: Rutland

National data may be unavailable at the time of reporting. As such, please use data that may only be available system-wide and other local intelligence.

Challenges and Support Needs Please describe any challenges faced in meeting the planned target, and please highlight any support that may facilitate or ease the achievements of metric plans

Achievements Please describe any achievements, impact observed or lessons learnt when considering improvements being pursued for the respective metrics

Metric	Definition	For information - Your planned performance as reported in 2023-24 planning				For information - actual performance for Q1	For information - actual performance for Q2	Assessment of progress against the metric plan for the reporting period	Challenges and any Support Needs in Q3	Q3 Achievements - including where BCF funding is supporting improvements.	Checklist Complete:
		Q1	Q2	Q3	Q4						
Avoidable admissions	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	105.0	117.0	112.0	103.0	119.8	161.5	Not on track to meet target	It continues to be a challenge to prevent such hospital admissions, with a high proportion of older adults and higher risk of comorbilitidies.	A new Health and Care Collaborative project is due to start. Part of this will be implementing a Risk Stratification model for the PCN. People with multiple co-morbilities will trigger a response/intervention for	Yes
Discharge to normal place of residence	Percentage of people who are discharged from acute hospital to their normal place of residence	90.7%	90.9%	91.2%	91.2%	90.6%	91.5%	On track to meet target	Availbility of suitable accommodation is always a risk and difficult to control. There will always be some people who have become too ill or frail to return to their original place of residence.	Home First continues to be a strong approach in use for hospital discharge. D2A processes are in place and are effective.	Yes
Falls	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.				1,155.4	327.2	391.0	Not on track to meet target	The LLR Falls Steering Group is in place to co-ordinate falls services.	There are several falls prevention services operating, including extensive work from therapy with care homes.	Yes
Residential Admissions	Rate of permanent admissions to residential care per 100,000 population (65+)				193	2022-23 ASCOF outcome: 674		Not on track to meet target	The forecast is 230 per 100,000 of the population based on Q1 to Q3 * no Q2* actuals. While this is still not on target, this is an improvement from Q2 *no Q1* where there was a steep increase in placements.	All alternative community options are considered prior to a decision being made to make a long term care placement. The target set for 2023-24 was very ambitious based on exceptionally low placements rates	Yes
Reablement	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services				95.7%	2022-23 ASCOF outcome: 92.3%		On track to meet target	Snapshot data for December 2024 is 91% effectiveness. This is an improvement from the snapshort from September 2023 of 88%	Reablement at home across therapy and inhouse domiciliary care helps to facilitate timely and effective discharges.	Yes

Better Care Fund 2023-25 Quarter 3 Quarterly Reporting Template

6. Spend and activity

Selected Health and Wellbeing Board: Rutland

Checklist						Yes		Yes		Yes	Yes
Scheme ID	Scheme Name	Scheme Type	Sub Types	Source of Funding	Planned Expenditure	Actual Expenditure to date	Planned outputs	Outputs delivered to date (estimate if unsure) (Number or NA)	Unit of Measure	Have there been any implementation issues?	If yes, please briefly describe the issue(s) and any actions that have been/are being implemented as a result.
221	Wellbeing and independence - support to live well with health issues	Carers Services	Carer advice and support related to Care Act duties	Minimum NHS Contribution	£115,290	£86,468	178	138	Beneficiaries	No	
222	Wellbeing and independence - support to live well with health issues	Carers Services	Carer advice and support related to Care Act duties	Minimum NHS Contribution	£30,830	£23,223	89	30	Beneficiaries	No	
223	Wellbeing and independence - support to live well with health issues	Carers Services	Carer advice and support related to Care Act duties	Minimum NHS Contribution	£41,510	£31,133	72	93	Beneficiaries	No	
223	Wellbeing and independence - support to live well with health issues	Carers Services	Carer advice and support related to Care Act duties	iBCF	£39,970	£0	72	0	Beneficiaries	Yes	There was difficulty recruiting to a second member of the Carers Team. Practitioners in other ASC teams have been completing carer assessments alongside the Carer Liason Worker. BCF funding is being redistributed to account for this.
232	Sustaining independence at home	Assistive Technologies and Equipment	Assistive technologies including telecare	Minimum NHS Contribution	£31,980	£10,500	374	127	Number of beneficiaries	No	
241	Home adaptations DFG	DFG Related Schemes	Adaptations, including statutory DFG grants	DFG	£270,255	£361,298	47	53	Number of adaptations funded/people supported	No	
251	Core social care support	Carers Services	Respite services	Minimum NHS Contribution	£20,000	£14,000	30	21	Beneficiaries	No	
321	Transfer of care and reablement	Home-based intermediate care services	Reablement at home (to support discharge)	Minimum NHS Contribution	£676,534	£507,401	2,937	2681	Packages	No	
511	Additional Discharge Funding	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	ICB Discharge Funding	£3,241	£0	6	0	Number of placements	Yes	A small budget was agreed for usage of beds for D2A in the city of Leicester. To date these have not been utilised by Rutland residents, as they feel this is too far away from home. Beds in thios location will not be budgeted for in the Rutland 2024-25 BCF discharge fund.
513	Additional Discharge Funding	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	ICB Discharge Funding	£25,992	£19,665	30	23	Number of placements	No	
514	Additional Discharge Funding	Bed based intermediate Care Services (Reablement, rehabilitation, wider short-	Bed-based intermediate care with reablement	Local Authority Discharge Funding	£28,678	£21,735	30	23	Number of placements	No	

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Rutland Health and Wellbeing Board
Work Plan 2024-25 v1

STANDING AGENDA ITEMS	AUTHOR
Apologies Record of Previous Meeting Actions arising Declaration of interest Petitions, deputations, and questions Questions with notice from members Notices of motions from members	Statutory Agenda Items
LLR Integrated Care System: update	Sarah Prema, Chief Strategy Officer, LLR Integrated Care Service
JSNA: Updates & Timeline	Adrian Allen, Assistant Director - Delivery, Public Health
Joint Health and Wellbeing Strategy	Katherine Willison, Health and Integration Lead.
Better Care Fund: 2023-2025	Katherine Willison, Health and Integration Lead.

MEETING DATE	PROPOSED ITEM	AUTHOR	PURPOSE
June 2024 (date tbc)	Election of Vice-Chair	Chair	Statutory Decision

MEETING DATE	PROPOSED ITEM	AUTHOR	PURPOSE
October 2024 (date tbc)			

MEETING DATE	PROPOSED ITEM	AUTHOR	PURPOSE
January 2025 (date tbc)			

MEETING DATE	PROPOSED ITEM	AUTHOR	PURPOSE
April 2025 (date tbc)			

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