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Rutland County Council

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Meeting:	**PEOPLE (ADULTS & HEALTH) SCRUTINY PANEL**
Date and Time:	**Thursday, 18 February 2016 at 7.00 pm**
Venue:	**COUNCIL CHAMBER, CATMOSE, OAKHAM, RUTLAND, LE15 6HP**
Clerk to the Panel:	**Corporate Support 01572 758311** **email: corporatesupport@rutland.gov.uk**

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Helen Briggs
Chief Executive

A G E N D A

APOLOGIES FOR ABSENCE

1) RECORD OF MEETING

To confirm the record of the meeting of the People (Adults & Health) Scrutiny Panel held on 3 December 2015 (previously circulated).

2) DECLARATIONS OF INTEREST

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

3) PETITIONS, DEPUTATIONS AND QUESTIONS

To receive any petitions, deputations and questions received from Members of the Public in accordance with the provisions of Procedure Rule 217.

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

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

4) QUESTIONS WITH NOTICE FROM MEMBERS

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

5) NOTICES OF MOTION FROM MEMBERS

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

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

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

SCRUTINY

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

7) QUARTER 3 FINANCE MANAGEMENT REPORT

To receive Report No. 27/2016

(Previously circulated under separate cover)

8) QUARTER 3 PERFORMANCE MANAGEMENT REPORT

To receive Report No. 37/2016

(Previously circulated under separate cover)

9) CQC INSPECTION REPORT

THE LODGE TRUST
To receive Report No. 44/2016 from the Director for People
(Pages 5 - 20)

10) LOCAL SAFEGUARDING ADULTS BOARD: BUSINESS PLAN

To receive Report No. 47/2016 from Paul Burnett, Chair of the Leicestershire and Rutland Safeguarding Children and Adults Boards
(Pages 21 - 58)

11) PUBLIC HEALTH: SEXUAL HEALTH STRATEGY

To receive Report No. 48/2016 from Mike Sandys, Director of Public Health for Leicestershire & Rutland
(Pages 59 - 108)

12) REDUCING SUBSTANCE MISUSE HARM IN RUTLAND: PROPOSAL FOR COMMISSIONING COMMUNITY TREATMENT

To receive Report No. 54/2016 from Mike Sandys, Director of Public Health
(Pages 109 - 116)

13) PEOPLE: CONTRACTS AND PROCUREMENTS

To receive Report No. 43/2016 from Karen Kibblewhite, Head of Commissioning
(Pages 117 - 122)

14) BCF PROGRAMME REVIEW & 2016/17 PLAN

To receive Report No. 42/2016 from Mark Andrews, Deputy Director for People
(Pages 123 - 162)

15) PROGRAMME OF MEETINGS AND TOPICS

a) SCRUTINY PROGRAMME 2015/16 & REVIEW OF FORWARD PLAN

To consider Scrutiny issues to review.

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

16) ANY OTHER URGENT BUSINESS

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

17) DATE AND PREVIEW OF NEXT MEETING

Thursday 14 April 2016 at 7 pm

Agenda items:

1. Care Home Subjects
   To receive a report from Sandra Taylor/Mark Andrews
   ADDED AT THE REQUEST OF THE PANEL AT THE MEETING ON 03/12/15

2. Director of Public Health: Annual Report 2015
   To receive a report from Mike Sandys
   This year's report describes the role of communities and community-centred approaches to improving health and wellbeing in Rutland.

3. Local Review of the 2012 National Dental Survey
   Findings of the review
   ADDED AT THE REQUEST OF THE PANEL AT THE MEETING ON 03/12/15

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

Mrs L Stephenson (Chairman)

Miss R Burkitt
Mr W Cross
Mr A Mann
Mr A Stewart
Mr A Walters
Mr G Conde
Mr R Gale
Mr C Parsons
Miss G Waller

OTHER MEMBERS FOR INFORMATION

Report No: 44/2016
PUBLIC REPORT

SCRUTINY PANEL

18th February 2016

CQC INSPECTION REPORT: THE LODGE TRUST

Report of the Director for People

Strategic Aim:	Creating a brighter future for all	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr R Clifton, Portfolio Holder for Health and Adult Social Care	
Contact Officer(s):	Tim O'Neill, Director for People and Deputy Chief Executive	01572 758402 toneill@rutland.gov.uk
	Mark Andrews, Deputy Director for People	01572 758339 mandrews@rutland.gov.uk
Ward Councillors	Rachel Burkitt, Marc Oxley & Lucy Stephenson	

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

1 PURPOSE OF THE REPORT

1.1 To note the content of published CQC Care Home reports.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 There has been one CQC report published since the last Scrutiny Panel which was for The Lodge Trust.

2.2 This latest report was published on 30th December 2015, following an inspection on 29th October and 3rd November 2015. The report showed an overall rating of good.

2.3 A copy of the CQC Report is attached for information.

3 CONCLUSION

3.1 The latest CQC report gives assurance of the standards at the home being maintained in 4 of the 5 areas looked at by the inspectors. The one area needing improvement on this occasion is “administration and storage of medicines”.

