Rutland County Council

Catmose, Oakham, Rutland, LE15 6HP.
Telephone 01572 722577 Email:governance@rutland.gov.uk

Ladies and Gentlemen,

A meeting of the **RUTLAND HEALTH AND WELLBEING BOARD** will be held in the Council Chamber, Catmose, Oakham, Rutland, LE15 6HP on **Tuesday, 3rd March, 2020** 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/

Please note hard copies of the agenda will not be available at the meeting. If you require a hard copy of the agenda please email your request to governance@rutland.gov.uk or telephone (01572) 720991.

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 14 January (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) RESILIENT RUTLAND

To receive a presentation from Lyn Harte and Morag Tyler from Resilient Rutland.

A copy of the Annual Review is attached.
(Pages 5 - 12)

6) CHILDREN AND ADOLESCENT MENTAL HEALTH SERVICES

To receive a presentation from Elaine Egan Morriss, CAMHS Lead Commissioner and Children and Young People Whole System Transformation Lead.

A copy of the Highlight Report is attached.
(Pages 13 - 28)

7) VIOLENCE REDUCTION NETWORK

To receive Report No.53/2020 from Paul Hindson, Chief Executive of the Office of the Police and Crime Commissioner for Leicestershire.
(Pages 29 - 48)

8) DRAFT RUTLAND JOINT HEALTH AND WELLBEING STRATEGY

To receive Report No.52/2020 from the Director for Public Health.
(Pages 49 - 64)

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

To be confirmed.

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TO: ELECTED MEMBERS OF THE RUTLAND HEALTH AND WELLBEING BOARD

1	Cllr Alan Walters	Rutland County Council
2	Cllr Samantha Harvey	Rutland County Council
3	Dr Hilary Fox	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)
4	Dawn Richards	Spire Homes
5	Paul Hindson	Chief Executive of the Office for the Police and Crime Commissioner
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)
14	Insp. Siobhan Gorman	Leicestershire Constabulary
15	Melanie Thwaites	Leicester City CCG

OTHER MEMBERS FOR INFORMATION

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RESILIENT RUTLAND

COMMUNITY FUND

Resilient Rutland Annual Review
Jan 2020

YOUNGMiNDS
fighting for young people's mental health

Resilient Rutland
Published by Morag Tyler · May 13 ·

RUTLAND FIRST IS SEEKING 3 NEW BOARD MEMBERS

Rutland First is a Community Interest Company whose aims are to undertake and encourage a broad range of work and other activities relating to improving, promoting and enhancing the wellbeing of the people of Rutland.
The company's main activity is management and oversight of the Resilient Rutland project into improving the mental health and wellbeing of young people attending school in the county. This project has been funded by t...
See More

BBC RADIO LEICESTER

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Resilient Rutland Annual Review - Jan 2020

1.0 Overview

This report will provide an overview of activities and main learning points from the first year of the Resilient Rutland project.

The document will then cover a proposed revision to the original plan and requests for Lottery consideration.

2.0 Year one – Jan 2019 to present

Since officially launching our project on 29th Jan 2019 Resilient Rutland has had an extremely busy year. We have developed strong relationships with key groups and have made significant advancements in a number of our key areas. We have received fantastic support from our young people, our schools and also the wider network of professionals.

Although progress had been good, our work has not proceeded as quickly as we had originally planned as our second employee, although being offered the position in Feb 19, was unable to start with us until the beginning of the academic year in Sept 19.

During this first year we have learnt many things – perhaps the most important is about the need for strong communication. We are not the experts on what resources are needed and the only way to identify what is required is by listening to those who are receiving and delivering the support. By being led by our stakeholders we can ensure, that to the best of our ability, what our project will deliver will match the needs of our young people and have a lasting impact.

2.1 General activities

The implementation of the **Academic Resilience Approach** by YoungMinds has been a fundamental element of our plans. We are very aware that our project must deliver sustained change, and successful implementation of a Whole School Approach (WSA) is crucial. This work is having a significant impact in our secondaries and we are proposing to widen this out to include the primary schools.

Starting in Sept 2019 we have been piloting an **in-school counselling** service delivered by Relate Leicestershire in our three state secondaries. This is at a significantly lower level than proposed in our bid document. We are recommending continuing this support and, due to a small waiting list, we are proposing to slightly increase the number of sessions delivered in each school.

Emotional Literary Support Assistance training (ELSA) has been jointly funded with our schools and Rutland County Council and has to-date been delivered to 17 of our 18 primaries. This has proved immensely successful and feedback from all involved indicates an extremely positive impact. Further funding to support additional training and also supervision is proposed, and Rutland County Council has committed to future match funding. We have also enlisted the support of a volunteer ELSA to coordinate a county wide support group.

We have established a **Primary Working Group** with representatives from our schools, RCC, and the Rutland Teaching Alliance. This group has been key to identifying needs, understanding current status and practical challenges.

Our initial discussions with primaries identified **Quiet rooms** as a requirement. We were advised by the Lottery that funding for this is not permissible under the terms of our grant and therefore we

committed to explore alternative external funding sources. This has been very successful and funds for three schools have been identified to-date.

To date we are pleased to report that both the local authority and schools have **match funded** elements of our spend and we will ensure that all such opportunities continue to be explored.

2.2 Young people

We have always pledged that our project will be led by our young people.

We have kindly been invited to work with RCC Youth Council and have conducted a wellbeing discussion with their group to gain youth voice on current challenges. The aim is to develop young person led initiatives for support and change in school, family and the community.

YoungMinds and Lyn Harte have conducted pupil focus groups in our secondaries (as part of the ARA implementation) to gain feedback on school experience and identify areas for school focus. Further sessions are planned, and these groups will eventually be led by school staff to ensure that young people are empowered to have full participation now and in the future.

At primary level, we have piloted two schools to develop age appropriate dialogue regarding wellbeing and activity/support. This has been a success and will be rolled out across all schools.

2.3 Reliable information and signposting to services

Having access to trusted information and easy to navigate signposting has been consistently mentioned by all parties: children, parents, schools and GPs included. We are working jointly with Rutland County Council to take this forward. However, we do not want to 'reinvent the wheel' and are currently investigating existing platforms which could be utilised.

In the short term we were kindly given permission by Route to Resilience to share their signposting information.

We have researched a comprehensive list of both local and national services available and early in 2020 we will update our website with key information and send out a 'one-page overview' to parents.

2.4 Appointment of our School Liaison Officer

Lyn Harte joined the team in Sept in the part-time role of School Liaison Officer. Lyn has been a leader in education for many years and cares deeply about the continuous improvement of the mental health and wellbeing provision. Lyn is supporting the schools in implementing their plans to support a whole school approach and is a champion for the voice of young people.

2.5 Governance/working groups

We have established a number of groups to ensure that we are following the agreed Governance structure and have the relevant experts we need to help shape the project.

- Primary working group – representatives from all our 18 primaries invited to take part.
- Programme Board – key representatives from schools and Rutland County Council
- Steering group – experts in a range of disciplines who meet monthly
- Rutland First CIC Board – strengthened to cover expertise in Finance, Governance, Project Management, Mental Health and Marketing/PR.
- Young people

As we have been operating for one year and as the project is moving into the implementation stage, it has been felt appropriate to review the governance arrangements, and this is now underway.

2.6 Research

Extensive research to understand latest thinking and best practice has been undertaken by the project team. This has been both primary and desk research, and has been extremely useful in advising our thinking and informing our future plans.

2.7 Groups we have been working with and external landscape

Very early on the importance of working collaboratively was recognised, and an open and honest approach to communication has continued throughout. We are proud of the relationships that we have developed, and this has allowed us to capture input from a variety of stakeholders and those who are delivering best practice.

We have worked closely with **Rutland County Council** to ensure that we are aware of their plans and our proposals complement rather duplicate effort.

We have offered our research and knowledge to support the 2020 Leicester, Leicestershire and Rutland bid to be a **Mental Health Trailblazer**. In turn this has given us access to the latest thinking and research from their pilot areas.

As part of the **LLR providers network** we can ensure that as far as possible we are aware of regional plans which may affect Rutland.

Groups we have been working with include:

- YoungMinds
- Mental Health Trailblazers
- Public Health
- NHS Innovation Accelerator
- Rutland Teaching Alliance
- Rutland Primary and Secondary schools
- CCG
- CAMHS
- Relate Leicestershire
- Rutland County Council
- Rutland Youth Council
- LLR Providers group
- Route to Resilience
- HeadStart Newham and central information
- Active Rutland
- Lincroft Academy

2.8 Marketing and communications

Spreading the word about mental health and well-being to target groups and the wider community is a key element of the project. As the images on the front page show there has been lots of activity to share the Resilient Rutland message.

Some of our activities are listed below:

- Launch event attended by over 100 people and hosted by our Patron the Lord-Lieutenant.
- Launched Resilient Rutland website, Facebook and Twitter accounts.
- Created a recogniseable logo with input from our young people.
- BBC Radio Leicester – Geoff Thompson was interviewed.

- Rutland Radio – covered a number of our stories.
- Monthly Resilient Rutland newsletter
- Rutland Youth Council Awards 2019 - our Youth team won joint first prize in the 'Super Group' category.

2.9 Evaluation

Evaluating the impact of the Resilient project is critical. One method we are using for this is the **CORC Wellbeing Measurement Framework**. The first benchmark surveys took place in March 2019 in all our secondaries, where Year 7 and 9 pupils answered questions on their mental health and well-being. Each school has received the results reports and is using the data to inform their planning. The annual surveys will continue throughout the lifetime of the project with preparations currently underway for the 2020 survey.

3.0 Main challenges/learning points

- The area of children's mental health and well-being is constantly changing, and significant effort is required to keep abreast of all external activities and avoid duplication of effort.
- School resources are limited, and we need to be very clear on our expectations on what support they can give to our project. Our aim is to work with schools to put in place challenging yet achievable plans which give the best chance of hitting our target milestones.
- A careful balance has to be struck with schools regarding levels of communications. It is important for us to be viewed as being helpful and supportive.
- The nature of our project makes it challenging for us to give opportunities for volunteers to deliver direct support. We are therefore using volunteers to support other elements e.g. Marketing /PR.
- Managing/coordinating even a small number of schools is very time consuming.
- The project needs to have the pastoral care lead as the main contact and the support of the Head. This ensures commitment and the appropriate level of influence is achieved.
- The Project Manager has a holistic view of all activities and is therefore able to link people together and to pass relevant information on to those who will find it useful.
- Able to use our research to support other's activities e.g. CCG used RR direct support research in their Trailblazer bid document.
- Project management and keeping all parties updated has to be carefully managed. The aim being to ensure relevant persons have had an input and are on board.
- The support our project is delivering does not always require funding. It is about working together, sharing best practice and ensuring resources are optimised.

4.0 Revision to proposed activities

We have always been committed to following a co-design approach and putting people in the lead. Therefore, shortly after we were awarded the grant we re-engaged with our stakeholders. These constructive conversations generated various challenges and questions on some of the elements that had been included in our bid. It also highlighted that since the initial research for the project was undertaken the external landscape for children's mental health and wellbeing had changed.

As these discussions developed, we acknowledged that it was necessary for us to reassess the efficacy of our original plan. Therefore, whilst implementing elements of our initial strategy, for the past 12 months we have worked collaboratively with a vast array of stakeholders including schools, young people and parents to review our proposal.

As part of this, our local CCG Commissioner facilitated a joint session with our secondary schools and a number of items were considered. The major spend item in our bid was £192k for 'Resilience Therapists' in our secondaries – working with the pastoral teams we reassessed this requirement and it was agreed that an initial pilot of £10k would be allocated. Following the 3-month review, schools advised that they are extremely satisfied with this service, waiting lists are minimal and we have identified that a total spend of £40,520 should cover the need in this area. This is significantly lower than first thought.

At this same meeting, the secondaries questioned why more support wasn't being given to primary schools – they felt that to address issues and build resilience earlier was a definite advantage. This feedback was mirrored by parents, the council, Secondary Heads and other professionals that we approached. We therefore set up a Primary Working Group to discuss and learn how schools could improve their support for young people's well-being.

The move towards supporting primaries reflects accepted research, which advocates early intervention as being the most effective approach. Effective early intervention works to prevent problems occurring, or to address them head-on when they do, before issues worsen. It also promotes young people to foster a whole set of personal strengths and skills that prepare them for adult life - it builds their resilience.

