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Rutland County Council

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Meeting:	**PEOPLE (ADULTS & HEALTH) SCRUTINY PANEL**
Date and Time:	**Thursday, 6 April 2017 at 7.00 pm**
Venue:	**COUNCIL CHAMBER, CATMOSE, OAKHAM, RUTLAND, LE15 6HP**
Clerk to the Panel:	**Corporate Support 01572 720954** **email: corporatesupport@rutland.gov.uk**

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Helen Briggs
Chief Executive

A G E N D A

APOLOGIES FOR ABSENCE

1) RECORD OF MEETING

To confirm the record of the meeting of the People (Adults & Health) Scrutiny Panel held on 2 February 2017 (previously circulated).

2) 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.

3) 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 217.

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.

4) QUESTIONS WITH NOTICE FROM MEMBERS

To consider any questions with notice from Members received in accordance with the provisions of Procedure Rule No 219 and No 219A.

5) NOTICES OF MOTION FROM MEMBERS

To consider any Notices of Motion from Members submitted in accordance with the provisions of Procedure Rule No 220.

6) CONSIDERATION OF ANY MATTER REFERRED TO THE PANEL FOR A DECISIONS IN RELATION TO CALL IN OF A DECISION

To consider any matter referred to the Panel for a decision in relation to call in of a decision in accordance with Procedure Rule 206.

SCRUTINY

Scrutiny provides the appropriate mechanism and forum for members to ask any questions which relate to this Scrutiny Panel's remit and items on this Agenda.

7) QUARTER 3 FINANCIAL MANAGEMENT REPORT 15 min

To receive Report No. 37/2017 from the Director for Resources.
(Report circulated under separate cover)

8) QUARTER 3 PERFORMANCE MANAGEMENT REPORT 15 min

To receive Report No. 36/2017 from the Chief Executive.
(Report circulated under separate cover)

9) DIRECTOR OF PUBLIC HEALTH: ANNUAL REPORT 2016 20 min

To receive Report No. 76/2017 from the Director of Public Health.
(Pages 5 - 38)

10) EXTERNAL PROVIDER QUALITY ASSURANCE **15 min**

To receive Report No. 74/2017 from the Director for People.
(Pages 39 - 48)

11) HOMECARE RECOMMISSIONING **30 min**

To receive Report No. 75/2017 from the Director for People.
(Pages 49 - 60)

12) POVERTY IN RUTLAND – UPDATE **10 min**

Report to follow

PROGRAMME OF MEETINGS AND TOPICS **5 min**

13) SCRUTINY PROGRAMME 2016/17 & REVIEW OF FORWARD PLAN

To consider Scrutiny issues to review.

Copies of the Forward Plan will be available at the meeting.

14) ANY OTHER URGENT BUSINESS **5 min**

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

15) DATE AND PREVIEW OF NEXT MEETING **5 min**

Date to be advised.

Agenda items: Sustainability and Transformation Plan Update

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TO: ELECTED MEMBERS OF THE PEOPLE (ADULTS & HEALTH) SCRUTINY PANEL

Mr G Conde (Chairman)

Mr N Begy	Miss R Burkitt
Mr W Cross	Mr R Gale
Mr A Mann	Mr C Parsons
Mrs L Stephenson	Miss G Waller

OTHER MEMBERS FOR INFORMATION

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Report No: 76/2017
PUBLIC REPORT

SCRUTINY PANEL

6th April 2017

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2016

Strategic Aim:	Meeting the health and wellbeing needs of the community improving the health of the population	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr R Clifton Portfolio Holder for Health and Adult Social Care	
Contact Officer(s):	Mike Sandys, Director of Public Health	0116 305 4239 Mike.sandys@leics.gov.uk
	Trish Crowson, Senior Public Health Manager	01572 758 268 trish.crowson@leics.gov.uk
Ward Councillors		

DECISION RECOMMENDATIONS
That the Panel: … 1. Notes the Director of Public Health's Annual Report. 2. Endorses the recommendations in the report.

1 PURPOSE OF THE REPORT

1.1 To provide an overview on the health of the population of Rutland which will also provide intelligence for future service and community planning.

2 BACKGROUND

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

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

2.3 The report uses the analysis within the national health profiles to identify those areas where further investigation and work are necessary. These are the red

indicators of ‘recorded diabetes’ and ‘killed and seriously injured on roads’ and the amber indicators of ‘excess weight in adults’, ‘infant mortality’, ‘excess winter deaths’, ‘hospital stays for self harm’ and ‘hospital stays for alcohol related harm’.

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

3 CONCLUSION AND SUMMARY

3.1 The report describes the health of the population of Rutland and identifies areas for further investigation and focus.

4 BACKGROUND PAPERS

4.1 Health Profile for Rutland 2016

http://fingertipsreports.phe.org.uk/health-profiles/2016/e06000017.pdf

5 APPENDICES

5.1 None

A Large Print or Braille Version of this Report is available upon request – Contact 01572 722577. (18pt)

ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2016

RUTLAND

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

FOREWORD

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

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

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

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

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

Mike Sandys

Director of Public Health

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1. INTRODUCTION

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

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

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

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

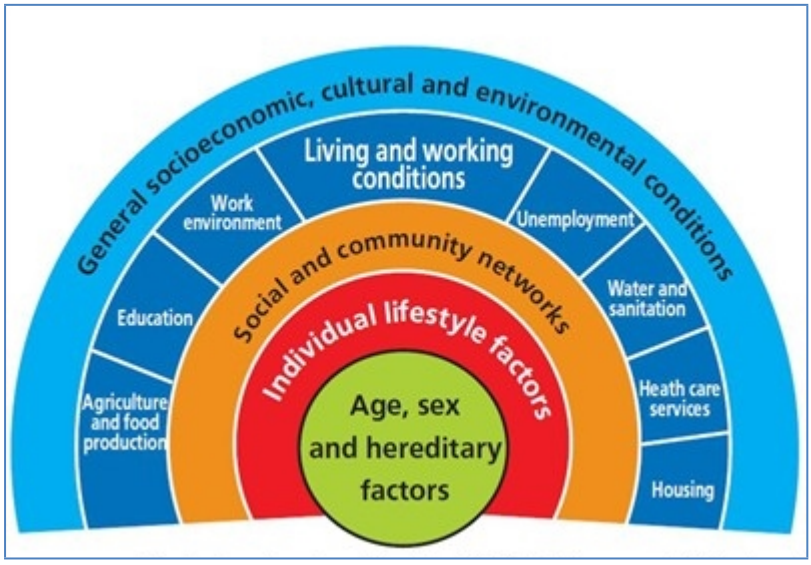

Figure 1 The wider determinants of health (4)