4 BACKGROUND PAPERS (IF NOT STATE 'THERE ARE NO ADDITIONAL BACKGROUND PAPERS TO THE REPORT')

4.1 None

5 APPENDICES

5.1 CQC Inspection Report: The Lodge Trust – dated 30th December 2015

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

Appendix A. CQC Inspection Report: The Lodge Trust

Copy attached

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The Lodge Trust

The Lodge Trust

Inspection report

Main Street
Market Overton
LE15 7PL
Tel: 01572 767234
Website: www.lodgetrust.org.uk

Date of inspection visit: 29 October and 3 November 2015
Date of publication: 30/12/2015

Ratings

Overall rating for this service	**Good**
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

This was an unannounced comprehensive inspection that took place on 29 October and 3 November 2015.

The Lodge Trust is a care home registered to accommodate up to 30 people who are aged over 18 and who have learning disabilities or Autistic Spectrum Disorder. The home had seven separate houses where people lived. One house was being updated so that each room had en-suite facilities; all other rooms had en-suite facilities. There were single person flats that people could choose to live in if they wanted more independence, with communal areas, or shared houses. People had been allowed to decide which house they wanted to live in, and could choose to move to a different house if there was a space available. At the time of the inspection 30 people were living at the service.

The Lodge Trust is a registered charity with an evangelical Christian foundation. It is set in four acres of garden and had an additional sixteen acres of parkland. There is a country park that is open to the public, along with two holiday log cabins and a shop/café. People who live at the service participate in work opportunities in the café, the garden and the laundry, as well as making products that were sold in the shop in woodwork and crafts.

Summary of findings

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.'

The feedback from relatives we spoke with was that they felt people were cared for very well.

People received care and support that was centred on their individual needs. Their care plans included information about how they wanted to be supported and how to develop and maintain their independence.

People were supported to understand their rights and how to keep safe. Staff knew how to identify and report abuse and the provider had a system in place to protect people from the risk of harm.

The provider had a recruitment process in place and carried out pre-employment checks.

Staff were supported through training and supervision to be able to meet the needs of the people they were supporting.

People were involved in decisions about their care and support and care plans included assessments of risks associated with this. Support was offered according to people's likes, dislikes and preferences. Staff knew people well and understood their care needs. Staff treated people with dignity and respect.

People were supported to take their medicines by staff who had received training in medicines management. Medicines were not stored or administered correctly.

People were supported to take part in a wide range of activities and work related tasks to maintain their independence and develop their skills.

Staff and relatives told us they were happy to raise any concerns with the manager and felt confident they would be listened to.

There were effective systems in place to monitor the service being provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People were supported to understand their own rights and how to keep safe. Staff knew how to recognise and respond to abuse correctly.

Individual risks had been assessed and identified as part of the care planning process.

Medicines were not always stored or administered correctly.

Requires improvement

Is the service effective?
The service was effective.

Staff received regular training to develop their knowledge and skills to support people effectively.

People's choices were respected and staff understood the requirements of the Mental Capacity Act. Consent needed to be sought where CCTV was used in communal areas.

People had access to the services of healthcare professionals as required.

Good

Is the service caring?
The service was caring.

Staff were kind and treated people with respect and dignity. Staff knew people's likes, dislikes and preferences.

People's privacy was respected and relatives and friends were encouraged to visit regularly.

Good

Is the service responsive?
The service was responsive

People's care plans were developed around their needs and were kept up to date and reflected people's preferences and choices.

A wide variety of activities were available to enable people to develop their skills and gain qualifications.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

People, relatives and staff felt supported by the management team and felt comfortable to raise concerns if needed.

The provider had effective quality assurance meetings in place to monitor the quality of the service provided.

The Lodge Trust

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 29 October and 3 November 2015 and was unannounced. The inspection was carried out by two inspectors and a pharmacist inspector

The service was previously inspected on 29 October 2013 when it was found to be fully compliant with the regulations. Before the inspections we reviewed the Provider Information Return (PIR). The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information we held about the service and information we had received about the service from people who contacted us. We contacted the local authority that had funding responsibility for all of the people who used the service.

We met 15 people who used the service and we spoke with five people on a one to one basis. We observed staff communicating with people who used the service and supporting them throughout the day. We spoke with five relatives of people who used the service. We spoke with the registered manager, the training manager, the administration services manager and four members of care staff.

We looked at the care records of five people who used the service and other documentation about how the home was managed. This included policies and procedures and records associated with quality assurance processes. We looked at four staff recruitment files to assess the recruitment process.

Requires improvement

Is the service safe?

Our findings

People who used the service told us that they felt safe. Comments included, "I feel safe," "It's safe here, the staff are nice to you. They don't do anything you don't like" and "I'm safe, no worries." All relatives who we spoke with told us that they felt that the service was safe. One person told us, "We do feel that [person's name] is safe." Another relative told us, "They are as safe as they can be."

We saw that at residents meetings people were encouraged to discuss their rights, what to do if they were unhappy and who to go to if they were concerned. This meant that people were being empowered to understand what was right and wrong and how to report any concerns that they had. Staffing levels had been determined so that staff were available at the times people needed them. We saw that staff were always present in communal areas talking and engaging with people, as well as staff being available to support people to meet their individual needs. Staff we spoke with had a good understanding of how to protect people from other types of harm. They understood their responsibilities to report any safeguarding concerns to a senior staff member. The management were aware of their responsibilities to report any safeguarding concerns to the local authority. Staff told us they were confident that any concerns they raised would be taken seriously by the registered manager. Staff training records confirmed that staff had received appropriate safeguarding training that was up to date, this included staff completing scenario based training to develop their understanding.

