Rutland County Council

Catmose, Oakham, Rutland, LE15 6HP
Telephone 01572 722577 Facsimile 01572 758307

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, 25th June, 2019** commencing at 2.00 pm when it is hoped you will be able to attend.

Yours faithfully

Helen Briggs
Chief Executive

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

A G E N D A

1) APOLOGIES

2) RECORD OF MEETING

To confirm the record of the meeting of the Rutland Health and Wellbeing Board held on 5 March 2019 (previously circulated).

3) DECLARATIONS OF INTEREST

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

4) PETITIONS, DEPUTATIONS AND QUESTIONS

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

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

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

5) ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2018

To receive Report No.96/2019 from the Director of Public Health.
(Pages 5 - 48)

6) HEALTH PROTECTION ASSURANCE BOARD ANNUAL REPORT 2018

To receive Report No.97/2019 from the Director of Public Health.
(Pages 49 - 76)

7) JOINT HEALTH AND WELLBEING STRATEGY DISCUSSION

To receive a presentation from Dr Kath Packham, Consultant in Public Health.
(Pages 77 - 86)

8) RUTLAND BETTER CARE FUND PROGRAMME 2018-19 AND 2019-20

To receive Report No. 87/2019 from the Strategic Director for People.
(Pages 87 - 120)

9) ANY URGENT BUSINESS

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

10) DATE OF NEXT MEETING

The next meeting of the Rutland Health and Wellbeing Board will be on Tuesday, 1 October 2019 at 2.00 p.m. in the Council Chamber, Catmose.

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DISTRIBUTION

MEMBERS OF THE RUTLAND HEALTH AND WELLBEING BOARD:

1	Cllr Alan Walters	Rutland County Council
2	Cllr Samantha Harvey	Rutland County Council
3	Dr Hiliary Fox	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)
4	Dawn Richards	Spire Homes
5	Insp. Siobhan Gorman	Leicestershire Constabulary
6	Helen Briggs	Rutland County Council
7	Dr Janet Underwood	Healthwatch Rutland
8	Mike Sandys	Rutland County Council - Public Health
9	Rachel Dewar	Leicestershire Partnership NHS Trust
10	Frances Shattock	NHS England Local Area Team
11	Simon Mutsaars	Community & Voluntary Sector Rep
12	Mark Andrews	Rutland County Council
13	Tim Sacks	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)

OTHERS FOR INFORMATION

14	John Morley	Rutland County Council
15	Karen Kibblewhite	Rutland County Council
16	Sandra Taylor	Rutland County Council
17	Simon Pizzey	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)
18	Wendy Hoult	NHS England Local Area Team

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Report No: 96/2019
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

25 June 2019

ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2018

Presented by:	Dr Kath Packham, Consultant in Public Health
Report Author(s) and contact details	Mike Sandys, Director of Public Health Email: mike.sandys@leics.gov.uk Trish Crowson, Senior Public Health Manager Email: trish.crowson@leics.gov.uk

RECOMMENDATIONS
That the Rutland Health and Wellbeing Board: 1. Notes the Director of Public Health Annual Report 2018 as appended to this report 2. Supports the report's recommendations.

1 PURPOSE OF THE REPORT, INCLUDING LINKS TO HEALTH AND WELLBEING PRIORITIES EG. JSNA AND HEALTH AND WELLBEING STRATEGY

1.1 The purpose of this report is to present the Director of Public Health's Annual Report for 2018. A copy of the full report is appended.

2 BACKGROUND AND MAIN CONSIDERATIONS

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 purpose of a Director of Public Health's annual report is to improve the health and wellbeing of the people of Rutland. This is done by reporting publicly and independently on trends and gaps in the health and wellbeing of the population and by making recommendations for improvement to a wide range of organisations.

2.3 One of the roles of the Director of Public Health is to be an independent advocate for the health of their population. The Annual Reports are the main way by which

Directors of Public Health make their conclusions known to the public.

2.4 This year's report presents on the changing population of Rutland, the prevalence of individual and multiple conditions (otherwise known as multiple morbidity) in the population and data on excess winter deaths and place of death. The growing number of people living with multiple health conditions presents as bigger challenge to public services as the overall growth in the number of older people.

2.5 The health and care system should promote 'healthy ageing'. Ways to achieve this are by:

- tackling social isolation
- promoting social prescribing
- reducing falls
- promoting physical activity throughout life and into older age
- supporting carers

2.6 Being socially connected to friends, family and the wider community is a key element of healthy ageing.

2.7 'Social prescribing' is a key way in which broader services can help support the frail, and those with multiple health conditions to maintain independence.

2.8 Falls are a serious health issue for older people, with around a third of all people aged 65 and over falling each year. Regular physical activity, can develop and maintain strength and balance in frail patients. Public Health will continue to support the implementation of the Falls programme with an emphasis on evaluating the effectiveness of the postural stability programmes.

2.9 Physical activity is a key preventative element of healthy ageing – from protecting against some forms of dementia, to reducing the risk of depression, heart disease and the risk of a fall in older age. Working with partners in Leicester-Shire and Rutland Sport (LRS) and Rutland County Council, Public Health will ensure that muscle strengthening activity and physical activities of older people are reflected in sport and physical activity plans.

2.10 Supporting Carers and including supporting them to be healthy is a key element to ensuring a good outcome for the frail and those with multiple health conditions. The recently adopted Carer's Strategy across Leicestershire, Leicester City and Rutland sets out a broad programme of support for carers.

2.11 The health and care system needs to continue its redesign work so as to enable the individual to be treated as a whole person, not as a series of separate illnesses or conditions. The recently produced LLR Frailty Resource Pack is a welcome step to local health services understanding, and responding to, frailty.

3 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

3.1 The profound changes caused by population change and the increasing numbers of people living with multiple health conditions will raise further strains and challenges for health and social care services. It is vital that organisations in Rutland promote 'healthy ageing' throughout life and provide suitable support within

communities to mitigate the effect of these profound changes.

3.2 The Director of Public Health's (DPH) Annual Report is a statutory independent report on the health of the population of Rutland. By considering the report the Board will help inform future commissioning decisions.

4 BACKGROUND PAPERS

4.1 There are no additional background papers to the report.

5 APPENDICES

5.1 Appendix A: Annual Report of the Director of Public Health 2018.

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

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Rutland County Council

ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2018

RUTLAND COUNTY COUNCIL

POPULATION CHANGE, HEALTH STATUS AND MULTI-MORBIDITY IN RUTLAND

Contents **Page**

Annual Report of the Director of Public Health 2018

1. Foreword

Welcome to my annual report for 2018. In my last annual report I presented an infographic picture of many different aspects of the health of Rutland.

Presenting such an analysis led to a range of further work. As can be seen in the 'update on recommendations', the report has led to detailed further work on the needs of the serving military and their families, analysis of anti-depressant prescribing within Rutland and rural poverty.

In this year's report I have focused on the ageing population and, in particular, the challenges of 'multi-morbidity'.

We are all aware of the profound changes in our population structure and the demand that places on health and council services. But, in itself, getting older is not the problem. It's the increasing number of years spent in poor health that drives demand for services.

It is important to recognise this and think about how services might be delivered in such a way that takes account of the increase in multi-morbidity. As a whole system, we need to continue our efforts to promote good health throughout all ages, if we want effective care for our future generations.

I would like to thank Natalie Davison and Kajal Lad for their tremendous work in constructing the infographics and narrative that underpin this report, and Trish Crowson and Kath Packham from Public Health for their contributions to the report and continued hard work on improving the health of Rutland people.

Mike Sandys

Director of Public Health

2. Introduction

Directors of Public Health have a statutory duty to write an Annual Public Health Report that describes the state of health within their communities.

It is a major opportunity for advocacy on behalf of the population and, as such, can be used to help talk to the community and support fellow professionals, providing added value over and above intelligence and information routinely available such as that contained within health profiles or the Joint Strategic Needs assessment (JSNA).

It is intended to inform local strategies, policy and practice across a range of organisations and interests and to highlight opportunities to improve the health and wellbeing of people in Rutland.

However, the report is not an annual review of public health outcomes and activity. The annual report is an important vehicle by which Directors of Public Health can identify key issues, flag up problems, report progress and thereby serve their local populations. It is also a key resource to inform stakeholders of priorities and recommend actions to improve and protect the health of the communities they serve.

Within this report, data is presented on the changing population of Rutland, the prevalence of individual and multiple conditions in the population and data on ‘excess winter deaths’ and place of death. The content should be used by commissioners and providers of services to respond to changes in the health of Leicestershire residents.

3. Recommendations and Summary

Like last year's report, I am aware that this one is 'data heavy'. Each slide should contain something of relevance for commissioners and providers of services to reflect on in their plans, as well stimulating wider public debate on the changing nature of the population's health. There are, though, actions I intend to progress through the work of the public health department and Rutland County Council more generally:

If there is one thing we can all do it is to promote 'healthy ageing'. There are many ways to do this:

Promote Social Prescribing in Rutland

'Social prescribing' is a key way in which people are supported to improve their health and wellbeing by connecting them with a range of services in their community who can provide non-medical support; including help to remain independent, social support and activities that reduce isolation and loneliness. Whilst social prescribing is for all ages it is predominantly used for those with multiple health conditions and can help promote healthy ageing. The social prescribing model being developed in Rutland recognises that many organisations and individuals have a role in this; some in more generic roles and others more specialist. A comprehensive system is being developed to connect and support cross agency referrals based on the principle that there should be 'no wrong front door'. This model is being shaped by front line workers, but to be fully successful it needs to be underpinned by an effective information system, tools and resources for staff and a secure referral system.

Falls

Falls are a serious health issue for older people, with around a third of all people aged 65 and over falling each year. Regular physical activity, can develop and maintain strength and balance in frail patients.

We will continue to support the implementation of the Falls programme with an emphasis on evaluating the effectiveness of the postural stability programmes.

Physical Activity

Physical activity is a key preventative element of healthy ageing – from protecting against some forms of dementia, to reducing the risk of depression, heart disease and the risk of a fall in older age.

Working with Active Rutland and Leicester-Shire and Rutland Sport (LRS), Public Health will ensure that muscle strengthening activity and physical activities of older people are reflected in sport and physical activity plans.

Carers

Supporting Carers and supporting them to be healthy is a key element to ensuring a good outcome for the frail and those with multiple health conditions.

The recently adopted Carer's Strategy across Leicestershire, Leicester City and Rutland sets out a broad programme of support for carers. Within public health I will ensure we play our part the implementation of the Carer's strategy, ensuring that public health information services provide good advice to carers.

Support the health care system to treat the person, not the individual condition

As the report shows healthcare systems are not currently designed to treat patients with multiple illnesses. The recently produced LLR Frailty Resource Pack is a welcome step to local health services understanding, and responding to, frailty.

Through the specialist support provided by public health consultants to CCG's and the broader health system, public health can play a part in redesigning pathways to take account of frailty and multi-morbidity. The introduction of risk stratification software in GP practices will give better quality, comprehensive data on multi-morbidity. Public Health should use this to target work and influence pathway development.

4 Population Change, Health Status and Multi-morbidity

4.1 Population

In 2017, 4.7% of the population was aged 0-4 (1,858 people), 17.1% was aged 5-19 (6,740 people), 53.7% was working age (21,192 people aged 20-64) and 24.5% was older than 65, this includes 3.3% of the total population that was aged 85 and over (1,290 people). Compared to nationally, Rutland has a higher proportion of the population aged over 65 and 85 respectively.[1]

Nationally the over 65 population is predicted to grow by 42.8% and the over 85 population by 91.7% between 2019 and 2039. In Rutland, both the over 65 population and over 85 population is predicted to grow at a faster rate than nationally, by 45.0% in the over 65 population from 10,000 to 14,500 people, and by 121.4% in the over 85 population from 1,400 to 3,100 people. The largest change is predicted to be in the 75-79 age band with an increase of 1,000.[2]

Living alone

According to the 2011 census, 6.25% of households in Rutland were occupied by a single person aged 65 and over living alone (2,142 households). This is higher than the England value of 5.24%.[3]

Carers

Family carers play a key role in supporting the health and wellbeing of those they care for. The Care Act 2014 requires that carers are supported in their role by social services. The number of carers supported by Rutland County Council during 2017/18 increased by 25%, from 143 to 194 (503 per 100,000 population). In 2016/17, 62.1% reported that they were satisfied with the support they had received, relative to an English average of just 39%, and 79.5% said that they found it easy to find information about services, relative to an English average of 70.6%.

In 2017, the total number of people aged 65 and over providing unpaid care to a partner, family member or other person in Rutland was estimated to be 1,385. This is expected to increase by 33.9% to 1,855 carers by 2035.[4]

It can be difficult for carers to maintain their own connection to what is important to them while fulfilling their caring role. According to the Personal Social Services Carers

survey, the latest data from 2016/17 shows carer reported quality of life in 2016/17 was rated as 7.9 in Rutland, similar to the English average of 7.7. In the same survey less than a third (31.1%) of adult carers who use support services in Rutland and felt they have as much social contact as they would like. This is lower than the national percentage of 35.5%.[8]

4.2 Gap in healthy life expectancy at birth and life expectancy at birth

Nationally, life expectancy at birth has increased by 0.1 years for males between 2014-16 and 2015-17 whereas in females, over the last four time periods life expectancy has stabilised at 83.1 years respectively. In Rutland, life expectancy at birth has increased by 0.2 years for males and 0.3 years for females between 2014-16 and 2015-17.[8]

At a national level, healthy life expectancy at birth has increased by 0.1 years for males but decreased by 0.1 years in females. In Rutland, healthy life expectancy at birth has increased by 1.0 years for males compared to the previous time period, from 68.8 years to 69.8 years, whereas in females healthy life expectancy at birth has decreased 1.8 years from 70.2 years to 68.4 years.[8]

The gap in life expectancy at birth and healthy life expectancy at birth infers the number of years a person is likely to live in poor health. As shown by the graph, females, on average, live longer but spend more years in poor health. The latest data shows in Rutland males spend 12.5 years in poor health compared to 17.4 years in females. The national gap currently stands at 16.1 and 19.3 years for males and females respectively.[8]

4.3 Prevalence of conditions in GP Practices

With the introduction of the new General Medical Services (GMS) contract in April 2004, a quality framework of indicators (QOF) was developed for general practice, the QOF. An integral part of the QOF is the collection of prevalence data to allow practices to case find those patients that require specific management. Prevalence data within the QOF are collected in the form of practice registers. Please note, while many patients are likely to suffer from co-morbidity, i.e. are diagnosed with more than one of the clinical conditions included in the QOF clinical domain, robust analysis of co-morbidity is not possible and therefore patients may be on more than one disease register if they have multiple conditions or risk factors.

The table shows the percentage of patients recorded on a QOF disease register in Rutland General Practices. In 2017/18, over 6,000 patients (16.7%) were on the Hypertension disease register and over 1,300 patients (3.6%) were on the Depression disease register in the county. Both these percentages are significantly higher than the national percentages of 13.9% and 3.1% respectively. Over 2,000 patients aged 17 years and above (6.5%) in Rutland were recorded on the Diabetes Mellitus register.[5] This is similar to national prevalence, but still represents a substantial burden of ill-health locally.

4.4 Loss of hearing

A person who is not able to hear as well as someone with normal hearing, hearing thresholds of 25 decibels (dB) or better in both ears, is said to have hearing loss. Unaddressed Hearing Loss can have a serious impact on health and wellbeing:

- People with hearing loss are more likely to experience emotional distress and loneliness.
- Hearing loss doubles the risk of developing depression.
- People with hearing loss are at least twice as likely to develop dementia.

Action on Hearing Loss have estimated the number of people with hearing loss of at least 25 dB in each Local Authority area in the UK, using mid-2014 ONS population estimates. In 2014, approximately 8,000 people in Rutland were estimated to be affected by hearing loss, over a fifth (21.0%) of the total population.[6]

4.5 Loss of sight

Over two million people in the UK live with sight loss. That's around one person in 30. It is predicted that by 2020 the number of people with sight loss will rise to over 2,250,000. And by 2050, the numbers of people with sight loss in the UK will double to nearly four million.[7] This is because:

- the UK population is ageing and as we get older we are increasingly likely to experience sight loss
- there is a growing incidence in key underlying causes of sight loss, such as obesity and diabetes

Prevention of sight loss will help people maintain independent lives as far as possible and reduce needs for social care support, which would be necessary if sight was lost permanently. The counts of new completions of Certifications of Visual Impairment (all causes - preventable and non-preventable) by a consultant ophthalmologist as a rate of the resident population in the county have been examined. In Rutland the rate of sight loss certifications per 100,000 population has fluctuated to perform significantly worse (higher) and similar to the national average since 2010/11. The latest data shows in 2016/17 there were 26 new certifications in the county, which equates to a rate of 67.3 per 100,000 population. This is significantly worse (higher) than the national rate of 42.4 per 100,000 population.[8] Whilst a higher level of sight certifications is deemed to be worse, completing the sight loss certification initiates the process of registration with a local authority and leads to access to services. This may well indicate that people with sight loss in Rutland are being proactively identified and therefore able to access the help and support they require. However sight loss can develop for a number of preventable reasons, for example related to diabetes or smoking, and therefore it is worth considering whether some of these sight loss certifications could be avoided through better diabetic control, or through improving smoking cessation rates.

Where the cause of sight loss is Age-related Macular Degeneration (AMD) or Glaucoma, the rate of new completions of Certifications of Visual Impairment due to these disorders have been examined separately. For the last six years, the rate of sight loss due to AMD in those aged 65 years and above has remained similar to the national average. The rate of sight loss due to glaucoma in those aged 40 years and above performs similar to the national average in 2016/17 with 6 new certifications.[8]

4.6 Dementia

With the introduction of the new General Medical Services (GMS) contract in April 2004, a quality framework of indicators (QOF) was developed for general practice, the QOF. An integral part of the QOF is the collection of prevalence data to allow practices to identify those patients that require specific management. Prevalence data within the QOF are collected in the form of practice registers. Please note, while many patients are likely to suffer from multi-morbidity, i.e. are diagnosed with more than one of the clinical conditions included in the QOF clinical domain, robust analysis of multi-morbidity is not possible. Identifying these patients may rely on finding those that are on more than one chronic disease (or long term condition) register.

The recorded dementia QOF prevalence examines the number of people with dementia recorded on GP practice registers as a proportion of the people (all ages) registered at each GP practice. In Rutland the dementia QOF prevalence has significantly increased over time from 0.6% in 2011/12 to 0.9% in 2017/18. Throughout this time, the prevalence in Rutland has remained significantly higher than the national average. The latest data reflects 336 patients have been diagnosed with dementia in Rutland.[9]

Increasing the number of people living with dementia who have a formal diagnosis enables patients, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes. In 2018 in Rutland, 56.5% of those patients estimated to have dementia had been diagnosed; this is significantly worse (lower) than the national average of 67.5% and significantly lower than the national benchmark of 66.7%.[8]

Examining the trend in the directly age standardised rate of emergency inpatient hospital admissions for people with a mention of dementia in any of the diagnosis code positions (aged 65 years and above) per 100,000 population is useful to understand the variation in the provision of care of people with dementia. Over the last six years in Rutland the rate has remained significantly better (lower) than the national average. The latest data shows there were 249 emergency admissions with a mention of dementia in the population aged 65 years and above in Rutland in 2017/18.[10]

The ratio of inpatient service use to recorded diagnoses provides an indication of the use of inpatient general hospital services for people diagnosed with dementia. The indicator illustrates the variation in the percentage of admissions for dementia (with a mention in the diagnosis code) compared to dementia primary care registers. Over the last six years in Rutland the rate has remained similar or significantly lower than the national average and the latest data shows in 2017/18 the ratio of inpatient service use to recorded diagnoses was 53.9% in Rutland, this is similar to the national percentage of 56.5%.[10]

4.7 Forecasted prevalence of long term conditions in people aged 65 years and above

The projected number of people over the age of 65 years with a long term condition between 2017 and 2035 in Rutland have been examined in the chart below. The numbers are based on the current prevalence rates applied to projected populations.

Please note, the numbers refer to people on individual registers i.e. people with multi-morbidities will be counted on each register, therefore the totals will be greater than projected populations for the over 65s.

The projected increase in number of people with the following conditions between 2017 and 2035 in Rutland is: Dementia (78.8%), Stroke (47.5%), Heart attack (44.8%), Bronchitis and emphysema (42.9%), Depression (41.6%), Diabetes (41.1%), Obesity (34.2%).[4]

4.8 Risk stratification using the ACG System of Rutland population

Risk stratification is a concept used to help understand the needs of the population so that services can be better planned and delivered. Risk stratification involves segmenting the local population into groups by what kind of care they need as well as how often they might need it. It then examines who, within each segment, has the greatest risk of needing intense care such as a hospital admission.

The Johns Hopkins Adjusted Clinical Groups (ACG) System is used to identify patients in Rutland with the highest burden of health needs and then identify those most likely to use health services. This approach is commonly used and based on widely available GP practice data and Secondary Uses Service data (SUS). The variables used in the ACG system fall into the 8 categories, as identified by the below figure.

Figure 1 – Overview of the ACG System Predictive Modelling Process (taken from 'Predictive Models in the ACG System' by Johns Hopkins)

It is important to note, the modelling processes to identify these cohort of individuals most likely to use health services are driven primarily by the concept of overall disease burden, the nature of individual diseases and co-morbidity combinations. The weights associated with prior utilisation and prior costs are very low, as admissions (for example) in the previous year are not the key determinant of high cost or admission in the future. This contrasts with the ethos behind other predictive models that assign very high weights to the number of emergency admissions in the last year and/or secondary care use.

4.8.1 Stratifying the population by cost utilisation

Running GP practice data through the ACG risk stratification tool will provide an output that shows the number of people in each risk strata based on costs. Please note, currently no costs for pharmacy or primary care costs are available but will be in later iterations of the ACG tool.

It is well known that the cost of health care is not even distributed across the population; it is concentrated in a small proportion of people. The ACG System allows

us to look at the specific figures for Rutland and ascertain how costs are concentrate within a small proportion of the population. The shares of the registered population in GP practices in Rutland are examined by secondary care costs over a period of one year. The pyramid shown in Figure 2 illustrates that around 5% of the population accounts for around half (50%) of all secondary care costs over a year. Furthermore, almost a fifth (17%) of secondary costs are concentrated in just 0.5% of the population of Rutland (c. 200 people) while the majority of the population (80%) account for just 13% of costs.

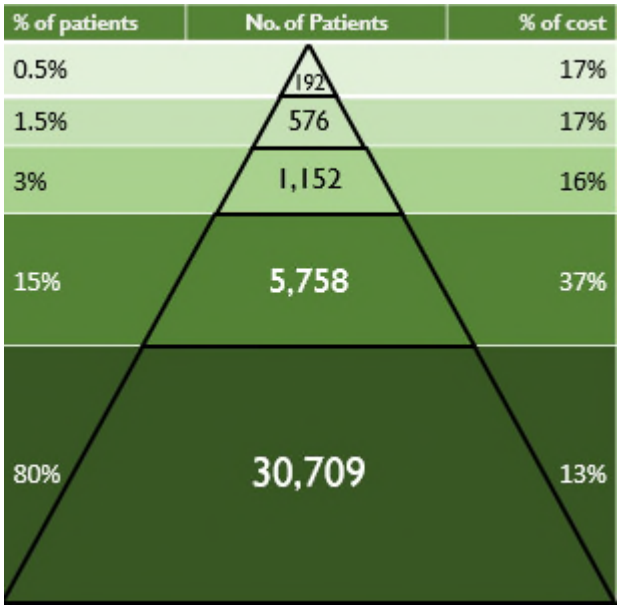

Figure 2 – All secondary care costs by population.

A similar, but more pronounced, pattern is evident for emergency admission costs. The pyramid shown in Figure 3 illustrates that around 2% of the population of Rutland (roughly 750 people) account for three-quarters (75%) of all emergency admission costs in the previous year, with specifically around 0.5% of the population of Rutland (roughly 200 people) accounting for over two-fifths (43%) of all emergency admission costs over the previous year. The majority of the population (80%) incur no emergency admission costs.