2. RECOMMENDATIONS

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

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

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

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

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

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

3. OVERVIEW OF THE HEALTH PROFILE 2016

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

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

Rutland - Health in summary

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

Health inequalities

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

Child health

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

Adult health

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

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

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

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

Table 1 – Rutland Health Profile 2016

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

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

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

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

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

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

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

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

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

Issues of concern

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

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

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

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

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

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

Recommendations

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

4. THE ROLE OF WORKPLACE HEALTH IN IMPROVING HEALTH

4.1 HEALTH AND WELLBEING OF WORKING AGE ADULTS

Introduction

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

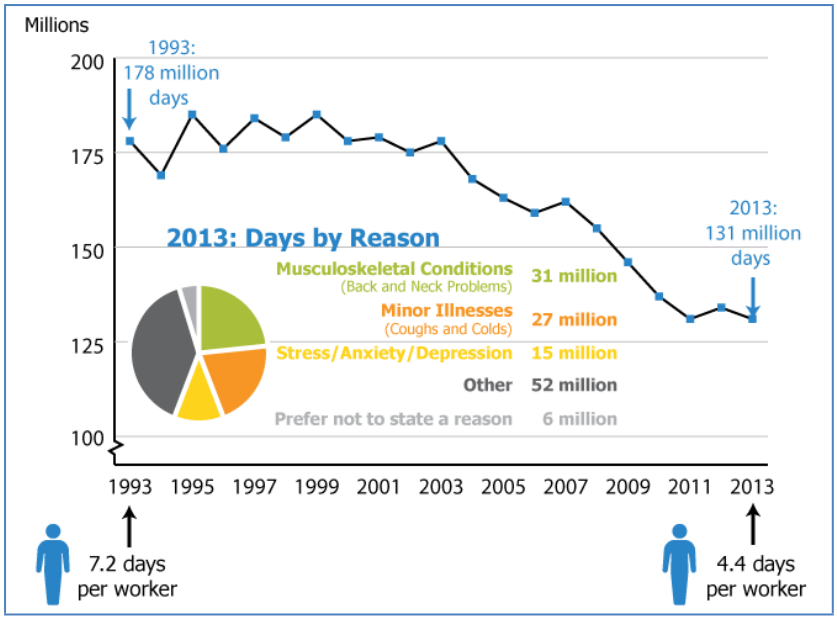

Figure 2 Number of working days lost due to sickness absence, 1993 to 2013, and the top reasons for sickness absences in 2013, UK (5).

Work and health

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

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

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

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

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

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

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

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

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

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

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

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

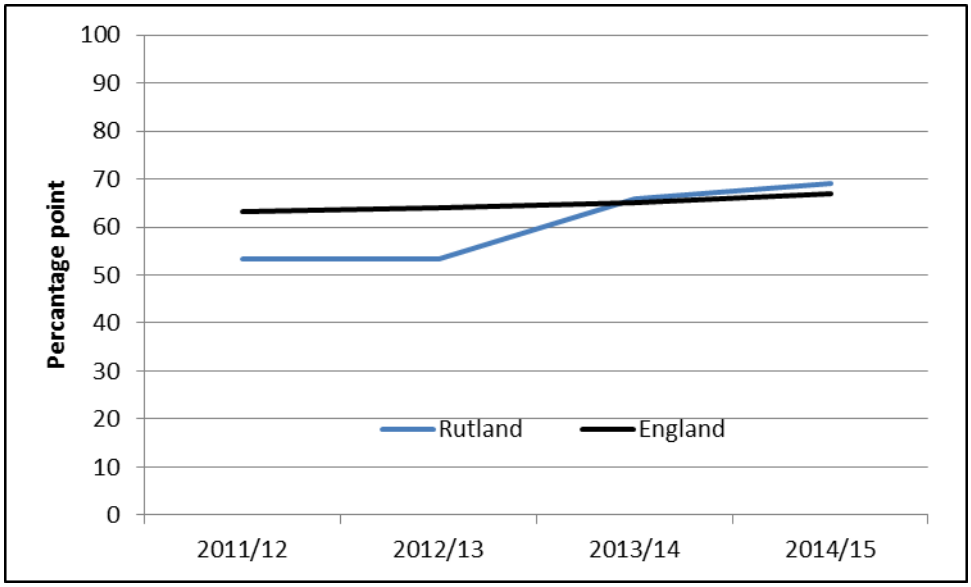

Figure 5 Gap in the employment rate between those with a learning disability and the overall employment rate