Staff managed the risks related to people's care well. Each care plan had detailed information about the risks associated with people's care and how staff should support the person to minimise risk. For example one person was supported to access their kitchen. They had a risk assessment in place around using kitchen equipment so that they carried out this activity safely. Risk assessments were reviewed at least annually, or when someone's needs changed. This was important to make sure that information was current and was based on people's actual needs.

Staff understood the needs of the people they provided support to. They knew the triggers for behaviour changes and the risks related to a person's care. The training manager told us that the emphasis was to create 'a home' where people had a shared vision and felt safe'. We saw that people had detailed guidance in place to support them if they displayed challenging behaviour. This included a description of the behaviour, what it meant, and how staff could support the person. It detailed what stress factors there were for the person and things that had worked well when they had been supported. Staff had received training in Positive Behaviour Support and this included the safe use of restrictive physical interventions. This meant that staff were trained to help the person to manage their behaviour and support the person proactively to avoid their behaviour escalating. The training manager advised that if it was deemed appropriate to use restrictive physical interventions, this would be agreed with all professionals involved in the persons care and a risk assessment would be completed.

Staff maintained records of all accidents and incidents and near misses. These were discussed at the monthly health and safety meeting. We saw from the minutes of the meeting that the actions that had been taken were reviewed, it was also identified if anything further needed to take place. The number of accidents, falls, or near misses each person had was monitored to see if there was a pattern that required action to be taken.

People were supported to clean their own rooms. The premises were clean and tidy, cleaning schedules were in place. Fire extinguishers and blankets were in kitchen areas and we saw that regular testing of fire equipment and evacuation procedures had taken place. We saw that when someone had a need for additional support with evacuation this had been documented and a specific plan was in place for that individual. Where someone had specialist equipment, for example a hoist, we saw that this had been regularly serviced.

The provider had a recruitment and selection procedure in place to ensure that appropriate checks were carried out on staff before they started work. We looked at the staff records for four people who currently worked at the service; the files contained relevant information including a picture of each staff member, a record of a Disclosure and Barring (DBS) check, and records that these had been resubmitted on a regular basis, and references.

People could not be assured that they would receive their medicines as presecribed by their doctors. We saw people's medicines were not always administered or stored appropriately. Some staff members were not correctly following appropriate procedures or their own policy to ensure people's medicines were administered safely. We

Requires improvement

Is the service safe?

saw two members of staff handling medicine without always washing their hands after handing medicine to other people. We observed during medicines rounds that staff were distracted and not solely focused on administering medicines. We found that staff were not always preparing medicines appropriately to make sure that all medicine was given. For example staff sprinkled the powdered contents of medicine from capsules onto the top of a mugful of pre-thickened orange flavoured paste and only administered the top quarter layer of the contents. This meant that the person may not have received all of the medicine. We found that the GP or pharmacist had not always been involved in decisions about how to administer medicine, or the use of homely remedies which can be purchased over the counter. We saw that 'when required' protocols were not in place for all people who had medicine that they took when it was required. This meant that it may not be clear in what circumstances this medicine could be given.

We saw that staff had usually signed the medication administration records confirming they had given people their medication as prescribed. However, during our inspection we were informed of a discrepancy of one tablet remaining for one person, although all medication administration records were fully signed and double signed to confirm this medicine was administered. The Deputy Manager immediately went to investigate and made a report of this incident. We saw some staff had received 'new' training and competency assessments and the training manager advised that all staff will have completed this by 30 November 2015. We saw recent reports of medication errors made. The Manager and training manager reassured us that more robust investigation and frequent spot checks and audits including daily balance counting of medicines and topical medicines training would take place to ensure staff remained competent.

Good

Is the service effective?

Our findings

People told us that they were cared for by staff who knew them well, and that the staff knew what they were doing. Comments included, "The staff are good" and there are "lots of nice staff." Relatives told us that they felt that the staff had the skills and knowledge to carry out their role. One relative told us, "The staff are marvellous, they support [person's name] very well. They go on training about how to support her." Another said, "Staff are well trained, they seem to know and understand her."

People were supported by well trained staff. We spoke with the training manager who told us that they were developing new training regularly to make sure that the staff team were supported in their roles. We saw the training matrix that was used to monitor the training needs of the staff team. This showed that staff had completed training in a range of subjects, including training that was specific for the needs of the people they worked with. Staff told us that they were 'very impressed' with the training, it was 'good quality' and there was always 'something to do'. The registered manger confirmed that there was an induction process in place and this had been adapted to be modelled on the new care certificate. This is a nationally recognised qualification designed to give staff an understanding of their role. We saw that volunteers were offered training and they were supported by a volunteer co-ordinator.

Staff told us that they felt supported by the management structures within the home. Comments included, "Supervisions and one to ones are helpful", "Excellent support, very happy," and "I have supervision monthly, my manager is very good." The registered manager told us that the aim was for all staff to have supervision meetings every six weeks. We saw in records that this target had not always been met. The staff we spoke with told us that they had received a supervision meeting within the last six weeks. There were monthly staff meetings held and the minutes of these demonstrated that issues raised by staff had been addressed and resolved.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that where people may have been deprived of their liberty the registered manager had made applications to the 'Supervisory body' for authority. These were awaiting authorisation. We found that not all areas where a person may have been deprived of their liberty had been included in the applications. Where kitchen cupboards were locked for the safety of one person, this also impacted on other people who shared that house and it needed to be considered if this was depriving them of their liberty.