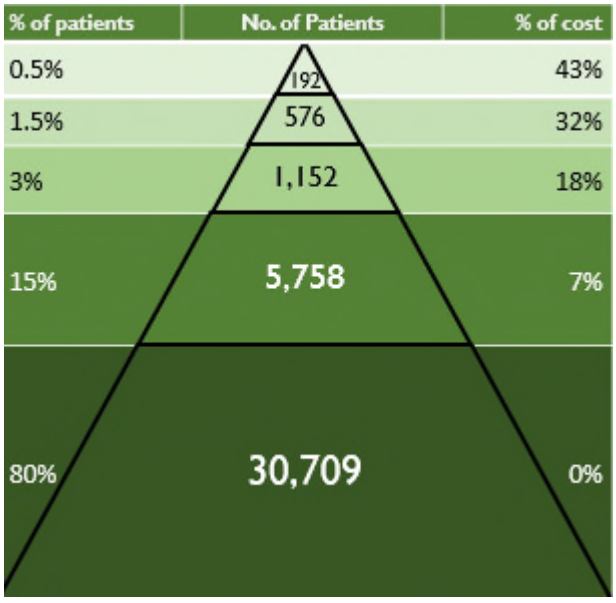

Figure 3 – Emergency care costs by population

4.8.2 Long term conditions (LTCs) by age

The number of patients with counts of long term conditions (LTCs) by age is collected through the ACG System. The data for Rutland (Figure 4) shows, regardless of gender, as we age the prevalence of multi-morbidity increases. In the county, around 1 in 4 patients (24%) aged 85 years and above have 8 or more LTCs compared to 1 in 25 patients aged 65-74 years. However, there are fewer people aged over 85 years than there are aged 65-74 years, so it is important that absolute numbers are considered alongside proportions. In terms of absolute numbers, there is a higher count of patients with 5 or more LTCs in the 65-74 years age group than those aged 85 years and above, at 918 and 720 patients respectively. When thinking about service planning and delivery it is useful to where best to target intervention to prevent escalating health care costs and improve patient outcomes. Although, there may be higher costs associated with those aged over 85 years, with 8 or more long-term conditions it may be that there is limited room to reduce or prevent health and care costs for this cohort and that they are already receiving all the health and care that they require. However, it may be that, for example, people in the 45-64 age band, with 2 to 4 long-term conditions could be an area for intervention where it is possible to improve patient outcomes and reduce or prevent escalating health and care costs.

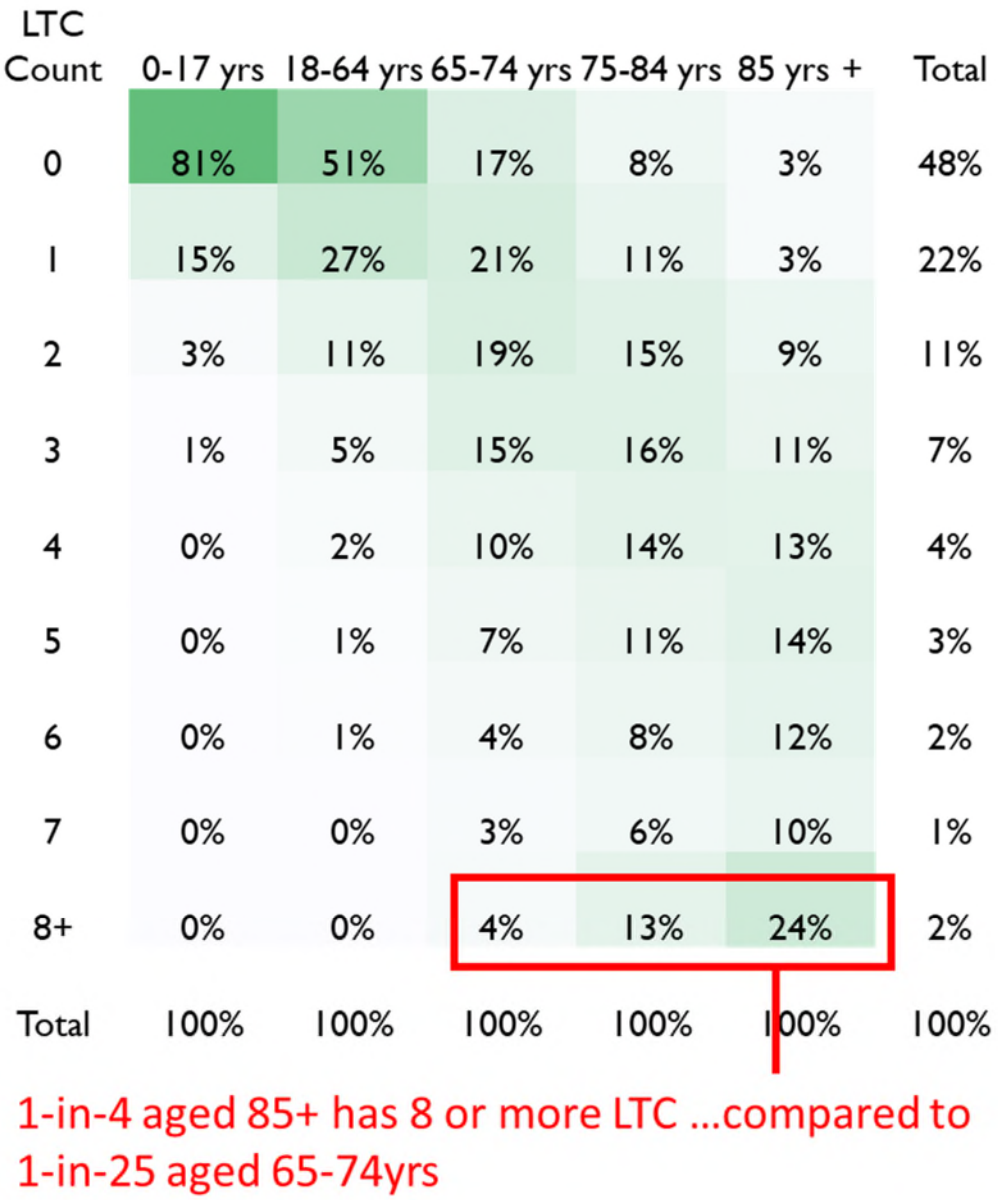

Figure 4 – Long Term Condition count by age bands (percentages)

Figure 5 (below) underlines the normalisation of multi-morbidity in patients of Rutland. This illustrates that all patients with heart failure have at least one other chronic condition and around two-thirds of people with heart failure have 7 or more other chronic conditions. The condition which has the highest proportion of people with no other chronic conditions is diabetes and even there only 8% of people diagnosed with diabetes have no other chronic conditions. Around a quarter of people with diabetes (26%) have 7 or more other chronic conditions. This illustrates that multimorbidity is the norm for people with long-term conditions and it varies by condition type. It also highlights that treating a single condition such as diabetes, is unlikely to have a huge

impact for that individual if their other long-term conditions are not also treated. Or, put simply, treat the person, rather than the condition.

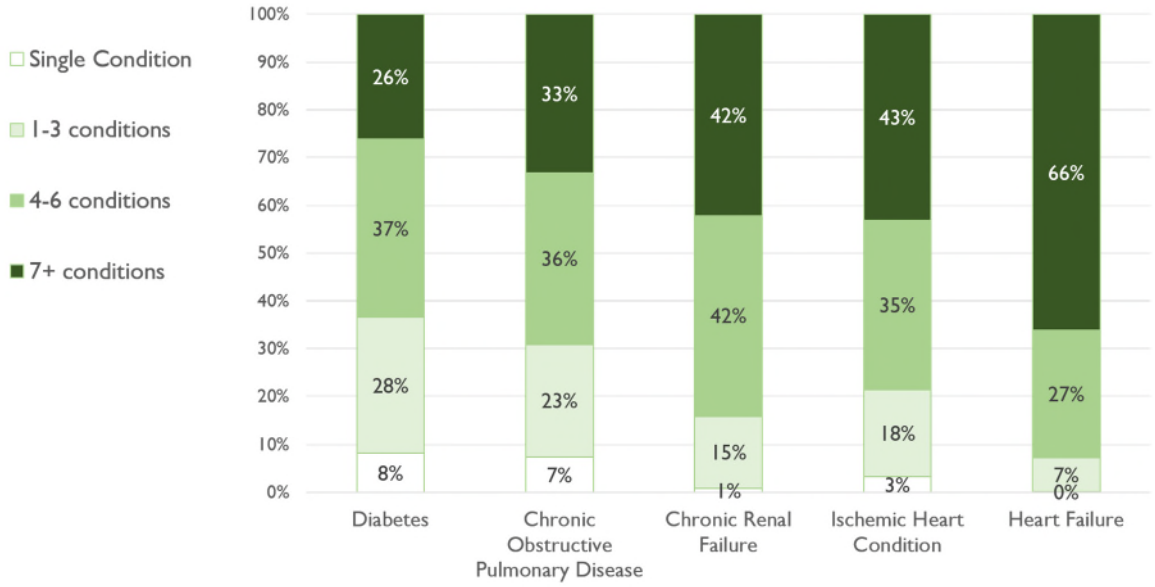

Figure 5 – Multimorbidity by condition type for Rutland patients

The table below (Figure 6) highlights that increasing multimorbidity is associated with higher costs and resource use. Multimorbidity is known to be associated with a greater use of health services, including A&E attendances, outpatient attendances, hospital admissions and polypharmacy.

As expected, the data shows people with multiple conditions were more likely to experience higher hospital admission costs than those with only one condition. For example, the average total admitted patient cost (APC) was almost £2500 higher for patients with 8 or more LTCs than for patients with one condition alone. Similarly, the annual hospital admission costs for patients with diabetes and only one other condition are £30 higher than for patients with diabetes alone.

One of the most common consequences of being affected by multiple health conditions is being prescribed multiple medications for long periods of time, a phenomenon known as polypharmacy. While some polypharmacy can be appropriate, it can be harmful if poorly managed, especially among people living with frailty. As shown by the table, the count of unique prescription types increases considerably as

the number of long term conditions a patient has increases.

The final two columns in the table in Figure 6 are risk scores calculated using the ACG System. The first of these risk columns is the 'risk of persistent high cost' and is calculated as the probability of a patient being in the top 20% of high cost patients in each of the next three 6-month periods. The second risk column is the percentage likelihood of emergency admission in the next 12months. Both ways of calculating future risk show that risk increases as the number of long term conditions increases. For those with 8 or more long term conditions the risk of persistent high costs and of emergency admission in the next 12 months is above 50% - i.e. more likely to happen than not.

			Mean values								
No. of Long Term Conditions	Number of patients	% of patients	A&E attendances	Outpatient attendances	Elective admissions	Emergency admissions	Total APC cost	Emergency admission cost	Unique presciption types	Risk of persistent high cost	Risk of emergency admission (next 12mths)
0	18,297	48%	0.2	0.4	0.0	0.0	£ 42	£ 20	0.8	1%	6%
1	8,333	22%	0.3	1.0	0.1	0.0	£ 122	£ 33	1.8	2%	11%
2	4,186	11%	0.3	1.8	0.2	0.1	£ 251	£ 68	3.0	6%	16%
3	2,554	7%	0.3	2.3	0.3	0.1	£ 436	£ 110	4.5	10%	21%
4	1,651	4%	0.3	3.1	0.4	0.1	£ 607	£ 144	5.7	15%	25%
5	1,125	3%	0.4	3.8	0.6	0.2	£ 823	£ 242	6.9	22%	31%
6	782	2%	0.5	4.3	0.7	0.3	£ 1,243	£ 452	8.0	28%	37%
7	508	1%	0.7	5.0	0.8	0.3	£ 1,295	£ 457	8.9	34%	43%
8+	950	2%	1.1	5.9	0.9	0.8	£ 2,578	£ 1,522	12.0	50%	56%
Total	38,386	100%	0.3	1.3	0.2	0.1	£ 260	£ 98	2.4	6%	13%

Figure 6 – Health service use and cost stratified by the number of long term conditions

As discussed above, multimorbidity does not just occur in the elderly. Figure 7 (below) shows the population segmented by combining two measures: the age of patients (denoted by a letter, increasing with age) and the number of chronic conditions grouped together (e.g. 0, 1, 2-4, 5-7, 8 or more). Five age bands and five bands for Multimorbidity were created as follows:

- A = 0-17 years
- B = 18 – 44 years
- C = 45 – 64 years
- D = 65 – 79 years
- E = 80+ years

- 0 = zero chronic conditions
- 1 = 1 long term condition (LTC)
- 2 = 2 to 4 LTCs
- 5 = 5 to 7 LTCs
- 8 = 8 or more LTCs

This process placed all Rutland patients into one of 26 different segments according to their age and how many long term conditions they had (e.g. B5 = people aged 18-

44years with 5 to 7 long-term conditions).

Looking at the mean emergency cost for across all segments of the population shows that the highest costs are found in the population with 8 or more conditions, regardless of age. This highlights that multimorbidity more than age drives emergency admission costs. Rather than the oldest age group, age group with the highest emergency costs in Rutland is 45-64 years, followed by those aged 18-44 years (with 8 or more long term conditions).

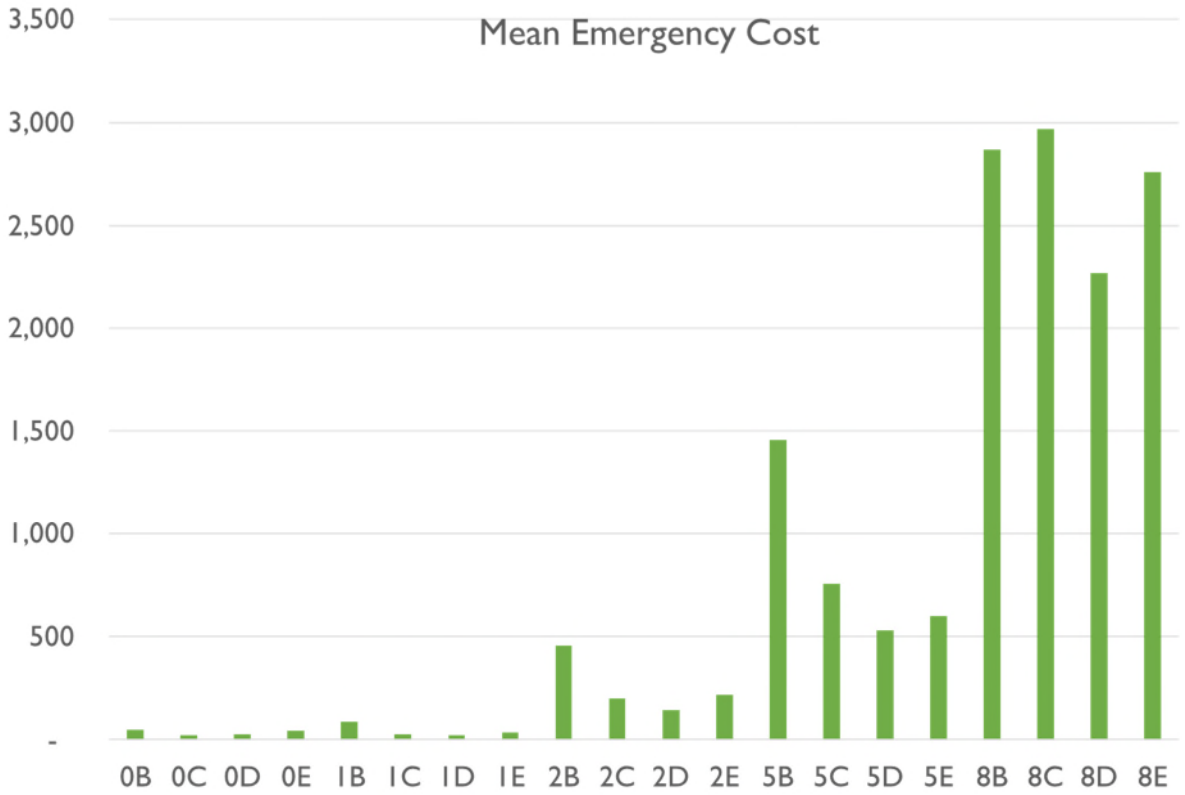

Figure 7 – Mean emergency costs segmented by age-group and multimorbidity bands

4.9 Hospital admissions

4.9.1 Emergency Admissions

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

Against a strong national trend of rising emergency admissions, the rate of emergency admissions has been maintained at a steady level in Rutland, with the 2017/18 rate only 0.5% higher than the rate in 2014-15. Non elective admissions rose by 9% in England over the same period according to national hospital activity data.[11]

In 2017/18, the crude rate of emergency admissions for patients aged 65 years and above in Rutland is 18,815 per 100,000 population aged 65 years and above. This equates to 1,822 emergency admissions in the population aged 65 years and above in Rutland. This is the 2nd lowest rate out of the 16 CIPFA nearest neighbours to Rutland.[12]

4.9.2 Falls

Nationally falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. they are a major precipitant of people moving from their own home to long-term nursing or residential care. The highest risk of falls are in those aged 65 years and above and it is estimated that about 30% people aged 65 years and above living at home and about 50% of people aged 80 years and above living at home or in residential care will experience an episode of fall at least once a year.

The local data for Rutland shows the rate of emergency admissions for falls increases with age, with the rate of admissions for those aged 80 years and above being seven times higher than those aged 65 to 79 years. The rate of emergency admissions for falls for those aged 80 years has remained similar to the national average for five of the last eight time periods. The most recent data for 2017/18 shows there were 130 emergency hospital admissions for falls in persons aged 80 and above, an increase by 20 admissions compared to the previous year.[8]

The rate of emergency hospital admissions for hip fractures in persons aged 65 and above and in persons aged 80 and above (separately) has increased each year between 2014/15 to 2017/18. In the older age band, the national rate has declined slightly year on year.

The latest data in 2017/18 shows the rate of emergency hospital admissions for hip fractures in persons aged 65 and above and in persons aged 80 and above (separately) has increased (worsened) to perform significantly worse than the national rate. This represents an additional 22 admissions in the 65 and above age band and 26 admissions in the 80 and above age band, compared to the previous year. When

examining by gender, in 2017/18, the rate of emergency hospital admissions for hip fractures in males aged 65 and above per 100,000 population is similar to the national average, whereas the rate in females is significantly worse than the national average.[8]

4.10 Minimising unnecessary time in hospital

Delayed Transfers of Care (DToC) are the additional days that a person may stay in hospital, once medically fit for discharge, because they are unable to move on to their onward destination, e.g. because there is a lack of capacity in non-acute hospital for convalescence, or a package of care is not yet in place for them. Where DToCs can be avoided, as well as freeing up hospital capacity, this reduces the risk to individuals of hospital-contracted infections and of deconditioning due to prolonged inactivity, which can then impede recovery and independence.

DToC rates in Rutland have been reducing over time, and now match those of some of the best performing parts of the country: Rutland was ranked 19th out of 152 Health and Wellbeing Board areas in England in 2017-18 for its DToC rate, at 5.5 delays per day per 100,000 adult population. This was the lowest rate in the East Midlands, where rates ranged between 5.5 and 24.2.

4.11 Regaining the ability to manage at home after a hospital stay

Reablement helps people to learn new ways to accomplish day to day tasks that they can no longer manage as well as they used to, prolonging their ability to manage independently.

In Rutland, in 2016-17, 3.1% of people aged 65 years and over who were discharged from hospital were offered reablement services, which was similar to the England average. This is an improvement on previous patterns: in 2013-14 the rate was 2.8%, 0.5% below the then England average of 3.3%. The 2016-17 rate equals the rate of reablement being offered in Leicester and is 0.7% higher than that in Leicestershire.

Rutland has achieved very high rates of success with reablement services. In 2016-17 and 2017-18, more than 95% of individuals who received reablement services were still at home 91 days after being discharged from hospital. The 2016-17 rate of 97.2% was the best in the country.

4.12 Mortality

The directly age standardised mortality rate (ASMR) is calculated to take into account

the age structures of the population. Since 2004, the ASMR for all ages in Rutland has remained significantly lower than the national average. The latest data in 2015 shows when the ASMR is broken down into age groups, those under 65, between 65 and 74, between 75 and 84 and above 85 years all have a similar rate to the national average.[9]

In Rutland, 10.1% of all deaths in 2015 were in those aged under 65. This is significantly lower than the national percentage of 14.8% and has decreased year on year from 13.2% in 2012. Of all deaths in Rutland, 46.6% were from those aged 85 and above, this is significantly higher than the national percentage of 40.4%. The percentage of deaths in this age group has increased significantly over time, likely due to the ageing population.[9]

4.12.1 Place of death

Over a third (38.9%) of all deaths in Rutland in 2016 were in hospital, followed by: in the home (27.7%), in care homes (27.7%), hospices (3.2%) and other places (2.4%). This pattern of place of death is reflected nationally. The latest data shows Rutland has a significantly lower proportion of deaths occurring in hospital and a significantly higher proportion of deaths in care homes compared to nationally. In Rutland the trend is significantly decreasing over time for in-hospital deaths and significantly increasing over time for deaths in care homes.[9]

In Rutland, over half (51.9%) of deaths in the under 65 years age group occurred in hospital in 2016, this is the highest percentage out of all age groups. The lowest percentage of in-hospital deaths occurred in those aged over 85 years. In 2016, less than a third of deaths (29.8%) in this age group were in hospital, significantly lower than the national percentage of 43.8%. The trend of in-hospital deaths has been significantly decreasing across the 65-74 age band and 85 and above age band over time.[9]

As age increases, the percentage of deaths in care homes increases. Almost half (45.7%) of all deaths in the 85 and above age bands occurred in care homes, a significantly higher percentage to the national average (36.7%). The trend of care home deaths has been significantly increasing in the county across the 85 and above age band over time.[9]

Nationally the percentage of deaths at home decreases with age. In 2016 in Rutland, over a third (39.7%) of deaths in those aged 65-74 years died at home, similar to the national percentage of 30.3%. This was the highest percentage out of all age bands

in Rutland residents. In those aged 85 and above, a quarter (24.5%) of all deaths were in the home. This is a significantly higher percentage compared to the national average (16.4%).[9]

In 2016, hospice deaths accounted for 3.2% of all deaths in Rutland. This is similar to the national percentage of 5.7%. In Rutland the trend is significantly increasing over time for deaths in hospices.[9]

4.12.2 Deaths in Usual Place of Residence

In Rutland, over half (52.4%) of all deaths were in usual place of residence (DiUPR) in 2015, this is significantly higher than the national percentage of 46.0%. The trend has increased significantly in Rutland over time and the percentage of DiUPR has continued to have a significantly higher percentage than nationally since 2006. Two-thirds (66.1%) of all deaths from those aged 85 and above in Rutland were in the usual place of residence, this is significantly higher than the national percentage of 54.1%. The percentage of DiUPR in this age group has increased significantly over time.[9]

When examining DiUPR by cause of death in 2015, this showed Dementia and Alzheimer's disease had the highest percentage of DiUPR (87.3%), followed by Circulatory disease (49.0%), Cancer (48.0%) and Respiratory disease (32.5%). Trend analysis for Rutland shows that the percentage of deaths in usual place of residence for Cancer has shown a significant increase over time whereas Dementia and Alzheimer's disease, Circulatory disease and Respiratory disease have all shown no significant change in the percentage of DiUPR.[9]

4.12.3 Excess winter deaths

In common with other countries, more people die in the winter than in the summer in England and Wales. The Excess Winter Deaths (EWD) Index is defined as the ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths. Between August 2014 to July 2017 there were an estimated 43 excess winter deaths in Rutland. This represents a EWD Index of 12.0%, which means that 12.0% more deaths occurred in the winter months compared with the non-winter months.[8] As it is common to observe large fluctuations in EWDs for which trends over time are often not smooth, we have presented a three-year moving average to smooth out any short-term fluctuations and make the trend over time clearer in the graphs presented.