A variety of sessions have taken place with young people and they have discussed what really matters to them in terms of mental health and well-being. We listened to their suggestions and they have identified a number of initiatives to improve resilience that we could support e.g. gardening club, podcasts and yoga. Access to activities will be via an agreed referral route which will be managed by the pastoral teams. Full briefings will be given to any suppliers ensuring they are aware of the 'building resilience' context in which the service is being delivered.

The importance of specialist training in mental health and well-being has also been identified by schools as a requirement. This will upskill staff to identify, understand and support young people and also maximise sustainable change after the project has been completed. We would propose opening up elements of our training programme to other voluntary groups who work with young people across the county.

To avoid 'reinventing the wheel', understand best practice and to learn from others, we have also undertaken extensive research with other organisations e.g. HeadStart and the Government funded Mental Health Trailblazers.

Giving support to parents has also been identified by many of our stakeholders as a key element to building resilience. This includes improving parents' understanding of the challenges facing young people, practical advice and giving solid information on where to go for help.

We will continue to evaluate the success of the project and where appropriate we will put in place processes to capture and assess feedback. Our CORC Well-being Measurement Framework will provide us with reports that monitor the mental wellbeing of our young people compared with others around the country.

These are just a few examples of how our people led approach has advised us that ideally a much broader project is required; including early intervention in primary schools, parental support and positive activities to build resilience.

In order for us to have time to successfully implement and embed this support, it has been agreed by all to request an extension to a four-year project.

Main movements in our proposed spending are as follows:

Activity	Bid	Revised	Change	Reason
In-school counselling in state Secondaries	£192,000	£40,520	(£151,480)	Having discussed with secondaries the need for this specific intervention their needs were lower.
Office space	£15,000	£0	(£15,000)	Schools providing meeting rooms gratis.
Mindfulness (in original bid).	£34,000	£60,400	£25,800	Widened out to include other well-being activities e.g. yoga
Primary – whole school approach	£0	£20,000	£20,000	To provide the framework for primary activities.
Building whole family resilience	£3,000	£32,000	£29,000	To ensure that families have access to knowledge and advice to support their young people.
Training and supervision for school staff (secondaries and primaries).	£0	£66,925	£66,925	To upskill school staff to better identify, support and deliver appropriate interventions e.g ELSA, MHFA.
Young people directly led initiatives	£0	£30,600	£30,600	To allow young people to identify, develop and lead initiatives.
Primary evaluation	£0	£6,670	£6,670	To allow us to support primaries in evaluation of young people's mental health needs.
TOTAL	**£244,600**	**£257,115**	**£12,515**	

5.0 Summary

Elements of our original plan have been implemented during 2019, however, it is evident that to achieve the greatest impact and legacy our plans ideally need to be revised. We have been encouraged by our stakeholders to make these changes and they continue to provide enormous support and reassurance that our project is moving in the right direction.

Throughout this process our end goal has not wavered. We are confident that our revised plan offers the best chance of achieving true culture change and championing our young people's resilience and well-being.

This document has been reviewed and unanimously approved through our Governance process:
9th Jan – Programme Board
9th Jan – Steering Group
14th Jan – Rutland First CIC Board

6.0 Requests for Lottery consideration

Our two requests for Lottery consideration are:

1) A revision to the project detail.
2) Extension to a four year project (no additional funding to be provided).

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HIGHLIGHT REPORT

Programme	**CHILDREN AND YOUNG PEOPLE EMOTIONAL HEALTH AND WELLBEING**			**Reporting Period**	February 2020
				Date Prepared	February 2020
Programme Sponsor:	Chris West, Director of Nursing and Quality LCCCG	**Programme Lead:**	Elaine Egan- Morris, CAMHS Lead Commissioner and C&YP Whole System Transformation Lead	**Last BRAG Status**	**Amber**
				Current BRAG Status	**Amber**

Summary	The refreshed Future in Mind Transformation Programme plan identifies our achievements over the last year and sets out our future plans for C&YP emotional mental health and wellbeing services. It has been aligned to the requirements of NHSE to deliver against National targets set out in the Long Term Plan for the coming year. The plan has not been published as the financial allocation has not been signed off by the CCGs as they are undertaking discussion with NHSE regarding the funding allocated to deliver all priorities within the long term plan. The emotional, mental health and wellbeing whole system includes, a number of work streams, this month the team have been working on; • **Eating Disorders Current Position -** Commissioners are working with the Eating Disorder service and provider leads to address the performance of the ED service. Funding was allocated by the CCGs to implement a short term plan from December to address the waiting times for treatment - new staff were recruited, resulting in an improvement in performance and January showed the ED service meeting their 1 week and 4 week access to treatment targets. A business case for the uplift funding allocation to deliver sustained improvements in the service in on hold awaiting results of CCG and NHSE discussions and decisions on the long term plan priorities . • **CAMHS Waiting Times –** Waiting times onto the specialist CAMHS service remains a concern, and providers and commissioners are working together to address this. LPT have local plans and the commissioners are working system wide with C&YP service providers to work in partnership to support the delivery of a wide range of services, including prevention,

on line support and early intervention with an aim to reduce the number of referrals into CAMHS. Work is underway to develop a new **Neurodevelopmental Pathway** with a separate service specification and budget line that can focus specifically on this area of greatest, the time line for this has slipped from April to June 2020. 2020. **A business case for further investment into the CAMHS Out Patient Service has** been developed and presented internally to LPT

- **Crisis and Home Treatment Service Development –**

  The long term plan sets out the need to ensure that there is a robust CRHTx service offered to C&YP. LLR currently offer a 24 /7 services with the adult CRHTx delivering the service overnight. Our aim is to enhance the current service offer, by developing a suite of services addressing crisis that include including prevention and de –escalation.

  A Developing de-escalation/crisis Cafe and chill zone in the community

The De-escalation task & finish group met on 13th February and partners agreed to scope the potential for the Triage Car to deliver face to face contact in the community.

B Chill Zone' for those children that need some quiet time

The Chill Zone Task and Finish Group met on 3rd February to discuss potential locations, buildings, staffing and training needs to deliver locality based chill zones

A multi-agency working group has been established to include, the current CRHTx team, police, ward 3 in patients, A&E, LD team and Leicester City FC charitable team to scope the service and develop the model. CRHTX team are working with the C&YP and their parents to gain their views on the service model.

- **Triage and Navigation -** The Triage and Navigation Service was procured in October 2019. There will be a set up phase between November 2019 and March 2020, this will include the development of joint operational processes across all providers, and sharing of information to clarify inclusion and exclusion criteria to support getting C&YP to the right care. Work will be undertaken on System One to ensure it is fit for the purpose. DHU will be meeting individually with the providers, and working with Early Intervention, CAMHS Access and the Early Help Front Doors to learn from their experience of accepting and triaging referrals. Recruitment of staff is underway. A multi-agency proforma has been developed and sent to all Providers.

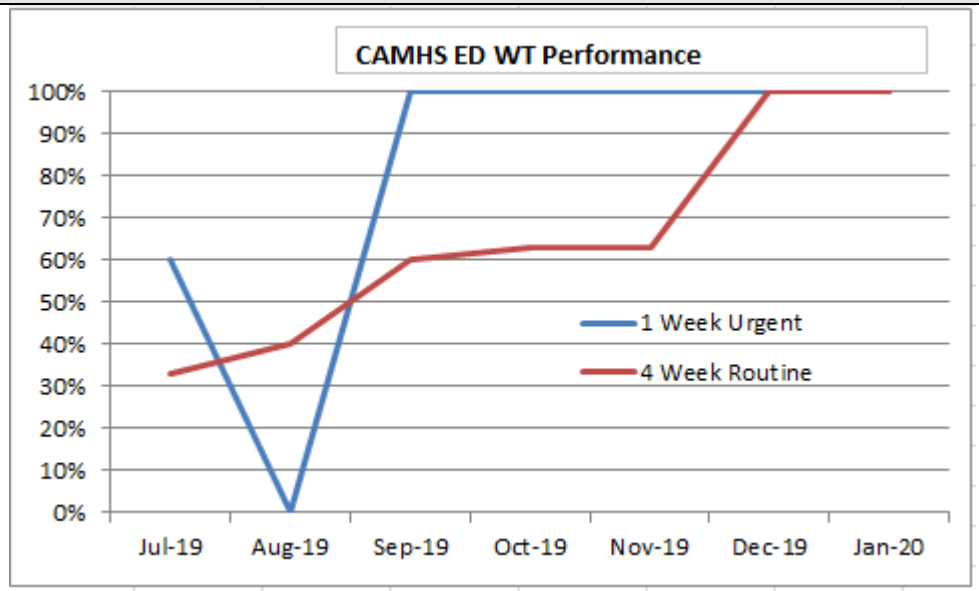
- **Mental Health Support Teams in Schools**

The Task and Finish Groups have developed a bid for 3 MHSTs, covering City, County and Rutland and Melton. Each area

	will identify a senior school with a number of primary feeder schools. The bid needs to be submitted to NHSE by 16th March, prior to this CCG needs to agree a route for this to be reviewed. In the meantime commissioners continue to work with the LA to identify the schools to be included in the programme. We currently have agreed the Leicestershire and Rutland schools , but we have not had full commitment from the schools in the city. Commissioners are awaiting feedback from City LA re their discussions with city schools . . • **Adverse Childhood Experiences -** The CCG's were successful in bidding for youth justice 2 year funding (2017-19) to deliver a pilot project providing trauma informed approaches work and training for C&YP with ACE's, in the Youth and Justice System. There was a recommendation from NHSE to continue this work across LLR from 2020. Commissioners have spoken to NHSE regarding continued financial support, NHSE agreed to fund 50% of the cost of the service, Public Health are putting in a bid to fund the remaining 50%. Commissioners have been working in partnership with LA, public health and the police to jointly fund an extended service, that would deliver training to all staff across C&YP mental health and wellbeing services. • **Mental Health Services Dataset -** In 2018/19, only LPT were flowing data to the MHSDS. 3690 CYP accessed services (using NHSE's 2 contact definition) which equates to around 17% of our prevalent population accessing services. In 2019/20 Relate, CEIPS and Kooth began flowing data. After month 8, 3990 CYP have accessed services which equates to 18.7% towards this year's ambition of 34%. During February, NHSE have re-estimated our prevalent population at 20,215 compared with 21,286 that we have been using until now. This increases out access to 19.7% this year – we are awaiting clarification from NHSE as to which figure to uses The NHSI tracker estimates the most optimistic performance for this year will be 25.6%. In 2020/21 additional providers have agreed to commence flowing data which we estimate will allow us to achieve the 35% access target. NHSI are to undertake individual training with these providers.

Work Stream Status

	Work Stream	Lead	Progress during reporting period Summary of progress/position	Planned actions for next period/ Proposed escalation action for Red/Amber items	Overall Status
1.	**Improving Access to Care**		**1. Eating Disorders Service** – Commissioners are working with the Eating Disorder service and provider leads to address the performance of the ED service. **A** Short term plan The short term has been developed aimed at reducing the number of C&YP waiting to be seen and reduce the length of time they wait for routine appointments. A paper was presented at the Executive Leaders Team Meeting (9th September 2019) to secure funding for additional posts (Band 7, Band 6 and agreement to recruit to consultant post) to increase capacity and mitigate clinical risks. These posts were recruited to in December 2019 **As a result of implementing the short term plan performance has improved**	Work to commence with providers to develop ED model	

	Work Stream	Lead	Progress during reporting period Summary of progress/position	Planned actions for next period/ Proposed escalation action for Red/Amber items	Overall Status
17			 **B** Long Term Plan A meeting took place arranged between LPT and commissioners on 12th December 2019 to agree the long term plan for the Ed service. This included the development of a detailed service model. The new service model deliver the whole range of services, including disordered eating and long term sustainable support for C&P. To be implemented by April 2020 - The new model of care is under development to add additional resource to enable the service to meet the national targets and address the national service specification.	Decision to bid for uplift funding is dependent on results of discussions with CCG and NHSE executives	