The registered manager told us that consent was sought from people to allow the staff to provide care and support; however CCTV was in use in communal areas. The registered manager told us that they had agreed this was in people's best interests to monitor their safety overnight when staffing levels were lower. It had not been considered that when someone was not able to consent to this monitoring that the use of the CCTV may be depriving them of their liberty. The registered manager agreed that they would review the decisions to ensure that the correct process had been followed.

People told us that staff offered them choices. One person said, "They support me to make decisions about what to do every day." Staff told us that they had received training in MCA and DoLS. They had an understanding of MCA and DoLS and could tell us about how people made choices. For example one staff member told us that they had assessed people's understanding by asking questions and using pictures of food. Care plans included information about how people made choices and how they communicated them. We saw that mental capacity assessments and best interest decisions had been made for specific decisions. The paperwork for this was in place in individual care plans.

Good

Is the service effective?

People were supported by staff at mealtimes. Where support was required staff offered this to the individual. We saw that people had a choice about where they ate, including a large shared dining room that people called the 'canteen'. There was a menu in the kitchen with planned meals for evening meals for each house. We saw that meal choices had been discussed during residents meetings. People told us that they enjoyed the food and were involved in setting the table. Throughout the day people were offered drinks and snacks. We observed a 'tea break' in the morning where people came from their activities to a communal area to have a break.

People had care plans which included detailed information on dietary needs and levels of support required. We saw that where people had dietary needs appropriate referrals had been made to the dietician and Speech and Language Therapists (SALT). The information that had been given by the health professionals was recorded within the care plans.

People's healthcare was monitored and where a need was identified they were referred to the relevant healthcare professional. Records showed that people were supported to attend routine appointments to maintain their wellbeing, such as the dentist and optician. We saw that staff supported people weekly to monitor their health and this was recorded. A relative told us that they felt [person's name] had access to good healthcare, and they were involved in healthcare decisions. Care plans showed that people had regular reviews of health action plans and information from health appointments was recorded in the plan.

We saw that staff monitored any change in people's needs, sought advice from health professionals and recorded what actions they had taken. Diabetes blood tests were recorded daily, and we saw a protocol and plan of what staff should do if results went beyond safe acceptable limits. However, we saw no record in their care plan when a recent result went beyond safe acceptable limits. This meant people could not be assured that their diabetes was appropriately assessed to safely meet their needs. The registered manager agreed that she would discuss this with all staff.

Good

Is the service caring?

Our findings

People spoke very highly of the care provided and the staff. One person told us, "I like the staff, they do everything I like." Another said, "The staff are unique and beautiful." Relatives told us that people were happy. Comments included, "She is happy, it is the best place for her," "We are happy with the home, we spent many months looking for the right place," "[Person's name] is much happier there than when she comes home," and, "The whole ethos is very caring and dedicated." One member of staff told us, "It's a genuine shared purpose, residents and staff in it together." Another said, "It's a family atmosphere. Residents look after each other."

Some people had been living at the home for many years and other people had moved in more recently. Two people we spoke with had lived at the home for over 20 years. Staff knew the people they cared for, they were able to tell us about what people liked, and disliked and how they used this information to support and care for people. We saw that staff were not rushed in their interactions with people. We saw that staff, volunteers and the registered manager all spent time chatting with people individually. One person told us that the staff were 'very supportive'. We saw that when someone asked for a staff member to help them, the staff supported the person at that time and did not leave them to wait while they completed a task. This showed that the support people received was not task led.

People told us that they had been involved in writing and reviewing their own care plans. Comments included, "I ask for help with my care plan", and "I had my review last week, we discussed my care plan." We saw that the care plans had information included about what the person wanted and what they had said. We saw that some people had signed their care plan and written their own comments in the document. This showed that people were involved in planning their support.

People told us that they had residents meetings. One person told us, "I go to the Lodge meeting, we talk about health and safety and any other business." We saw that the minutes were available in an accessible format to make them easier to read. These were available on the computer but had not been printed out and distributed. We saw that people who used the service had presented certificates to staff for training that they had completed and staff had presented people with certificates for training they had completed. We also saw that consent to care; the Mental Capacity Act and Deprivation of Liberty had been discussed.

Staff told us how they protected people's privacy and dignity, examples of this included knocking on doors, using people's preferred names and getting people to do as much for themselves as possible through encouragement and prompting. We saw that staff provided reassurance and explanations to people when they supported them. We saw that staff showed respect for the people they supported.

People told us that their family visited them. One person said, "I saw my sister last week." Relatives told us that they could visit when they wanted to. One relative told us, "I visit when I can, sometimes I tell them I'm coming, other times I don't." We saw that a relative was volunteering at The Lodge Trust and they did this each Thursday.

People were encouraged to personalise their own private space to make them feel at home. We saw three bedrooms and they were reflective of the person and the things they liked. People were happy to show us their rooms, and tell us about what they had in their bedroom.

Good

Is the service responsive?

Our findings

Peoples care plans were detailed and informative. Relatives told us that people had spent a week at The Lodge Trust before moving in as part of the assessment process. This gave people a chance to meet other people who lived at the service, get to know staff and the service. One relative told us the registered manager had attended a review at their home prior to [persons' name] moving in as part of the assessment process. They were impressed by this as they lived a long way away.