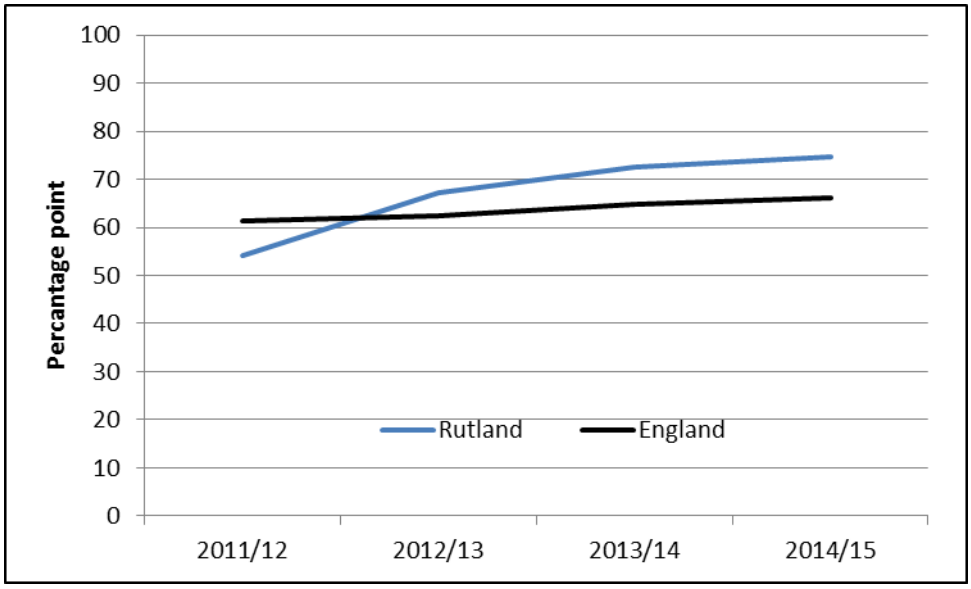

Figure 6 Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate [7]

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

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

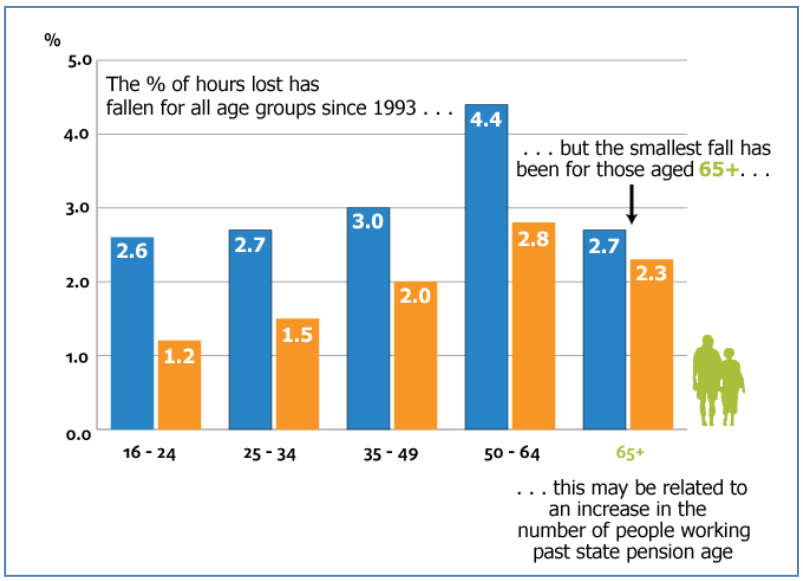

Figure 7 Percentage of working hours lost to sickness by age group – 1993 (blue) and 2013 (orange) (6)

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

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

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

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

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

Figure 8) (6)

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

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

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

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

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

4.2 WORKPLACE HEALTH

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

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

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

What is the Workplace Wellbeing Charter?

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

How does the standard work?

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

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

The Standard has three levels:

1. **Commitment**

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

2. **Achievement**

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

3. **Excellence**

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

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

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

Conclusions

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

Recommendations

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

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

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

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

Background

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

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

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

Creating Healthy Places

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

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

(a) our ability to maintain independence

(b) our resilience

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

Health in all Policies

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

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

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

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

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

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

Documents that have supported this process include:

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

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

1. Community asset: sense of community

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

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

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

2. Community asset: environment

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

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

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

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

3. Community asset: community buildings

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

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

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

4. Traffic and parking

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

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

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

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

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

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

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

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

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

5. Changing population

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

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

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

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

Ways to mitigate some of these risks include:

- Promotion of home improvement schemes such as warm home

- Developing village befrienders

- Developing community activity classes particularly for older residents

- Supporting older residents with garden maintenance

6. Other points of note

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

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

Health in All Policies Recommendations

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

5. FEEDBACK FROM RECOMMENDATIONS 2015

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

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

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

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

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Report No: 74/2017
PUBLIC REPORT

SCRUTINY PANEL

6 April 2017

EXTERNAL PROVIDER QUALITY ASSURANCE

Report of the Director for People

Strategic Aim:	Meeting the health and wellbeing needs of the community	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr R Clifton, Portfolio Holder for Health and Adult Social Care	
Contact Officer(s):	Karen Kibblewhite, Head of Commissioning	01572 758127 kkibblewhite@rutland.gov.uk
	Craig Howarth, Quality Assurance Officer	01572 758365 chowarth@rutland.org.uk

DECISION RECOMMENDATIONS
That the Panel: 1. Notes the content of this report and offer comments.

1 PURPOSE OF THE REPORT

1.1 To provide an overview of the Quality Assurance process with external providers and to note the changes made.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The Council currently commissions services with 11 in-county residential care providers and 12 domiciliary care agencies. The Council has a responsibility to ensure that the services delivered are fit for purpose, meet the needs of the Service Users and comply with Care Quality Commission regulations and relevant legislation.

2.2 **How Quality Assurance previously operated:**
The Quality Assurance process was shared within the Procurement and Contract Management Team by the two Senior Procurement Officers. The Officers completed annual contract monitoring visits, received quarterly information returns from providers and completed targeted inspections in response to safeguarding and/or compliance concerns. This met the Council's statutory responsibilities and is in line with how other local authorities currently operate.

2.3 Officers identified that there were risk associated with this approach to Quality Assurance, particularly given the limited number of Rutland's providers. The

impact of a suspension of placements or collapse of a provider in Rutland would be much greater than in other local authority areas. In addition, officers noted that concerns were being addressed on a reactive basis with providers, rather than working proactively to ensure that issues were prevented or dealt with in their infancy.