	Work Stream	Lead	Progress during reporting period Summary of progress/position	Planned actions for next period/ Proposed escalation action for Red/Amber items	Overall Status
18			The long term plan was to develop a business case and a new model of care A business case has been developed to be presented at Q&P Jan 20th, if Agreed it will be presented at CCC for sign off. This proposal seeks investment to fund 3 additional posts as well as fund 3 further posts which will ensure continued adherence to the national waiting time targets as well as improve the multidisciplinary working within the team which closes the gap to the staffing Recommendations in the Access and Waiting Times standards. In addition, this proposal will enable the service to start developing a home treatment and paediatric support offer over a 7 day week. These are components of the service offer that the Access and Waiting Times Standard Commissioning Guidance Business case to be presented at Q&P in Jan 2020		
			2. CRHTX Service Development The long term plan sets out the need to ensure that there is a robust CRHTx service offered to C&YP. LLR currently offer a 24 /7 services with the adult CRHTx delivering the service overnight. Our aim is to enhance the current service offer, by developing a suite of services addressing crisis that include including prevention and de –escalation. **A. Developing de-escalation/crisis Cafe in the community** **A working group has been established to include, the current CRHTx team, police, ward 3 in patients, A&E, LD team and Leicester City FC charitable team to scope the service and develop the model.**	Development stage continues	

	Work Stream	Lead	Progress during reporting period Summary of progress/position	Planned actions for next period/ Proposed escalation action for Red/Amber items	Overall Status
19			The De-escalation task & finish group met on 13th February and partners agreed to scope the potential for the Triage Car to deliver face to face contact in the community. B. **Chill Zone' for those children that need some quiet time –** The Chill Zone Task and Finish Group met on 3rd February to discuss potential locations, buildings, staffing and training needs to deliver locality based chill zones. Commissioners will work with partners in a workshop session to develop the plans of how Chill Zones will be delivered. CRHTX team are working with the C&YP and their parents to gain their views on the service model. The aim is to have identified the model and implementation plan for each of the services by April 2020.	Reviewing potential partners and sites for; 1. Chill Zone (Low level) 2. De Escalation Suite (High level) 3. Plans to be developed for the chill Zones ahead of next meeting early March(TBC)	

	Work Stream	Lead	Progress during reporting period Summary of progress/position	Planned actions for next period/ Proposed escalation action for Red/Amber items	Overall Status
20			**3. CAMHS Access** **Urgent Waits** **Routine Waits**		

Urgent Waits

Access 4 Week	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Number Of Referrals	52	51	54	39	75
Number Of Discharges	33	51	35	34	25
Completed Pathway (92% Target)	100.0%	90.2%	88.9%	94.6%	73.0%
Longest Wait (Incomplete) Weeks	4	5	4	5	7
Longest Wait (Complete) Weeks	4	6	6	6	7

Routine Waits

Access 13 Week	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
Number Of Referrals	151	245	211	196	205
Number Of Discharges	134	190	133	143	142
Completed Pathway (92% Target)	98.1%	99.5%	99.3%	100%	99.5%
Longest Wait (Incomplete) Weeks	11	10	14	14	13
Longest Wait (Complete) Weeks	15	14	13	13	14

	Work Stream	Lead	Progress during reporting period Summary of progress/position	Planned actions for next period/ Proposed escalation action for Red/Amber items	Overall Status
21					
			4 Triage and Navigation – The Triage and Navigation Service was commissioned in October 2019 and is currently working to a phased implementation date of 1st April 2020. Derby Hospitals United (DHU). The integrated model will transform services, focus on a whole system approach to emotional, mental health and wellbeing, social care and will move away from the traditional and existing CAMHS led model. In addition, there is a national requirement to implement 'self-referral' into CAMHS by 2020, which will be met as part of the proposed new service. There will be a set up phase between November 2019 and March 2020, this will include the development of joint operational processes across all providers, and sharing of information to clarify inclusion and exclusion criteria to support getting C&YP to the right care. During this time work will be undertaken on system one to ensure it is fit for purpose. DHU will be meeting individually with the providers, and working with Early Intervention, CAMHS Access and the Early Help Front Doors to learn from their experience of accepting and triaging referrals. **Progress** • Recruitment of staff to deliver the service is underway • A multi-agency criteria pro forma has been developed and sent to all providers • The provider is organising meetings with current providers of services along the system wide pathway, to understand the current acceptance	Progress continues live date April 2020	

	Work Stream	Lead	Progress during reporting period Summary of progress/position	Planned actions for next period/ Proposed escalation action for Red/Amber items	Overall Status
22			and referral criteria. • Development of system one platform is underway to accept referrals • Providers not able to access System one will complete a MARF referral form • DHU plan to meet with support team to develop the Prism Forms for system one DHU are integrated in the monthly provider's network and are working alongside current services to deliver a whole system for children's mental health in LLR. DHU are interested in being part of the Link Programme workshops, delivered by Anna Freud Centre. These workshops bring together schools and services within an area to discuss better collaborative working. These workshops are to be arranged March 2020.		
			5 Mental Health Support Teams in Schools The proposal for 3 MHSTs, covering City, County and Rutland and Melton, has been developed in partnership with stakeholders. Final paper to be shared with Rachel Lewis form NHSE for sign off by CCC , sent to HWB Boards	Paper due to be submitted by March 16th to NHSE	
			6 Adverse Childhood Experiences The CCG's were successful in bidding for youth justice funding in 2017 to deliver trauma informed approaches work and training on ACE's. The service delivers the following outputs: • Screen and assess all C&YP • Create integrated care plans that will follow the child or young person • Create integrated care pathways across multi-agencies	Paper to be presented CCC in Feb 2020	

	Work Stream	Lead	Progress during reporting period Summary of progress/position	Planned actions for next period/ Proposed escalation action for Red/Amber items	Overall Status
23			• Create additional referral routes to appropriate services for continuing care • Increase the number of C&YP accessing therapeutic interventions • Increase the knowledge and skills of Youth Offending staff and partners. This project contributed to the C&YP Health and Justice priorities that have been highlighted within the NHS Long Term Plan (LTP) January 2019. Over the past 2 years the ACEs Pilot Project has proven successful. The national and regional leads, evaluated the project positively, and they have recommended that the CCG's continue to fund this work. Commissioners have spoken to NHSE regarding the current financial commitment across the system wide C&YP emotional mental health and wellbeing offer, and NHSE have agreed to fund 50% of the cost of the service, Public health have agreed to bid for the other 50% of the funding. Office of the Police Crime Commissioner and Public Health are committing further funding to enhance the training offer. Implementation will be seamless within the current model, there will be additional resource recruited to deliver the perinatal mental health element of the training, There will be further opportunities to bid for funding through the long term plan later in the year		
			7 Mental health Services Data Set In **2018/19** - only LPT were flowing data to the MHSDS. 3690 CYP accessed services (using NHSE's 2 contact definition) which equates to around 17% of our		

	Work Stream	Lead	Progress during reporting period Summary of progress/position	Planned actions for next period/ Proposed escalation action for Red/Amber items	Overall Status
24			prevalent population accessing services. In **2019/20** Relate, CEIPS and Kooth began flowing data. After month 8, showing that 3990 CYP had accessed services which equates to 18.7% towards this year's ambition of 34% **The NHSI tracker estimates the most optimistic performance for this year will be 25.6%** In **2020/21** the challenge increases again to 35% **Plans to achieve the 35% Target** additional services to be flowing data from April, including: **The 3 Local Authorities** - We have worked in partnership with the three local authorities to mobilise them to flow data onto the MHSDS. Commissioners have arranged for NHSE Improvement to support the LA's to flow. • City & Rutland Council - To capture contacts by Wellbeing Workers – will identify additional children that can be reported on and flowed to the MHSDS • County – To capture contacts by Wellbeing Practitioners It is expected this will have a significant impact (8%) on progress towards the 35% target.		

	Work Stream	Lead	Progress during reporting period Summary of progress/position	Planned actions for next period/ Proposed escalation action for Red/Amber items	Overall Status
25			Commissioners anticipate that progress will be made with the two local **authority School Nursing Teams** to add an additional 4% **MHSTS** 2%, And **ACES/Syrian Refugees** projects a further 1%. It is important to note that this is a data capture exercise and it does not fully reflect the total number of C&YP accessing emotional mental Health and wellbeing support and treatment across LLR.		

	Work Stream	Lead	Progress during reporting period Summary of progress/position	Planned actions for next period/ Proposed escalation action for Red/Amber items	Overall Status
26					

CYP Access Planning and Tracking Tool

Planner and Progress Tracker

LLR

Financial Year: 2019/20

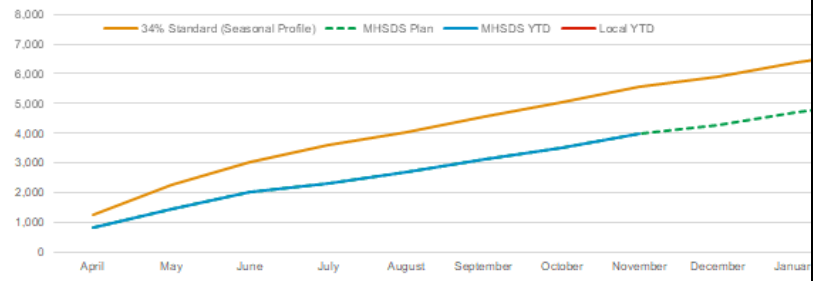
Access Standard

Estimated Prevalence 21,286

MHSDS Forecast Year-End 24.4%

MHSDS Planned Year-End 25.6%

Local Forecast Year-End Local



YTD Total Treated	MHSDS Actual	825	1,460	2,000	2,325	2,690	3,110	3,515	3,990	
	MHSDS Plan								4,288	4,687
	Local									
YTD % Access	MHSDS Actual	3.9%	6.9%	9.4%	10.9%	12.6%	14.6%	16.5%	18.7%	
	MHSDS Plan								20.1%	22.0%
	Local									
Forecast Year-End % Access	MHSDS Actual	22.3%	21.9%	22.5%	21.9%	22.6%	23.3%	23.7%	24.4%	
	MHSDS Plan								24.7%	25.0%
	Local									

		April	May	June	July	August	ieptembe	October	Novembe	December	January
Total MHSDS actual is **not calculated automatically** due to NHS Digital rounding	MHSDS Actual	825	635	540	325	365	420	405	475		
	MHSDS Plan									298	399
	Local										
LPT (3968)	MHSDS Actual	725	545	395	270	255	300	290	350		
	MHSDS Plan	691	554	400	338	233	273	276	283	191	251
	Local										
CEIPS (100)	MHSDS Actual	20	0	15	0	0	5	0	10		
	MHSDS Plan	17	14	11	8	6	7	6	8	5	6
	Local										
Relate (1800)	MHSDS Actual	65	55	105	20	50	75	65	75		
	MHSDS Plan	313	252	186	149	105	124	125	128	87	114
	Local					50	150		119	183	152
Kooth (300)	MHSDS Actual	0	0	20	30	60	40	25	35		
	MHSDS Plan	52	42	31	25	17	21	21	21	15	19
	Local	39	39	20	27	59	36	27	39	24	
Family Action (40)	MHSDS Actual	0	0	0	0	0	0	0	0		
	MHSDS Plan	0	0	0	0	0	0	0	0	0	9
	Local									13	
Other	MHSDS Actual	15	35	5	5	0	0	25	5		
	MHSDS Plan	0	0	0	0	0	0	0	0		
	Local										

Significant Milestones

Ref	Event Milestones ahead	Target Date	Status	Comments
	Implement the short term plan for ED	Jan 2020		Achieving 1 week and 4 week target from Dec 2020
	2020 Funding for ED service presented at CCC	Feb 2020		Business case on hold - awaiting result of exec decisions re priorities for 2020
	Develop a bid for MHSTs in schools	Jan 2020		On track
	Introduce the Triage and Navigation service	Feb 2020		On Track
	Develop new Neurodevelopmental system wide model	April 2020		Delay until June 2020

Issues (New Medium or High Rated Live Issues Only)

27

Ref	Date added/ updated	Issue Description	Issue Reduction Measures	Owner	Severity (H/M/L)	Status
	14th Jan	Inability to recruit to all vacant posts across the system	Introduce a varied skill mix and range of different professionals within the workforce	Shared		

Risks (Medium and High Rated Only)

Ref	Date added	Risk Identified (Description)	Current Risk Rating	Mitigating Control (Actions)	Post Mitigation Likelihood x Consequence	Planned Completion Date
	11th Sept	Failure to deliver ED service that meets National requirements and clinical risks to C&YP	3x4	Dedicated ED review and short and long term plans developed. Additional funding sourced to reduce clinical risk	3x3	April 20
		Failure to reduce waiting times for specialist CAMHS due to delay progress of the neurodevelopmental pathway	4x4	To be discussed		
		Failure to develop ED services to meet national servcie specifications	3x5			

KEY	
Blue	Completed
Green	In Progress and on track
Amber	In Progress but some slippage/issues emerging
Red	Work not began/at risk of non-achievement

Risk Matrix

Severity	*Likelihood* 1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic	Score:5	Score:10	Score:15	Score:20	Score:25
4 Major	Score:4	Score:8	Score:12	Score:16	Score:20
3 Moderate	Score:3	Score:6	Score:9	Score:12	Score:15
2 Minor	Score:2	Score:4	Score:6	Score:8	Score:10
1 Negligable	Score:1	Score:2	Score:3	Score:4	Score:5

Report No.53/2020
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

5 March 2019

The Prevention Board and the Violence Reduction Network

Board Lead:	Paul Hindson	Office of the Police and Crime Commissioner for Leicestershire
Report Author(s) and contact details:	**Paul Hindson** – Chief Executive paul.hindson@leics.pcc.pnn.gov.uk 0116 229 8980 **Grace Strong** – Strategic Director for the Violence Reduction Network– grace.strong@leics.pcc.pnn.gov.uk 07814 616123 **Simon Down** – Head of Strategy and Commissioning simon.down@leics.pcc.pnn.gov.uk 0116 229 8980	

RECOMMENDATIONS

That the Rutland Health and Wellbeing Board:

1. Note the contents of this report
2. Consider how members can contribute to the work of the Violence Reduction Network
3. Consider how members can contribute to the work of the Prevention Board
4. Consider a further report at the next Health and Wellbeing Board regarding an LLR approach to mental ill health

1. PURPOSE OF THE REPORT

1.1. The purpose of this report is to provide an update on the establishment of a Violence Reduction Network for Leicester, Leicestershire and Rutland and a new sub-regional Prevention Board.