Nationally, EWDs are generally higher in females and the elderly. In Rutland, for all but one data point in August 2006 to July 2009, the EWD Index for those aged 85 years and above has been consistently higher than those of all ages since recordings began. When examining by gender, on a national level, the EWD Index for females aged 85 and above has been higher than males (although not always significantly) for the last 13 time periods. In Rutland, the EWD Index for females aged 85 and above has been higher (although not significantly) than males in the same age group for the last four time periods.[8]

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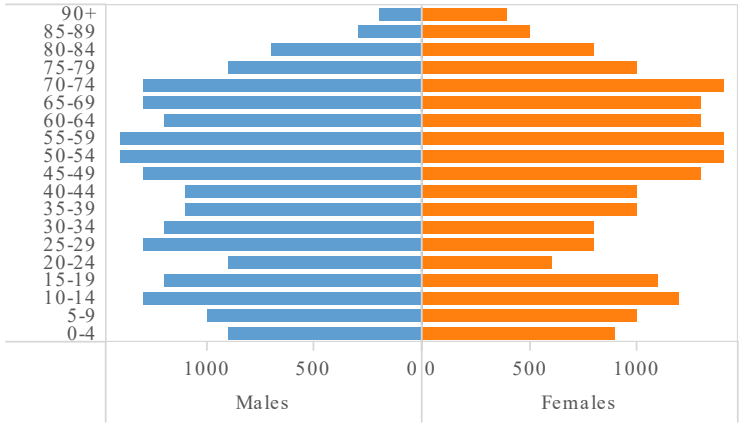
[12] Department of Health and Social Care (2018) Local area performance measures: NHS social care interface dashboard. Available at: https://www.gov.uk/government/publications/local-area-performance-metrics-and-ambitions

2016-based population projections in Rutland

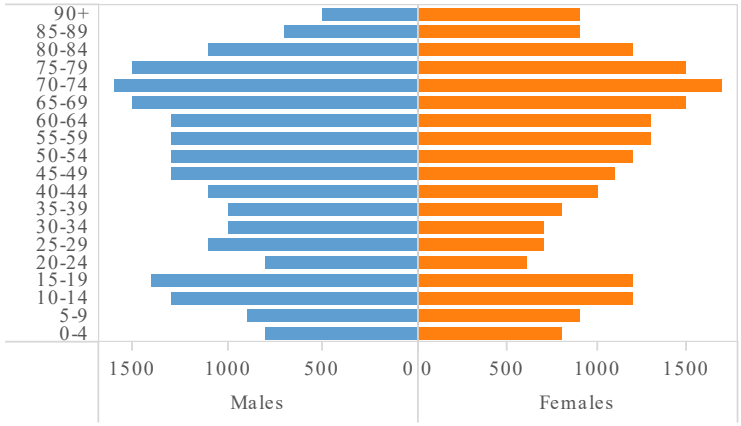
The 2016-based population projections provide statistics on the potential future size and age structure of the population. They are used as a common framework for informing local-level policy and planning as they are produced in a consistent way. The projections take the revised mid-2016 population estimates as their starting point. The projected local authority populations for each year are calculated by ageing on the population from the previous year, applying local fertility and mortality rates to calculate the number of projected births and deaths, and then adjusting for migration into and out of each local authority. The local authority fertility, mortality and migration assumptions are derived using estimated values from the five years before the base projection year.

Please note the population projections are not forecasts. They do not attempt to predict the impact of future government or local policies, changing economic circumstances or other factors that may influence demographic behaviour.

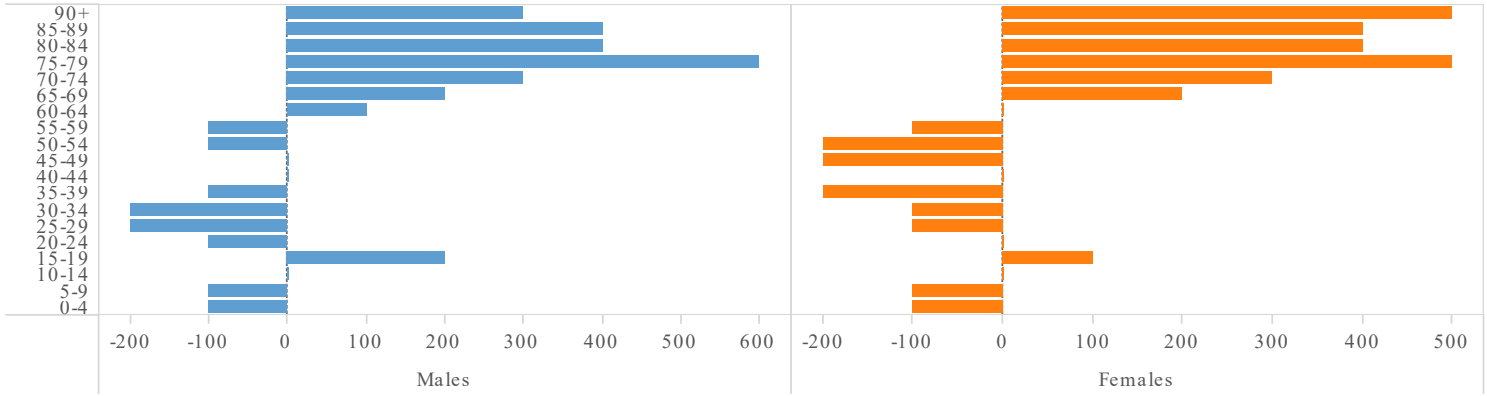
Population 2019



Population 2039



Population Change 2019 to 2039

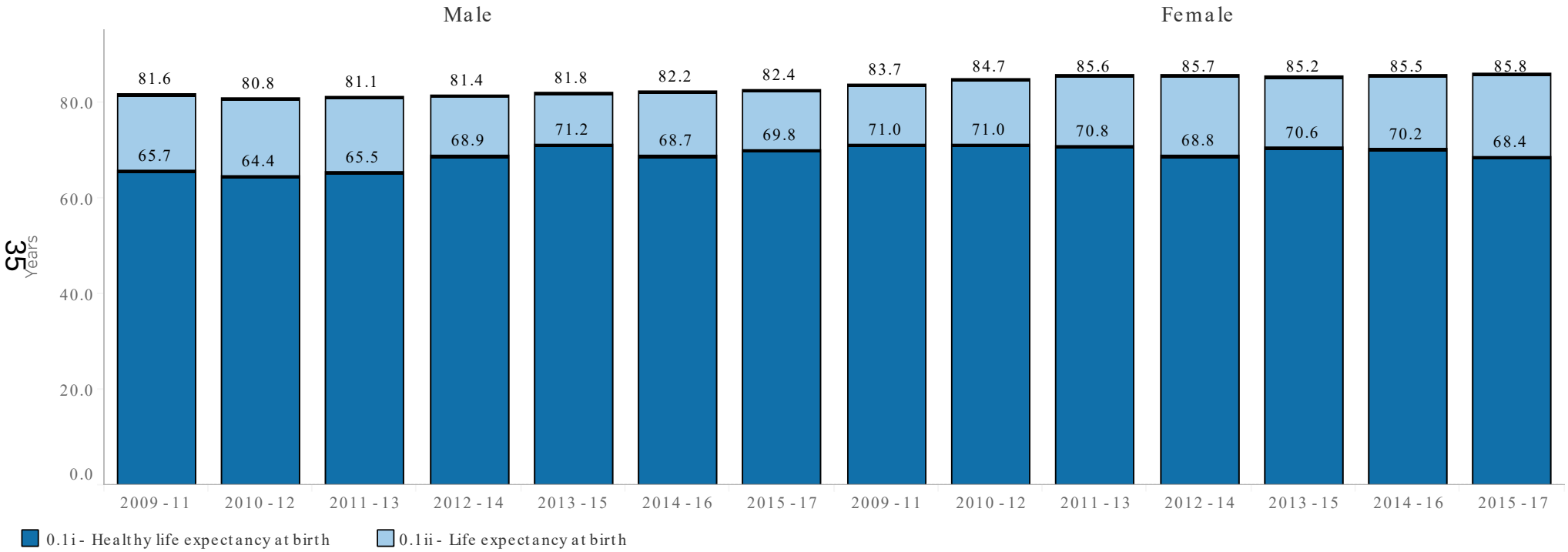


Source: Office for National Statistics (ONS), 2018.

Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

Life Expectancy at Birth &Healthy Life Expectancy at Birth in Rutland

Nationally, life expectancy at birth has increased by 0.1 years for males between 2014-16 and 2015-17 whereas in females, over the last four time periods life expectancy has stabilised at 83.1 years respectively. In Rutland, life expectancy at birth has increased by 0.2 years for males and 0.3 years for females between 2014-16 and 2015-17. At a national level, healthy life expectancy at birth has increased by 0.1 years for males but decreased by 0.1 years in females. In Rutland, healthy life expectancy at birth has increased by 1.0 years for males compared to the previous time period, from 68.8 years to 69.8 years, whereas in females healthy life expectancy at birth has decreased 1.8 years from 70.2 years to 68.4 years. As shown by the graph, females, on average, live longer but spend more years in poor health. The latest data shows in Rutland males spend 12.5 years in poor health compared to 17.4 years in females. The national gap currently stands at 16.1 and 19.3 years for males and females respectively.



Source: Public Health Outcomes Framework, PHE

Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019

QOF Recorded Prevalence in Rutland, 2017/18

With the introduction of the new GMS contract in April 2004, a quality framework of indicators (QOF) was developed for general practice, the QOF. An integral part of the QOF is the collection of prevalence data to allow practices to case find those patients that require specific management. Prevalence data within the QOF are collected in the form of practice registers. The purpose of a QOF disease register is to define a cohort of patients with a particular condition or risk factor. Please note, while many patients are likely to suffer from co-morbidity, i.e. are diagnosed with more than one of the clinical conditions included in the QOF clinical domain, robust analysis of co-morbidity is not possible and therefore patients may be on more than one disease register if they have multiple conditions or risk factors.

Indicator Name	Local Register	England Prevalence %	
Number of people with learning disabilities known to GPs: % on register	135	0.5%	0.4%
Severe mental illness recorded prevalence (QOF): % of practice register (all ages)	266	0.9%	0.7%
Stroke: Recorded prevalence (all ages)	861	1.8%	2.3%
Diabetes: QOF prevalence (17+)	2,011	6.8%	6.5%
Dementia: Recorded prevalence (all ages)	336	0.8%	0.9%
CHD: Recorded prevalence (all ages)	1,351	3.1%	3.6%
Depression recorded incidence (QOF): % of practice register aged 18+	347	1.6%	1.2%
Osteoporosis: QOF prevalence (50+)	90	0.6%	0.5%
Hypertension: QOF prevalence (all ages)	6,320	13.9%	16.7%

Statistical Significance compared to England

Higher Lower Similar

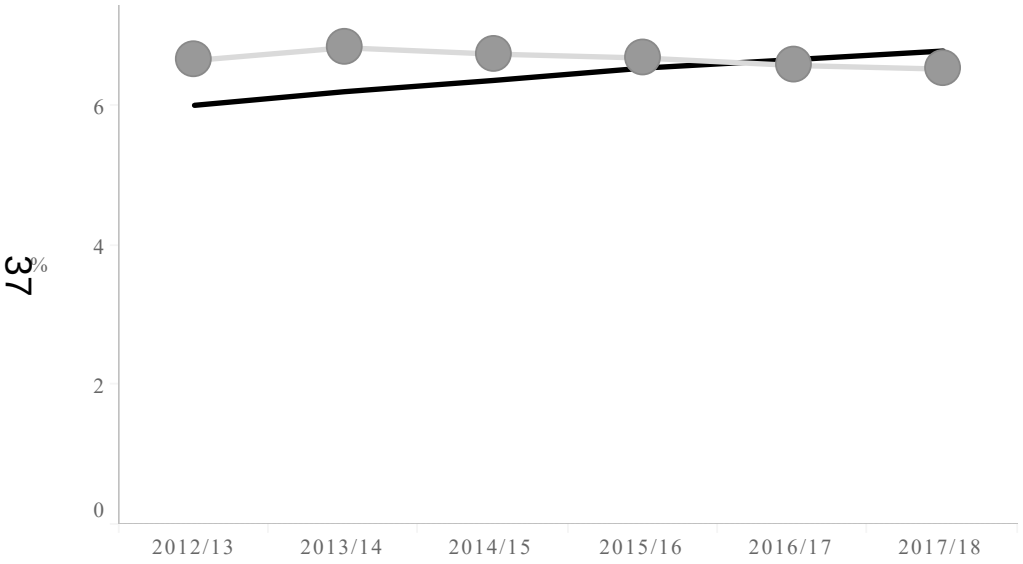
Source: Fingertips, Public Health England

Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

Diabetes prevalence and estimated diabetes diagnosis rate in Rutland

For Local Authorities, Clinical Commissioning Groups and local Health and Wellbeing Boards to understand the scope for prevention and make headway in tackling the rising numbers of people with or at risk of diabetes, it is important to understand not only how many people have diabetes (number of cases of diabetes recorded on QOF register) but also the estimated number of people expected to have diabetes given the characteristics of the population. This will help identify the scale of the challenge in terms of numbers and costs in developing diabetes identification and prevention programmes. It will also help monitor the progress of closing the gap (i.e. meeting previously unmet need) between observed prevalence (number of cases of diabetes recorded on QOF register) and actual prevalence in identifying people at high risk or with undiagnosed diabetes.

Recorded QOF prevalence (aged 17+)



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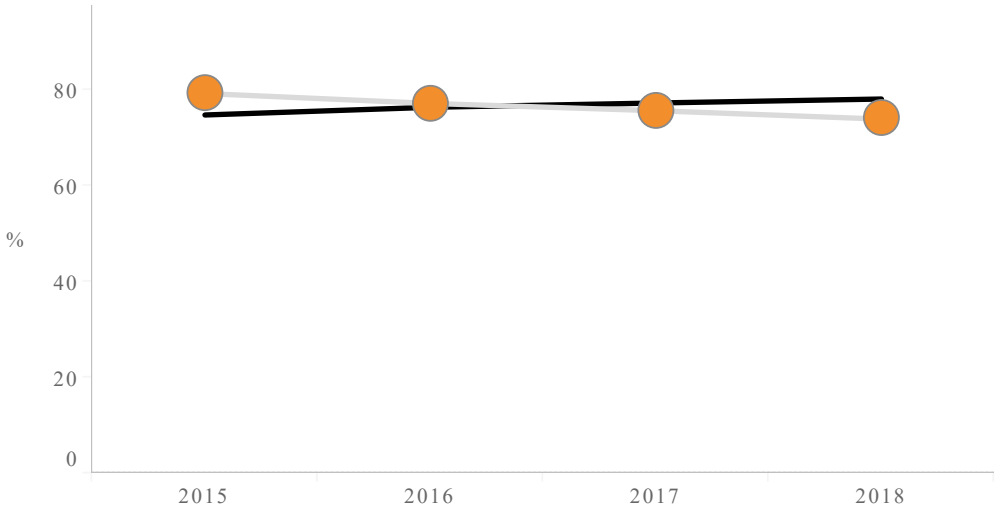
Statistical Significance compared to England

Similar

Source: Fingertips, Public Health England

Trend of estimated diagnosis rate for people with diabetes aged 17+



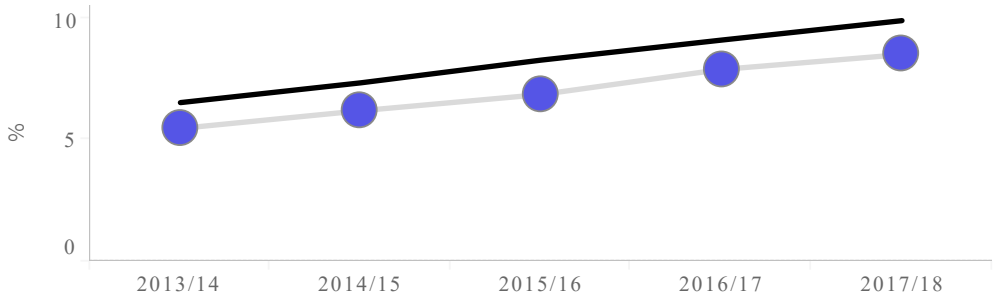
Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

Depression and Anxiety in Rutland

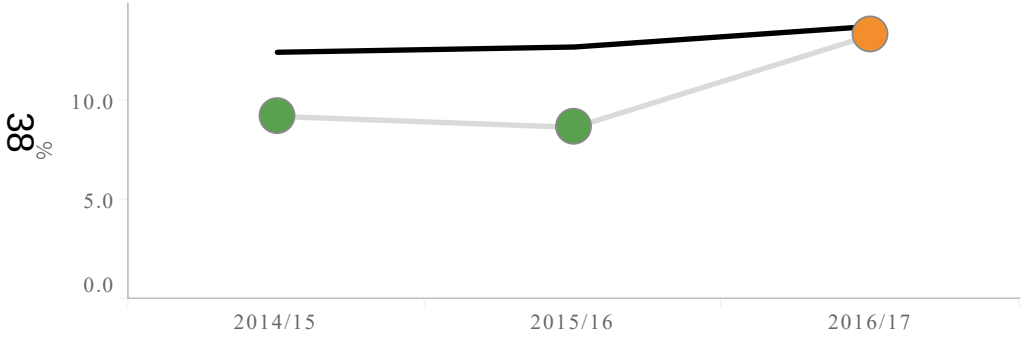
The depression recorded prevalence from QOF examines the percentage of the practice register with a diagnosis of depression. In contrast, the indicator reporting the percentage of depression or anxiety among patients is sourced from the GP Patient Survey. Across all time periods presented, the prevalence of depression or anxiety identified in this survey is higher (13.3% compared to 7.9% in 2016/17), perhaps because patients who have chronic conditions are more likely to respond. However, differences in the two prevalence estimates might also reflect an under-diagnosis of depression in General Practice.

It is well known that mental illnesses are frequently comorbid with physical illnesses and vice versa. The bar chart shows the prevalence of anxiety or depression in Rutland is higher (but not significantly) for those with a musculoskeletal (MSK) condition compared to those without a MSK condition. At a national level, this pattern is replicated but shows a significant difference.

Depression recorded prevalence (QOF): % of practice register aged 18+



Percentage reporting depression or anxiety (GPPS)

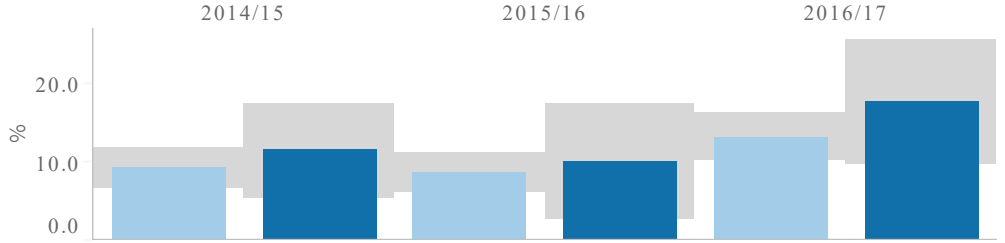


Statisitcal Significance compared to England:

Better Similar

Source: Fingertips, Public Health England

Percentage reporting a long term MSK problem who also report depression or anxiety (GPPS)



N.B. Grey bars display 95% confidence intervals

% reporting depression or anxiety

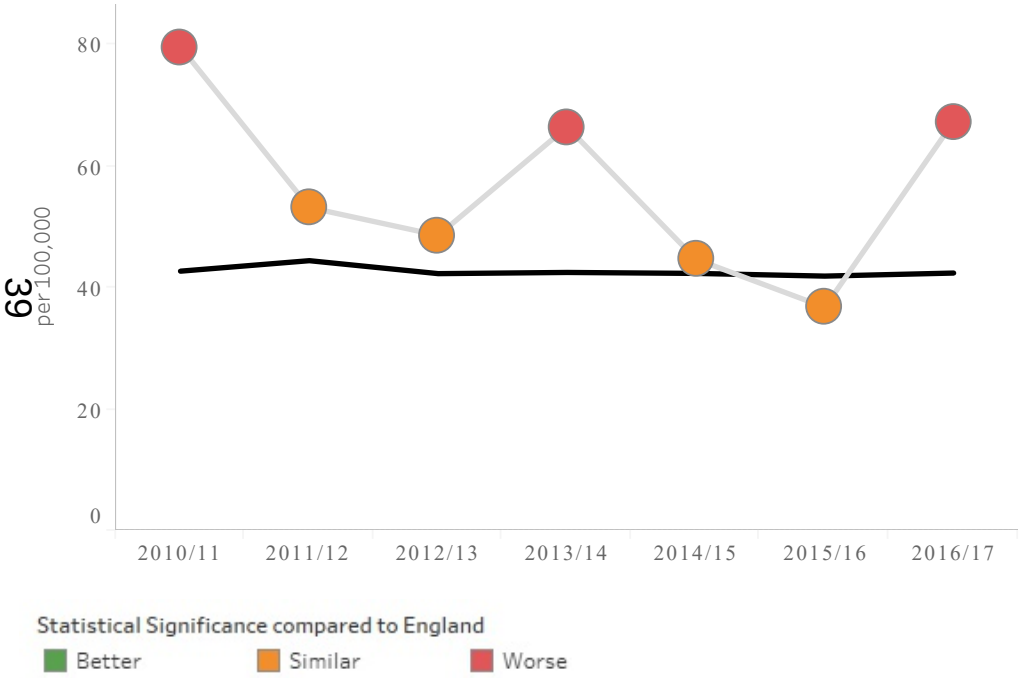
% reporting a long term MSK problem who also report depression or anxiety

Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

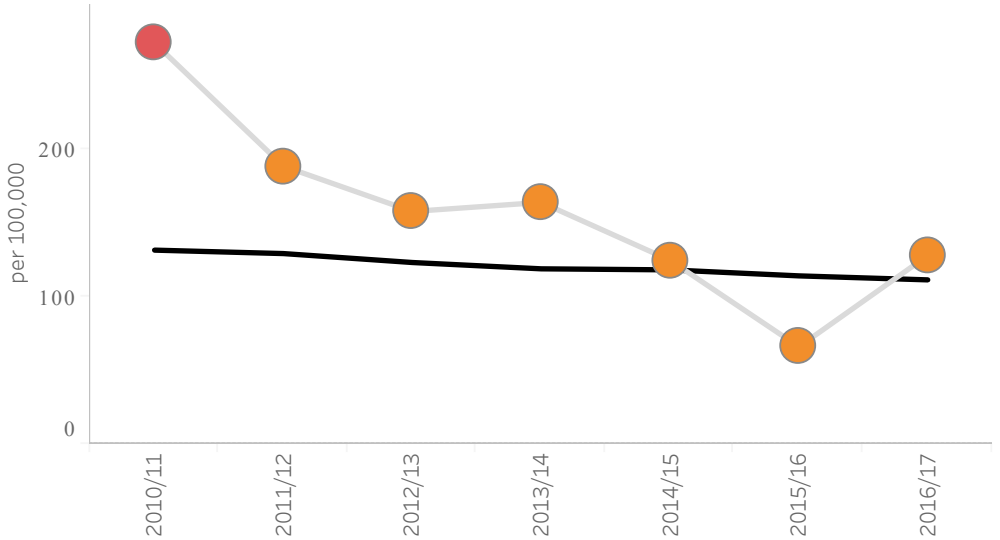
Preventable sight loss in Rutland

Prevention of sight loss will help people maintain independent lives as far as possible and reduce needs for social care support, which would be necessary if sight was lost permanently. The indicators presented show the counts of new completions of Certifications of Visual Impairment (all causes - preventable and non-preventable) by a consultant ophthalmologist as a rate of the resident population in the county. Where the cause of sight loss is Age-related Macular Degeneration (AMD), the rate of new completions of Certifications of Visual Impairment due to this disorder has been examined separately. Completing the sight loss certification initiates the process of registration with a local authority and leads to access to services.