2.4 To address this, a Business Case was made for the provision of a dedicated Quality Assurance Officer role and this was recruited to in May 2016. This aligned with the Care Act requirements to facilitate and support our local provider market, and enabled a specific role focussed on achieving high quality care for local Service Users.

2.5 **Purpose of the Quality Assurance Officer role:**
The main purpose of the Quality Assurance Officer role is to provide a consistent approach to contract and compliance monitoring; ensure joint working with Safeguarding; and establish links with other local authorities' Compliance Teams to support cross-border placements. The role also allows the Council to take a more proactive approach with providers to identify potential issues and resolve more quickly.

2.6 **How Quality Assurance now operates:**
Each provider receives an annual contract monitoring visit per year. Where providers are deemed non-compliant in any aspect, an action plan is devised with the provider and regular support visits are scheduled in. The support visits are both to monitor progress and to ensure the provider has the support to improve in a timely manner. An update visit is completed within three months of the date of the initial visit to ensure that all actions have been completed.

2.6.1 Where a provider is fully compliant but potential areas for improvement are identified, a similar approach is taken to support the implementation of the improvements.

2.6.2 All providers also receive a minimum of quarterly visits to ensure that regular communication is maintained. The number of visits that a provider receives is decided according to the level of support that the provider requires and/or requests.

2.6.3 Closer links have been established between the Safeguarding Team and Quality Assurance role. Regular in-house information sharing meetings take place to discuss safeguarding alerts and to plan how to progress these with providers.

2.6.4 In addition, a shared 'Live Status List' has been created to ensure that real time information on any concerns is always available to all Adult Social Care staff, reducing the risk of placements being made with providers inappropriately. This list includes information from Leicester and Leicestershire currently, and is being expanded to include information across all local authorities where placements are made. Previously, ASC staff contacted the Senior Procurement Officers for this information at the point a placement was going to be made; the shared list speeds up the process and ensures the information is always available.

2.6.5 Social Care Workers undertake joint visits as appropriate with the Quality Assurance Officer which ensures that concerns are looked at both from a safeguarding and a compliance aspect.

2.6.6 Safeguarding alerts are distributed to partner agencies and neighbouring local authorities whenever a safeguarding enquiry commences, which ensures a clear line of communication and enables additional information and concerns to be collated.

2.6.7 Regular external information sharing meetings between RCC, other local authorities, health commissioners and he Care Quality Commission provide updates on current enquiries and compliance concerns. This ensures that Officers are aware of the situation across neighbouring authorities, and any changes to providers which may have an impact locally.

2.6.8 The dedicated Operations Delivery Manager role, which was also introduced in May 2016, focusses on ensuring compliance with The Care Act and internal Quality Assurance. This links with the Quality Assurance Officer to ensure that a consistent approach is taken to Quality Assurance across internal and external providers. The two roles work jointly to deliver the Provider Fora, identify training and workforce issues, and support Care Act compliance.

2.7 **The impact of the revised Quality Assurance approach:**
There has been a positive shift in Care Quality Commission ratings for providers contracted by the Council since the revised approach to Quality Assurance has been introduced:

i) Previously there were 5 in-county residential providers with 13 ratings of "Requires Improvement" between them; this is now 4 providers with 4 ratings of "Requires Improvement" between them. All in-county residential providers are currently rated as "Good" overall.

ii) There were 2 domiciliary care providers with 5 ratings of "Requires Improvement" between them; this is now 1 provider with 1 rating of "Requires Improvement". All domiciliary providers are currently rated as "Good" overall.

Appendix A gives the overall ratings for all in-county contracted providers.

2.7.1 There has been significantly improved attendance and participation at the Council's Provider Fora. The fora are designed to allow open discussions with Council officers in which providers can raise queries or concerns, offer updates on policy and guidance changes, and deliver brief training sessions.

2.7.2 There are now not only closer working relationships between the providers and the Council, but also improved communication between the providers themselves. An example of this is the work Officers have undertaken to facilitate shared training resources between providers.

2.7.3 Officers are able to evidence several case studies where the new approach has proactively supported a provider and this has had a positive impact on the service overall and also for the service users accessing these services.

2.8 **Future plans:**
As part of the Quality Assurance process, there is some additional work planned for this year to run alongside the ongoing safeguarding, compliance and contract monitoring work:

i. **Fire Awareness Sessions** in partnership with Leicestershire Fire and Rescue Service for both internal and external providers to enable workers to identify potential risks in service users' homes.

ii. **Landielijke Pravelentiemeting Zorgproblemen (LPZ) Project** due to commence in November 2017, which works with providers to improve service users' physical safety within care homes.

iii. **Specialist training** for providers such as Dementia Awareness and Understanding Behaviours that Challenge, sourced in response to provider requests.

iv. **Facilitation of shared resources** to assist providers in accessing NVQ qualifications for their staff.

3 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

3.1 The Council has developed a new Quality Assurance process with the Quality Assurance Officer and Operational Delivery Manager role which enables a greater proactive approach to Quality Assurance internally and externally.

3.2 This has ensured that there is earlier identification of risks, a reduction in risk and greater assurance that providers within Rutland are delivering safe and high quality services.

3.3 Better, consistent communication has been established both internally and externally which enables the Council to ensure that all concerns are dealt with swiftly and effectively.

3.4 The improved working relationships with the providers have also led to improved standards in care and consequently better Care Quality Commission ratings.

3.5 Further work is planned to ensure that the market within Rutland is stable, to further improve quality, and to ensure that providers have access to relevant qualifications and training.