1.2. Both the Violence Reduction Network and the Prevention Board sit under the Strategic Partnership Board which is includes representatives from all public services across LLR. The Strategic Partnership Board Terms of Reference focus on a single purpose of minimising harmful behaviours within our communities. The term “harmful behaviours” was deliberately chosen to encompass the work of all public services including health. This reflects the fact that health outcomes have a major impact on criminal justice outcomes and vice versa. It also reflects the belief that many of the challenging problems facing our communities have their roots in social and lifestyle attitudes and behaviours which cannot be addressed without collaborative commitment across agencies and communities. The Index of Multiple Deprivation has often been used to provide underpinning analysis of local crime issues. It tends to

demonstrate that challenging issues overlap each other in local communities, confronting health, social care and criminal justice agencies equally.

1.3. More broadly the Police and Crime Plan focusses on the long term prevention of criminal behaviours, recognising that this requires input with individuals at an early stage before those behaviours have become established. This recognition is shifting the emphasis of OPCC activity from reactive responses to emergency situations to the long term development of communities and early intervention with individuals at risk of developing offending behaviours.

2. BACKGROUND AND MAIN CONSIDERATIONS

2.1 The Office of the Police and Crime Commissioner (OPCC), Leicestershire Police and the Public Health Departments for Leicester and Leicestershire have been working on the development of a public health informed response to violence reduction since early 2019. This culminated with an event on 6 August 2019 wherein the proposals were presented to the Strategic Partnership Board (SPB). Immediately before this event, the Home Office approached the OPCC to bid for a sum of £880,000 specifically to set up a violence reduction unit. LLR had been selected, alongside 17 other areas, on the basis of the level of knife-related injuries dealt with by the city's main hospital (in Leicestershire's case the Royal Infirmary).

2.2 The bid for funds was successful and the LLR Violence Reduction Network (our VRU) commenced operations on 1 September 2019. Funding is currently up until 31 March 2020 although the Home Office has allocated a further £880,000 to LLR for 2020/21. At the time of writing this report we are awaiting details of the application process for this funding.

2.3 In relation to Home Office expectations, the VRN needs to deliver the core function: 'To offer leadership, establish a core membership and, working with all relevant agencies operating locally, provide strategic coordination of the local response to serious violence'. The prescribed core membership is: Chief constables, the PCC, the local authorities with responsibility for the geographical areas targeted by the activities of the VRU, CCGs, Public Health England, the Youth Offending Team and appropriate representation of relevant local educational institutions. The VRN is also expected to adopt a 'public health' approach in developing the local response to reducing violence and take advice from Public Health England in doing so. There are also two mandatory products that have to be delivered within the period of the grant agreement, a 'strategic needs assessment', identifying the drivers of serious violence locally and the cohorts most affected and a 'response strategy', describing the multi-agency response being delivered locally and the action being taken by the VRN to enhance local responses. There is also an expectation that at least 20% of the funding will be spent on interventions.

2.4 The VRN and its programme of work is supported by a central team led by Grace Strong, Strategic Manager. This small team largely comprises of seconded staff including colleagues from Leicestershire County Council, the Police, Public Health England, OPCC and the VCSO. Although the VRN commenced in September 2019, the full team was not in place until December 2020. The governance for the VRN is

through the sub-regional VRN Programme Board, comprising of senior officers representing the core membership.

2.5 Alongside this, the OPCC has also been working with Leicestershire Police to ensure that "prevention" is a key element of the developing police operating model. This reflected the broader commitment to the prevention of harmful behaviours contained in the Police and Crime Plan and the wider commitment across the Strategic Partnership Board. The OPCC has consulted with Directors of Public Health across LLR about how best to integrate its work with the endeavours of both public health departments and established a new Board entitled the Prevention Board. The details of the board are contained in appendix A.

2.6 The VRN recognises the wide-ranging activity already underway in relation to violence prevention and a key ambition is to shape, adapt and improve connections between policy, partnerships, services and initiatives so that they operate more as a violence prevention system. Given that violent behaviour has a long gestation period and areas such as parenting and education are central to primary prevention, the VRN is taking a life-course approach and is keen to engage with all relevant agencies and communities in its work.

2.7 This is entirely consistent with the methodology of the Prevention Board, which has now met once, directly after the VRN Board, having as it does, a very similar membership. Essentially the Prevention Board will focus on a range of harmful behaviours, one of which is violence. In that sense we anticipate that the Prevention Board will ultimately oversee the work of the VRN: but in the short term we will run them side by side to ensure that we meet the requirements of the Home Office.

2.8 Although the Prevention Board has only been recently established, two developments already sit underneath it: the People Zones' development is already underway and operating in local communities with a clear focus on the public health model; a new development is an emerging focus on the behaviours arising from mental ill-health/distress that drive demand for emergency services. A joint SPB/County HWB deep dive into mental health has already been undertaken and we are keen to widen this debate to include the City and Rutland Health and Wellbeing Boards.

3. VIOLENCE REDUCTION NETWORK PROGRESS UPDATE

3.1 The VRN has been working across 7 different projects and to date has made the following progress of note:

- Work to ensure the Strategic Needs Assessment and Response plan is delivered on time.
- The mobilisation of a new service aimed at providing support and intervention for young people attending the LRI's Accident and Emergency department with injuries arising from violence
- A small grants scheme aimed at grass-root community groups which, together with the provision of training and support, is aimed at supporting the development of community-led responses to preventing violence
- A series of Network events for VCSOs and Community Safety Partnerships

- Investment in and coordination of multi-agency training on Adverse Childhood Experiences and Trauma-Informed Training
- Preparation for the commencement of the Mentors in Violence Prevention Programme in secondary schools (due to commence in 2020/21)
- The redesign of Engage, a non-statutory team providing tailored support for young adults at risk of offending
- Investment in a film on child exploitation, led by Leicestershire Police
- The commissioning of Barnado's to engage with schools and develop strategic messaging and a tool box for violence prevention
- The design of an Evaluation Framework by Leicester University to ensure commissioned projects can be evaluated from next financial year
- A series of community and young people engagement meetings and events
- Mobilisation for the new Serious Violence legal duty expected to be introduced in 2020.

3.2 The team are now in the process of finalising the Strategic Needs Assessment and will meet with the Programme Board early March to agree the Response Plan and the details of the application for 2020/21.

4. IMPLICATIONS FOR RUTLAND

4.1 Rutland is represented on the VRN Programme Board by the Strategic Director for People, Rutland County Council who has ensured that relevant officers from RCC have engaged in various workshops and meetings. The same role represents Rutland on the Prevention Board. As a consequence, the Strategic Director has experienced excellent engagement and collaboration with the VRN. The majority of the above developments are relevant to Rutland, however below is a summary of how the VRN is ensuring that the needs of Rutland are being reflected in its work.

- Data for the Strategic Needs Assessment is being broken down to the Rutland area wherever possible.
- One of the training days for the ACEs and Trauma-Informed Practice training is being hosted by Rutland County Council and has been reserved for Rutland partners.
- Two Rutland secondary schools have expressed an interest in becoming phase 1 of the Mentors in Violence Prevention programme

4.2 Whilst Rutland CSP has indicated that they do not wish to have a Serious Violence Network Event at this stage, the Strategic Director has been invited to present at the next CSP and at various other partnership meetings.

5. FINANCIAL IMPLICATIONS

5.1 The VRN is fully funded by the Home Office.

6. LEGAL/GOVERNANCE CONSIDERATIONS

6.1 None

7. CONCLUSION AND SUMMARY OF THE REASONS FOR THE RECOMMENDATIONS

7.1 Both the VRN and the Prevention Board provide opportunities to work in strong partnership to tackle both serious violence and wider harmful behaviours. This work has the potential to deliver results and outcomes against the breadth of statutory strategic plans across LLR and Board members are invited to consider what their role in these areas of work might be.

7.2 There is a growing sense across the partnership that there is an opportunity to better co-ordinate and shape our approach to mental ill health and the board are invited to consider a future paper on this matter to build upon the work that has initially been undertaken with the County's Health and Wellbeing Board.

8. BACKGROUND PAPERS

8.1 Appendix A is the Strategic Partnership Board paper regarding the setting up of the Prevention Board which gives greater detail on the nature of the board.

9. APPENDICES

9.1 Appendix A as referenced above

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

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Appendix A: Details of the Prevention Board

POLICE & CRIME COMMISSIONER FOR LEICESTERSHIRE

STRATEGIC PARTNERSHIP BOARD

PAPER MARKED

F

Report of	**OFFICE OF POLICE & CRIME COMMISSIONER**
Subject	**PREVENTION BOARD**
Date	**TUESDAY 5 NOVEMBER 2019**
Author :	**PAUL HINDSON, OPCC CHIEF EXECUTIVE**

1. Purpose

1.1. This report proposes the establishment of a Prevention Board to replace the existing People and Place Board as a sub-group of the Strategic Partnership Board (SPB).

2. Context

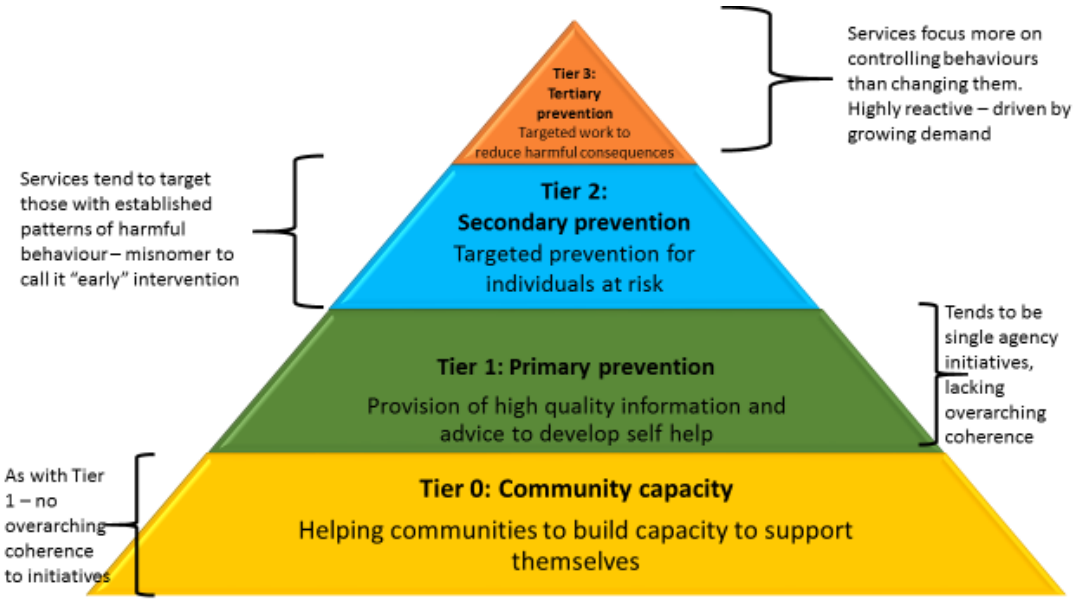
2.1. The People and Place Board was established as one of the original sub-groups of the SPB under the existing terms of reference. The People and Place Board established the People Zones initiative and oversaw its implementation. The terms of reference of the People and Place Board included a focus on “preventing” harmful behaviours and this was part of the rationale for the People Zones.