Rate of sight loss certifications per 100,000 population



Rate of sight loss due to age related macular degeneration (AMD) in those aged 65+ per 100,000 population

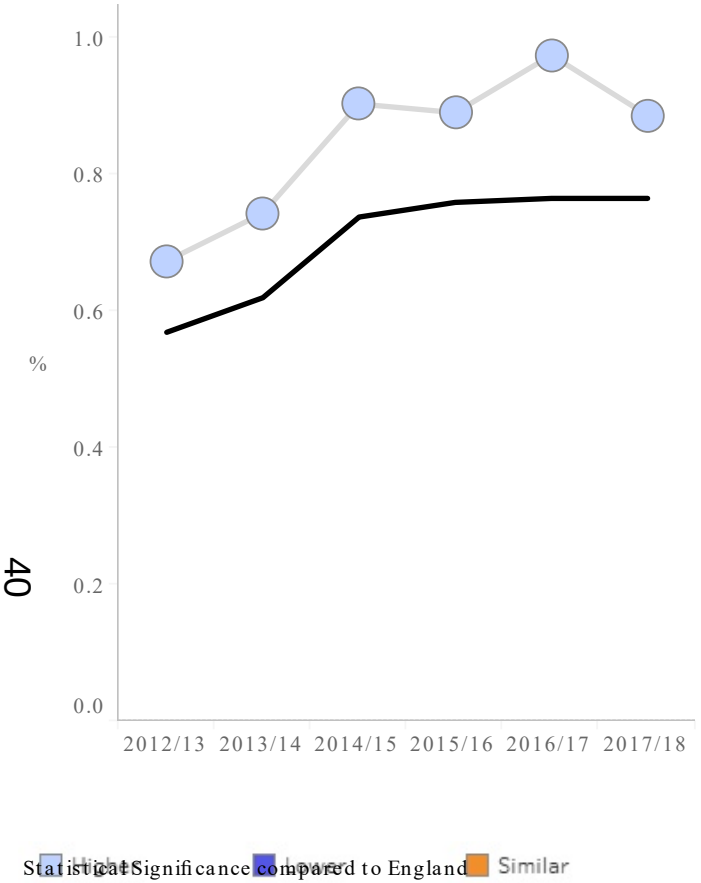


Source: Public Health Outcomes Framework, Public Health England

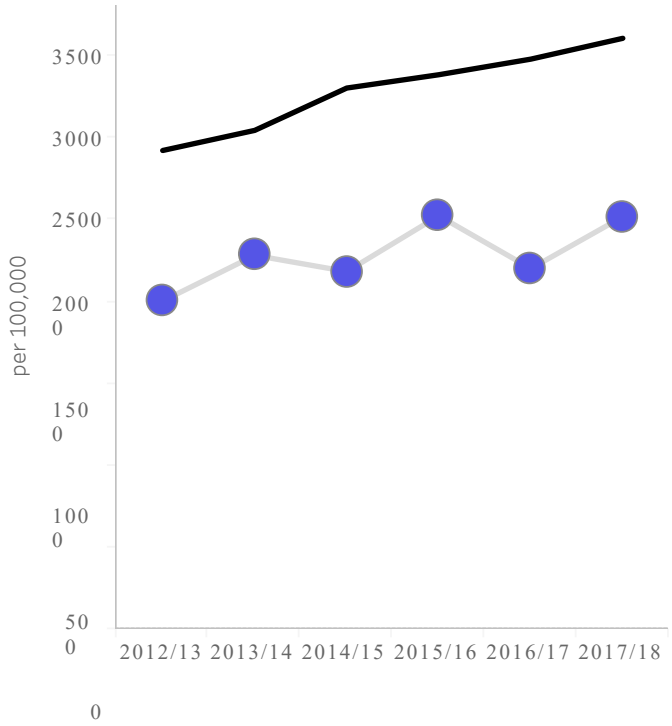
Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

Dementia prevalence and emergency admissions rate in Rutland

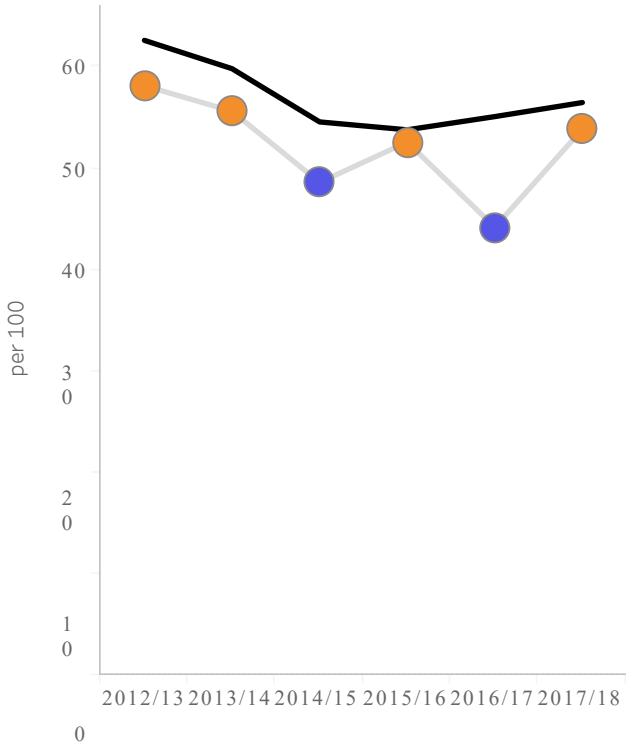
Dementia: Recorded prevalence (all ages)



Dementia: Direct standardised rate of emergency admissions (aged 65 years and over)



Dementia: Ratio of inpatient service use to recorded diagnoses



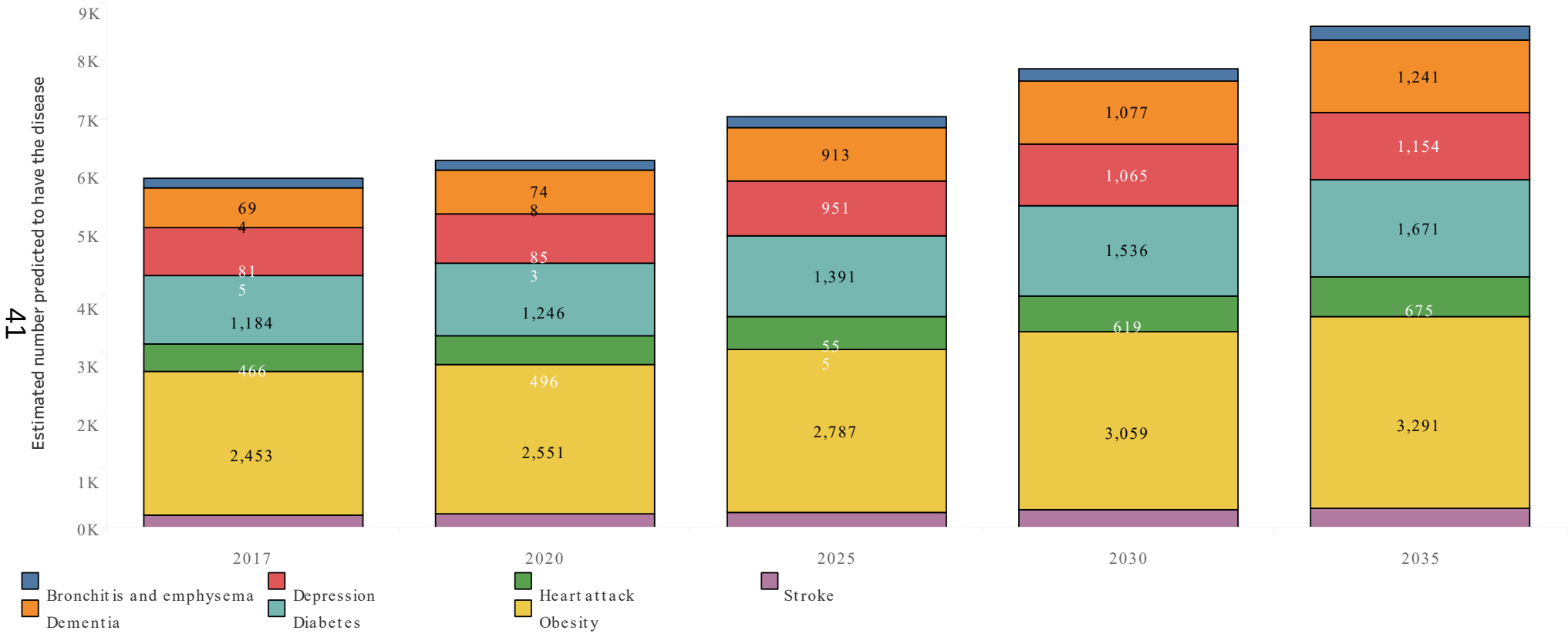
Statistical Significance compared to England: Similar

Source: Fingertips, Public Health England

Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

Forecasted prevalence of limited long term conditions in people aged 65 and above in Rutland

The chart shows the projected number of people over the age of 65 with a long term condition between 2017 and 2035 in Rutland. The numbers are based on the current prevalence rates applied to projected populations. Please note, the numbers refer to people on individual registers i.e. people with multi-morbidities will be counted on each register, therefore the totals will be greater than projected populations for the over 65s. The projected increase in number of people with the following conditions between 2017 and 2035 in Rutland is: Dementia (78.8%), Stroke (47.5%), Heart attack (44.8%), Bronchitis and emphysema (42.9%), Depression (41.6%), Diabetes (41.1%), Obesity (34.2%).



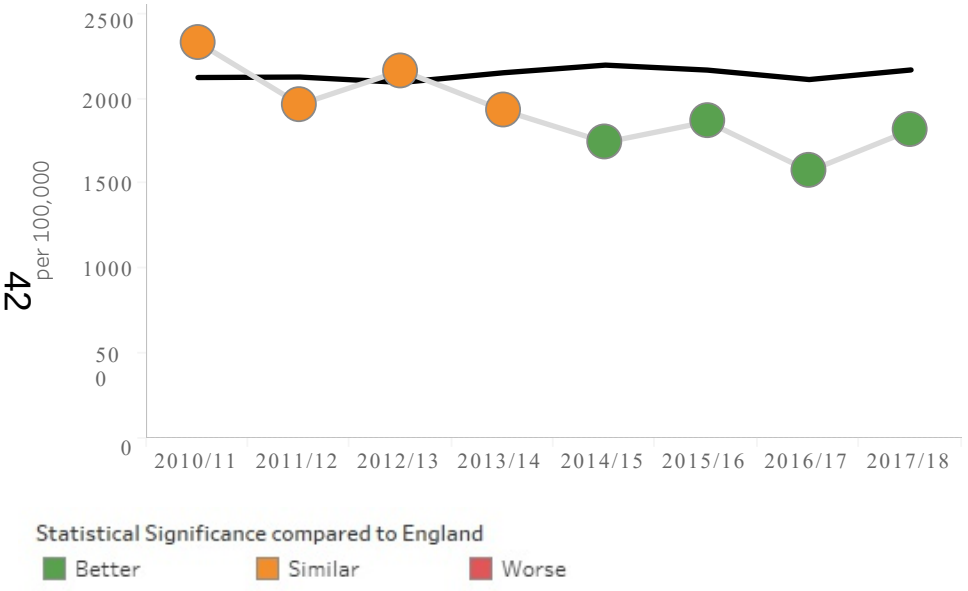
Source: POPPI

Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

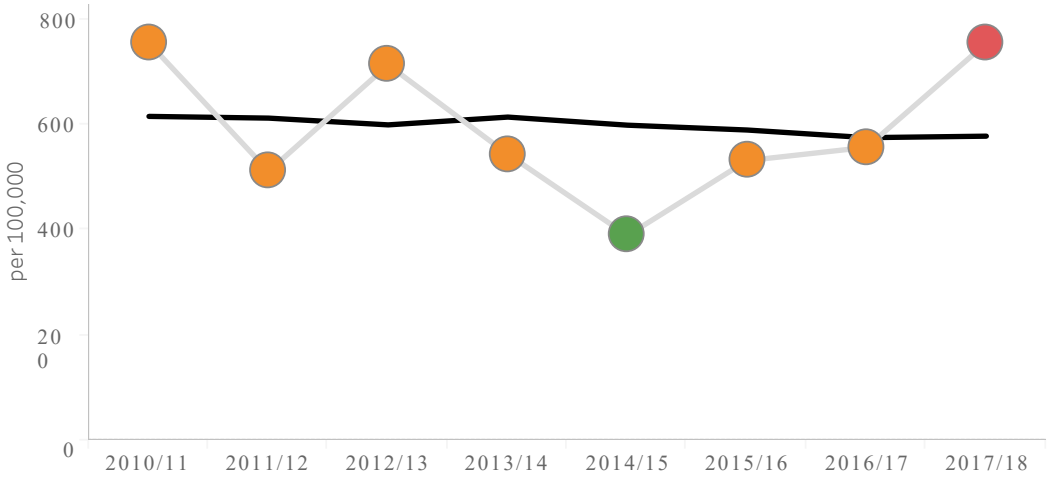
Emergency admissions (aged 65+) due to falls and hip fractures in Rutland

Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. they are a major precipitant of people moving from their own home to long-term nursing or residential care. The highest risk of falls is in those aged 65 and above and it is estimated that about 30% people aged 65 and above living at home and about 50% of people aged 80 and above living at home or in residential care will experience an episode of fall at least once a year. Hip fractures may result from a fall. Hip fracture is a debilitating conditions with only one in three people that suffer a hip fracture return to their former levels of independence. The condition is so debilitating that one in three sufferers end up moving into long-term care facilities.

Emergency hospital admissions due to falls in people aged 65 and over, directly age standardised rate per 100,000 population



Emergency hospital admissions due to hip fractures in people aged 65 and over, directly age standardised rate per 100,000 population



Source: Public Health Outcomes Framework, Public Health England

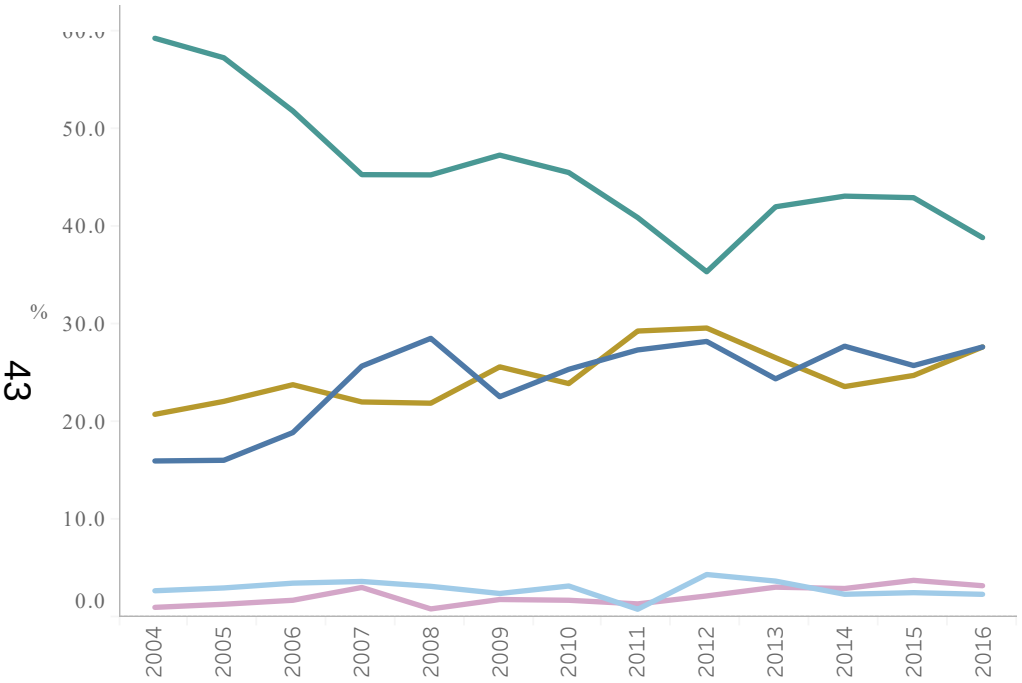
Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

Place of death in Rutland

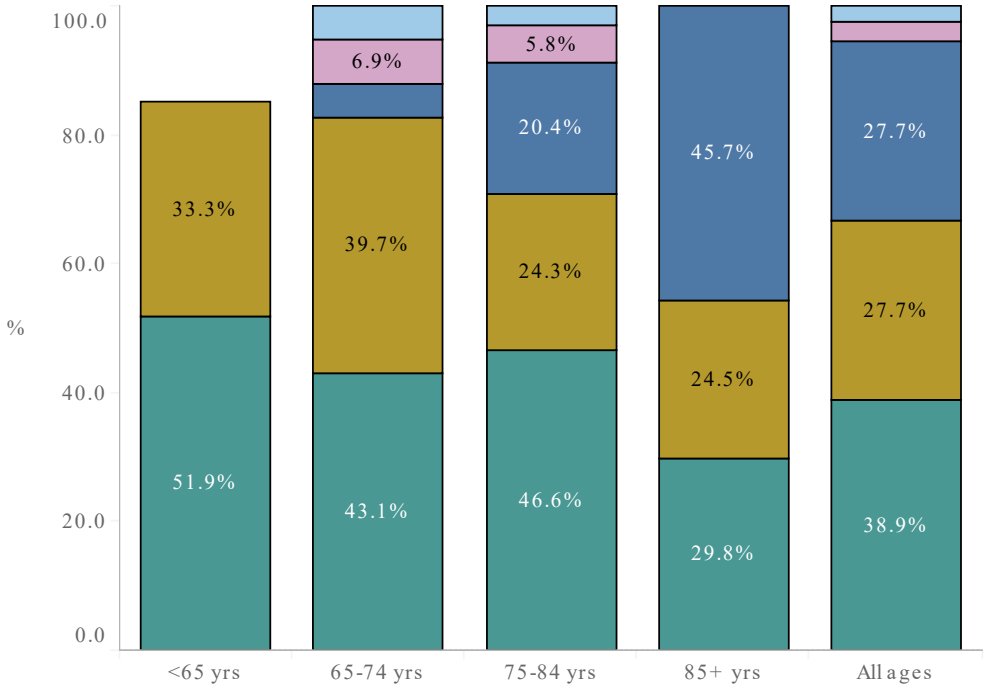
Age Range
All ages

The following indicators have been examined to understand the trends and variations in place of death as proxy indicator for quality of end of life care. The data shows the majority of people die in hospital; however the proportion of deaths in this location has shown a significant decline over the last five years. The latest data from 2016 shows as age increases, the proportion of people dying in a care home increases while the proportion of home deaths and deaths in hospices decreases.

Trend of place of deaths by All ages in Rutland



Place of death by age in Rutland, Persons, 2016



Place of Death

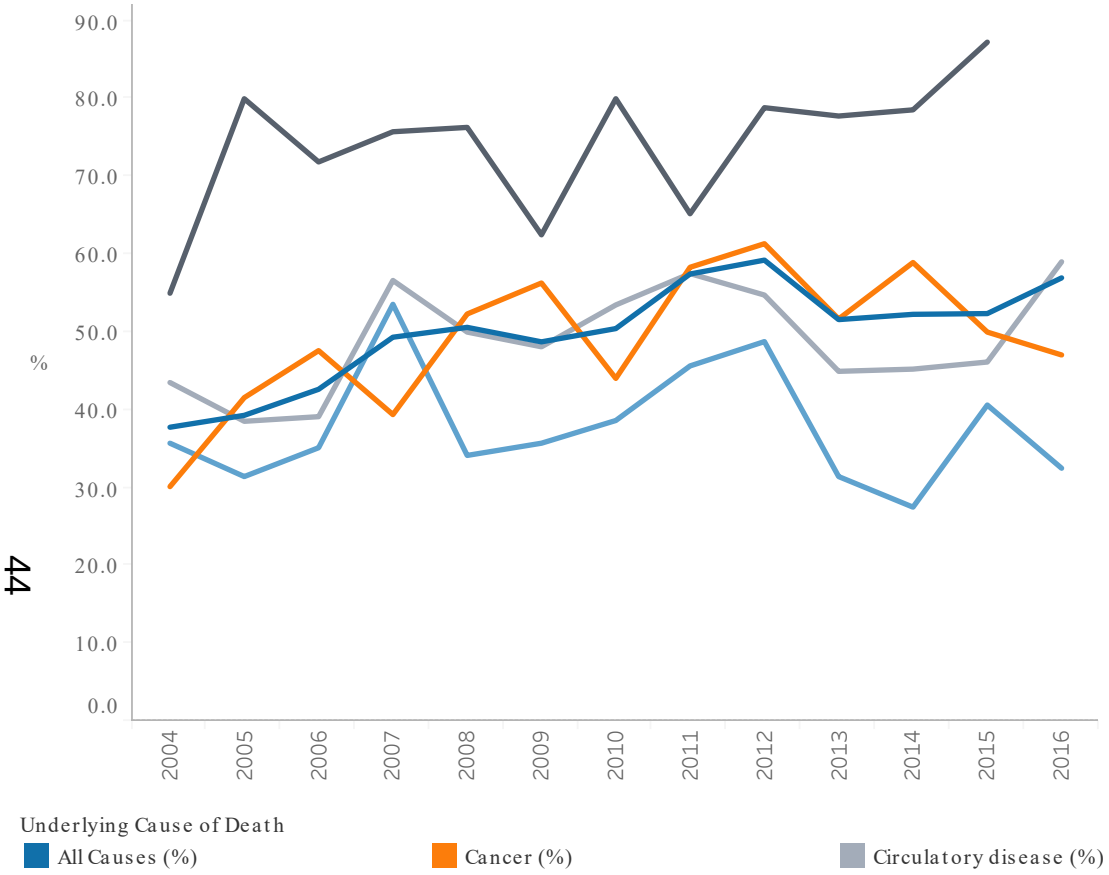
Care home deaths (%) | Deaths in Other Places (%) | Home deaths (%) | Hospice deaths (%) | Hospital deaths (%)

Source: End of Life Care Profile, PHE

Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

Death in Usual Place of Residence (DiUPR) in Rutland

Trend of DiUPR by Underlying Cause of Death in Rutland

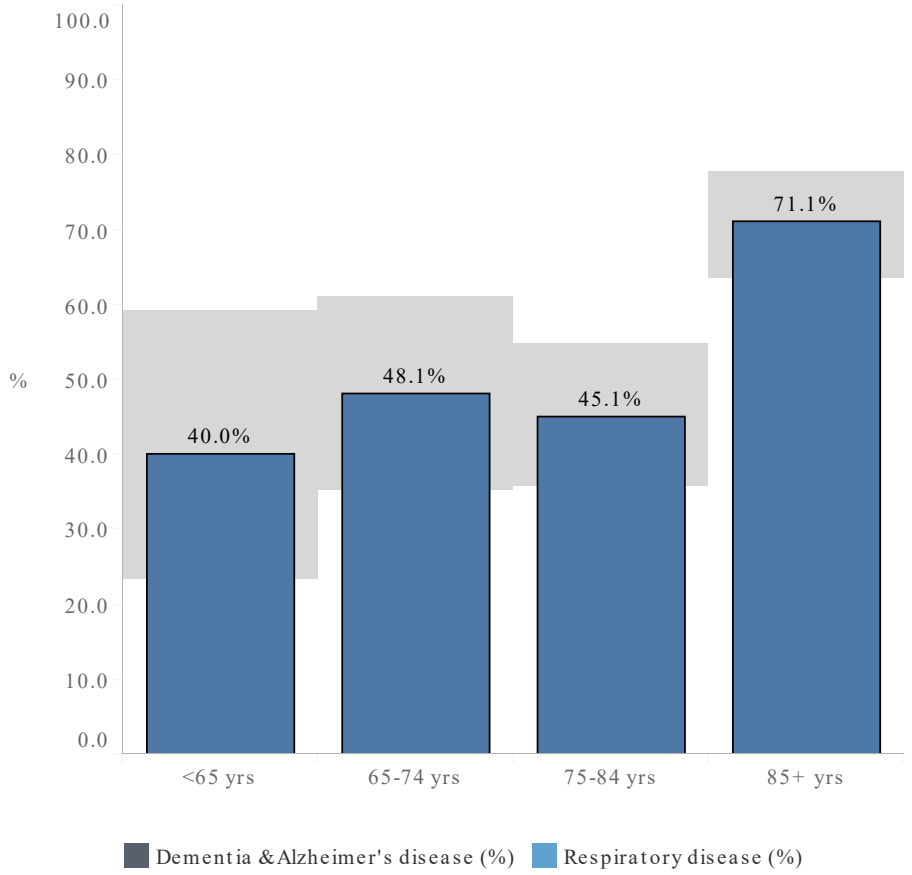


Underlying Cause of Death

All Causes (%) | Cancer (%) | Circulatory disease (%)

Source: End of Life Care Profile, PHE

DiUPR by age in Rutland, Persons, 2016



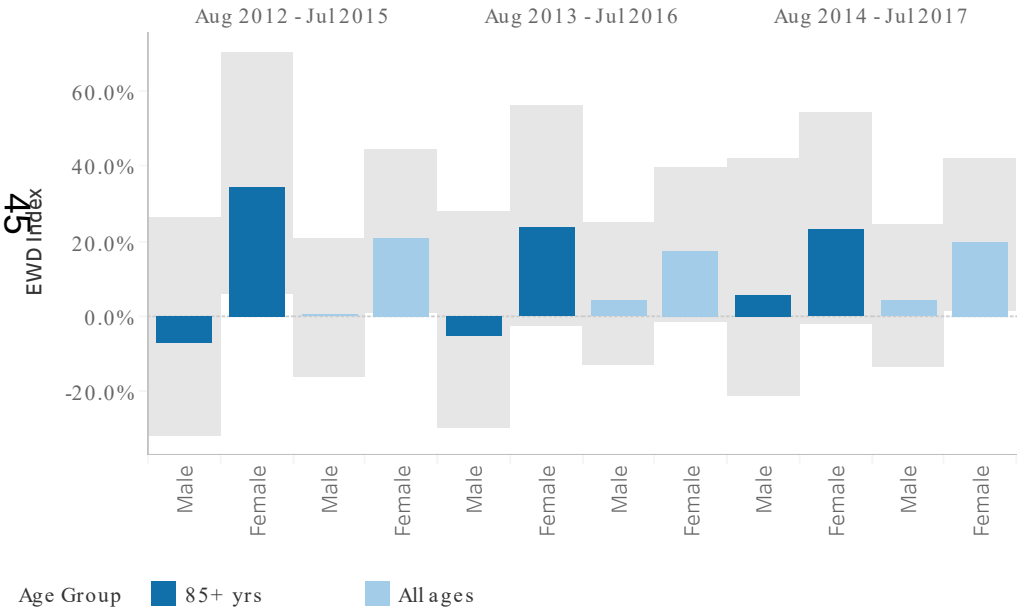
Dementia & Alzheimer's disease (%) | Respiratory disease (%)

Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

Excess Winter Deaths in Rutland

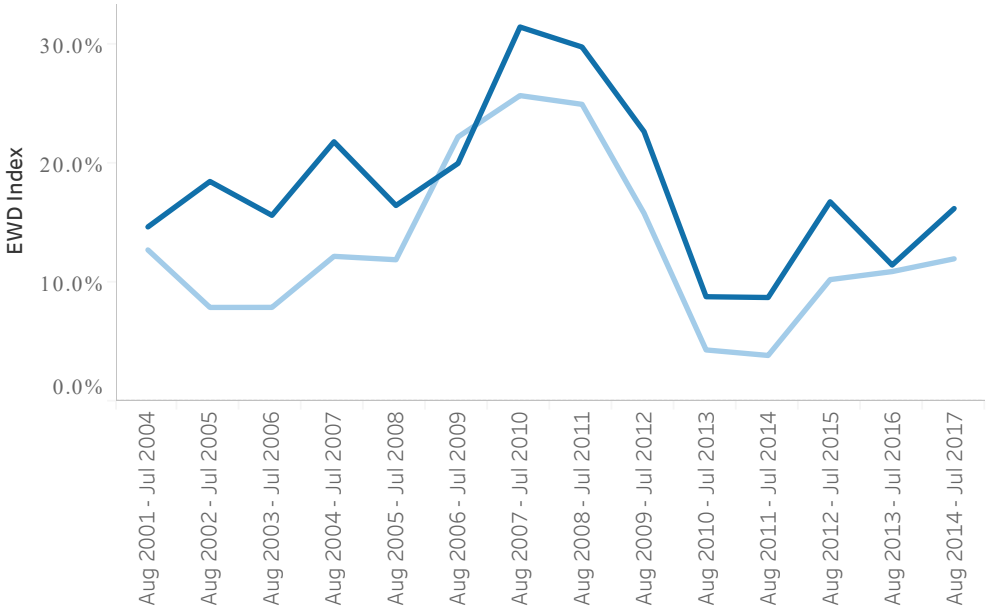
In common with other countries, more people die in the winter than in the summer in England and Wales. The Excess Winter Deaths (EWD) Index is defined as the ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths. Between August 2014 to July 2017 there were an estimated 43 excess winter deaths in Rutland. This represents a EWD Index of 12.0%, which means that 12.0% more deaths occurred in the winter months compared with the non-winter months. As it is common to observe large fluctuations in EWDs for which trends over time are often not smooth, we have presented a three-year moving average to smooth out any short-term fluctuations and make the trend over time clearer in the graphs presented. Nationally, EWDs are generally higher in females and the elderly. In Rutland, for all but one data point in August 2006 to July 2009, the EWD Index for those aged 85 years and above has been consistently higher than those of all ages since recordings began. When examining by gender, on a national level, the EWD Index for females aged 85 and above has been higher than males (although not always significantly) for the last 13 time periods. In Rutland, the EWD Index for females aged 85 and above has been higher (although not significantly) than males in the same age group for the last four time periods.