4 BACKGROUND PAPERS

4.1 There are no additional background papers to the report

5 APPENDICES

5.1 Appendix A – CQC Ratings for RCC Contracted Providers

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

Appendix A. Care Quality Commission Ratings

	CQC prior to May 2016					Date of Inspection	CQC after May 2016				
Care Home	Safe	Effective	Caring	Responsive	Well-Led		Safe	Effective	Caring	Responsive	Well-Led
Belton House	R. Impr	R. Impr	R. Impr	R. Impr	R. Impr	13/09/2016	Good	Good	Good	Good	Good
Chater Lodge	R. Impr	R. Impr	Good	Good	Good	17/12/2016	Good	Good	Good	Good	Good
Crown House	Good	Good	Good	Good	Good	02/07/2016	Good	Good	Good	Good	Good
Manton Hall	R. Impr	R. Impr	R. Impr	R. Impr	Good	21/10/2016	R. Impr	Good	Good	Good	Good
Oak House	Good	Good	Good	Good	Good	09/06/2016	Good	Good	Good	Good	Good
Tixover House	Good	Good	Good	Good	Good	11/08/2016	Good	Good	Good	Good	Good
Willowbrook	Good	Good	Good	Good	Good	17/08/2016	Good	R. Impr	Good	Good	Good
Wisteria House	Good	Good	Good	Good	Good	01/02/2016	Good	Good	Good	Good	Good

	CQC prior to May					Date of Inspection	CQC after May				
Provider	Safe	Effective	Caring	Responsive	Well-Led		Safe	Effective	Caring	Responsive	Well-Led
A&R Guardian	No CQC inspection – last RCC contract monitoring visit 01/09/2016. Required improvement, action plan put in place – actions completed 16/02/2017.										
Care In Comfort	No CQC inspection – last RCC contract monitoring visit 02/12/2016. Required improvement, action plan put in place – due for re-visit April 2017.										
Cathedral Home Care	No CQC inspection – last RCC contract monitoring visit 07/12/2016. Required improvement, action plan put in place – due for re-visit April 2017.										
Evolving Care	Good	Good	Good	Good	Good	05/07/2016	Good	Good	Good	Good	Good
For You Healthcare	Good	Good	Good	Good	Good	29/07/2016	Good	Good	Good	Good	Good
Help at Home	Good	Good	Good	Good	R. Impr	06/09/2016	Good	Good	Good	Good	R. Impr
The Caring Company	Good	Good	Good	Good	Good	28/11/2016	Good	Good	Good	Good	Good
Unique Superior Care	R. Impr	R. Impr	Good	R. Impr	R. Impr	01/02/2017	Good	Good	Good	Good	Good
Velvet Glove	Good	Good	Good	Good	Good	14/05/2016	Good	Good	Good	Good	Good

The following providers have not had a CQC inspection after May 2016; therefore there is no measurable impact to the ratings.

Care Home	Date of Inspection	CQC Inspection Ratings				
		Safe	Effective	Caring	Responsive	Well-Led
Aberdeen House	05/10/2015	Good	Good	Good	Good	Good
Rutland Care Village	16/07/2015	Good	Good	Good	R. Impr	Good
The Lodge Trust	30/12/2015	R. Impr	Good	Good	Good	Good
Bluebird Care	28/09/2015	Good	Good	Good	Good	Outsta.
Provision Care	24/12/2015	Good	Good	Good	Good	Good

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Report No: 75/2017
PUBLIC REPORT

SCRUTINY PANEL

6 April 2017

HOMECARE RECOMMISSIONING

Report of the Director for People

Strategic Aim:	Meeting the health and wellbeing needs of the community	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr R Clifton, Portfolio Holder for Health and Adult Social Care	
Contact Officer(s):	Mark Andrews, Deputy Director for People	01572 758339 mandrews@rutland.gov.uk
	Karen Kibblewhite, Head of Commissioning	01572 758127 kkibblewhite@rutland.gov.uk

DECISION RECOMMENDATIONS
That the Panel: 1) Notes the content of the report and presentation, and for Members to provide input into potential options for homecare prior to soft market testing.

1 PURPOSE OF THE REPORT

1.1 To inform members of the potential homecare models that could be effective and sustainable in Rutland and for further comments from members prior to soft market testing.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 Currently the Council commissions over 63,000 hours of homecare support per year to approximately 85 people. This figure is set to rise in the future due to an ageing population, people living longer with more complex conditions, and people having the choice to remain living at home with appropriate support in place. The Council need to ensure that homecare services are able to meet future demands and are fit for purpose; therefore we are looking at other models for commissioning these services.

2.2 The Council tendered homecare provision in 2013 and currently has a framework agreement in place with 4 domiciliary care agencies to provide care packages to older people. The framework contract is in place until May 2018 and allows the Council to directly award care packages to providers when the need arises.

2.3 Although there were 8 providers initially on the Framework, over the life of the

Framework 3 have withdrawn due to the low volume of work or to difficulties of staffing calls in Rutland.

2.4 In order to ensure sufficient carers are available to meet packages, a number of additional providers have been awarded contracts. These are known as 'second tier' providers and are used where those on the Framework have no capacity. There are 7 such providers currently.

2.5 The two tier approach to providers makes the process of commissioning packages more complex, but as the current contracts are structured is necessary.

2.6 Over the lifetime of the current contract, the market has struggled to respond to the challenge of providing home care support within Rutland due to capacity issues, and due to staffing recruitment and retention difficulties.

2.7 As part of the re-commissioning process it is important to understand the views of service users, carers and providers in relation to support given, the challenges, and how improvements might be made.

2.8 Scrutiny received a report in February 2017 (Report No: 28/2017) setting out the way in which feedback was obtained from service users, carers and providers regarding the current homecare provision in Rutland and the themed responses, including:

- **Standard of care**: The quality of care and support provided by staff who are well trained, and have a knowledge and understanding of service user needs.
- **Consistency of call times**: The times required to support and whether these are at a regular time each day, to which the service user has agreed.
- **Consistency of carers**: The regularity with which carers visit the same service user, and having an understanding of their support needs.
- **Rate of pay**: The rate paid to the provider for the cost of services and the pay received by a carer.
- **Communication**: the way in which service users, providers, carers, and social care share relevant information with each other to ensure effective and safe services.
- **Recruitment and retention of staff**: Recruitment of suitable staff to meet service needs and retaining current staff in the workforce.