2.2. Since then two further developments have led to the proposals contained in this paper. The first is the establishment of the Violence Reduction Network (VRN), which is built around the Public Health Model, following on from the success of applying that methodology in Scotland. The second is the development of an operating model for People Zones, which argues that the original model was too broad and requires simplification in order to maximise agency and community commitment. The original methodology for People Zones was entirely consistent with the Public Health Model, albeit not clearly articulated in that format

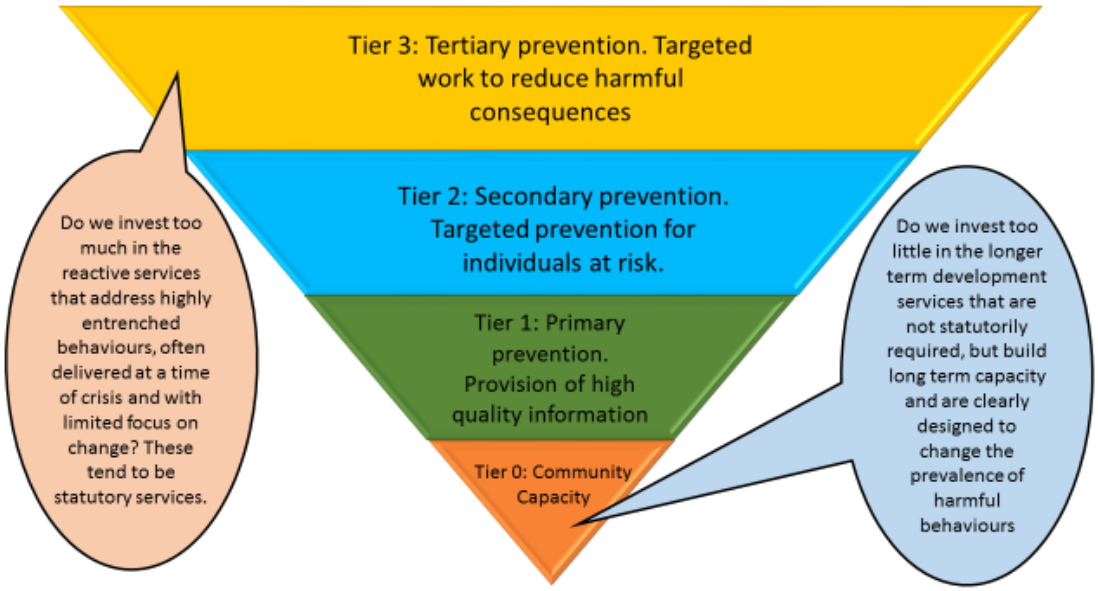
3. The Existing Landscape

3.1. As mentioned above, the Public Health Model is central to the development of the VRN. It is a simple model that is easily understood and accepted by practitioners across the public service sector and could provide a focal point for the development of shared strategies.

3.2. In developing the VRN the team has undertaken a preliminary analysis of the existing delivery arrangements across Leicester, Leicestershire and Rutland (LLR) that are relevant to the behaviour of violence and in line with the Public Health Model. This assessment has highlighted some strengths and weaknesses in the existing service delivery arrangements. These are highlighted in the diagram below.



3.3. In terms of investment, it could be argued that the triangle is currently upside down, with most of the investment going into services that have very limited prospect of achieving long term changes in patterns of harmful behaviour across the communities of LLR. This is depicted in the diagram below.



3.4. The emerging hypothesis is that our capacity to "prevent" harmful behaviours over the longer term is inhibited by the challenge of building the lower tiers of the Public Health Model to the degree that is required. On top of this "prevention" in the higher tiers is limited because the majority of services tend to have a greater focus on "controlling" behaviour rather than enabling the rehabilitation of those who exhibit the behaviour and a tendency to focus on individual "perpetrators" rather than considering the wider network of individuals they interact with and influence.

3.5. Indeed austerity may have exacerbated the problem from a public health perspective, as the higher tiers tend to be statutory and crisis based: the core elements of demand; whilst the lower tiers tend to be non-statutory and longer term. In periods of retrenchment it is inevitable that services will be more narrowly focussed and those that are not statutorily required and do not satisfy immediate demand will experience higher levels of disinvestment. The analysis suggests that this approach merely drives more and more short term crisis based services, whilst doing nothing to stem the long term flow of demand.

3.6. The preliminary VRN service mapping exercise suggests that services at tiers 2 and 3 currently have a very limited focus on prevention. The services most likely to respond to violent behaviour in adults are police, EMAS, A&E, probation and prison. The police response is not designed to change the behaviour of the individual perpetrator and police training does not focus on rehabilitative interventions. Leicestershire Police has invested in services such as Braunstone Blues and People Zones and has developed a Serious Harm Reduction Unit to focus on longer term initiatives as well as building its neighbourhood policing capability. But the response to individual incidents is largely to apprehend and convict the perpetrator.

3.7. EMAS and A&E tend to respond to the "victims" of violent behaviour rather than the perpetrators, albeit the distinction between victim and perpetrator can become blurred in some types of violent incident. The prison service clearly works directly with perpetrators of violence and delivers some services to impact on the attitudes underpinning the behaviour. Nevertheless, the recent crisis of mushrooming violence within our prisons does not suggest that violence prevention will blossom in that environment. Indeed the consultant supporting the development of the VRN described prison as reinforcing the very trauma that underpins violent behaviour.

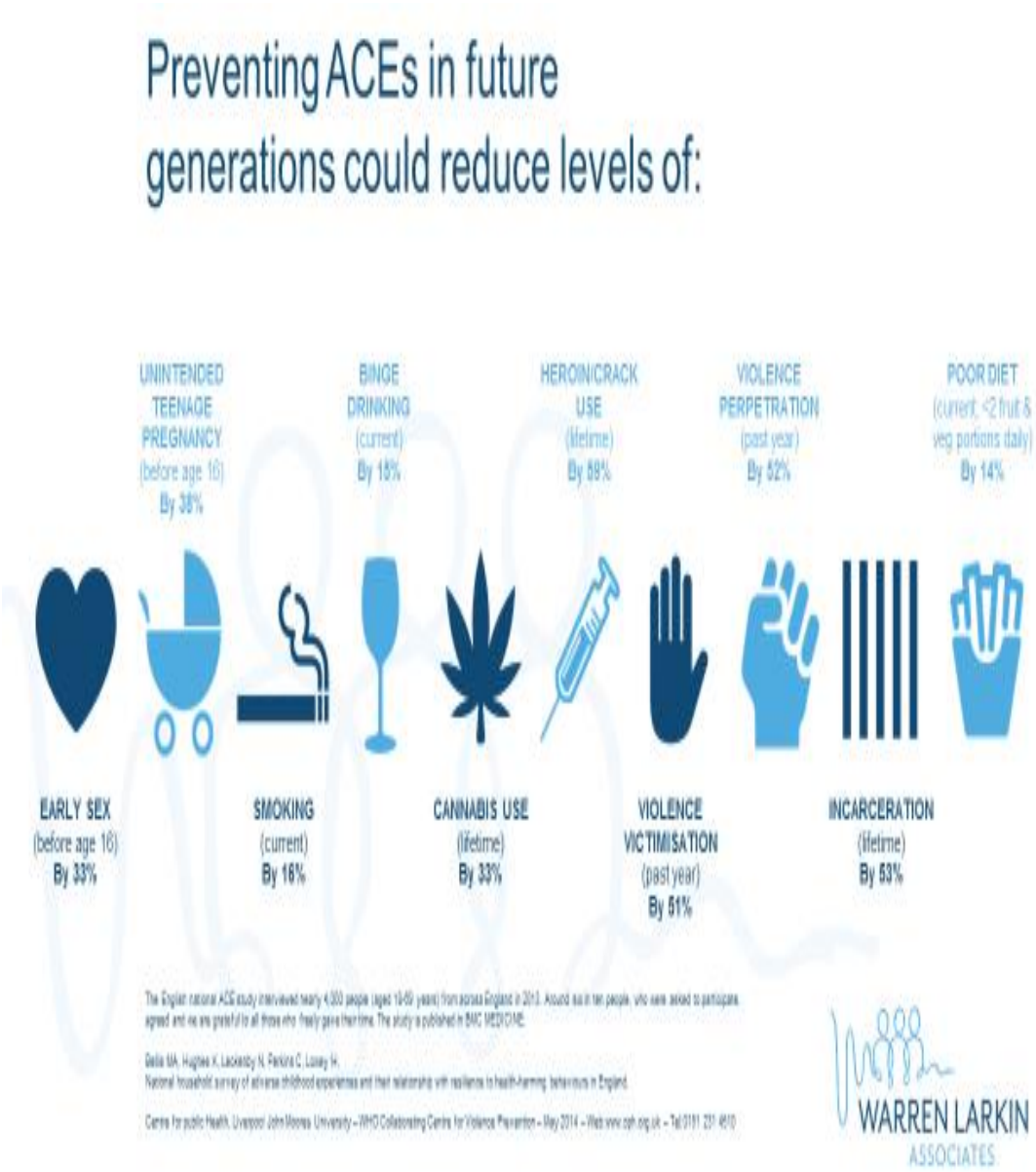
3.8. The probation service probably has the largest focus on rehabilitation of all these services, but has undergone major organisational upheavals in recent years, with more to come. Even then that service is arguably more focussed on controlling the behaviour of those who pose a threat to public protection rather than investing in their long term rehabilitation. It clearly does not routinely work across the network of individuals who are influenced by perpetrators and therefore obviously cannot impact on the inter-generational nature of these behaviour patterns.

3.9. The response from the Youth Offending Service for younger perpetrators of violence may provide a more promising focus on rehabilitation as well as a willingness to engage with the wider network of individuals who influence and are influenced by the individual. This approach is likely to have a longer term effect, but the truth is that the vast majority of perpetrators are in the higher age range.

3.10. The pattern emerging from the early VRN analysis is that the top two tiers of the Public Health Model are unlikely to generate long term changes in the pattern of behaviour and the bottom two tiers are insufficiently developed to build long term community resilience. There are some very promising initiatives in the bottom two tiers, including the development of Local Area Co-ordinators in the county, street based youth work, and the generic vulnerability checks undertaken by fire officers. Whilst these sorts of initiative will undoubtedly have some positive impact, they clearly have not contained the growing levels of serious violence as highlighted in the analysis presented to the Board on 6 September 2019.

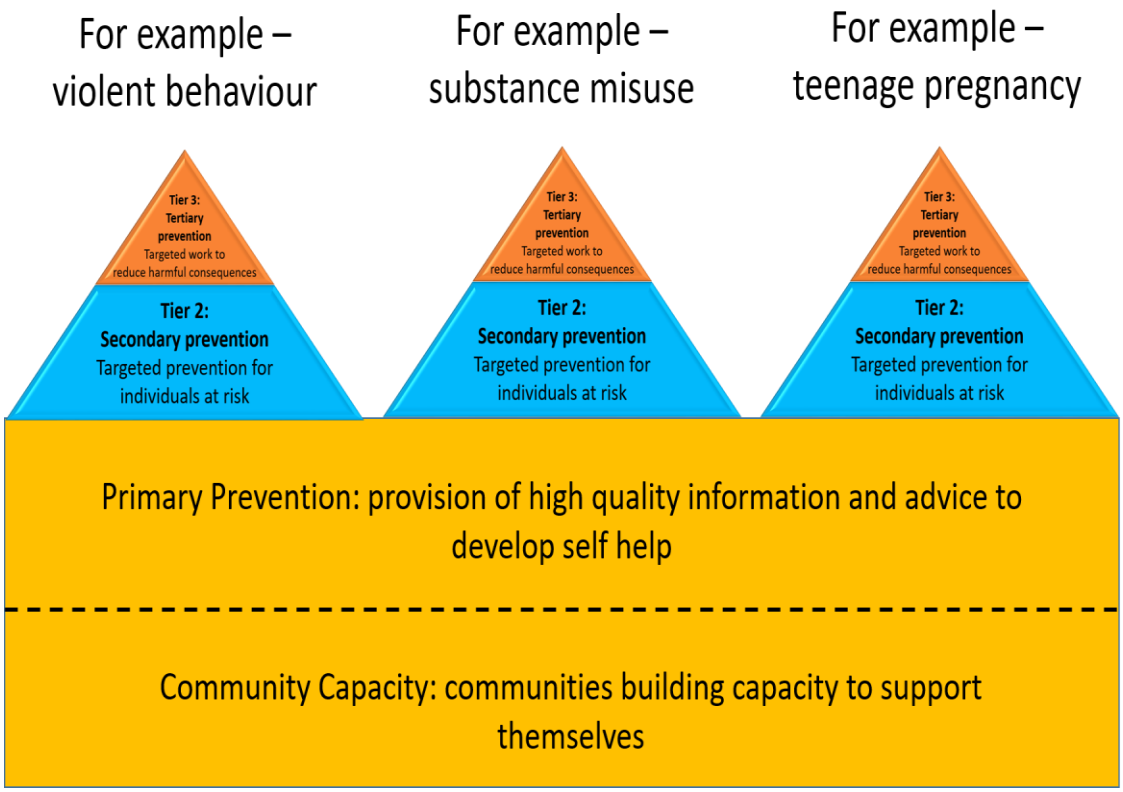
4. A Different Perspective on the Public Health Model

4.1. We tend to address harmful behaviours individually as though each one has unique drivers and perpetrators and victims. But the reality is that certain communities tend to exhibit patterns of multiple deprivation resulting in a myriad of harmful behaviours. Recent analyses of Adverse Childhood Experiences (ACEs) demonstrate that higher levels of trauma in early life are very closely correlated with a range of negative behavioural outcomes. At the same time it implies that making an impact on one behaviour, could have a wider impact on other harmful behaviours. This generic impact is highlight in the diagram below.