We saw that care plans had extensive information about each person, their needs, how best to support them and any changes to their needs. The care plans had been updated regularly to help ensure the information was accurate. The care plans provided staff with clear guidance on each person's individual care needs and contained sufficient information to enable staff to provide personalised care effectively. The care plans included clear instructions for staff to encourage people to be as independent as possible, and information about what the person liked and what was important to them. We saw that people had detailed information about how to communicate with them; good ways to give the person information and what people needed to know to spend time with the person. We saw that people had person centred plans that identified what each person wanted to achieve and how they would be supported to do this.

People told us that they attended their reviews. Relatives told us that they were invited and that they contributed to the development of people's care plans and person centred plans. One relative told us, "I attend reviews and have input on what is going on." Another relative told us, "We are involved in decisions about [person's name] care."

Information about people was shared effectively between staff. A staff handover was held between staff. There was a senior member of staff on call and a handover from one person on call to the next was also held. Staff shared information about how people had spent their day and any changes to care needs. This meant that staff received up to date information before the beginning of their shift.

People told us that they took part in activities both at the Lodge Trust and in the local area. One person told us, "We're busy during the day." Another said, "I have been at work today." Relatives told us that they were pleased that people got to use their skills. One relative told us, "I'm pleased about [person's name] doing courses, getting certificates, and using her skills." Another relative told us, "[person's name] is occupied all the time." We saw that people were supported to take part in activities. Each person had a weekly plan that recorded what they would be doing for the week. The plan covered the times from 9:30am to 5pm and included two tea breaks and a lunch break. People participated in up to six sessions per day. These included walking, woodcraft, gardening, domestic skills and horse skills. We saw that people were involved in working in the café that was open to the general public improving cooking, customer service and money handling skills. Other people were involved in making products for sale in the shop, and maintenance work in the grounds. We saw that people were also offered training courses to enable them to develop skills and accredited training through ASDAN. ASDAN is an awarding body, that offers people training and qualifications.

People were supported to attend church. This included local churches as well as prayers that were held at the home. All the people we spoke with told us that they attended church and they enjoyed this. One relative told us, "We see [persons name] at church every week." The registered manager explained that the home had good links with local faith groups.

We saw people were involved in the planning and development of new ideas for the home. Residents meetings were held monthly and people were encouraged to raise concerns. The registered manager told us that people were empowered to see that the Lodge Trust was their home and that they views mattered. For example one person said they were having trouble moving around the home because of stony paths. The paths were changed to make them smooth all around the home.

All of the people we spoke with told us they would raise any concerns with the registered manager or staff. All relatives we spoke with told us they knew how to make a complaint and were confident to do so. We saw a complaints policy was in place and was displayed in the home as well as being available on the website. We saw that six complaints had been received and had been dealt with within the agreed timescales. The registered manager told us that they had received 40 written compliments in the last twelve months.

19

Good

Is the service well-led?

Our findings

People told us that they were happy living at the Lodge Trust. Comments included, “It’s the best,” “I like living here, I’m happy,” and “”I like it here.” Relatives told us that they felt happy with the care provided. One relative told us, “It couldn’t be any better than it is.” Another relative said, “I’m very happy with the Lodge Trust and how it is run.” One staff member told us, “It’s a nice environment, not too institutionalised.” Another staff member said, “It’s a very beautiful place to work.”

We received feedback from a local funding authority who told us that the home was very good in terms of delivery of care and care planning.

People told us that they could approach the registered manager if they were concerned about anything. Relatives we spoke with all said they would be happy to approach the registered manager or the Chief Executive. One relative said, “They are very approachable, I often have chats with both of them”. Another relative told us, “She is a good manager, I do complain and go and see her.” Staff told us that they felt supported by the management. One staff member said, “The organisation is open and transparent, Staff speak up with issues.” On the day of the inspection we walked around the premises with the registered manager. We saw people and staff approach her and talk to her, and they appeared comfortable to do so.

People were encouraged to provide feedback and their views were actively sought by managers. Residents meetings were held monthly. A relative told us that families had meetings three times a year. This was to talk about what people had been doing and what the plan was for the service moving forwards, including fundraising. Minutes of the meetings demonstrated that feedback was valued and acted upon so that the service could work to constantly improve. A monthly newsletter was produced that was available to people who used the service and relatives. We saw a copy of this and it included stories about people and information about what was happening. This offered people a way to keep up to date with what was happening at the service.

On the day of the inspection people were very excited about an open day that was due to happen. People told us about this and how they had been involved. One person told us, “On the open day, the car park is next to my house, I like it”. This event was arranged to raise funds for the people living at the service. Other events had been arranged to raise funds for accessible bikes earlier in the year. The service engaged positively with the local community and recruited volunteers, including people’s relatives. The volunteers were responsible for some of the maintenance and supported with activities around the home.

Each month a quality, and a health and safety meeting had been held. These were used to monitor areas such as falls, accidents, safeguarding referrals, mental capacity assessments, health and safety, complaints and results from surveys. We saw the minutes from these meetings were used to put actions into place and monitor progress against these. The trustees meet monthly with the senior management, and carried out visits with the people who used the service to seek feedback.

We saw that relatives and staff had received surveys in the last twelve months to seek their feedback on the service and to listen to any comments that they had. Following the survey the results had been discussed and agreed actions were put in place.

The registered manager understood their responsibilities under the terms of their registration with CQC. They had reported events they were required to report.