Excess Winter Deaths Index (3 years) by sex and age group



Source: Public Health Outcomes Framework

Trend in Excess Winter Deaths Index (3 years) by age group



Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

5. Feedback on recommendations for 2017

Recommendations and summary

Military Health

The military population has a significant bearing on the population of Rutland and its use of health and other services. Although there are good links between public health and the military on specific issues, the importance of serving military, veterans and their families in Rutland calls for a review, in line with national publications, on the links between the military defence services and public health.

Response:

A detailed Health assessment of the needs of the serving military and their families has been undertaken. Originally, to be the subject of this report, it is currently undergoing review and comment by the Army. It is intended that a summary version will now form the basis of the 2020 Public Health Annual Report.

Mental Health

Mental health problems are widespread, at times disabling, yet often hidden. We shall undertake a piece of work examining the link between anti-depressant prescribing and mental health in Rutland.

Response: Investigations found anti-depressant prescribing in Rutland was in line with East Leicestershire and Rutland and West Leicestershire CCGs. Much work this year was devoted to updating the Joint Strategic Needs Assessment (JSNA) for Rutland which was been published in December 2018, this included a stand-alone chapter on Mental Health in Adults in the county. This needs assessment found the GP recorded prevalence for depression in Rutland is significantly lower compared to national; however, the prevalence has significantly increased over the past five years. This increasing trend is also witnessed nationally.

Poverty

Rutland is one of the most affluent counties in the country, however, it is fundamental that we are able to disaggregate our population and pinpoint pockets of deprivation that exist among rural affluence. We shall undertake a detailed piece of work examining poverty in Rutland, drawing on the scrutiny commission work done on poverty previously.

Response: The recently completed Joint Strategic Needs Assessment (JSNA) sets out data on the health and wellbeing needs of Rutland both now and into the future. The JSNA sets out the key rural health issues that should be borne in mind by commissioners and providers.

Farmers and other agricultural workers are included amongst occupational groups that are at particularly high suicide risk (other groups include nurses and doctors). For example, GPs in rural areas, aware of the higher rates of suicide in farmers and agricultural workers, will be well prepared to assess and manage depression and suicide risk.

The recently launched ‘Start a Conversation’ campaign tackling attitudes and stigma towards death by suicide, recognises the importance of rurality as a risk factor. The Leicestershire and Rutland Rural Partnership holds a series of suicide prevention awareness training workshops.

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Report No: 97/2019
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

25 June 2019

LEICESTER, LEICESTERSHIRE AND RUTLAND HEALTH PROTECTION ASSURANCE REPORT

Presented by:	Dr Kath Packham	LLR Public Health
Report Author(s) and contact details:	Dr Mike McHugh, Consultant in Public Health Leicestershire and Rutland County Councils Email: Mike.McHugh@leics.gov.uk Tel: 0116 3054236	

RECOMMENDATIONS
That the Rutland Health and Wellbeing Board; 1. Receives the Health Protection Board Report January 2018- December 2018. 2. Notes the specific health protection issues that have arisen locally, and steps taken to deal with these. 3. Notes the focus for particular areas of work in the coming year

1. PURPOSE OF THE REPORT, INCLUDING LINKS TO HEALTH AND WELLBEING PRIORITIES

1.1 The purpose of this report is to provide a summary of the assurance functions of the Leicestershire, Leicester 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 considered in the past year that have emerged from January 2018 to December 2018.

1.2 Health protection assurance is a statutory duty of the local authority, via the Director of Public Health (DPH). It is therefore a key element of the Joint Health and Wellbeing Strategy and of Rutland County Councils 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.

2. BACKGROUND AND MAIN CONSIDERATIONS

Policy Framework and Previous Decisions

2.1 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.

2.2 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. The scope of health protection in this context includes these key domains:

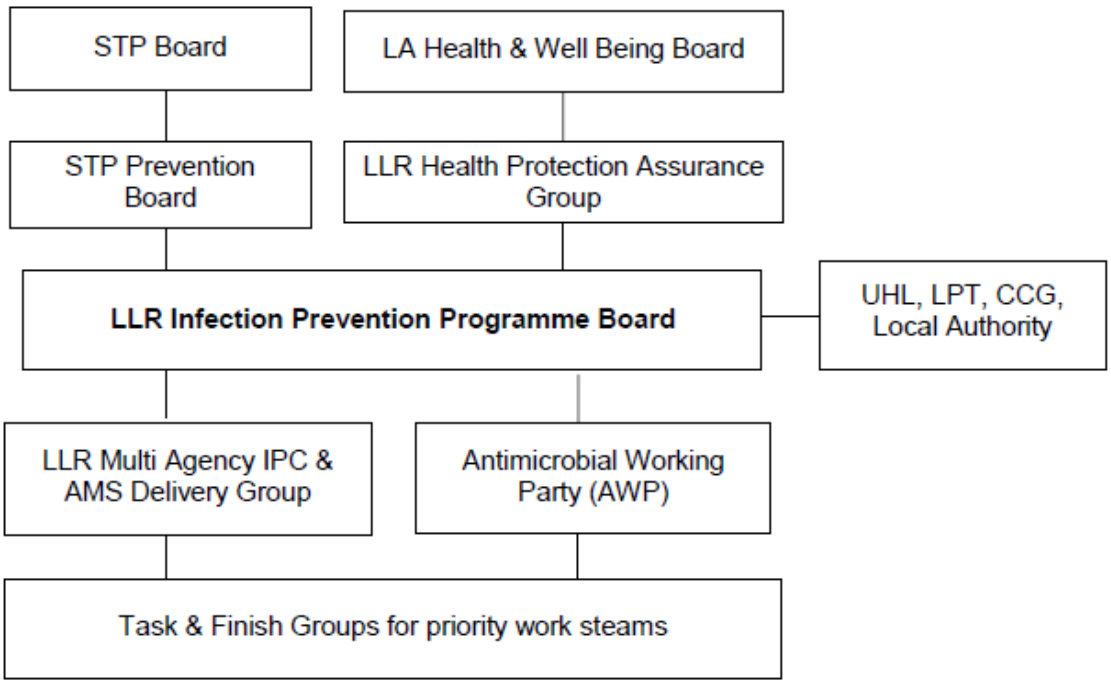
- Prevention and control of infectious diseases
- National immunisation and screening programmes
- Health care associated infections
- Emergency planning and response (including severe weather and environmental hazards)

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 absolutely 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.

2.4 This is a local leadership function which requires the DPH 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.

2.5 The Leicestershire, Leicester and Rutland Health Protection Assurance Board is a sub-group of the three Health and Wellbeing Boards for Leicester, Leicestershire and Rutland (LLR) and enables local authorities to discharge their health protection assurance responsibilities.

2.6 Quarterly dashboard reports and/or updates are received and reviewed at the quarterly Assurance 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 Health Protection Assurance Committee is linked into a number of other Health Protection groups across the local system:



Key domains of health protection assurance

3. PREVENTION AND CONTROL OF INFECTIOUS DISEASES

Organisational Roles/Responsibilities

3.1 Public Health England (PHE) leads 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.

3.2 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 Clinical Commissioning Groups to use contractual arrangements with provider organisations to make relevant resources available (includes screening/diagnostic and treatment services).

3.3 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.

Sexual Health

Table 1 in **Appendix 1** summarises the latest diagnostic and treatment rates for the main sexually transmitted infections in Leicestershire.

3.4 Leicestershire and Rutland Public Health commission the integrated sexual health services which detect, prevent and treat sexually transmitted infections in our local population. The service has comprehensive arrangements including online testing for Sexually Transmitted Infections and a variety of testing options for HIV.

3.5 The main Sexual Health contract covering Leicestershire, Leicester and Rutland was re-tendered in 2018 and the new contract commenced 01/01/19. There is a now a greater emphasis on self-managed care whilst preserving the quality of testing, results notification and partner notification. The main site of delivery of services has moved to the Haymarket Shopping Centre Leicester.

3.6 Chlamydia Screening:
Whereas the chlamydia detection rate is lower than the benchmark and England average, the prevalence rate in Rutland is lower than national average. Our aim is to screen those at highest risk. The newly procured Sexual Health Service model of delivery is providing increased access to on-line self-sampling tests for Rutland residents and this will potentially increase screening rates.

Key Issues for 2019 (Sexual Health)

An action plan has been developed with key actions for 2019/20 relating to:

- Improving promotion of offer of STI tests using wider range of social media options.
- A review of STI screening in wider services such as prisons, termination of pregnancy services and maternity pathways to improve offer and uptake.
- Improving partner notification systems in integrated sexual health service to increase uptake of partner testing and retesting.

Tuberculosis (TB)

3.7 Prevalence of TB remains relatively low in Rutland. See **Appendix 2**

Key Issues for 2019 (TB)

- Continue to explore options and opportunities to provide TB screening and active case finding among migrants and other under-served populations.
- Review commissioning arrangements for paediatric TB patients
- Explore the potential for use of mobile x-ray units (MXUs) for use in prison.

- Clearly agree and outline local sustainable funding arrangements for TB incidents and outbreaks.

Other Outbreaks

Multi-Drug Resistant Organisms (MDROs)

3.8 During the summer of 2018 there was an outbreak of a Carbapenemase Resistant Organism (CRO), at the University Hospitals of Leicester (UHL). Further outbreaks have occurred sporadically over recent months. CRO are increasingly prevalent pathogens in hospitalized patients and can cause a variety of infections such as urinary tract infections, wound infections and respiratory tract infections.

3.9 The importance of CRO derives from the fact that they can spread rapidly in the hospital setting, and that they are commonly multidrug resistant (MDR). There are still few therapeutic options available to treat these MDR pathogens. Health and care partners across LLR are working collaboratively to (1) screen for CRO in high risk patients and (2) effectively manage those patients who are shown to be positive whether in hospital or community settings. Public Health England have developed a set of toolkits to support this work:

https://www.gov.uk/government/publications/carbapenemase-producing-enterobacteriaceae-non-acute-and-community-toolkit

Key Issues for 2019 (CRO)

- Fully embed practical advice to prevent or reduce the spread of Carbapenemase Resistant Organisms (CRO) in community and non-acute healthcare settings.

4. IMMUNISATION AND SCREENING

Organisational Roles/Responsibilities

4.1 NHS England commission most national screening and immunisation programmes through their Local Area Teams.

4.2 PHE is responsible for setting screening and immunisation policy through expert groups (the National Screening Committee and Joint Committee on Vaccination and Immunisation). At a local level, specialist public health staff, employed by PHE are embedded in the NHS Local Area Teams to provide accountability for the commissioning of the programmes and provide system leadership. PHE provides quarterly surveillance reports for each of the national immunisation and screening programmes.

4.3 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.

Immunisation

4.4 Coverage of childhood immunisations continues to be higher than the England average in Rutland. However, coverage for 2nd dose MMR at age 5 is consistently below the levels recommended to build 'herd immunity' (95%). Good coverage helps ensure that the local population is protected and does not become susceptible to outbreaks of vaccine preventable diseases. Further work is needed in Rutland to improve uptake of childhood vaccination particularly where there are pockets of lower levels of vaccination in order to avoid potential outbreaks in the future. See **Appendix 3** for childhood immunisation cover.

Seasonal Flu

4.5 Flu uptake rates remain sub-optimal and there is an ongoing need to strengthen flu vaccine uptake. See **Appendix 4.**

Key Issues for 2019 (Immunisation)

Further work is required to increase uptake of childhood immunisations, particularly:

- MMR in Rutland. NHS England commission immunisation programmes through their Local Area Teams in which specialist public health staff are employed by PHE to provide accountability for the commissioning of the programmes and to provide system leadership. NHS England local area immunisation teams need to further strengthen links to local communities through local authority and voluntary sector partners and with primary care to maximise immunisation uptake.
- Introduction of HPV vaccine for boys in year 8
- Ongoing need to increase flu vaccine uptake particularly in people with susceptibility due to underlying health conditions.

Screening

4.6 Both cancer and non-cancer screening coverage continues to be higher than the national average in Rutland.

4.7 Cervical screening coverage remains below the national target of 80% and this reflects recent national trends. Breast screening coverage in 2017/18 is stable and meets the national target of 80%. Bowel screening coverage increased in 2017/18 in all areas and also remains above the national target of 60%. Performance in the abdominal aortic aneurysm (AAA) screening programmes continues to be excellent, and coverage is stable and meets acceptable national standards.

Key Issues for 2019 (Screening)

- Continue to strengthen collaborative multi-agency action plans to target areas of poorer uptake and coverage for each of the screening programmes.
- Need to strengthen relationships between local authority, NHS England and CCGs
- Move to primary HPV testing for cervical screening
- Introduction of FIT testing to bowel screening programme

5. HEALTH CARE ASSOCIATED INFECTIONS

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

Organisational Roles/Responsibilities

5.2 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 CCGs to account for performance against indicators under this domain, which includes incidence of preventable healthcare associated methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia and incidence of *Clostridium difficile.*

5.3 PHE through its consultants in communicable disease control will lead the epidemiological investigation and the specialist health protection response to health care associated infection outbreaks and has responsibility to declare a health protection incident.

5.4 The Local Authority through the Director of Public Health has overall responsibility for the strategic oversight of a health care associated infections impacting on their population's health. See **Appendix 5.**

MRSA

5.5 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 the three local Clinical Commissioning were exempt from completing a formal post infection review as this was now only for organisations with the highest rates of infection.

MSSA

5.6 Mandatory reporting of all Methicillin 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 Clinical Commissioning Groups continue to hold providers to account for the number of reported MSSA cases.

C.difficile infection

5.7 From April 2017 NHS providers were required to input additional information to the PHE data capture system relating to information prior to admission to hospital. This additional 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 CCGs 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 Clostridium *difficile* infection. During 2017/2018 both UHL and the three local commissioning groups achieved their nationally set trajectories.

E.coli bacteraemia

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

Multi-drug Resistant Organisms (MDROs)

5.9 See above section.

<u>Key issues for 2019 (Health Care Associated Infections)</u>

- Need to strengthen role of Sustainability Transformation Plan in terms of governance and oversight of Health Care Associated Infections
- Work across health and social care to reduce Gram negative bacteraemia
- Strengthen outbreak monitoring to ensure timely patient transfers, system flow and resilience.
- Aim for and achieve the zero target for pre 48-hour MRSA blood stream infections – there are currently no trajectories set relating to pre 48hrs MRSA BSI cases.
- Reduce the number of Clostridium *difficile* pre 72hour community cases – There are currently no national CDI objectives for community services providers

6. ANTI-MICROBIAL RESISTANCE (AMR)

6.1 Antimicrobial resistance happens when microorganisms (such as bacteria, fungi, viruses, and parasites) change when they are exposed to antimicrobial drugs (such as antibiotics, antifungals, antivirals, antimalarials, and anthelmintics). Microorganisms that develop antimicrobial resistance are sometimes referred to as “superbugs”. As a result, the medicines become ineffective and infections persist in the body, increasing the risk of spread to others.

6.2 Antimicrobial resistance occurs naturally over time, usually through genetic changes. However, the misuse and overuse of antimicrobials is accelerating this process. System-wide action to address anti-microbial resistance. Oversight of efforts to tackle AMR sits with the LLR Infection Prevention and Control (IPC) Programme Board and also with the LLR IPC Multiagency Delivery Group (MADG).

Key Issues for 2019 (Anti-microbial Resistance)

- Further progress is required to develop and implement an LLR Antimicrobial Resistance (AMR) strategy
- Increasing focus on tackling CRO
- Reducing overall prescribing of antibiotics in primary care.
- Specifically reducing prescribing of cephalosporin, quinolone and co-amoxiclav
- Reviewing arrangements for oversight of infection prevention and control outside hospital settings.

7. EMERGENCY PLANNING AND RESPONSE (including severe weather and environmental hazards eg. Air quality)

7.1 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.

7.2 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.

Key issues for 2019 (Emergency Planning)

- Build on the LHRP Survey capabilities survey to address gaps in the system, particularly related to capacity, resources and governance
- Work to ensure partners are clear on the response structure to major incidents, the causes of delays in action and on the coordination of groups.

- Further discussions are needed at Local Health Resilience Partnership (LHRP) to confirm major incident cover especially over longer-term major incidents.
- Continue to review contingency plans as appropriate according to national and local guidance and ensure further testing response arrangements.
- Ensure that there is an on-going approach to learning from experience and that issues identified from real events are acted upon.
- Clarify psychological support requirements in the event of mass casualty events

8. AIR QUALITY

8.1 There is currently both national and local policy and guidance demanding a call to action on air quality and its negative health impacts. Poor air quality is the largest environmental risk to the public's health, leading to significant levels of morbidity and premature mortality. Annually in the UK, particulate matter (PM) air pollution causes 29,000 deaths and 340,000 life years lost. Meanwhile Nitrogen dioxide (NO2) air pollution shortens lives by an average of around 5 months and causes nearly 23,500 deaths in the UK per year. The Royal College of Physicians (amongst others) of possible links with a range of other adverse health effects including diabetes, cognitive decline and dementia, and effects on the unborn child.

8.2 Air pollution was identified as an 'emerging national risk to health' in Rutland's DPH 2017 Annual report[i]. Data, and related analysis, was used to illustrate the scale of the issue across the County.

8.3 Public Health England, in its 2014 publication '*Estimating Local Mortality Burdens Associated with Particulate Air pollution*', assesses that annually roughly 17 deaths in Rutland can be attributed to PM2.5 pollution and from Nitrous Oxides. This equates to approximately 5% of all-cause mortality. Poor air quality particularly affects the most vulnerable in society: children and older people and those with heart and lung conditions. Poor air quality are also often the less affluent areas.

8.4 By its nature, air quality cannot be controlled by geographical boundaries or by a single individual alone. Instead collective, systematic efforts are required to reduce air pollution and its harmful effects on health. focus on four key areas:

- Aligning and collaborating on local air quality initiatives
- Prioritising structural efforts to reduce emissions of air pollutants
- Universal and focused efforts to reduce exposure to poor quality for all and specifically those most at need
- Strengthening cross organisational working

8.5 Interventions that improve local air quality for everyone, not just at pollution hotspots, will have the greatest impact on improving people's health. For this reason, partnership working is essential to achieve these stepped improvements

in how we understand air pollution, reduce our contribution to it and mitigate against its risks to health.

8.6 Many of the solutions to poor air quality also have enormous co-benefits by increasing levels of physical activity – for example by encouraging active travel. Future housing developments should encourage physical activity by design – making active travel the easiest, quickest and most enjoyable option.

8.7 Rutland County Council produced its 2018 Air Quality Annual Status Report (ASR) in October 2108, in fulfilment of Part IV of the Environment Act 1995, Local Air Quality Management. The report suggested that Rutland's air quality is generally good in relative terms and the report found there is currently no evidence to suggest that the Air Quality objectives have or are likely to be breached. The highest levels in the county are closely correlated with major roads and road junctions, such as the A1. The NO_2 diffusion tube monitoring program will continue with the aim of identifying locations where there may be any increases in NO_2 that could result in exceedances of the Air Quality Objectives.

8.8 The Rutland 2017 ASR referred to the Environment Strategy as being potentially Rutland County Council's commitment to protect and enhance air quality, through actions and policies that could be pursued through Local Plans. Whilst the Environment Strategy has yet to be adopted, there has been consultation on Local Plan specific sites for the review to 2036. With the outcome of this pending, this will be used towards the completion of this strategy.

8.9 In Rutland there will continue to be a commitment to ensure potential impacts on air quality are considered, assessed and if necessary mitigated against when responses for Planning Applications and Pre-application advice is sent to Development Control. The NO_2 diffusion tube monitoring program will continue with the aim of identifying locations where there may be any increases in NO_2 that could result in exceedances of the Air Quality Objectives.

8.10 Rutland County Council is also working towards the following measures in pursuit of improving local air quality: The Proactive Development Control Consultation, and the Travel 4 Rutland car and lift sharing scheme.

<u>Key issues 2019 (Air Quality)</u>

- Continue commitment to ensure potential impacts on air quality are considered, assessed and if necessary mitigated against when responses for Planning Applications and Pre-application advice is sent to Development Control.

- Prioritise structural i.e. spatial planning, infrastructure development efforts to reduce emissions of air pollutants**.** Further promotion of active travel, physical exercise and their co-benefits, where possible making active travel the easiest, quickest and most enjoyable option. Support Planning and Highways Authorities to implement a hierarchy of sustainable travel which prioritises

walking and cycling above other forms of transport. This includes prioritising investment in walking and cycling infrastructure, especially where this would encourage and facilitate active travel to schools and workplaces in areas of high urban density.

- Continue to work closely with industry and agricultural sectors to support improvements in techniques to minimise emissions of pollutants and share consistent and clear health messages with key workforce groups.

- Align and collaborate on local air quality initiatives. Rutland is an active member of the LLR Air Quality Forum. A cross Leicestershire air quality partnership has now been formed and the steering group has been meeting since January 2019. The emerging partnership action plan for air quality in Leicestershire is being developed and will focus on better data and intelligence, active travel promotion in identified hot spots, and a communications campaign to educate the wider public on both the acute and longer-term effects of poor air quality so that they can better protect themselves and their families. At present the Air Quality and Health partnership action plan is Leicestershire focused but join up with Leicester and Rutland colleagues may happen in due course.

9. FINANCIAL IMPLICATIONS

9.1 Most Health Protection actions and interventions are the financial responsibility of partners outside of Rutland County Council.