2.9 The views of both those who are receiving, and those who are providing home care support have contributed to the development of these models.

2.10 The models developed need to ensure they address the issues identified, as well as take into account the aging population in Rutland and the priority for health and social care to support people to maintain their independence for longer and in their own homes.

2.11 The models developed have also taken account of good practise examples both in the UK and abroad.

2.12 As a result various models of homecare have been identified that could be suitable to meet the needs of Rutland residents both now and in the future. Three models that have been developed are:

i) An improved Framework of preferred providers

ii) Relationship-based homecare

iii) 'Whole care' approach with relationship based support

Appendix A gives further details on each model, the illustrative figures within each, and other models not considered suitable for Rutland - this is for reference as a presentation on the options will be given in the meeting.

2.13 Specialist service provisions for support at home have not been included in these models. These services are provided by staff with specialised training in relation to a particular condition.

3 NEXT STEPS

3.1 Officers propose to carry out soft market testing with the models considered throughout April and May 2017, followed by procurement (dependent on the model) in August 2017.

4 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

4.1 The way in which home care is provided in Rutland needs to change to reflect the growing population and demand for services as well as supporting people to manage long term conditions more effectively, reducing the need for acute services. In order to support this, a new innovative provision of home care will need to be considered that addresses some of the fundamental issues that affect supporting someone in their own home not only now but in the future.

4.2 As recruitment and retention have been an issue in Rutland for some time it is important to consider how these models support the growth, development and progression of staff working in this industry as a result of their training and experience.

4.3 Officers have developed three models which have incorporated the feedback from service users, carers, and providers and consider the future demand for services in Rutland.

4.4 Illustrative figures have been included but will be developed further as more information is gathered which may affect the cost of each model. However, as the market is changing and the demand for these services increases we need to look at a balance of sustainable cost against outcomes achieved for those receiving support.

4.5 That Members consider the options of models for the provision of domiciliary services in Rutland and provide input prior to soft market testing.

5 BACKGROUND PAPERS

5.1 Report 131/2016 Home (Domiciliary) Care tabled at People (Adults & Health) Scrutiny Panel July 2016 sets out background detail on the provision of home care in Rutland.

5.2 Minutes of the meeting of the People (Adults & Health) Scrutiny Panel held on Thursday, 22nd September, 2016.

6 APPENDICES

6.1 Appendix A: Options for home care models in Rutland

6.2 Appendix B: Timetable for the re-commissioning of domiciliary care provision in Rutland.

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

Appendix A:

Options for home care models in Rutland

1. **Option 1: An improved framework of preferred providers**

What this model is and how it will work

1.1. A framework enables a single procurement process for multiple providers of a service, who are then 'called off' (purchased) from the framework to provide services for individuals. These providers have a contract with the Council. As care packages are required these are brokered to providers based on the individual's support needs and call time requirements.

1.2. This model commissions packages of care based on the time taken to support an individual with a particular task(s) in order for their support needs to be met.

1.3. Although this model is similar to the current homecare provision improvements would be made within the contract in relation to the quality of service delivery; standards of support; minimum training requirements for staff; and expectation of providers.

1.4. Providers applying for a position on the framework will need to evidence that they have the following in place:

- A sustainable wage that is competitive with other service industries, promotes employment, attracts staff who can deliver quality and addresses issues such as payment for travel and training time
- An hourly rate that includes good quality mandatory training across a range of care areas, and inclusive of travel time
- Career progression and training that is aligned to the national Skills for Care programme for this sector
- Values based recruitment practice for all care workers and agency staff to ensure that they recruit caring people.

1.5. Providers will need to evidence that the support given is outcome focussed ensuring that they are continually working with individuals to promote independence, and evidence will be required to show how this is assisting with improving a person's quality of life and reducing the level of support required.

1.6. Framework review intervals will take place annually in which if further providers are required they will be able to join the framework. Where providers are under-performing they will be removed from the framework.

1.7. With a smaller pool of framework providers there will need to be a positive move in ensuring care packages in similar locations are distributed more effectively so that there are fewer providers working in the same area, or on the same street.

Risks and issues

1.8. The issues with the model of a preferred provider framework is that providers on the current framework have limited capacity to support new packages of care, there are recruitment and retention difficulties, training opportunities within Rutland are limited, and there are more rural areas in Rutland affecting the time required to travel between calls. These could be potential risks should a similar model be considered – these may be reduced in future by actions outlined below. However capacity

amongst providers has been a long standing issue and is unlikely to be resolved quickly or without significant changes.

1.9. Another potential risk would be that of the cost of services and if the fee rate is viable for providers going forward. To reduce this, the Council could increase the cost per hour to be in line with that advised by the United Kingdom Homecare Association (UKHCA) or providers could bid for a contract, advise what level of cost would be appropriate and provide a breakdown of cost to support this. This could prove to be an expensive alternative if requested increases in rates were high, or it may reduce the number of potential providers where providers felt the rate would not be substantial enough. The risk with this is that the Council may be left with a limited amount of providers working in Rutland.

1.10. An alternative to this would be two fees rates for Rutland: an urban and a rural hourly rate. For this to be implemented there would need to be discussions as to which areas would be classed as urban and rural. This would assist where there have previously been difficulties covering care packages in the villages that are further from the main towns, requiring more travel time, and where fewer care packages are located.

1.11. A further risk would be how providers continue to support the more complex care packages, even with the additional payment. From the current framework providers have struggled to manage and continue supporting complex cases and as a result have handed care packages back to the Council. Should this model be implemented there would be the risk that similar situations occur. This not only affects the market and the provision of services but affects service users and their wellbeing due to the inconsistency of support and transition across services and/or providers.