4.2. However, the ACE analysis also suggests that patterns of harmful behaviour have a long gestation period and are established over many years. Essentially the behaviour is a "symptom" of long term deprivation. This makes the behaviours very difficult to change once they are entrenched. All the indications are that investing early in building resilience to the causes of the behaviour in the first place is a more profitable route to pursue; therefore investing in tiers 1 and 2 of the public health model.

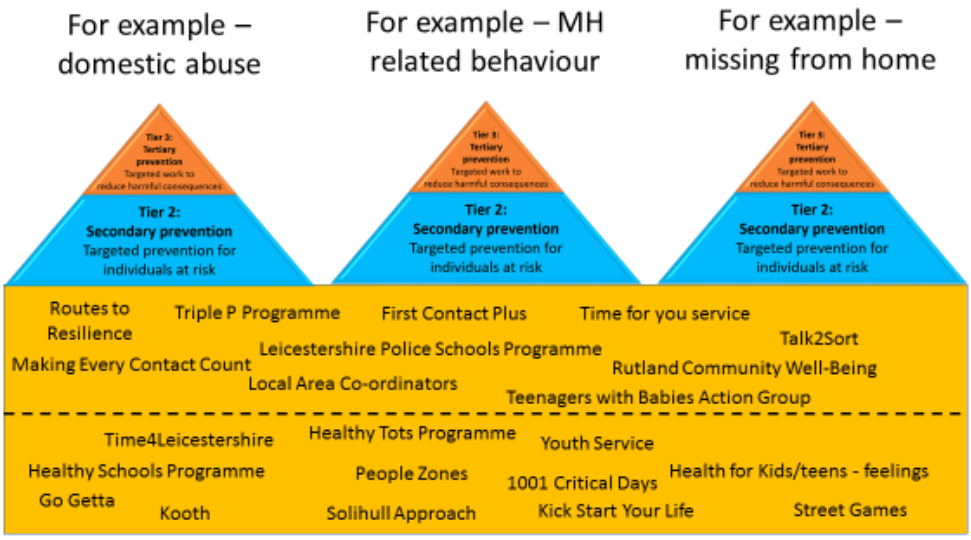
4.3. Investing in the lower tiers of the Public Health Model has the added advantage of being non-behaviour specific. If we build resilience to one form of harmful behaviour we are likely to build resilience to them all. In this sense the Public Health Model is more like a Toblerone than a triangle as depicted in the diagram below.



4.4. On this basis we could establish a model wherein the lower tiers are seen as generic and developed collaboratively across public service agencies, whereas the higher two tiers are targeted more specifically at individual behaviours as indicated in the diagram above. This approach can build upon existing initiatives across LLR, some of which have been mapped by the VRN work. The approach would also enable a much higher level of collaboration across public services than has been possible to achieve hitherto.

4.5. At present, insofar as we develop initiatives at the lower tiers, some of them are developed to address specific behaviours rather than building wider resilience in our young people and local communities. For instance many violence reduction units outside of LLR are targeting schools and local communities to promote messages in relation to knife crime/serious violence. If we adopted this behaviour-specific approach for each of the harmful behaviours we want to focus on, the schools and communities would be inundated and there would be a risk of conflicting messages resulting in confusion. The proposed approach is more generic, developing some core messages to promote and build a wider level of overarching resilience to a range of harmful behaviours. Reassuringly this is the approach adopted by Leicestershire County Council via their successful Youth Endowment Award programme to be delivered in schools by Barnardo's.

4.6. The diagram below is drawn from the preliminary VRN mapping and gives an indication of the sorts of existing resources that are available in local communities at tiers 1 and 2 (no distinction is made between those tiers in the diagram). Clearly the community itself is the source of many other resources to enable resilience building.



5. A Worked Example – Mental Health

5.1. The proposed methodology has already been tested via some work already undertaken in the area of mental health. Mental health issues are referred to in the Police and Crime Plan as an area of vulnerability that generates very reactive work for the police and other agencies, without delivering long term benefits.

5.2. The Proactive Vulnerability Engagement Team (PAVE) was established via the OPCC's Strategic Partnership Development Fund (SPDF) to develop an enhanced response to frequent callers to emergency services with complex issues of vulnerability. As part of the recent review the scope and remit of PAVE was considered alongside the services offered by Leicestershire Partnership Trust and by Primary Care services and other organisations to support this cohort of people. What has emerged is a proposed holistic approach to these individuals that draws on services and support at all levels of the Public Health Model. The proposals will be considered at a special leaders' event on 25 November and is described more fully in a separate paper to this meeting of the SPB.

5.3. However, the key ingredients are that a key behaviour was identified – low level mental health generated demand for emergency services; a collaborative analysis was undertaken and an inter-agency strategy developed to address the behaviour. This is the approach proposed for other behaviours that have yet to be defined.

6. Alignment with Health

6.1. The worked example described above, and other complex behaviours that the Prevention Board is likely to address, are bound to have a health component. The solutions identified will only be effective if they align with the strategic initiatives of the Clinical Commissioning Groups (CCGs) and local health providers.

6.2. In order to promote this alignment it is proposed to take this paper to the Health and Well-Being Boards that cover Leicester, Leicestershire and Rutland (LLR) and to align work between the SPB sponsored Prevention Board and the Unified Prevention Board that is building a similar health-based preventive approach across Leicestershire, and any equivalent forums in other jurisdictions across LLR.

6.3. Taking this a step further there will always be considerable overlap between the issues addressed by SPB and those taken forward by Health and Well-Being Boards. Bearing this in mind it is proposed to establish an annual joint forum, wherein overlapping issues are identified and considered. The proposal for this will be developed more fully and brought before a future meeting of the SPB.

7. Alignment with Place

7.1. The diagram in 4.6 above demonstrates that there is already quite a lot of activity going on in tiers 0 and 1, but this varies considerably by place. Many of the programmes referred to in 4.6 are commissioned by Leicestershire County Council, which may partly reflect the knowledge base of the person who did the preliminary VRN mapping – but it may also demonstrate that there is variation in provision between upper tier local authority areas. Clearly there may also be variations between lower tier authorities, but that is more difficult to map at this stage because of the resources available for mapping and because of the overlapping provision offered by Leicestershire.

7.2. Nevertheless the Board does need to understand the variations in provision by place in order to know where to target services and stimulate community resources, including the deployment of a revised People Zone methodology. The proposal is for the Board to develop its own expectations of what is required at tiers 0 and 1 in order to facilitate the prevention of harmful behaviours, and to put in place arrangements to review and monitor this. In the first place the review and monitoring can be undertaken at upper tier level.

8. Alignment with the VRN

8.1. The methodology described for the Prevention Board entirely accords with the approach adopted by the VRN. In essence violence is one of the harmful behaviours that the Prevention Board will be concerned with. The work that the VRN undertakes to enhance tiers 1 and 2 of the Public Health Model across LLR will provide immediate benefits to the VRN and any work that the Prevention Board commissions to address other harmful behaviours will have similar synergistic effects.

8.2. Bearing this in mind the VRN and the Prevention Board need to work particularly closely and need to align their programmes. Wherever possible agencies will ensure that membership of the Boards is held in the same person. Over the longer term it may be that the two Boards are brought together as one, but in the short term, the funding requires the VRN to be a separate Board and its pioneering development probably requires dedicated commitment from each agency. This will be reviewed over time.

9. Implications for the Prevention Board

9.1. Translating this into the development of a multi-agency Prevention Board the remit of that Board would be to do the following:

9.2. Identify the harmful behaviours that it chooses to prioritise. This exercise will be undertaken in collaboration with initiatives in the health world, such as via the Unified Prevention Board and the Health and Well-Being Boards as well as taking account of the emerging developments in Primary Care Networks.

9.3. Review existing preventive work undertaken at Tiers 2 and 3 for each of the prioritised harmful behaviours, leading to recommendations for change and the preparation of a multi-agency strategy to enhance the achievement of preventive initiatives.

9.4. Build a self-assessment toolkit for individual agencies to enhance the quality of their work on prevention. This will include the testing of the toolkit with individual agencies to ensure its

efficacy.

9.5. Map and co-ordinate initiatives to build Tiers 1 and 2 of the Public Health Model. This will be done across LLR identifying gaps either geographically or in specific elements of the preventive model, with an emphasis on generic initiatives that are not specific to individual behaviours. .

9.6. Identify specific geographical communities where resilience is particularly low and undertake work to enhance the resilience of those communities using the revised methodology for People Zones, which is attached at Annex B.

9.7. This approach will complement the work being undertaken by the Violence Reduction Network, which is currently engaged in each of the activities identified above, albeit focussed on serious violence.

9.8. A proposed Terms of Reference for the Prevention Board is attached at Annex A.

10. Recommendation

10.1. The Board is asked to agree to the establishment of the Prevention Board to replace the People and Place Board, in line with the Terms of Reference contained in Annex A.

Annex A: Terms of Reference for the Prevention Board

The Prevention Board: Terms of Reference

1. Purpose

1.1. The primary purpose of the Prevention Board is to develop strategies to prevent harmful behaviours by deploying the Public Health Model.

1.2. The Public Health Model adopted by the Prevention Board is presented in the diagram below

1.3. Harmful behaviours are defined as any behaviour which undermines the safety and well-being of the whole community of LLR or of specific communities within LLR. There is also an expectation that the harmful behaviours to be addressed by the Prevention Board will demonstrate high levels of complexity, requiring inputs from a range of agencies. Harmful behaviours which fall within the remit of single agency would not normally be addressed by the Prevention Board.

1.4. However, the Board will define the behaviour it is addressing as specifically as possible. For instance, crime is a behaviour, but it is not a single behaviour: it takes myriad different forms requiring a multiplicity of responses. However, domestic violence is a sub-group of crime, enabling more detailed analysis of the patterns and causes in order to develop effective preventive strategies. More specifically the Board could focus on specific types of domestic violence, or even domestic violence within specific communities.

1.5. Whatever behaviours the Prevention Board chooses to address, its aim is to minimise the expression of each behaviour, albeit recognising that the positive changes may be realised over a long time period.

2. Approach

2.1. As mentioned above, the Prevention Board will deploy the Public Health Model in addressing the targeted behaviours. More specifically this means the following:

2.2. A recognition that the targeted behaviour is usually a symptom of more long term causes and that the aim of the Board is to understand and address the long term causes, whilst also deploying strategies to minimise the expression of the behaviour in the short term.

2.3. In order to understand the causes the Board will have to analyse the behaviour in detail and draw conclusions from the data. This requires the Board to have an analytical capability at its disposal and it is assumed that each agency will contribute its own data to achieve that analysis.

2.4. In order to identify the targeted behaviours, the Board will maintain an issues log, which all members will contribute to. This will record the behaviours that members consider cause the most significant harm to the community (or specific communities) of LLR. The issues in the log will be reviewed in order to prioritise the targeted behaviours.