10. CONCLUSION AND SUMMARY OF THE REASONS FOR THE RECOMMENDATIONS

10.1 Overall the Leicestershire Director of Public Health is assured that the correct processes and systems are in place to protect the health of the population.

10.2 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 (e.g. severe weather and environmental hazards)
- Maintaining and improving progress on key health protection indicators particularly relating to:
- Communicable disease
- Environmental hazards especially air quality
- Screening
- Immunisation
- Hospital Acquired Infections

11. BACKGROUND PAPERS

11.1 Public Health England (2013) Protecting the health of the local population: the new health protection duty of local authorities under the Local Authorities (Public Health Functions and Entry to Premises by Local Healthwatch Representatives) Regulations 2013. PHE, London. Available online at http://ow.ly/FXuj309HpNE

REPORT OF THE DIRECTOR OF PUBLIC HEALTH, LEICESTER, LEICESTERSHIRE AND RUTLAND HEALTH, PROTECTION ASSURANCE REPORT,2017
http://politics.leics.gov.uk/documents/s127313/Health%20Protection%20Annual%20Report.pdf

Rutland County Council produced its 2018 Air Quality Annual Status Report (ASR)

12. APPENDICES

Appendix 1: Rutland sexual health indicators, 2018
Appendix 2: TB epidemiology Rutland 2018
Appendix 3: Childhood Immunisations Rutland 2018
Appendix 4: Seasonal Flu uptake (Immform Monthly data January 2019)
Appendix 5: Screening programmes uptake Rutland, 2018
Appendix 6: Healthcare association infections incidence 2017-18
Appendix 7: Leicestershire,Leicester and Rutland Health Protection Risk Matrix

Circulation under the Local Issues Alert Procedure

The report affects all areas of Leicestershire and the wider LLR.

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

[i] Annual Report of the Director of Public Health 2017. Available at: http://www.lsr-online.org/uploads/dph-annual-report-2017.pdf

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Appendix 1

Table 1 Rutland sexual health indicators, 2018

	Indicator	Polarity	Target	Latest Time Period	CIPFA Rank	England Value	Latest Value
Sexual Health Indicators	3.02 - Chlamydia detection rate (15-24 year olds)	High	<1,900 1,900 to 2,300 ≥2,300	2017	8/16	1,881.90	1,881.90
	3.04 - HIV late diagnosis	Low	<25% 25% to 50% ≥50%	2015-17	N/A	41.1	*
	Gonorrhoea diagnostic rate / 100,000	Low	England	2017	6/16	78.8	23.1
	HIV diagnosed prevalence rate per 1,000 aged 15-59	Low	<2 2 to 5 ≥5	2017	2/16	2.3	0.6
	HIV testing coverage, total (%)	High	England	2017	2/16	65.7	80.6
	New HIV diagnosis rate / 100,000 aged 15+	Low	England	2017	1/16	8.7	0
	Syphilis diagnostic rate / 100,000	Low	England	2017	14/16	12.5	7.7

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Appendix 2:

Table 2. TB epidemiology Rutland 2018

	Indicator	Polarity	Target	Latest Time Period	CIPFA Rank	England Value	Latest Value
TB Indicators	3.05i - Treatment completion for TB	High	England	2016	N/A	84.40	
	3.05ii - Incidence of TB	Low	England	2015-17	9/16	9.9	3.4
	Proportion of pulmonary TB cases starting treatment within four months of symptom onset	High	England	2017	N/A	68.8	
	Proportion of TB cases offered an HIV test	High	England	2017	N/A	96.1	

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Appendix 3.

Childhood Immunisations Rutland 2018

Table 3. immunisation uptake at 12 months

	12 months DTaP/IPV/Hib (%)	12 months Rotavirus (%)	12 months Men B two doses for infants assessed at 6 months (%)
Q1 17/18	93.8	92.7	93.8
Q2 17/18	94.2	93.2	94.2
Q3 17/18	93.8	87.5	93.8
Q4 17/18	97.3	90.4	94.5
Q1 18/19	94.6	95.9	95.9
Q2 18/19	90.8	88.5	89.7
Q3 18/19	98.8	94.4	97.8

Table 4. immunisation uptake at 24 months

	24 months PCV booster (%)	24 months MMR (%)
Q1 17/18	96.4	95.5
Q2 17/18	88.9	88.9
Q3 17/18	94.4	94.4
Q4 17/18	95.5	94.3
Q1 18/19	95.8	95.8
Q2 18/19	95.9	95.9
Q3 18/19	95.3	94.1

Table 5. immunisation uptake at 5 years

	5 years Dtap/IPV booster (%)	5 years MMR 2nd dose (%)
Q1 17/18	87.9	87.9
Q2 17/18	85.3	89.2
Q3 17/18	91.7	94
Q4 17/18	91.7	91.7
Q1 18/19	91.7	92.6
Q2 18/19	95.5	93.2
Q3 18/19	87.9	87.5

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Appendix 4.

Table 6. Seasonal Flu uptake (Immform Monthly data January 2019)

Local Authority	65 and over (%)	Under 65 at-risk only (%)	All Pregnant Women (%)	All 2-year olds (%)	All 3-year olds (%)
Rutland (4 practices)	69.9	47.8	59.2	60.8	53
England	71.2	46.7	45	44.8	43
National Aspiration	75	55	55	48	48

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Appendix 5.

Table 7. Screening programmes uptake Rutland, 2018

	Indicator	Polarity	Target	Latest Time Period	CIPFA Rank	England Value	Latest Value
Screening Indicators	Breast cancer screening coverage	High	England	2018	2/16	74.90	81.00
	Cervical cancer screening coverage	High	England	2018	3/16	71.4	77.1
	Bowel cancer screening coverage	High	England	2018	1/16	59	67.5
	Newborn blood spot screening coverage	High	England	2017/18	N/A	96.7	

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Appendix 6.

Table 8.

Healthcare association infections incidence 2017-18

	Apr 18/19	May 18/19	June 18/19	July 18/19	Aug 18/19	Sept 18/19	Oct 18/19	Nov 18/19	Dec 18/19	Jan 18/19	Feb 18/19	Mar 18/19	YTD
CDI ELR	6	6	6	8	10	8	4	7	3	5	1	3	67
CDI LC	8	3	3	9	12	4	5	6	6	3	1	6	66
CDI WL	13	11	10	8	10	7	6	2	7	6	4	6	90
CDI UHL	12	4	5	4	7	2	6	4	6	2	0	5	57
CDI LPT	1	1	0	1	1	0	0	0	0	0	0	1	5
E.Coli ELR	19	18	17	16	15	18	23	10	13	15	14	14	192
E.Coli LC	20	29	17	18	12	25	14	15	11	15	14	20	210
E.Coli WL	18	24	21	17	23	15	17	14	22	22	11	16	220
Hospital onset E.Coli UHL	11	8	3	5	3	11	5	5	6	5	3	9	74
Community onset MRSA BSA LC	0	0	1	0	0	0	0	1	0	0	0	0	2
Community onset MRSA BSA ELR	0	0	2	0	0	0	0	0	0	0	1	0	3
Community onset MRSA BSA WL	0	0	0	0	0	0	0	0	0	0	0	0	0
Hospital onset MRSA BSA UHL	0	0	0	1	0	0	0	0	0	0	1	1	3

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Appendix 7. Leicestershire, Leicester Rutland Health Protection Risk Matrix

November, 2018			
	Main issue(s)	**Mitigation**	**Anything more to do locally at this point**
Anti-microbial resistance	(1) Lack of progress made on AMR strategy-> increased prevalence of AMR infections. (2) CRO	AMR Board in place. Also Oversight by LEICESTER, LEICESTERSHIRE AND RUTLAND (LLR) INFECTION PREVENTION & CONTROL PROGRAMME BOARD and also LLR IPC MULTIAGENCY DELIVERY GROUP (MADG)	Need to strengthen role of STP in terms of governance and oversight of this issue
Healthcare Associated Infections (HCAI)	Healthcare associated infections are preventable and have significant impact on patients and on wider NHS and care systems	Oversight at LEICESTER, LEICESTERSHIRE AND RUTLAND (LLR) INFECTION PREVENTION & CONTROL PROGRAMME BOARD and also LLR IPC MULTIAGENCY DELIVERY GROUP (MADG)	Need to strengthen role of STP in terms of governance and oversight of this issue
Emerging and re-emerging infectious diseases	Increased prevalence of virulent strain of TB in Loughborough and Leicester City.	PHE leads and co-ordinates outbreak groups and meetings	Communicable Disease Outbreak Management (PHE) recently published-needs further discussion and dissemination.
Pandemic influenza	Pandemic influenza is the most significant civil risk facing the UK	Links to emergency planning (see below)	

Emergency planning*	Partners not always clear on the response structure to major incidents, causing delays in action and coordination of groups. Capacity, resources and governance		Further discussions needed at Local Health Resilience Partnership (LHRP) to confirm major incident cover especially over longer term major incidents. Additional input needed from regional HP network Need to follow up on LHRP audit of health protection capability, 2017
Climate change and extreme events-floods, heat, cold	See emergency planning above		
Immunization	Intermittent supply issues	Need good communication between NHSE, CCGs and pharmacies	PH to flag issue up at CCGs
Screening	On-going sub-optimal uptake of different screening programmes e.g. cervical screening	Continued oversight at HP Assurance Board	Build on relationships between LA, NHSE and CCGs
Air Quality	Causes significant premature mortality	Leicestershire Air Quality Strategy now in place	Complete (1) Air Quality JSNA chapter and (2) Air Quality **Action plan**
Miscellaneous	Lack of capacity in LLR, environmental health & regulatory teams to deliver statutory functions.	Continued oversight at HP Assurance Board	

Rutland County Council

Developing the Joint Health & Wellbeing Strategy 2019-2022

Dr Katherine Packham, Consultant in Public Health

Rutland County Council

Joint Health and Wellbeing Strategy

- Statutory responsibility
  - Local authorities and clinical commissioning groups have equal and joint duties to prepare JSNAs and JHWSs, through the Health and Wellbeing Board (H+WBB)
  - Intended to drive and support the agenda and work of H+WBB
- Joint Strategic Needs Assessment (JSNA) published in December 2018
  - Informs Joint Health and Wellbeing Strategy (JHWS)
- Previous Joint Health and Wellbeing Strategy published 2016

Rutland County Council

What is a Joint Health and Wellbeing Strategy?

- To inform and influence commissioning and delivery decisions about health and care services
  - So decisions are focused on the people who use services
  - To tackle the factors that impact upon health and wellbeing
- Used to drive and support Health and Wellbeing Board agenda and work

Rutland County Council

What's changed since the previous strategy?

- Primary Care Network development
- Integrated Care Systems planned
    - Discussions regarding system, place and neighbourhood and the decisions that could/should be taken at different levels
    - Place and neighbourhood may well be the same for Rutland
- How could the H+WBB contribute to the development of the Integrated Care System?
    - A role for H+WBB in driving forward the place/neighbourhood elements together with Rutland's primary care network.

Rutland County Council

Options for Rutland's strategy

1. Wider determinants of health and wellbeing
2. A life course approach
3. Illness and disease areas
4. Lifestyle factors

Rutland County Council

1. Wider determinants of health

- Focus on wellbeing and wider determinants of (influences on) health and wellbeing
- Could include priorities related to
    - Target resources in proportion to need to address the needs of any children living in poverty
    - Rural isolation
    - Access to services
    - Health and wellbeing inequalities
    - Further integration of health, care and related services

Rutland County Council

2. Life course approach

- Would look at Rutland's residents from birth throughout the life course
- Priorities could be spread through the life course, for example:
    - Every child lives in a happy and safe environment
    - We work together with young people and give them the support they need to grow into happy, successful and independent adults.
    - Keeping adults active for longer to prevent or reduce the impact of a range of health conditions particularly focused on those aged 45-65 years to improve healthy life expectancy.
    - Health and care services to work together to develop a holistic approach to Healthy Ageing that treats the patient rather than the separate conditions, reviewing commissioned pathways where relevant and appropriate.

Rutland County Council

3. Illness and disease areas

- Focus on specific illnesses to improve the health of Rutland's population
- For example, there could be priorities on:
    - Support and encourage healthy behaviour in pregnancy and beyond including maternal smoking, alcohol use, healthy eating and physical activity.
    - Work to prevent coronary heart disease, strokes and transient ischaemic attacks through supporting increased physical activity, weight management, reduced alcohol consumption and quitting smoking.
    - Develop the dementia pathway to increase the proportion of those with living with dementia who have a formal diagnosis, enabling them to access services and support.

Rutland County Council

4. Lifestyle factors

- Focus on a range of lifestyle factors
- Possible priorities could be:
    - Families are supported and empowered to create a nurturing environment where children can flourish.
    - Focus on getting adults active and keeping them active for longer to prevent or reduce the impact of a range of health conditions particularly focused on those aged 45-65 years to improve healthy life expectancy.
    - Develop workplace wellbeing programmes with active engagement with local employers.
    - Consider targeted interventions to tackle other potential causes of poor mental health e.g. loneliness, social isolation, and other wider determinants of poor mental health.

Rutland County Council

Next steps

- Rutland Joint Health and Wellbeing Board asked to DISCUSS and DECIDE which model of the Joint Health and Wellbeing Strategy they would like developed

- Rutland H+WBB to DISCUSS how the board may need to evolve to best fulfil the aims of the future Joint Health and Wellbeing Strategy once known

Report No: 87/2019
PUBLIC REPORT

HEALTH AND WELLBEING BOARD

25 June 2019

RUTLAND BETTER CARE FUND PROGRAMME 2018-19 AND 2019-20

Report of the Strategic Director for People

Strategic Aim:	Safeguarding	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr A Walters, Portfolio Holder for Safeguarding - Adults, Public Health, Health Commissioning & Community Safety	
Contact Officer(s):	Mark Andrews, Strategic Director for People (DAS/DCSS)	01572 758339 mandrews@rutland.gov.uk
	Sandra Taylor, Health and Social Care Integration Manager	01572 758202 staylor@rutland.gov.uk

DECISION RECOMMENDATIONS
That the Board: 1. Notes the progress and performance of the 2018-19 Rutland Better Care Fund (BCF) programme. 2. Endorses the direction of the 2019-20 BCF programme. 3. Delegates authority to the Strategic Director for People, in consultation with the Chair of the Rutland Health and Wellbeing Board, to approve the 2019/20 BCF programme for submission to NHS England.

1 PURPOSE OF THE REPORT

1.1 The purpose of this report is to update the Health and Wellbeing Board (HWB) on Better Care Fund (BCF) progress and performance in 2018-19 and to review and endorse proposals for 2019-20. The report also recommends that authority be delegated to the Strategic Director for People in consultation with the Chair of the Health and Wellbeing Board to approve the 2019/20 BCF programme for submission to NHS England.

2 THE BETTER CARE FUND IN 2018-19

2.1 Annual Better Care Fund programmes have been delivered in Rutland since the BCF was introduced in 2014-15, and have fostered wide ranging improvements in how health and care services are designed and delivered. This has established more integrated ways of working which benefit the public and make health and care services more sustainable in the face of a rapidly ageing population.

2.2 As set out in Appendices A and B, overall, BCF progress and performance were good across last year's programme. The majority of the programme is delivered via either ongoing staffing, who continue to evolve and improve their ways of working together, or via multi-annual contracts (eg. Community Wellbeing Service and Assistive Technology) which are now business as usual, and evolve through ongoing contract management and partnership working.

2.3 Innovations last year included a doubling of the Admiral dementia nurse capacity, increased change support to care homes, the introduction of the Healthy Rutland grant fund supporting capacity development in communities, the addition of a nurse to the MICARE complex care model, and the first steps in establishing a collaborative social prescribing model.

2.4 In addition, the governance arrangements were renewed, replacing the BCF-focussed Integration Executive with a Health and Care Board with a wider, more balanced remit and partnership across social, primary and community care and the voluntary sector. This was designed to be better suited to improving coordination across multiple local change programmes (including Community Services Redesign and the Primary Care Home work of the GP practices, now transitioning into the Primary Care Network), and to meet the future demands of a locality health and care system.

2.5 A minority of measures were affected by the significant changes underway to the local health and care environment, notably the Community Services Redesign exercise, and recruitment challenges. One technology pilot (the VitruCare self-care toolkit) was halted after extended technical difficulties outside the control of the supplier. Nevertheless, Rutland was well on track for most performance indicators and improving for the remainder. For the two more challenging indicators, there was a sustained Q4 improvement in both falls injuries and levels of Delayed Transfers of Care (DToC).

3 THE BETTER CARE FUND IN 2019-20

3.1 As in previous years, there has been a delay in the timetable for issuing the materials needed to develop and agree the 2019-20 programmes. The policy framework was published on 10 April, but the guidance, template and key lines of enquiry for the new programmes are still awaited.

3.2 When the template is released, there will be a six week deadline to prepare and submit a plan, which must first be approved by the Health and Wellbeing

Board or, via delegation, by the Strategic Director for People in consultation with the Chair of the HWB.

3.3 To get the process underway, provisional programme proposals are set out in Appendix C, for the consideration and indicative endorsement of the HWB.

3.4 The BCF plan has been developed relative to a number of reference points, notably the formal guidance and requirements, local strategic frameworks, the needs of the locality, progress to date and good practice frameworks.

3.5 The programme will encompass a number of budgets in 2019-20, totalling £2,627k, plus carry forward funds, giving the opportunity to plan this full scope in a more integrated way and streamline reporting:

- **Better Care Fund.** Anticipated to equal last year's amount (£2.138m) plus an increment of at least 1.79% for inflation, so a minimum of £2.176m. Potential increments may be as much as 5% in some areas, but exact numbers are still in discussion.
- **Disabled Facilities Grant.** Capital funding for home adaptations of £238k, to be spent on statutory DFG projects and on smaller, locally designed Housing and Prevention grants.
- **Improved Better Care Fund (i-BCF).** In the final year of this budget, £77k is anticipated, allocated to the rapid response social workers.
- **Social care winter pressures funding** of £135k.

3.6 2019-20 will be the last year in which the BCF mechanism is used in its current form. There is as yet no confirmation of what will supercede this model of funding delivery, although funding levels themselves are expected to remain similar going forward. In this context, and given the delays to reprogramming, we have followed national advice and prioritised continuity.

3.7 On that basis, the current programme structure will be sustained, but with changes at the measure level. It has been successful to date in supporting rapid change to health and care services and delivered good outcomes for Rutland residents.

- Priority 1: Unified prevention, including a strengthened focus on social prescribing
- Priority 2: Holistic health and wellbeing in the community (Long Term Condition Management)
- Priority 3: Hospital step up and step down, reinforcing the home first model
- Priority 4: Enablers

3.8 Key changes to the programme are as follows:

a) Priority 1 has a stronger emphasis on social prescribing, including potential for a short-term post to support the development of network

assets. The additional dementia nurse funding has been aggregated with the pre-existing dementia funding under Priority 2.

b) In Priority 2, the care home budget has been increased including for quality assurance support,

c) MICARE is now funded by mainstream social care funds.

3.9 The initial proposed allocations across the priorities are set out below, including all the funds listed above, plus carry forward monies, but excluding the £125k contingency fund which has been sustained across the lifetime of the BCF.

3.10 While the Unified Prevention priority has a lower budget than previously, this programme sustains the strong emphasis on enhancing primary prevention through its boosted social prescribing and community development ambitions. Priority 2 is larger than previously, with an increase in secondary and tertiary prevention, receiving additional funds from Priority 1 (transferring the additional dementia nurse), and from Priority 3 (transferring the Mental Health post to a more preventative focus). With hospital discharges (Priority 3) now running well, the ability to sustain the health and wellbeing of people in the community who already have impaired health, as pursued under Priority 2, is becoming a critical focus for the quality and sustainability of the local system.

Priority	Sum	Share
Priority 1: Unified Prevention	£287.00	10%
Priority 2: Living well with ill health	£1,375.91	47%
Priority 3: Hospital step up step down	£1,042.28	36%
Priority 4: Enablers	£107.40	4%
As yet unallocated	£102.66	4%
Total	**£2,915.2**	**100%**

3.11 Around £100k of mainly non-recurrent funding is still available for allocation by the partnership. As there is significant change underway, including with the formation of the Primary Care Network and the Community Services Redesign exercise, this funding pot offers some modest flexibility to address issues or opportunities that may arise out of imminent transitions, eg. via temporary staffing capacity, communications, improved processes or adjustments to IT solutions. Proposals which are already mature or can be launched rapidly must be prioritised as only three full quarters remain of the year.

3.12 In its structure, the Health and Care Board has agreed that the new programme can serve as the framework through which to organise the governance of a number of overlapping sets of integration activity, also spanning primary and community care, giving greater clarity and simplifying reporting and communications. There is already strong synergy between eg. GP transformation activity and the BCF programme.

3.13 The Health and Wellbeing Board is invited to

a) Consider and endorse the indicative programme proposal.

b) To confirm whether, when the timetable for programme submission is known, HWB members wish to delegate its approval to the Strategic Director for People in consultation with the HWB chair.

4 CONSULTATION

4.1 Programme proposals have been developed working with other system partners, including the members of the Health and Care Board, and this work is still underway.

5 ALTERNATIVE OPTIONS

5.1 As this is the final year of the BCF mechanism in its current form, parts of the health and care system are in flux, notably with primary care forming into Primary Care Networks, and the timetable is delayed nationally. As such, NHS England have recommended that programmes should not embark on significant change unless this is required due to urgent performance issues.

6 FINANCIAL IMPLICATIONS

6.1 The 2019-20 BCF programme will receive a financial uplift of at least 1.79% on the BCF element of the budget, with the exact multiplier still to be confirmed. The programme will be adjusted to the ceiling budget once the available sum is confirmed.

6.2 Dialogue with programme partners about the programme is still underway, so not all funding has as yet been tied to specific proposals. There is significant change underway in partners so this offers a modest element of flexibility to the partners. It will be important to get any new activities underway rapidly, however, in order to progress them with only three quarters of the year remaining.

6.3 Four national funds (BCF, social care winter pressures, Improved BCF and DFG) are being planned, managed and reported on via the BCF mechanism this year, which will streamline reporting routines that have become increasingly onerous and repetitive.

6.4 The approach for the hiatus between the 2018-19 and 2019-20 programmes, as in previous years, is to continue ongoing activity and spend, and to vary activities where required by agreement between key partners.

7 LEGAL AND GOVERNANCE CONSIDERATIONS

7.1 The BCF programming process is nationally defined, including conditions to be met in how the funds are allocated and managed. The draft programme has been defined to comply with these requirements, and can only be finalised when final templates and key lines of enquiry have been published.

7.2 There are no changes to the programme currently which pose new legal and governance considerations.

7.3 The programme continues to be supported by an underlying NHS Section 75 agreement which sets out how ELRCCG and the Council will work together to manage the BCF budget.

7.4 The programme must be locally approved in order to be approved nationally.

8 DATA PROTECTION IMPLICATIONS

8.1 Information Governance assurance for the programme is undertaken at the level of individual measures and projects, as and when significant changes are planned and implemented, rather than being undertaken in advance for the programme as a whole.

9 EQUALITY IMPACT ASSESSMENT

9.1 No new Equality Impact Assessment has been undertaken as yet for the draft programme as substantive change is limited. In its focus, the programme is designed to have a positive impact on equalities, and notably on the population living with disabilities.

10 COMMUNITY SAFETY IMPLICATIONS

10.1 BCF programmes impact positively on community safety through a number of their measures. For example:

c) The rapid response social work service is part of the Rutland response to the LLR Vulnerable Adult Risk Management (VARM) Framework, ensuring that there is capacity to act quickly in situations of social care risk to individuals as a result of their circumstances.

d) Assistive technology is deployed to enhance the safety of individuals, for example GPS technology enabling people with dementia to remain active in the community.

11 HEALTH AND WELLBEING IMPLICATIONS

11.1 The purpose of BCF programmes is to enhance health and wellbeing in Rutland by progressing health and care integration and reshaping services, focusing mainly on older adults. The programme complements other strategies such as the Rutland Health and Wellbeing Strategy, which has a broader scope.

12 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

12.1 To help advance preparations for submitting the 2019-20 BCF programme, the HWB is asked to feedback on and to endorse the provisional BCF programme set out here. This exhibits strong continuity with the 2018-19 programme, while increasing its emphasis on the health and wellbeing of those living with ill health in the community, aiming to increase near home responses in line with the wider LLR home first strategy and to reduce rather than better manage hospital admissions.