Benefits

1.12. By implementing framework reviews and allowing new providers to join this annually ensures the Council can monitor the level of need for services and ensure appropriate support is in place, building capacity within the service. This model would also support the sustainability of local businesses and ensuring providers are performing to the standard the Council and service users expect.

1.13. By considering how care packages are effectively distributed will reduce the travel time between visits, increase capacity for providers, and will provide service users with more consistent call times and regular carers. The Council can also work more effectively with a smaller pool of providers ensuring standards of care are maintained to a high level.

1.14. The benefits of this model, with the improvements to be made, is that there will be a mixed pool of providers continuing to offer service users the choice as to those suitable to meet their support needs at appropriate times for them. Staff will also be supported through better working conditions as a result of a competitive wage and available training opportunities.

1.15. By increasing the fee rate to providers with that advised by the UKHCA would include a percentage of the travel time per care visit, and be in line with the National Living Wage. This would allow providers to ensure carers receive a competitive wage to that of other industries and ensure they are paid for an aspect of the travel time rather than the current ‘contact time only’ model. Using the UKHCA per hour costing

model incorporating the National Living Wage, and allowing 15 minutes of travel time per hour of care, the fee rate required would be £18.66 per hour.

Financial implications

1.16. Officers have modelled a Framework approach with the current care packages in adult social care to see how it could be managed in Rutland with the pool of providers available. The cost of this model based on current and predicted increase in service needs throughout 2017/2018, and uplifting the current hourly rate from £16.46 to £18.66, would be between approximately £1.191m- £1.234m.

2. Option 2: Relationship-based Homecare

What the model is and how it will work

2.1. This model moves away from the traditional 'time and task' orientated model to one which is more responsive and outcome focussed by using salaried staff, enabling each carer to have a detailed knowledge of the individual prior to support and respond effectively to how a service user is feeling on that particular day. The support provided will be tailored to not only meet the physical needs, but also the social and emotional needs of the individual and (any) informal carer(s).

2.2. The model will consist of small self-managing teams providing co-ordinated care and support for a specific catchment area, typically consisting of between 13 to 16 service users. This would equate to 64 full time equivalent staff based on the current level of care packages.

2.3. The service user and carer are introduced and get to know each other before any support is carried out. They would be able to find out each other's like/dislikes, what's important to that person and how best they feel they can be supported. The carer and service user then identify how the relationship and care should be managed, including discussions on how they wanted their care delivered and what outcomes they wanted to achieve.

2.4. The support given would be flexible and appropriate to that service user on that day. For example should a service user need more support than usual then the carer would not need to request permission to carry out further support but would be able to assist, and where required refer onto other services ensuring any further risks or deterioration in health and wellbeing is supported and taking a more proactive approach to assisting someone living independently in their own home. The support would consist of daily activities, such as personal care, meal preparation and medication support, weekly activities, such as shopping and attending appointments, and flexi time to carry out particular hobbies and activities to promote community inclusion and reduce isolation.

2.5. The salaries of the staff would be competitive in comparison to other industries and are reflective of the increase in responsibilities. These would also increase dependent on the development and training achieved.

2.6. The service would link to and/or directly provide reablement support to actively promote self-care and independence, working with service users to prevent situations escalating.

Risks and issues

2.7. The risks involved with this model are that providers may not want to be involved/ bid due to the financial impact this may have with the intention of reinvesting any profit back into the business to ensure continued growth and development can be achieved. Providers may also feel it is not suitable to be part of a consortium as the service will need to be renamed and re-established therefore providers may feel this will affect their service, or recognition of service, that is already in situ.

2.8. Due to this model being delivered through potentially a single provider or consortium of providers, there could be issues affecting service delivery if the provider is not of an appropriate standard.

2.9. This model would also create difficulties in the quality assurance of the market as the Council would not be able to monitor providers outside of this model, unless in the event of a safeguarding incident, due to not commissioning packages of care with them.

2.10. As a result of this model being provided through a single organisation there would be difficulties in building in the multi-disciplinary support and clinical roles required, such as nursing support, without increasing the cost of this model. This could also mean there would still be duplication across organisations as they would not be directly linking with each other for the relevant support.

2.11. A further risk is that of service users transitioning between providers and the effect this may have on an individual's wellbeing. If the service user agrees to transfer to the new provider then there would need to be an implementation plan to mitigate any negative impact of transfer on the individual. Further options would need to be considered for those wishing to remain with the current provider, such as the use of direct payments where appropriate.

2.12. Due to the services remaining demand led it is important to ensure this model is open to growth and is subject to the demand of homecare support required within Rutland.

Benefits

2.13. With carers working in smaller areas this will reduce the travel time required between visits and will increase capacity for new packages of care. It will allow carers to spend more time appropriately supporting service users without longer journeys in between calls and without being constrained by time allocated visits. Reducing the number of carers working in each catchment will enable consistency for service users and will allow the carers and service users to build positive working relationships. Carers would be salaried which would encompass their whole working time rather than the traditional model of 'contact time'- the time spent supporting a service user.

2.14. By offering competitive salaries for staff will attract people into the care profession and provide improved terms and conditions. By recruiting and retaining well trained and knowledgeable staff ensures that service users receive a high standard of support.

2.15. Service users' advised that being able to have a positive working relationship with the carers has an impact on an individual's wellbeing and quality of life, achieving the outcomes they have set, and improving their independence. Carers also advised that

they felt better job satisfaction working with people more regularly as they are able to see a person become more confident, independent and they can see the general improvements to a person's overall wellbeing over time and how the support they have given has done this.

2.16. With staff having a good knowledge of the local community, some activities may be able to be supported by informal carers and community networks and individuals may just need the information on these in order to access them.

2.17. The success of this model would be measured by the number of service users with reduced support needs, overall satisfaction received from the service and improvements on a person's quality of life. This would be achieved by feedback from interviews, care management reviews and the journals that each staff member completes providing evidence that the service user is being supported to achieve the outcomes they have discussed and that are meaningful to them. A carer competency framework will ensure that the service is consistent, successful, effective and safe due to the working practises of individuals.