2.5. The key output of each targeted behaviour will be an inter-agency strategy to minimise the future expression of the behaviour. As a minimum the strategy will identify the required inputs at each tier of the Public Health Model, specifying any particular communities (geographic or non-geographic) where additional inputs are required.

2.6. The strategy will also identify any policy enablers that can be introduced and the anticipated alignment with other local and national strategies. The strategy will also clarify how it will monitor the behaviour over time.

2.7. Insofar as the strategy requires significant deployment of multi-agency resource and/or significant changes in multi-agency policy then the strategy will reported to the SPB for approval and may be monitored and reported at SPB level.

2.8. The Board may choose to develop enablers in order to achieve generic reductions in harmful behaviours, without focussing on a specific behaviour as described above. For instance, the Board may choose to invest in the development of community leadership skills, recognising that community leadership will facilitate the achievement of the Public Health Model.

2.9. Community leadership will also facilitate the sort of local intelligence that will enable the Board to focus on behaviours that are relevant to local communities. In this respect it would be helpful to have input from relevant community leaders on the Board.

2.10. Similarly the Board may recognise that its success is highly dependent on the achievement of a multi-agency data analytical capability, supported by effective data sharing arrangements. This may be difficult to achieve without investment.

2.11. Bearing in mind the potential for investment, the Board may also choose to develop a capability for accessing funding opportunities.

2.12. Finally, the Board will also require a horizon scanning capability in order to be aware of key developments in effective practice, new initiatives at national or local level, national and local strategies and patterns of change in harmful behaviours at a national and local level.

3. Schedule

3.1. The Board’s initial schedule of development will be:

3.2. Establish membership and meeting arrangements

3.3. Establish processes for collecting and monitoring issues

3.4. Agree minimum dataset for monitoring patterns of harmful behaviour, this will include the reporting of issues from local communities

3.5. Agree arrangements for horizon scanning

3.6. Identify harmful behaviours to focus on

3.7. Analyse and develop multi agency strategies for harmful behaviour(s)

3.8. Monitor and review ongoing patterns of harmful behaviour

4. Membership

4.1. Upper Tier Local Authorities

4.1.1. Public Health
4.1.2. Social Care

4.2. Police – strategic lead for Prevention/Neighbourhood Policing

4.3. OPCC – chief executive

4.4. Lower Tier Local Authorities – strategic lead for community safety

4.5. Representative from Public Health England

4.6. Representative from Clinical Commissioning Groups

4.7. Representative from University Hospitals Leicester

4.8. Representative from Leicestershire Partnerships Trust

4.9. Representative from EMAS

The representatives from health will ensure that the work of the Prevention Board is informed by developments within each of the organisations described above, as well as the Health & Well-Being Boards across LLR and the Unified Prevention Board in Leicestershire. Representatives will also be familiar with the development of Primary Care Networks and the Mental Health Partnership Delivery Programme Board. Representatives will also ensure that the work of those organisations and partnerships is informed by the work of the Prevention Board.

4.10. Fire – strategic lead for community safety

4.11. Probation – strategic lead for community safety

4.12. VCSE representative(s)

4.13. Academic representative(s)

4.14. Community leaders

4.15. Academic bodies

Annex B: Summary of Revised Operating Model for People Zones

Changes to People Zone Methodology

1. Background

1.1. The People Zones' methodology was launched in 2018 to support the work of the SPB. It has operated in three communities across LLR.

1.2. An evaluation is currently taking place and will be reported back to the Prevention Board, if the SPB agrees to establish it. An evaluation methodology has been prepared by Loughborough University.

1.3. A revised operating model has been developed by an independent body (Process Evolution) drawing on the feedback from participants. However, the revised model was developed prior to introduction of the Violence Reduction Network and the broad acceptance of the Public Health Model as the approach to adopt.

2. Learning

2.1. The concept of the People Zones has been wholly supported and still aligns very well with the key strategic drivers around which it was established.

2.2. Community leadership has been strong in two of the three People Zones and the initiative has had a positive impact in embedding and enhancing that leadership.

2.3. The initiative has stimulated activities at the local level including the ability to leverage funding in support of work in schools, drug treatment and other local services.

2.4. The initiative has stimulated commitment from the sporting bodies across LLR, with a range of sporting activities undertaken in each zone to engage young people.

2.5. The initiative has had a positive impact in promoting more collaborative working across agencies at the PZ level.

2.6. The initiative has built a creative relationship with the Community Payback scheme delivered by the Community Rehabilitation Company, wherein local people/agencies can identify sought after environmental improvements that can be addressed by Community Payback.

2.7. Despite these and other positive benefits there are areas that require further development as follows:

2.8. The People Zone initiative was intended to be cost neutral. This has been hard to realise in practice and has put pressure on three organisations in particular to maintain the work: the OPCC; the relevant local authorities; and the police. From the perspective of the OPCC three individuals within the office have taken responsibility for delivering the OPCC commitment to each PZ, on top of their other duties. This has been very difficult to sustain for a small organisation, particularly as staffing changes and new commitments, such as the VRN, have occurred.

2.9. The methodology for defining the target behaviour has been unclear and the target behaviours have arguably been too broad. This reflects the fact that the particular areas were chosen because of the high levels of multiple deprivation that were evident in those

communities. Bearing this in mind it has been difficult to focus on a single behaviour as there are so many issues to address, but without focussing on a single behaviour it is hard to demonstrate progress.

2.10. Although some agencies have made a strong commitment to the approach, others have more reserved, leaving gaps in the effective deployment of services.

2.11. Community leadership has been very limited in one of the PZs and is still developing in the others. Community leadership is clearly a key element of the model, but requires greater stimulation at the start of a PZ in order to be effective.

3. Proposed Developments

3.1. The fundamental proposal is that the PZ methodology is enhanced to provide a tool for the Prevention Board to deploy in particular geographic communities (at present the PZ methodology is not adapted for non-geographic communities, although this could be a future development) in line with the Prevention Board approach described above. Specifically this means that the Board will analyse a harmful behaviour and in doing so will identify any particular geographic communities wherein the harmful behaviour is especially prevalent. As part of its strategy for addressing the behaviour the Board will commission a PZ in a specified community or communities.

3.2. In order to do this the current revision of the operating model will be completed to achieve the following:

3.3. A more robust process for agreeing agency and community commitment at the outset of establishing a PZ, with the expectation that the PZ will only go ahead once the commitment is achieved.

3.4. A more robust process for defining roles within the PZ, particularly focussing on a lead role for agencies, a lead role for the community and a co-ordinator role. The expectation is that a co-ordinator will be a funded position.

3.5. The development of a practical toolkit that can be used by community leaders and agencies at the local level. This is currently underway, building on the initial toolkit that was prepared.

3.6. Adoption of the Public Health Model as part of the operating model. This will enable the local delivery team to focus on the management and rehabilitation of individuals exhibiting a very specific harmful behaviour at the top end of the model, whilst building more generic community resilience at the bottom end.

Report No: 52/2020
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

03 March 2020

---HEALTH AND WELLBEING STRATEGY ---

Board Lead:	Mike Sandys	Public Health
Report Author(s) and contact details:	Susan-Louise Hope, acting Senior Public Health Manager Email: Susan-louise.hope@leics.gov.uk	

RECOMMENDATIONS
That the Rutland Health and Wellbeing Board: 1. Notes the current report and progress to date.

1. PURPOSE OF THE REPORT

1.1 This paper is to update the Rutland Health and Wellbeing Board on the work underway to update and renew the Health and Wellbeing Strategy

1.2 The Health and Wellbeing strategy will build on the outcomes from the refreshed JSNAs. The JSNAs are the statutory process by which a Local Authority and Clinical Commissioning Group assess the current and future health, care and wellbeing needs of the local community to inform local decision making. A JSNA integrates a range of data, on topics such as health, housing, transport, employment and education, to identify needs of strategic importance to health and wellbeing.

1.3 The purpose of the JSNA and subsequent Health and Wellbeing Strategy is to improve the health and wellbeing of the local community and reduce inequalities for all ages. It should be viewed as a continuous process of strategic assessment and planning with the aim to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities.

1.4 The JSNA is used to help to determine what actions Rutland County Council, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing. The JSNA informs and underpins the Rutland Joint Health and Wellbeing Strategy.

2. BACKGROUND AND MAIN CONSIDERATIONS

2.1 The renewed JSNA was approved by the Board on December 4th 2018, work then began on drafting the Health and Wellbeing Strategy.

2.2 A strategy development workshop took place on October 9th 2019, which involved key stakeholders and partners both internal and external to Rutland County Council. Key outcomes for the workshop were to set the strategic vision, agree overarching priority areas and agree action and ownership for each priority area.

2.3 The following priority areas were identified.

a) Active Communities

b) Getting people more physically active

c) Starting well and living well longer – a whole life approach

d) Improving the health for All by ensuring a special focus on specific groups

2.4 The draft strategy has been compiled, and is included in the papers, which outlines what each of the above priorities mean, details what the current situation is, what actions are already being taken, what further actions will be taken and the measures for success.

2.5 The strategy is a joint strategy to which all partners, stakeholders and communities will be able to make positive contributions. It becomes the overarching Health and Wellbeing Strategy to which other strategies and action plans for individual areas of work are aligned.

2.6 Further work to be undertaken is engagement with stakeholders and the wider communities about the vision and priorities to ensure that those that have been identified at the workshop are reflective and shared. The process of identification of groups/individuals with whom to engage has begun and the intention is to undertake the engagement over March to May. An engagement report will be produced in May in time for the final version of the strategy to go to the Board for sign off in June 2020.

2.7 Key questions to ask are what health and wellbeing means to them, what they think is needed to achieve it and how they think they can contribute to the health and wellbeing of their communities.

3. FINANCIAL IMPLICATIONS

3.1 The Health and Wellbeing Strategy contributes to robust fiscal management of public sector budgets by helping to ensure that service planning and development considers the changing patterns of need for health and social care services. It ensures that commissioned services are strategically aligned to deliver against the identified priorities.

3.2 Delivery of this strategy is being met by existing budgets such as the Public Health Grant. Potential savings arise through effective integration of health and social care. Improvements in the health of the population and a reduction in years lived in poor health in turn contribute to the reduction of health inequalities and treatment costs.

3.3 The Health and Wellbeing Strategy supports the matching of services to the population which in turn supports sound financial planning and robust allocation of resources

4. CONCLUSION AND SUMMARY OF THE REASONS FOR THE RECOMMENDATIONS

4.1 It is recommended that the Health and Wellbeing Board note the current report and progress to date.

4.2 The timetable is tight with a draft strategy presented to the Board meeting on March 3rd 2020 and the full strategy to be presented to Board in June 2020.

5. BACKGROUND PAPERS

6.1 There are no additional papers to the report.

6. APPENDICES

7.1 Appendix A: Draft Joint Health and Wellbeing Strategy 2020-2025

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

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Rutland Joint Health & Wellbeing Strategy

2020 -2025

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1. Foreword

To be added.

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2. Introduction

This Joint Health and Wellbeing Strategy sets out our priorities for improving health and wellbeing in Rutland. Our aim is to prioritise prevention, to work together in partnership across organisations and with communities to support them to be active and to enable our residents to access help, advice and support when they need it.

The strategy is focussed on working in partnership across organisations rather than on routine work. Integrating health and social care was a significant part of our last strategy and has resulted in systematic joint working between adult social care and health services being the norm.

We know that strong social and community networks are good for health and wellbeing. Social and community networks include our family, friends and the wider social circles around us and they have a significant protective factor in terms of our health.

The Strategy is aimed at all ages, from good health in pregnancy, through to dignity at the end of life. It also seeks to ensure that everyone can have the same opportunity to live a healthy independent life, as we know that some groups currently have poorer health outcomes and/or reduced life expectancy.

The purpose of the strategy is to enable the Health and Wellbeing Board to be clear about our agreed priorities over the next 5 years; to embed them within our organisations, ensure they are reflected in our commissioning plans and to influence partners across Rutland; including engaging residents.

3. Our Vision and Goal

Our vision for the Health and Well Being Board is to create 'Safe, healthy, happy & caring communities through which people start and thrive together all their lives' and, in doing so achieve our goal of

'Active Communities Living Well'.

4. Our Priorities

Our priorities are informed by population health outcomes data and the Joint Strategic Needs Assessment for Rutland, published in December 2018, together with stakeholder views gathered through a Health and Well Being Board development session.