To ensure that the finalised programme can be submitted to the tight national deadline, which will be six weeks after publication of the guidance and template, the HWB is asked to delegate the authority to approve the 2019/20 BCF programme for submission to NHS England to the Strategic Director for People, in consultation with the Chair of the Health and Wellbeing Board.

13 BACKGROUND PAPERS

13.1 2019-20 Better Care Fund: Policy Framework, Department of Health and Social Care and the Ministry of Housing, Communities and Local Government, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/795314/Better_Care_Fund_2019-20_Policy_Framework.pdf

14 APPENDICES

14.1 Appendix A: Programme Progress 2018-19

14.2 Appendix B: Programme Performance 2018-19

14.3 Appendix C: Summary of proposed Rutland BCF priorities 2019-20

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

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Appendix A: BCF Programme Progress and Performance 2018-19

1 PROGRAMME PROGRESS 2018-19

PRIORITY 1: UNIFIED PREVENTION

1.1 The focus of the Unified Prevention priority has been on ensuring people can access relevant advice and support early to sustain their health and wellbeing and delay the onset or progression of health conditions and social care needs. Actions under both Priorities 1 and 2 of the programme have sustained Rutland's long-standing focus on prevention (spanning primary prevention - preventing disease, secondary - early intervention, and tertiary - reducing the impact of living with disease). The prevention focus is essential to managing demand for health and care services well into the future, a priority which is strongly evident in the NHS Long Term Plan (2019). The approach taken in Rutland coincides with recent Public Health England guidance (Health matters: Prevention - A life course approach, 2019) which underlines the need to respond holistically at each life stage or transition, rather than addressing individual issues or conditions in isolation.

a) Building on previous work to enhance the Rutland Information Service online directory (https://ris.rutland.gov.uk), the communication of available support was enhanced last year through two issues of a new care and wellbeing brochure 'Living well in Rutland' distributed via GP surgeries, libraries and front line advisors. This publication has been praised by the NHS Clinical Lead for Health and Social Care Integration as a practical and positive self help resource (**measure 1.1**). In parallel, Rutland Healthcare's new 'hub and spoke' website (https://rutlandhealth.co.uk/), which aggregates local and national health and self care information, is now live in all Rutland practices, again praised by NHS England as an innovative model.

b) In its second full year, the integrated Community Wellbeing Service (CWS) delivered by the Rutland Access Partnership has strengthened its public profile and matured its approach to offering a menu of support to individuals via a single front door (including healthy lifestyles, emotional and financial wellbeing, housing issues and ageing well) (**measure 1.2**). In parallel, RCC's rapid response social workers have enabled a consistently fast turnaround where people come forward in circumstances entailing urgent social care need or risk (**measure 1.2**). Further substantive services supporting prevention are set out in **Priority 2**.

c) The above services are elements of a much broader information, advice and support network across Rutland. Public Health in Rutland is leading a participative project to enhance and coordinate 'social prescribing', promoting a 'no wrong front door' approach. This involves key public sector funded front-line advisory services establishing a joint cooperative model, making the routes to support more visible and support more consistent, wherever it is requested. This harnesses the combined

expertise of over a dozen existing advisors plus the forthcoming Primary Care Network social prescribing role which will be provisioned locally under the NHS Long Term Plan.

d) The Healthy Rutland Grant scheme, part-funded by the BCF, is fostering sustainable ideas from groups or communities across Rutland, offering them modest kick start funding. This has included funding for equipment for Junior Parkrun, and a gardening and food project 'Plot to Pot' (measure 1.3). Across two funding rounds, the number and quality of applications has increased as has the range of applicant organisations. The process of bidding is in itself growing community capacity, building up essential skills in understanding needs, planning interventions and considering sustainability and the cost-benefit equation.

2 PRIORITY 2: LONG TERM CONDITION MANAGEMENT

2.1 In common with Priority 3, a significant amount of the funding under Priority 2 is allocated to roles in mainstream health and social care teams whose integrated working is now very much business as usual, and who are continuing to evolve how they work together to better serve local needs.

a) Strong demand continued for the Housing MOT scheme and Housing and Prevention (HaP) grants (**measure 2.5**). 57 HaP projects and 5 larger DFG projects were delivered in 2018-19. The total cost was £353k, offering a significant preventative impact for 62 Rutland households. The additional spend beyond the 2018-19 DFG budget of £220k and the £29k DFG uplift was met by the winter pressures social care grant and a contribution from RCC reserves. The DFG allocation for 2019-20 has been confirmed as £238k, an uplift of £18k from last year's basic allocation. Demand will be monitored closely in 2019-20 and prioritisation approaches considered.

b) Five members of the expanded Admiral Nurse led carer support team are in place (carer support, Integrated Care Coordination and dementia support (measure 1.2, 2.1, 2.5). A first review of early progress against the dementia and carers strategy delivery plans has been conducted to take stock and adjust where required. A key finding is how well embedded the team has become into the wider health and care network over the last 6-9 months, ensuring timely inputs improving the care and wellbeing of some of our most vulnerable citizens.

c) Allied with this, ELRCCG has confirmed its go-ahead to introduce a preventative Mental Health role for Rutland, including to better support those whose mental health is affected by living with complex health challenges. This role will be recruited for 2019-20 and will work closely with the GP practices for case finding.

d) The Vitrucare GP self care pilot ran for most of 2018-19, gathering around 100 participants living with diabetes or hypertension. However, owing to extended technical issues outwith the control of the supplier, momentum

was lost and Rutland GPs opted to end the pilot (measure 2.2). In parallel, success was achieved in working with pre-diabetic and diabetic patients using education and proactive follow up. There is an opportunity to build on this experience in the next programme, and also to capitalise on new self care options, for example, the national NHS App which has been launched locally, and an NHS 'app store' in place with clinically approved self care tools.

e) Extending the MICARE complex care service to a second part of Rutland was delayed due to recruitment issues, but is now being progressed in the East of the county, where it is also being used to build effective collaboration with Stamford health colleagues over the border with Lincolnshire (measure 2.3).

f) A local digital falls prevention trial has been agreed, where the same electronic devices will be used for falls risk assessment across Council reablement and therapy teams and LPT's falls programme. Implementation has been awaiting completion of an integration between the QTUG devices and SystmOne, the GP case management system, as this offers wider benefits than stand-alone assessments. Further falls prevention interventions are at the planning stage, with collaboration with the Fire service also being considered for falls prevention and response. Meanwhile, the care homes personalised falls prevention trial is complete and being written up, with some promising learning which will be rolled out to other homes, addressing residents as individuals rather than developing approaches at the level of the home.

g) Also targeting the most complex patients, we have enhanced the use of digital tools by care providers to access health information via a wider project. Four homes have completed NHS Information Governance accreditation and can now access NHSmail. Two homes plus MICARE and RCC Supported Living are also looking to become users of the SystmOne Electronic Patient Record care homes module, conditional on agreement to this by relevant Rutland GP practices. Information Sharing Agreements are being brokered by L-HIS (measure 2.4).

3 PRIORITY 3, HOSPITAL STEP UP AND STEP DOWN

3.1 Priority 3 is largely focussed on staffing and services associated with hospital discharge and reablement, with effective teams now very much business as usual.

a) After a challenging start to the year, to ensure prompt discharges, social care winter pressures funding was used to increase assessment capacity. Changes were also considered to improve the resilience of discharge pathways by ensuring there is a nominated 'lead coordinator' supporting each stage of a patient's transfer of care, with a clear process of 'passing the baton' at the appropriate time to the next lead professional.

b) Local data validation is improving steadily, but still with regular disparities between locally agreed and nationally reported data (the 'Sitreps') - see Section 3 below.

c) Reablement, enriched by wider signposting and referral activity to related schemes supporting different aspects of independence, delivered excellent results this year in terms of avoiding hospital readmission.

4 PRIORITY 4. ENABLERS

4.1 Priority 4 is for enablers – or interventions helping to underpin programme-led change - including funding for programme support, which also enables the programme to participate in LLR-wide strategic work around the enablers, analytics, support for Information Governance assurance and IT change. A key project this year has been an NHS Digital pilot project to allow Adult Social Care access to the GP Summary Care Record, accelerating social care assessment.

5 PROGRAMME PERFORMANCE IN 2018-19

5.1 Whole year BCF performance data is set out in **Appendix B: Performance report**. Five metrics were tracked across the year to capture BCF performance at a high level.

5.2 Performance was positive for the prevention-related indicators in 2018-19, but with some challenges.

a) **Sustaining independent living:** Rutland has been able to sustain its low numbers of people entering Council funded residential care, instead working to enable people to remain living at home where this is their wish. Numbers of people entering permanent council funded residential care were on track overall, with the ceiling target exceeded by just one admission, or 4% (29 relative to a target of 28). Relative to last year, this was the same number of admissions, against a rising population of over 85s. Care home admissions remain low compared with most other areas, with 0.3% of the over 65 population permanently entering residential care this year. This was 293 per 100,000 over 65 population.

b) **Avoiding hospital admission:** In 2018-19, the number of hospital admissions was 20% lower than the ceiling target set by the CCG based on the local population. While this is very positive, numbers of non elective admissions are growing, and faster than previously, with growth of 10% this year relative to last, in spite of a range of interventions that we would anticipate having a positive impact on admission numbers. As part of the Locality Pilot, stakeholders have been identifying actions across primary, social and community care to reduce numbers of (particularly) frail and complex individuals needing to be admitted, including during end of life care.

c) **Avoiding falls injuries.** Falls injuries in the over 65s ended the year 9% above the ceiling target overall, but had been improving steadily across 2018-19. They were at or below the ceiling target from December to March. Work under the Locality Pilot therapy workstrand is broadening and strengthening the falls prevention response (see above).

5.3 In the step down from hospital, timeliness of hospital discharges has returned to target levels after a difficult start to the year, while reablement performance was excellent.

a) **Avoiding delays to hospital discharge.** It has been a mixed year for the timeliness of transfers of care from hospital. On paper, the aggregate target for the year was exceeded by some 27%. However, this overstates the actual situation: some delays misallocated to Rutland could not be rectified after the event due to technical constraints at one of the trusts. Positively, while the early part of the year saw higher than usual DToCs, performance improved steadily over the latter part of the year, bringing DToC levels back well within the challenging NHS ceiling target by the end of the year (March's DToCs were 33% under the monthly target). DToC issues continue to evolve month on month and to be followed up proactively as they arise.

b) **Reablement**: in Quarter 4, 97% of those who received post-hospital reablement services were still at home 91 days later, against a target of 90%. Reablement enables people to learn new ways to accomplish daily tasks that have become more difficult as a result of health challenges. Reablement success is an important measure of the ability to optimise people's independence following a hospital admission. Increasingly, reablement is combined with other relevant interventions such as a Housing MOT or connection to the Community Wellbeing Service or similar where there are other challenges such as the impact of social isolation on psychological wellbeing. This also contributes to positive post-hospital outcomes.

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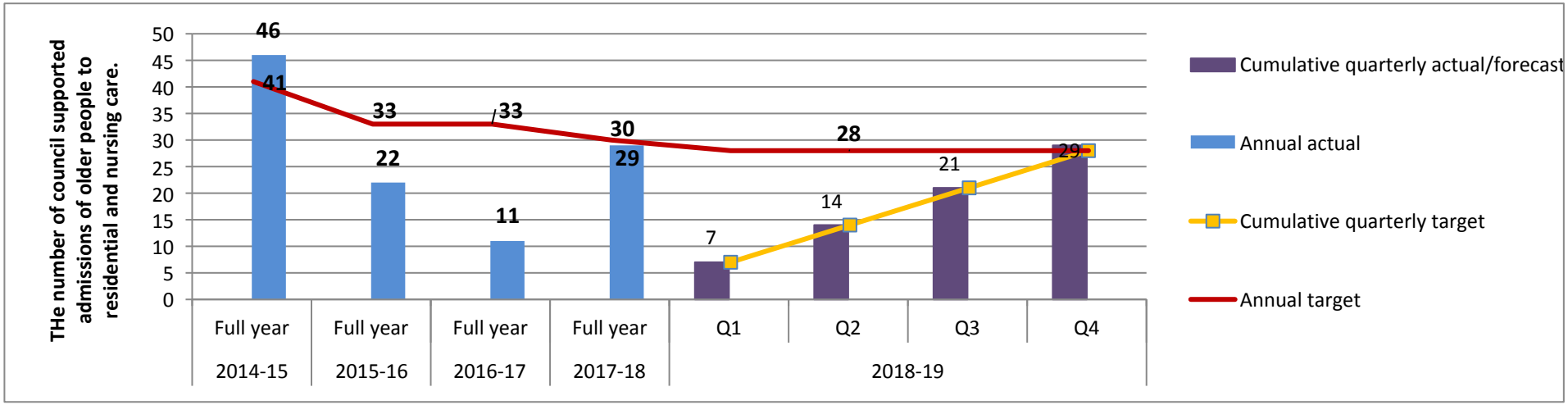
Metric 1 - Residential Admissions

TARGET: The 2018-19 residential admissions ceiling target is 28, 7% lower than last year's target of 30, which was met with 29 admissions. The targets aim to balance ambition and avoiding undue pressure to avoid residential admission where they are appropriate or an individual's choice.

Q3 2018-19 Performance: GREEN. There have been 29 permanent residential admissions in the year, so one over the ceiling target. 0.3% of the over 65 population has entered permanent Council funded residential care, equating to 293 per 100,000 over 65.

We are reviewing this year's admissions to identify whether any could have been prevented, with a view to adjusting support if so, and to confirm whether past involvement had helped to at least postpone these admissions. The emphasis of the Rutland social care approach, as reflected in a recent case study for an ADASS East Midlands comparative review, remains one of proactively enabling independence in the community wherever possible.

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



Outcome Sought:

Reducing inappropriate admissions of older people (65+) into residential care

Rationale:

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

Definition:

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

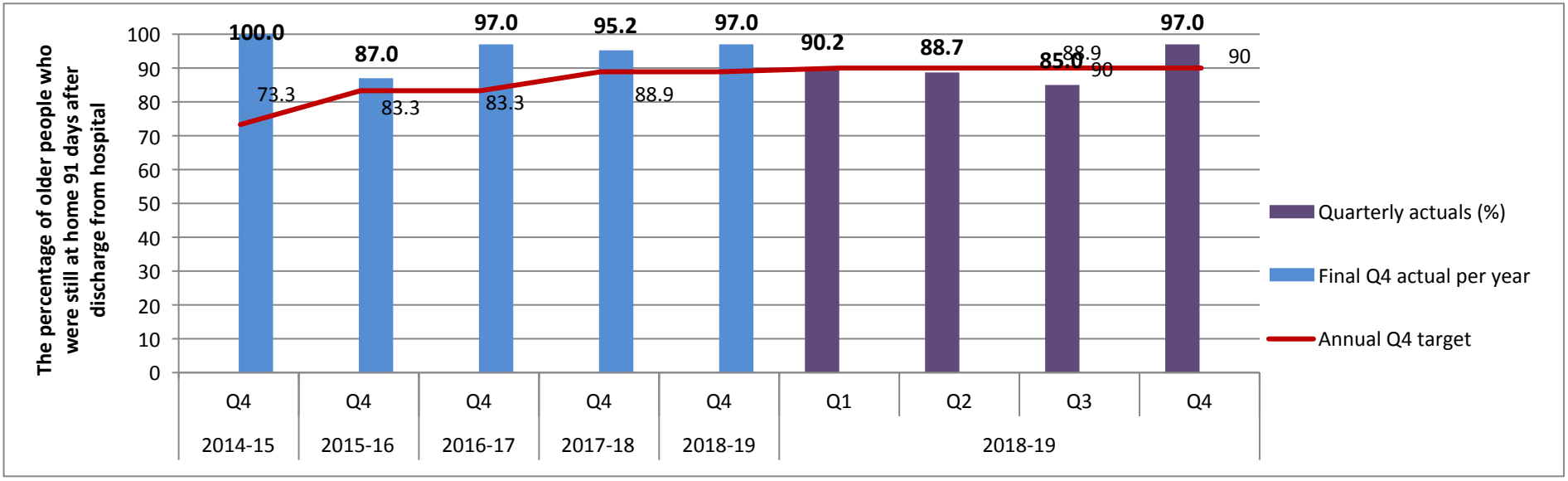
Reporting Schedule:

Metric will be reported quarterly. Q1 2019-20 update will be confirmed early August 2019.

Metric 2 - Reablement

TARGET: The reablement target is 90% success in 2018-19. The target is already very stretching and has not been raised further as, in an area of low population, the varying characteristics of cohorts receiving reablement can have a disporportionate impact on performance.
2018-19 Q4 Performance: GREEN: With 97% reablement success in Q4, this indicator is on track. The variable figures across the year are reflective of the generally advanced age and frailty of many of the Rutland service users, some of whom died in the period after reablement.

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



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

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

Definition:

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

Reporting Schedule:

Formally, the metric is updated annually. The number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital is collected **1st October to 31st December** for the relevant year. Same individuals are then checked 91 days later (i.e. January to March). Next formal update April/May 2019.
Local quarterly updates are calculated alongside this. Q1 2019-20 update early August 2019.

Metric 3 - Delayed Transfers of Care

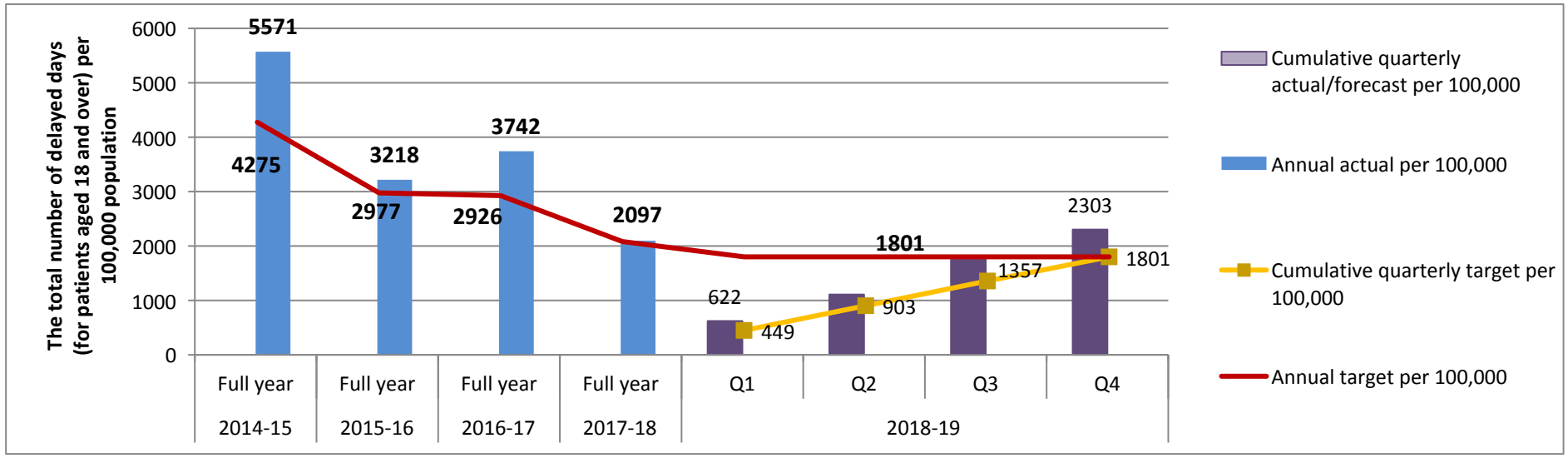
TARGET: Rutland DToC targets in 2018-19 match the Department of Health expectation targets, set this time based on a full quarter's performance (2017-18 Q3). See chart 3.2 below (yellow line) for performance against anticipated month by month targets.

2018-19 performance: AMBER, but improving. DToC performance has been improving steadily and was back within target by March. Aggregate DToC performance, however, has exceeded our national expectation target of 1.5 DToCs per day, by 28%. Most of the months exceeding target included contested DToC days - sufficient in November to bring performance back on target. The overall rate of DToCs has been 6.31 per day per 100,000 adults so, while higher than our local target of 4.9, is still substantially lower than the national overall target of 9.4.

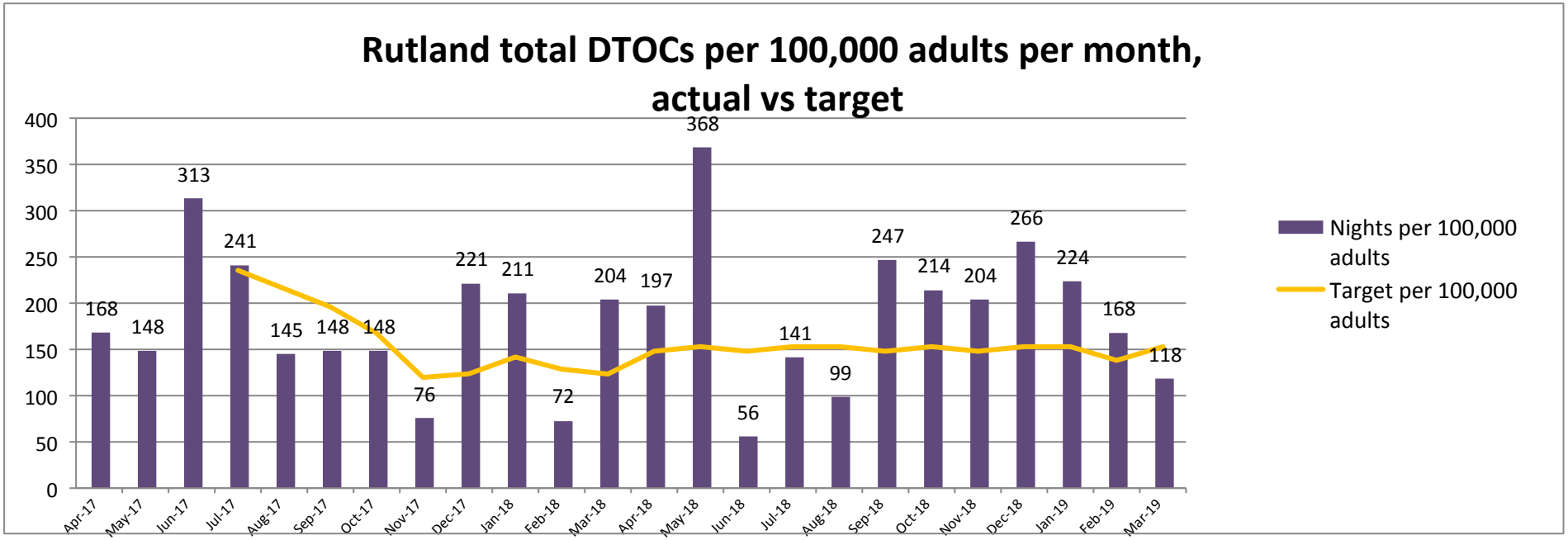
A long-running issue has occurred around the attribution of social care responsibility for particular cases (to Rutland or Leics, based on where their 'ordinary residence' is). However, the interpretation is not clear cut and means not all of these days are likely to be removed retrospectively from the statistics. The Discharge Team has asked PCH and LPT to request corrections, but these would also take some months to filter through.

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

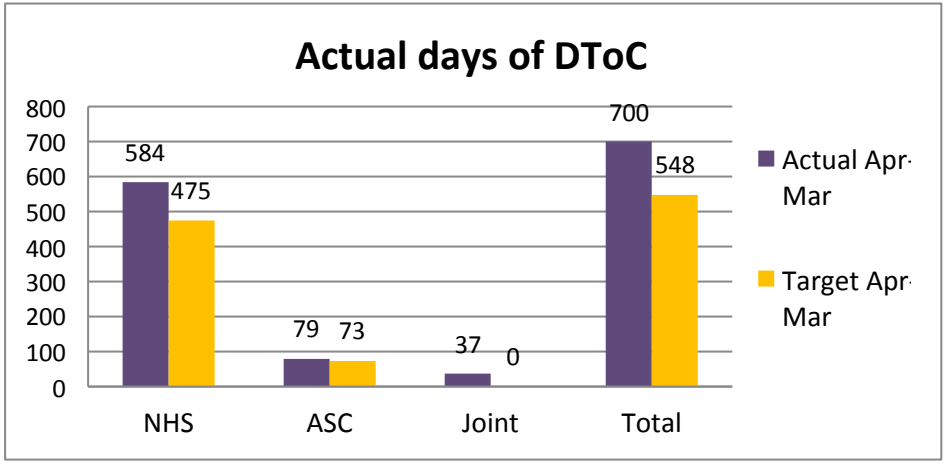
NB: For 2018-19, this chart shows the national expectation target for Rutland based on Q3 2017-18 performance. Actual target not yet agreed.