Report No: 47/2016
PUBLIC REPORT

PEOPLE (ADULTS AND HEALTH) SCRUTINY PANEL

18 February 2016

LEICESTERSHIRE AND RUTLAND SAFEGUARDING ADULTS BOARD (LRSAB) BUSINESS PLAN 2016/17

Report of the Independent Chair of the LRLSCB and LRSAB

Strategic Aim:	'Creating a brighter future for all'.	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Clifton	
Contact Officer(s):	Paul Burnett, Independent Chair of the LRSLCB and LRSAB	0116 305 0359 paul.burnett@leics.gov.uk
Ward Councillors	All	

DECISION RECOMMENDATIONS
That the Panel consider the Business Plans and make any comments or proposed additions or amendments to the report that will be considered as amendments to the current version of the report;

1 PURPOSE OF THE REPORT (MANDATORY)

1.1 The purpose of this report is to bring to the attention of the Rutland People (Adults and Health) Scrutiny Panel the Business Plan 2016/17 for the Leicestershire and Rutland Safeguarding Adults Board (LRSAB). This is brought for consultation and comment.

1.2 The Business Plan will have been considered by the LRSAB at its meeting on 29th January 2016 with final sign off anticipated to be secured at their meeting on 15th April 2016. We wish to provide the Scrutiny Committee with the opportunity to comment at an early stage so that any proposed additions and amendments proposed can be considered by the Boards at their meeting in April.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The LRSAB became a statutory body on 1st April 2015 as result of the Care Act 2014. The Act requires that the SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. It requires the SAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in 'Making

Safeguarding Personal'. It should also concern itself with a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:

- the safety of people who use services in local health settings, including mental health
- the safety of adults with care and support needs living in social housing
- effective interventions with adults who self-neglect, for whatever reason
- the quality of local care and support services
- the effectiveness of prisons in safeguarding offenders
- making connections between adult safeguarding and domestic abuse.

These points have been addressed in drawing up our Business Plan for 2016/17.

2.2 SABs have three core duties. They must:

- develop and publish a strategic plan setting out how they will meet their objectives and how their member and partner agencies will contribute
- publish an annual report detailing how effective their work has been
- commission safeguarding adults reviews (SARs) for any cases which meet the criteria for these.

It is the first of these duties to which the Business Plan relates since this plan essentially outlines our strategy for improvement.

2.3 The Annual Report of the LRSAB was considered by the Rutland People (Adults and Health) Scrutiny Panel in September 2015 and an opportunity to influence emerging priorities for the new Business Plan for 2015/16 was also provided. The views expressed by the Committee at that stage were fed into the formative process for the Plan and are reflected in the final versions of the Plans which are attached as appendices A and B.

2.4 As in 2015/16 the LRSAB has formulated an individual business plan supplemented by a plan that addresses priorities it will share with the Leicestershire and Rutland Local Safeguarding Children Board (LRLSCB). This is intended to secure a balance between achieving a strong focus on adult safeguarding issues and recognising that some safeguarding matters require approaches that cross-cut children and adult services and focus on whole family issues.

2.5 The future improvement priorities identified in the Annual Report 2014/15 have been built into the Business Plans for 2016/17. In addition to issues arising from the Annual Report the new Business Plans' priorities have been identified against a range of national and local drivers including:

- national safeguarding policy initiatives and drivers;
- recommendations from regulatory inspections across partner agencies;
- the outcomes of serious case reviews, serious incident learning processes, domestic homicide reviews and other review processes both national and local;

- evaluation of the business plans for 2015/16 including analysis of impact afforded by our quality assurance and performance management framework;

- best practice reports issued at both national and local levels;

- the views expressed by both service users and front-line staff through the Boards' engagement and participation arrangements.

2.6 The new Business Plan has been informed by discussions that have taken place in a number of forums since the autumn of 2015. These include:

- the annual Safeguarding Summit of chief officers from partner agencies held on 13th November 2015;

- meetings of the Scrutiny Panels in both Leicestershire and Rutland at which both the annual report 2014/15 and future priorities for action have been debated;

- meetings of the Leicestershire and Rutland Health and Well-Being Boards at which both the annual report 2014/15 and future priorities for action have been debated;

- discussions within individual agencies

2.7 Business Plan priorities were considered by the Rutland People (Adults and Health) Scrutiny Panel in September 2015. This was done electronically rather than through the meeting that month. As stated above all the issues raised as a result of this opportunity for comment have been incorporated into the draft Business Plan attached.

2.8 The proposed strategic priorities, priority actions and key outcome indicators set out in the new Business Plans were formulated through the annual development session of the two safeguarding boards held on 25th November 2015.

2.9 We have adopted a new approach to our business planning this year moving away from the five strategic priorities that have been in place for the last three year and focusing on areas that we have identified as priorities for development and improvement. At the Development Day Board members identified areas in which we had reached good levels of performance and agreed that these would not be included in the Business Plan but rather monitored through a core quality assurance and performance management framework to ensure performance remained at levels judged to be good or better. By focusing the Business Plan on areas identified for improvement we also hope better to target work on a reduced number of priorities in recognition of the need to be SMART at a time of increasing pressures on capacity.

2.10 There are two Business Plans being presented to the Scrutiny Panel. The first is that which relates specifically to the LRSAB. This is attached as Appendix A. The second is a plan developed jointly with the LRLSCB and focuses on those areas that cross-cut children and adult services. This is attached as Appendix B.