As we develop the work on our priorities we will **engage with local people**, societies and community groups to ask them what living well means to them; what would make the most difference and what they can do to help take this forward. This will not be a one-off engagement, but a routine approach to our work.

"The greatness of a community is most accurately measured by the compassionate actions of its members." Coretta Scott King

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Our four draft priorities are:

1. Active communities

Current situation:

Evidence shows that being part of a community and having connections with other people has a positive impact on our wellbeing. Rutland has many active and caring communities and lots of local groups and societies which we celebrate. We also recognise that it is a rural area, with some areas sparsely populated and an ageing population, so feelings of isolation and loneliness can be exacerbated. This also impacts children and young people.

Need data for Rutland.

Rutland is full of people and groups working at village and local levels to build or sustain vibrant and flourishing places that utilise natural and built assets to support the wellbeing of places and communities.

What are we doing now:

We are working to support that endeavour and energy through engagement and support – The Rutland Community Wellbeing Service is actively encouraging and supporting volunteering for all that it can bring to the wellbeing of participants and the ability of places and communities to thrive. The Service is also working to support the development of social sector groups including the provision of resources and advice, training and funding opportunities and updates, to supporting networking, collaboration and representation.

The Civil Society in county also has a tradition of cross sector partnership –working with private and public to deliver on shared priorities, as well as being driven at many levels to work to ensure that all residents are able to realise the benefits of, and contribute to, Rutland being one of the best places to live in the country. Rutland has so many focused people and organisation, relentless in their ambition to shape and secure opportunities to improve quality of life and levels of engagement.

Where do we need to get to:

“The power of community to create good health is far greater than any physician, clinical or hospital”

Mark Hyman

There is so much more to do. Our support for communities still needs to develop and be more widely communicated and utilised. Many groups have evolved independently and have to date been comfortable with that self-contained and determined position.

However, the world is changing and there are increased demands, expectations, pressure and opportunity to shape places and to deliver service and changes at a local level. We must work to bring these challenges into the realm of the achievable - providing accessible infrastructure services that provide information, advice and support across a range of subjects, building relevant resources and toolkits, developing training in response to key challenges, providing opportunities for sector representatives to meet, to be informed, to exchange ideas, to collaborate , to identify funding and resourcing opportunities, and to add their offer and thinking to forming and delivering countywide health and wellbeing strategies and activity.

We need to continue to listen and learn and build on that authentic voice, the place where natural creativity and sustainability exists, and to use that fundamental and necessary innovation and resource to shape the local behaviours and community services and assets that are so important in 21st Century health and Wellbeing in Rutland.

We will work with communities to secure an understand of local assets that will support health and wellbeing assets, where possible and reasonable to endeavour to secure additional investment where required, but also to realise the benefits of the richness of what we have, and what we can consider together.

We will tackle loneliness and provide support by working with parishes and community groups, to develop community activities for all ages. Those activities determined by local people and groups may include sustaining and support existing and developing good neighbour schemes, befriending activities, events, arts and cultural projects, community gardens and growing schemes, neighbourhood/village infrastructure youth groups, nature groups and enable people to get out an about so they can benefit from our countryside and Rutland Water.

We need to build on our ‘no wrong front door’ approach so people can access the support, advice and assistance they need no matter which organisation they contact. New social prescribing resources and aligned approaches will add to our capacity and reinforce our intent. Additionally we will need to work across all sector partners to support and encourage the cultural changes required to release innovation and enable purposeful collaboration. We will also work to identify and align funding opportunities to support ambitions– liaising with traditional social sector funders in attempt to influence priorities and targeting, and working internally to develop approaches to smarter commissioning.

We will work with communities to design our services so that they fit around people, meet needs and address the longer term. We will develop places and opportunities to talk and plan, so that we can all be involved in working to shape provision that responds to shared Health and Wellbeing ambitions.

Our services will ensure that people are supported into activities that promote the Five Ways to Wellbeing areas of connect, be active, take notice, keep learning and give – shown to have a positive impact on health.

We will work with community leaders including parish councils, district and town councillors, community groups,and other members of the civil society to listen to the views of communities and to work in partnership respond to issues raised and to target resources in the best way.

The population of Rutland is expanding with new housing developments planned. To ensure these have a 'sense of place' and active communities can develop, we will ensure that facilities and open green and communal space is included. We will work to ensure the needs of different groups are met in house and community design. This has started with our focus on dementia friendly design as part of early plans for St Georges Barracks.

We will engage the business community both in terms of exploring and focusing Social responsibility activity and aims, but also in supporting the development and encouragement of healthy working practices and wellbeing in organisations small and medium. We will work to develop opportunities for contractors, developers and builders to invest in activity and infrastructure that supports community led health and wellbeing development.

We will work across all policy and strategic settings to ensure that issues related to the wider determinants of heath are appropriately and routinely considered.

We will be innovative and creative working to consider freedoms and flexibilities that will encourage and support the engagement of communities now and in the longer term.

2. Getting people more physically active – a best buy for medicine.

Current situation:

Being physically active has many benefits: it helps improve our mood can boost self-esteem, sleep quality and energy, as well as reducing the risk of stress, depression, help us manage our weight better, lower blood pressure and risks of many physical health problems such as type 2 diabetes. It helps us have stronger bones, muscles and joints and lower risk of developing osteoporosis, improves our balance and reduces our risk of falls. In fact, a medical best buy!

Physical inactivity directly contributes to 1 in 6 deaths in the UK, the same number as smoking. Around 1 in 4 of us in Rutland are inactive and fail to do 30 minutes of activity a week.

What are we doing now:

We promote being physically active from early in life. Forming good habits and having access to enjoyable activities from the start helps support good healthy behaviours in the future. We work with schools to promote our extended School Games programme which includes opportunities for those less keen on mainstream team games. Our Energise Club programmes engage a significant number of pupils, and we have piloted a Whole School Approach project in primary schools across Rutland, offering physical literacy intervention sessions, targeting early year's foundation stage (EYFS) and key stage 1 (KS1) children.

We promote use of our green and open spaces, encouraging walking and cycling throughout the year, showing opportunities available during our annual Walking and Cycling Festival. We also offer gardening and growing opportunities through our Grow Together volunteer programme. Our volunteer gardeners are at the heart of this programme, leading projects of their own in their communities, sharing their knowledge, skills, experiences and stories with new growers and providing local natural outdoor opportunities close to where people live. Projects include; community beds and allotments, verge planting and growing / learning spaces. We work with a variety of partners on these projects including Walking for Health groups, walking and cycling groups, Leicestershire & Rutland Wildlife Trust, nature reserve, Root and Branch Out and enthusiastic volunteers.

Our Exercise on Referral, Steady Steps and Steady Steps Plus programmes support people with health conditions to benefit from tailored support around their health needs to begin to build more activity into their lives. We offer a timetable of activities at local and convenient community venues, delivered by highly trained instructors including specialised classes such as lower back pilates, cardiac rehab and falls prevention.

Where do we want to get to:

Having completed year 1 of the Whole School Approach project, we are extremely happy with the results we have achieved and the significant improvement in so many of the children involved. As a result, we want to increase the delivery of our programme for school age children and are working to embed the Whole School Approach with schools buying in to an early intervention and assessment programme. We are now looking at the wider impact the project will have on the young people and their progress in school, so we will be conducting structured interviews with PE leads and EYFS/KS1 teachers to find out about the changes and influence the programme is having on the attainment and progress of the young people in their classes.

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We will work with local employers to encourage active travel to work including walking and cycling as well as opportunities for staff to be more active during their working day such as encouraging active soles, spaces to exercise, lunchtime activities and staff challenges.

We will increase use of our green and open spaces through walking, cycling, gardening and growing opportunities. In particular, our Grow Together programme will run for a further year and we are sourcing additional funding to continue the programme long term. This will allow us to offer more community engagement events to support further volunteers and projects. We will also continue to support our walking and cycling groups, train volunteers and develop further informal opportunities as well as build on the annual Walking and Cycling Festival.

We will extend our Exercise on Referral programme to include specific classes for pulmonary and cancer referrals initially. Following this we will look to offer classes for stroke and diabetes. Additionally, we will deliver a further Steady Steps programme and continue to feed people into our maintainer (Steady Steps Plus) classes following the 24 week programme.

We will continue to build connections with our newly appointed social prescribing team, link up our existing programmes and ensure we have 2 way referrals to ensure the user is receiving the right support and provide them with the best experience.

3. Starting Well and Living Well for Longer - A whole life approach

Current situation:

[children, young people, adults?

Most have a good start in life, but challenges – affluent county, but some families living with poverty, high cost of housing, mental health challenges, difficult family circs, wider threats - county lines, child sexual exploitation, radicalisation, impact of reduced public sector investment on services, future economic uncertainty, climate change (critical moment).]

Life expectancy has increased in recent years but the number of years we live in good health has fallen. This means that in Rutland on average men spend 12.6 years in poor health and women 17.4 years, often suffering from several diseases and health conditions at the same time. This affects the individual and means they require more medical and social support with this often starting in middle age. Around 1 in 4 people aged 85 or more is living with 8 health conditions. How we can extend healthy life expectancy is a critical challenge.

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What are we doing now:

Rutland services aim to create safe, healthy, prosperous communities – across housing, transport, environmental protection, education, economic development, health and more – in which people can thrive throughout their lives.

The Council's strategy for children and young people is to enjoy a happy, safe and successful start in life. Families are supported and empowered to create a nurturing environment where children can flourish, while excellent educational opportunities prepare young people to achieve their full potential. Where early or additional support is needed, this is tailored to the potential and needs of individuals.

Following through into adult life, a wide range of services are there to equip people to maintain their mental and physical health and wellbeing, and to tackle lifestyle and life-stage challenges. Services aim to prevent, delay or minimise the impact of ill health, with a particular focus on impactable conditions such as type 2 diabetes, cardio vascular disease and pulmonary disease.

As ill health increases, empowering people to cope with changing circs, sustaining independence through technology, housing adaptations, physical therapy, reablement, health coaching, support to carers. Ensuring people have access to quality care closer to home, avoiding unwarranted deterioration or escalation, ending life with dignity and in the place of their choosing.

Where do we want to get to:

We want to nurture healthy, sustainable communities where people are well equipped to manage their health and wellbeing and achieve their potential.

Environmental challenges are growing globally. Where possible, we will pursue policies that achieve a triple win of improving health, the environment, and equity, building this objective more systematically into more of our individual and joint investment decisions.

We will promote good mental and physical health for all age groups, supporting schemes such as those detailed above, including support targeted at those with multiple health conditions. The aim is to help reduce the impact of conditions and to enable people to live their lives to the fullest, whatever their circumstances.

Prevention will focus particularly on people aged 45-64 with 2 to 4 long-term conditions where it is possible to improve outcomes and reduce or prevent health and care needs escalating.

Programmes will include social prescribing, mental health and care coordination, to help people access a range of health and community support services.

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4. Improve Health for All by ensuring a focus on specific groups

Current situation:

Good health is not the same for all. To ensure all people in Rutland have the help and support they need we will focus on some groups as a priority over the time of this strategy. This includes ensuring people in living in different circumstance to most people in Rutland have additional input. We will use data on health need to help determine these groups and adjust this as circumstances change. **Need data for Rutland.**

What are we doing:

TO FOLLOW

Where do we want to get to:

This could involve targeting services around specific groups with specific needs and areas in need of improvement, for example, military families, carers, people with multiple conditions, Adverse Childhood Experiences (ACE), as well as universal services to meet population need. We will the change the way we work together to commission and plan services so we have more focus on Rutland as a place and prioritise prevention

5. How will we know if we have made a difference?

We will use data which is regularly collated on a range of health indicators, including service user/patient feedback to tell us whether the health of our residents is improving. We recognise that some impacts will only become clear many years into the future.

We will include data that measures:

- Levels of happiness and satisfaction with life
- Participation and engagement in community activity
- Levels of physical activity – including results of the annual Active People Survey,
- Vaccination and immunisation
- Numbers of people with many health conditions
- Reduced use of crisis and statutory services because active communities provide support

Should we develop further into a draft outcomes framework?

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6. Partner organisations of the Rutland Health and Wellbeing Board

- Rutland County Council (Local Authority, including Public Health)
- East Leicestershire and Rutland Clinical Commissioning Group (NHS)
- NHS England
- Leicestershire Constabulary
- Rutland Healthwatch
- Local housing providers (represented by Longhurst Group)
- Rutland Voluntary and Community Sector (represented by Rutland Citizen's Advice)

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