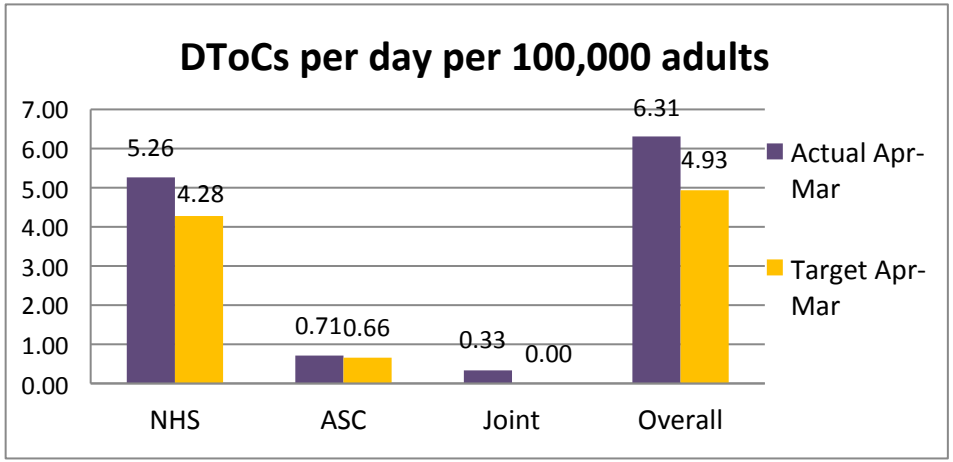


3.2. Delayed transfers of care (delayed days) from hospital (aged 18+), per 100,000 population - performance by month



3.3 Cumulative DToC position per sector (NHS, Social Care, Joint) and against target, Apr 2018-Feb 2019





Outcome Sought:

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

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

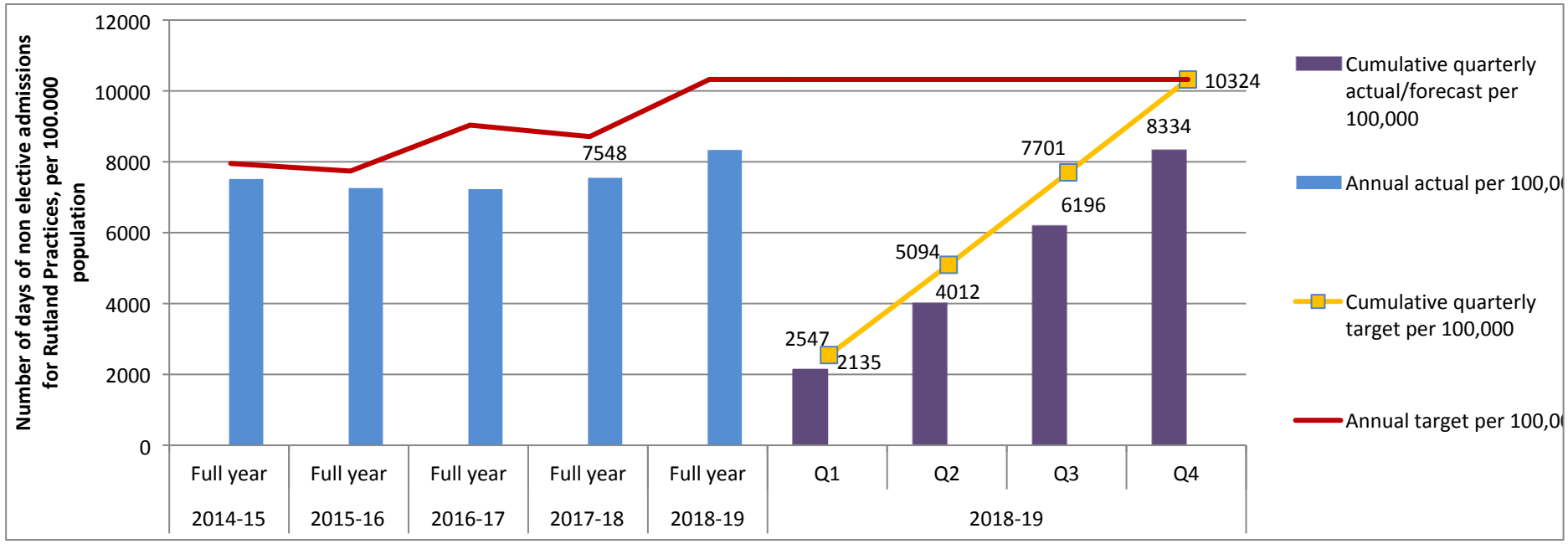
Definition:
Delayed transfer of care per 100,000 population per month.

Reporting Schedule:
Next full quarter available August 2019.

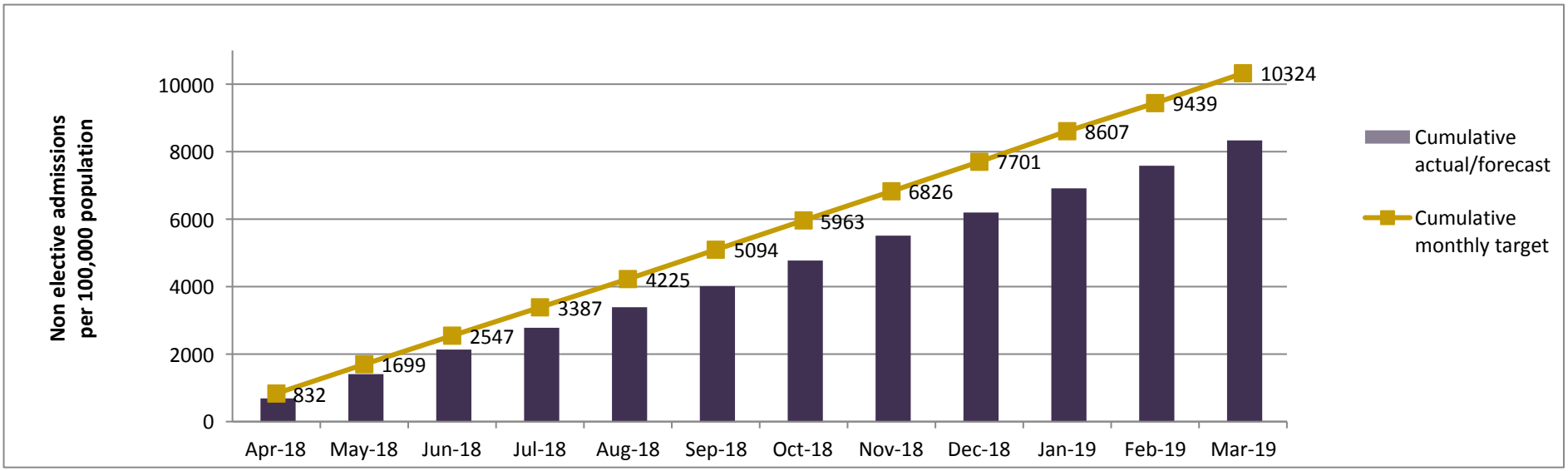
Metric 4 - Non-Elective admissions (general and acute)

RAG rating: Green as performance is well within raised ceiling targets.
TARGET: 2018-19 Rutland NEA targets have been raised by 23% to reflect the higher NEA targets agreed for 2018-19 in the new ELRCCG Operating Plan. The ELRCCG increase has been shared pro rata across the Rutland and Leicestershire plans based on population.
2018-19 Q4 Performance: Overall NEA levels per year have been rising for the last two years, albeit more slowly than would have been the case without interventions. **While NEA levels are now well within the CCG's ceiling target (running at 81% of this target), there were 10% more non elective admissions in total in Rutland this year than last.** As part of the Locality Pilot, we are working to identify actions across primary, social and community care with potential to reduce the number of (particularly) older people needing to be admitted in crisis. Linked to the NEA metric, there is a new policy priority to reduce the number of hospital stays over 21 nights, although monthly data are not available at this stage to support ongoing monitoring that aligns with the national methodology.

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



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



Outcome sought:

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

Rationale:

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

Definition:

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

Reporting Schedule:

Updated quarterly from non elective admission statistics for Rutland practices by Leics CC. Next full quarter available August 2019.

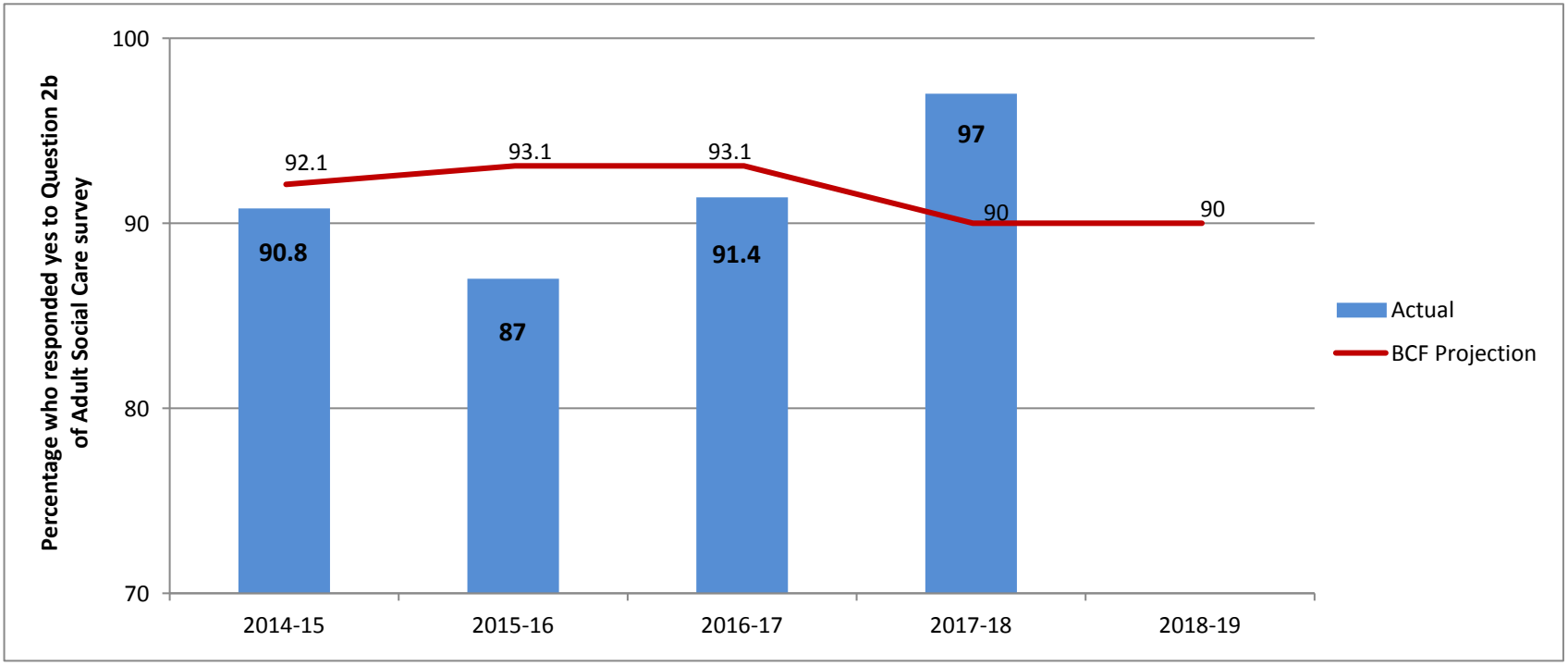
Metric 5 - Local Metric - Patient/Service User Experience

User experience is no longer a mandatory metric, but continues to be reported for the BCF as it is recognised to be an important yardstick of the quality of local health and care services. The user experience target set by the BCF programme has been extremely challenging. The target for 2017-18 and 2018-19 is an ambitious 90%.

2017-18 **performance:** This target was met comfortably for 2017-18, for the first time in four years, with the survey reflecting an extremely high 97% satisfaction wtih care services.

2018-19 performance: No data available.

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



Outcome Sought:

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

Rationale:

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

Definition:

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

Reporting Schedule:

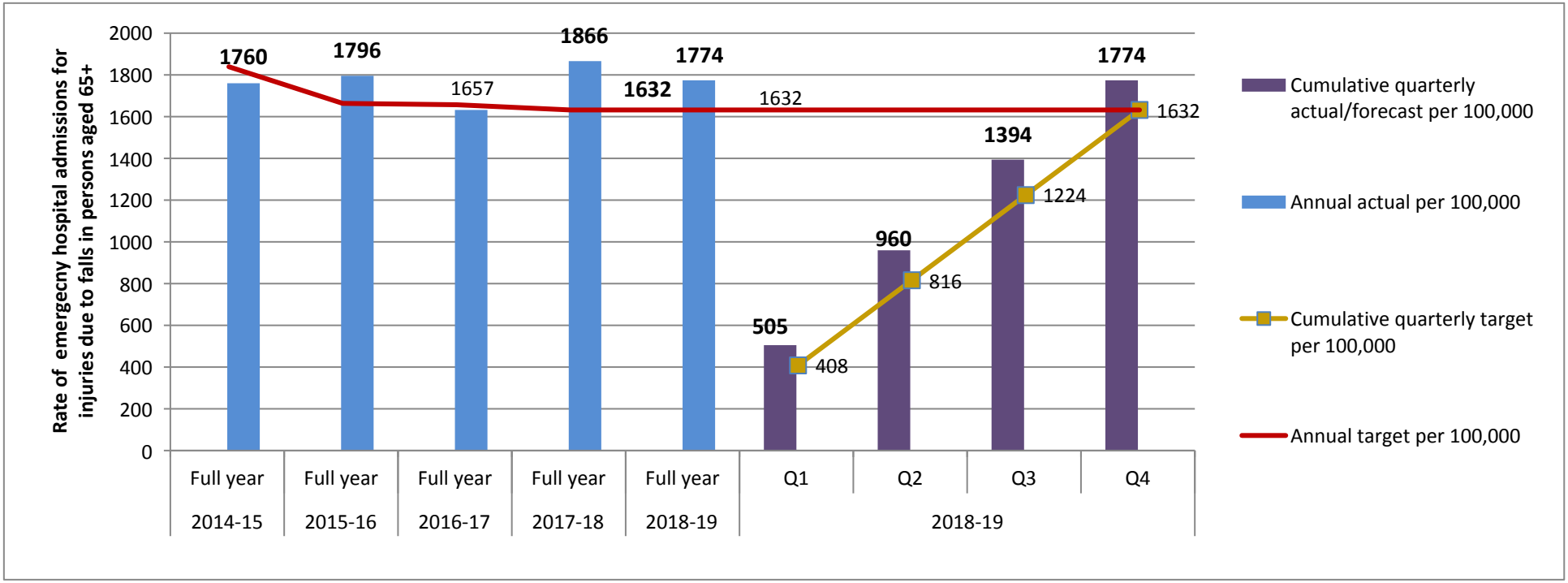
Data reported from annual Adult Social Care users survey. Next update will be April/May 2019.

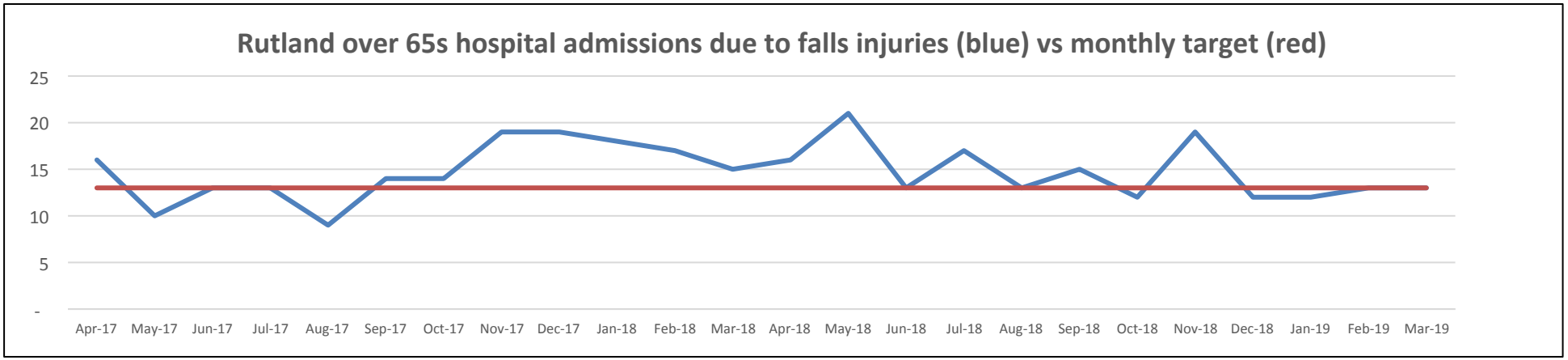
Metric 6 - Local Metric - Over 65s Falls Injuries

TARGET: We have sustained the local focus on falls prevention, although it is no longer a national obligation, as falls have such a significant impact on independence. The 2017-19 target is to equal 2016-17 performance (a rate of falls at or under 1632 falls injuries per 100,000 65+ population for the year).

2018-19 Q4 Performance: GREEN. 2018-19 performance: AMBER. The number of falls injuries has improved overall across the year, to end the year on target. However, the aggregate number of falls injuries across the year exceeded the annual target by 9% due to higher levels of falls in Q1 to Q3. Falls prevention activities have been enhanced in a number of ways and we are also reviewing activity to identify further areas of potential intervention.

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





Outcome Sought:

To reduce the number of admissions for injuries due to falls

Rationale:

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

Definition:

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

Reporting Schedule:

Sourced from Public Health Outcomes Framework.

Monthly data obtained via the CSU and processed by Leicestershire County Council Public Health analysts. Next full quarter of data due mid August 2019.

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Appendix C: Summary of proposed Rutland BCF priorities 2019-20

The programme set out below is still indicative pending further local stakeholder engagement and final confirmation of the BCF guidance, budget and templates.

1. Priority 1: Unified Prevention, including social prescribing and wellbeing services

1.1 It is proposed to sustain the prominence of prevention measures in the programme, also aligning with the increased emphasis on prevention contained in the NHS Long Term Plan, but with a clearer divide between earlier prevention activity under Priority 1 and secondary and tertiary prevention under Priority 2.

Priority 1: Potential 2019-20 Measures

Priority 1: Unified prevention		Indicative source	Budget
1.1 Healthy Rutland Consolidated 1.1 and 1.3 to a single measure. Refocused to support NHS Plan, building on local assets	**A. Multi-sectoral collaborative social prescribing model for Rutland** • **Collectively, deliver a visible, accessible and effective signposting and prevention service**, networking Rutland's social prescribers including in primary care to refer citizens at the right time to Rutland's prevention and wellbeing services. Using online resources to best effect directly and via advisors. Shared tools including a secure, efficient referral mechanism. Making every contact count for healthy lifestyles. • **Front line wellbeing signposters and service providers network** to share intelligence ongoing, enhancing prevention. • **Promote Rutland's wellbeing offer to the public** in ways that support self help and self care. **B. Raising healthy life expectancy by increasing healthy lifestyles, linking to GP prevention** • **Develop community capacity**, building on community assets, including via the Community Wellbeing contract. • **Encourage community-led approaches to supporting healthy lifestyles**, also to tackle health inequalities, considering approaches such as Healthy Rutland grants and skills exchange. • **Falls prevention** in the community **Parallel activity:** NHS Long Term Plan prevention focus, including PCN social prescribing.	RCC BCF & RCC (carry over)	£63k

1.2 Prevention and Wellbeing Services Ongoing and new elements. Dementia actions now grouped in P2.	**Enhanced prevention support:** A. **Community Wellbeing Service, Rutland Access Partnership** B. **Adult Social Care rapid response,** targeting hard to reach people at risk and urgent needs, with a prevention focus. **Parallel activity:** GP priorities of reducing inequality, prevention, early diagnosis.	RCC BCF RCC (i-BCF)	£147k £77k

2. Priority 2: Coordinated care for health and wellbeing

2.1 The focus of the locality pilots has been on primary, community and social care and the voluntary and community sector working effectively together in a defined area to support the health of people living with multiple long term conditions – including encouraging and enabling self-care. This priority aims to sustain and enable that innovation, to embed holistic, person-centred care models that help to maintain wellbeing, independence and quality of life for those with significant health and care needs.

Priority 2: Potential 2019-20 Measures

Priority 2: Coordinated care for health and wellbeing		Indicative source	Budget
2.1 Support services sustaining wellbeing and independence in the community Ongoing, grouped for more holistic response.	**Support helping individuals and their carers to live well with ill health, sustaining wellbeing and independence**: • **Living well with ill health:** Dementia care support (Admiral Nurses and dementia services), carers support • **Mental health outreach worker** linking to the GP surgery, and addressing challenges associated with life change and ill health. • **Falls prevention** interventions for people who have already fallen • **Sustainable homes**: Assistive Technology • **Develop self care models to support people to better manage the impact of health challenges**, taking forward the learning from the Vitrucare and diabetes management pilots, and drawing on evolving NHS approved self care tools. **Synergies:** Closely linked to Priority 1, but with a focus on tertiary prevention (living well with ill health).	RCC BCF RCC BCF carry ELRCCG BCF RCC BCF carry RCC BCF	£104k £79k £35k £65k

	Parallel PCN aims: GP pharmacy support – medication optimisation, personalised care, cardiovascular disease prevention		
2.2 Funding for care	**Funding for care:** • Carers packages including respite • Support for domiciliary care		£87k £26k
2.3 Housing adaptations	**Disabled Facilities Grants and Housing and Prevention Grants** sustaining independence	DFG ASC winter funds	£238k £54k
2.4 Integrated health and care services delivering 'home first' care Continuation, with ongoing learning	**Further integrate local community, social and primary care services,** particularly benefitting people living with long term conditions, frailty and complex needs. Including services for those at end of life. Consideration of how to serve different groups better, improving equality of care. Funds personnel. Mechanisms to include: • Integrated care coordinator acting as a bridge between primary and social care. • Multidisciplinary coordinated care, including innovations such as improved care planning and nursing coordination emerging from the Better Care Together programme, locality pilot and the Community Services Review. • MICARE nurse – supporting delegation of health tasks in care. **Parallel PCN aims:** GP pharmacy support – medication optimisation, personalised care	RCC BCF ELRCCG BCF	£169k £424k
2.5 Health and wellbeing of those in care homes Broadened	**Support care providers in the management of complex and frail service users** • QA support to care providers. • Tailored support: falls prevention, assistive technology, care planning, enhanced GP relationship, medication management. • Improving access to health information by domiciliary and residential care providers, including video calling and access to NHS mail (topping up wider work). **Potential to support PCN priorities:** GP enhanced health in care homes, reducing inequality.	RCC BCF RCC BCF carry	£27k £10k

3. Priority 3: Home first model for hospital step up and step down

3.1 Reducing avoidable hospital admissions and ensuring prompt transfers of care remain significant priorities, as do reabling patients post-hospital and supporting their ongoing independence.

Priority 3: Hospital flows		Indicative source	Budget
3.1 Integrated urgent response Continuing and evolving	Urgent response staffing. Evolving management of health crisis. Consideration of potential to reduce 'just in case' hospital admission (eg. care home support, virtual ward step up) or shorten hospital stays using local step down care.	RCC BCF ELRCCG BCF BCF carry over	£129k £145k
3.2 Transfer of care and reablement Continuing, with rapid cycles of change	Transfer of care and reablement staffing. Continuing the effective arrangements already in place for transfers of care and reablement. Implementing the next DTOC Action Plan to further raise the maturity of the system. To consider local clinical input to the discharge process to reduce readmission, and improve hospital flows for those residing in care homes. Sustaining a further social worker supporting transfers of care, and nomination of lead coordinators to support smooth transfers.	RCC BCF ELRCCG BCF i-BCF carry RCC winter funds	£592.5k £142.5k £35k £55k

4. Priority 4: Enablers

4.1 It is proposed that the funding for programme management and analytics should be continued, with support for complementary enablers activities supporting the 2019-20 proposals, including work to evolve case management tools so that they support local care pathways, sometimes spanning both health and care platforms.

Priority 4: Enablers		**Lead and source**	

4.1 Enablers
 	
Continuing.
 	
Activity tailored to current integration needs
	Programme management and analytics supporting evidence based change, plus a number of further areas of activity.
	• Integration between IT systems
	  ○ Single assessment for community health and social care
	  ○ Sustaining access to the GP Summary Care Record for social care
	• Information Governance assurance and data sharing arrangements supporting integrated working
	• Research capability to capture user experience of new services and approaches
	• Provider engagement and workforce development supporting new models of care
	
	Parallel PCN activity: GP TeamNet investment for improved sharing of policies and other information across the Primary Care Network and wider.
		RCC BCF
		
		2016-17 carry-over
			£77k
			
			TBC
			
			£30k

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