2.11 The specific priorities that have arisen for the LRSAB are:

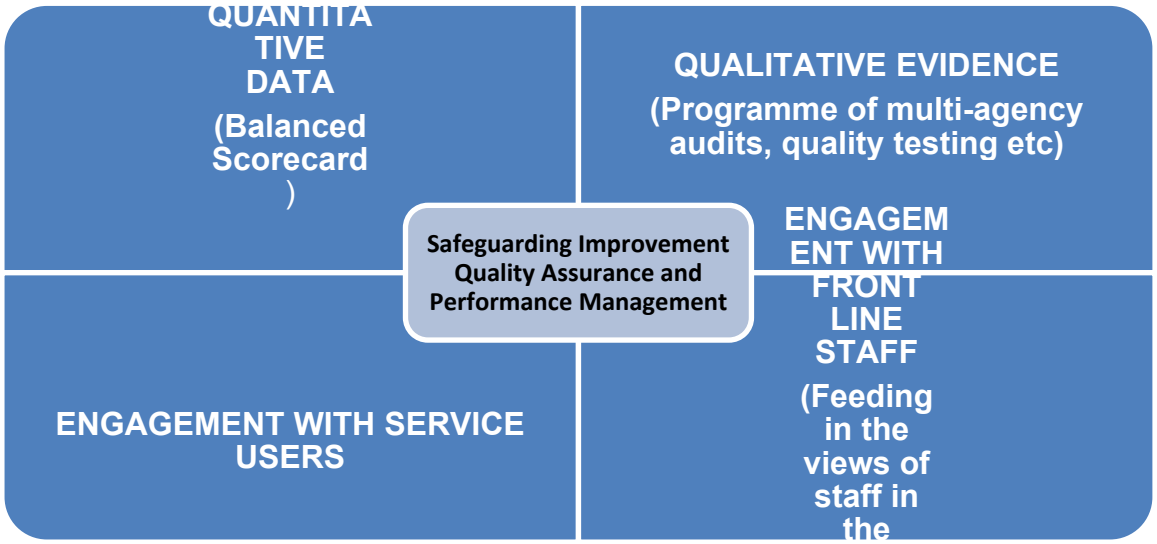
- Building Resilient Communities - that can safeguard themselves but know how to report risk when it arises
- Securing consistent application of safeguarding thresholds
- Championing and securing the extension of Making Safeguarding Personal across the partnership to improve service quality and outcomes for service users
- Assuring robust safeguarding in care settings – including health care at home, residential and nursing care settings
- Tackling neglect and omission

2.12 The priorities that have arisen for the part of the Business Plan shared with the LRSAB are:

- Domestic Abuse
- Reducing safeguarding risk arising from mental health issues – including monitoring of the implementation of the Mental Capacity Act and DoLS and its application to 16-18 year olds
- PREVENT

Consideration is also being given to whether, in the light of current international issues we should include a priority that considers safeguarding risks that may be faced by refugees. It would be helpful for the Scrutiny Panel to express a view on this area of consideration. Against each of these priorities the Boards are in the process of identifying key outcomes for improvement and the actions that will need to be taken over the next year to achieve these improved outcomes. These are set out in the draft Business Plans that are attached as Appendix A and Appendix B to this report.

2.13 The Quality Assurance and Performance Management Framework for the Board will be revised to ensure that it reflects the new Business Plan and enables ongoing monitoring of performance of core business that is not covered in the business plan. The final framework will be signed off by the Board at its meeting on 15th April 2015 but the Scrutiny Panel may wish to comment on specific indicators and evidence it would wish to include. Quality Assurance and Performance Management will continue to be framed around our 'four-quadrant' model as set out below:



2.14 A further change to our Business Plan this year is that against all priorities for action we will include cross-cutting themes that must be addressed both to strengthen safeguarding practice and also secure stronger evidence of impact for the quality assurance framework. The cross-cutting themes are set out in the grid below.

Priorities for improvement	Learning and Improvement drivers	Audit implications	User views and feedback	Workforce implications	Comms implications
Priority 1					
Priority 2					
Priority 3					

These cross-cutting activities will be agreed by those mandated to lead on each specific priority.

2.15 The views of a range of forums are being sought on the Business Plans. This includes the Cabinets, children and adult scrutiny committees and the Health and Well-Being Boards in both local authority areas.

3 ORGANISATIONAL IMPLICATIONS

3.1 Rutland County Council contributes £52, 250 to the costs of the LRLSCB (of a total budget of £335,525). In addition it contributes £8,240 to the costs of the Leicestershire and Rutland Safeguarding Adults Board (LRSAB) (of a total budget of £102,610).

4 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

4.1 It is recommended that the Scrutiny Panel consider the Business Plans and make any comments or proposed additions or amendments to the report that will be considered as amendments to the current version of the report;

5 BACKGROUND PAPERS

5.1 There are no additional background papers to the report.

6 APPENDICES (SIMPLY STATE IF THERE ARE NO APPENDICES)

6.1 The draft LRSAB Business Plan 2016/17 is attached as appendix A. The joint business plan of the LRLSCB and the LRSAB is attached as appendix B.