2.18. Through linking to and/or directly providing reablement support this would reduce the need for higher levels of support and/or the need for individuals to transition into acute services or residential care.

2.19. This service could be developed and managed through a not-for-profit model ensuring any surplus revenue was reinvested back into the business to support growth and development: this would assist with developing staff further through training and support, and recruiting staff to meet the demand for support in Rutland.

Financial implications

2.20. Officers have modelled this approach with the current care packages to establish the level of staff required and to identify how the catchment areas could be devised. Based on the current service needs, and the number of staff required to support this model, the cost would be approximately £1.334m.

3. Option 3: 'Whole care' approach with relationship based support

What the model is and how it will work

3.1. This model expands the concept of homecare to encompass end to end care within an integrated health and social care framework. This would provide a range of support and interventions, from lower end, basic support through homecare, reablement, and some healthcare interventions.

3.2. Using similar principles to model 2 staff would work in specific catchment areas, but with various professionals working throughout the team to support staff and service users across Rutland. This model is based on similar models throughout the UK and Europe including the Netherland's Buurtzorg model, Wiltshire's Help to Live at Home, and the Raglan Project in Wales.

3.3. This model has been based on taking a more holistic approach that looks at all aspects of support the individual may require within one service and how frontline staff can be trained to provide basic interventions and assistance which will reduce the need for several services visiting a particular individual. For example, staff will be trained to carry out specific healthcare tasks under clinical supervision therefore

reducing the need for health services although expertise in this area will be based within the team.

3.4. Several spot contracts would be held with providers locally in order to continue commissioning low level, packages of domiciliary support with an outcome based approach to encourage individuals to achieve the outcomes they have set and support with self-help and independent living.

3.5. Low level packages of care would be those that are non-complex ensuring the market could sustain the support for the duration required. Previously providers have found it difficult, or have been unable, to continue supporting some packages of care due to the complexity and level of support needed. This in turn affects the continuity and consistency of support for service users. Based on the current level of support 15% of care packages would be commissioned with providers. This will assist with maintaining the market and providing greater efficiencies across the provision of services.

Risks and issues

3.6. The risk with this model would be understanding the level of engagement and support required from the CCG and the wider engagement from health providers.

3.7. Further risks include the effect this model may have on the wider homecare market in Rutland and the sustainability of spot providers, and how packages would be commissioned with providers based on the level of need and complexity. With the current care packages and those with low level support needs approximately 15% would be commissioned with providers.

Benefits

3.8. This model would support the career progression of staff and reduce the duplication of services. The staff within this model would also be able to directly refer onto other services required and request assistance or advice from other professionals within the team based on their expertise is specific areas.

3.9. This model includes multi-disciplinary support and clinical supervision which would meet the whole care needs of an individual, and in a more responsive and dynamic way.

3.10. By continuing with several spot purchase contracts ensures the Council continues to support the market and is able to monitor the standard of support received by individuals through regular contract monitoring visits carried out.

3.11. This model builds on the existing integration of health and social care services in Rutland. It could potentially develop to become aligned to the wider multi-specialist community provider approach.

Financial implications

3.12. The ‘Whole care’ approach would be of a reduction in cost to option 2 as current staff and resources would be utilised more effectively and 15% of care packages would be commissioned to providers with the UKHCA recommended hourly rate of £18.66. The total cost would be approximately £1.101m.

4. Other options considered:

A number of other options were considered and rejected on the basis that they would not be effective in Rutland. These were:

Block contract:

4.1. This model allows the council to have a contract with providers for a set amount of hours per week or per month. This would ensure that a certain amount of hours are carried out by providers so they can support with care packages. Rutland currently commissions c1227 hours per week which in order to give sufficient block contracts, for this model to be sustainable for providers, would significantly reduce the overall number of providers contracted by the Council.

4.2. The pool of available providers would thereby be reduced and there would be a reliance on these providers to meet future demands. This could also cause the Council risk if a provider failed and would affect the remaining capacity across Rutland.

4.3. Although the block contract would specify the amount of hours a provider is required to carry out, generally block contracts do not specify when the hours must be provided. This can in turn affect capacity and ensuring call times are suitable to meet individual service users' needs.

Prime provider model:

4.4. Officers have looked at authorities who have implemented the prime provider model: the county is split into geographical areas or via GP zones and there is 1 provider in each area that will support with packages of care. The main provider can subcontract packages of care to other providers in the area but the prime provider will be responsible for this care package on-going. Having 1 provider per area enables providers to have more capacity as they are not picking up packages across a wide geography with more travel time required.

4.5. This model of domiciliary care would not be suitable for Rutland due to the size and geography: with only 2 central towns, and more rural locations than urban, the county would ultimately be split into 2 locations with the towns being central to these therefore only supporting 2 providers. Within both neighbouring authorities there has been significant difficulty in recruiting staff to support the geographical areas causing providers capacity issues. This would be reflected if Rutland supported this model as providers would require staff to continue supporting with private packages of care. This could also cause a high risk to the Council should there be issues with providers in terms of safeguarding and compliance where there are only 2 contractors involved.

Appendix B: Indicative Timetable for Re-commissioning of Domiciliary Care Provision (dependent on the model)

Stage	Date of completion
Consultation with service users, carers, and providers	Oct 2016- March 2017
Develop model- soft market testing	April - May 2017
Write specification, ITT preparation	June - July 2017
Cabinet for approval to procure	July 2017
Tender issued/ OJEU Notice published with mandatory pre-qualification questionnaire and ITT.	August 2017
Final Tenders submitted	October 2017
Final Tenders evaluated/ Clarification meetings	November 2017
Clarification meetings	November 2017
Award contract	December 2017
Implementation period/ sort of TUPE	December 2017- 30th May 2018
Start of contract	31st May 2018