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

Appendix A. LRSAB Business Plan 2016/17

Attached

Appendix B. LRLSCB and LRSAB Joint Business Plan 2016/17

Attached

SAB

1st DRAFT

BUSINESS PLAN 2016/17

SAB Priority 1 Owner: TBC

To build community safeguarding resilience and be assured that people living in the community who may be experiencing harm or abuse are aware and know how to seek help

PRIORITY	What are we going to do?	How are we going to do it?	Who is responsible?	When is it going to be done by?	Impact / what difference did it make?	Progress made
To build community safeguarding resilience, awareness of risk and how to report it.	Identify strategies and approaches that have been successful in building resilience and raising safeguarding awareness – including the 'community agent' approach in Rutland Analyse existing referral information and data to understand what works and where the gaps appear. Audit current community and service user awareness of abuse/harm Initiate campaigns and strategies to build resilience both	SEG to receive data and analysis and identify examples of success in other parts of the country Survey public understanding of safeguarding adults (abuse and harm) Executive and Board to consider and agree Leicestershire and Rutland approach Initiate campaigns including	Safeguarding Effectiveness Group Communications and Engagement Subgroup Executive/ Board Communications	April 2016 April – May 2016 July 2016 September –	Evidence of community resilience An increase in community based referrals/ proportion of community based referrals compared to those from residential settings (Detail of the QAPM to be developed by the Safeguarding Effectiveness Group prior to April 2016)	

	individually and collectively	awareness raising process. Agree and implement quality assurance and performance framerwork to test impact	and Engagement Group Safeguarding Effectiveness Grou9p	December 2016 March 2017		

SAB Priority 2 Owner – Jon Wilson

To be assured that thresholds for Safeguarding Adult Alerts are appropriate, understood and consistently applied across the partnership

PRIORITY	What are we going to do?	How are we going to do it?	Who is responsible?	When is it going to be done by?	Impact / what difference did it make?	Progress made
Secure consistent multi-agency understanding and application of safeguarding thresholds	Test out, through case audits, how thresholds are currently applied. Identify gaps in knowledge about and application of thresholds	Thresholds Framework to be placed on MAPP Webpage Audit to establish current understanding.	Safeguarding Effectiveness Group	April 2016 April – June 2016	Improvement in the consistency of threshold application (Detail of the QAPM to be developed by the	

	Thresholds document updated and agreed. Relevant workforce development undertaken in areas of service where consistency is not recorded. Carry out subsequent audits to test improvement in levels of consistency	Review and updating of thresholds document Secure assurance that relevant workforce development is undertaken Further auditing to test impact	Procedures and Development Subgroup Training and Development Subgroup Safeguarding Effectiveness Group	July 2016 March 2017 March 2017	Safeguarding Effectiveness Group prior to April 2016)	
SAB Priority 3 Owner: TBC **To champion and support the extension of Making Safeguarding Personal (MSP) across the Partnership and secure assurance of the effectiveness of multi-agency processes/working and evidence of positive impact for service users.**						
PRIORITY	**What are we going to do?**	**How are we going to do it?**	**Who is responsible?**	**When is it going to be done by?**	**Impact / what difference did it make?**	**Progress made**
Embed MSP across the SAB partnership and be assured of its positive impact on service quality and outcomes for service users.	Develop and agree Implementation plan for MSP across the partnership Increase understanding and competence in the use	Board to carry out a 'deliberative enquiry' session to agree partnership approach to MSP Create a multi-agency task and	LRSAB LRSAB	April 2016 May 2016	Embedding of MSP across partnership safeguarding services and evidence of impact on service quality and	

	of Making Safeguarding Personal through workforce development programme Agree quality assurance and performance management framework to test impact Monitor and evaluate implementation and its impact on service quality and performance.	finish group to lead on this priority Develop and implement a multi-agency programme to embed MSP across the SAB partnership Quantitative and qualitative audit process	MSP Task and Finish Group Safeguarding Effectiveness Group	September 2016 March 2017	outcomes for service users (Detail of the QAPM to be developed by the Safeguarding Effectiveness Group prior to April 2016)	

SAB Priority 4: Owner: TBC

Assure robust safeguarding in care settings – including health and social care at home, residential and nursing care settings

PRIORITY	What are we going to do?	How are we going to do it?	Who is responsible?	When is it going to be done by?	Impact / what difference did it make?	Progress made
To be assured of continuous improvement in safeguarding effectiveness within care settings with a	Clarify safeguarding frameworks in home care settings and secure assurance that there is appropriate practice guidance in	Analyse current safeguarding performance in home care settings and identify any areas requiring	Safeguarding Effectiveness Group	July 2016	Evidence of consistent reporting from all settings. Increase in	

particular focus on home care provision.	place. Review quality assurance and performance management framework to test effectiveness of safeguarding in care settings to include home care settings. Identify any workforce development requirements to support improved quality and performance and be assured that this is delivered.	improvement/development. Review frameworks for securing effective safeguarding in home care settings in light of the above. Revise current QAPM framework to create comprehensive framework. Identify workforce development needs and secure implementation.	Procedures and Development Subgroup Safeguarding Effectiveness Group Training and Development Group	October 2016 July 2016 March 2017	reporting (in the short term)from those settings where there has been low incidence of reporting. Evidence of safeguarding quality and performance improvements in those settings identified as needing improvement. Evidence of positive impact from workforce initiatives. (Detail of the QAPM to be developed by the Safeguarding Effectiveness Group prior to April 2016)	

SAB Priority 5 Owner: TBC **Develop a preventive framework to reduce incidence of neglect and omission** **Strengthen frameworks for the identification, assessment and service response (both individual agency and collective) to acts of neglect and omission.**						
PRIORITY	**What are we going to do?**	**How are we going to do it?**	**Who is responsible?**	**When is it going to be done by?**	**Impact / what difference did it make?**	**Progress made**
Develop a preventive framework to reduce incidence of neglect and omission	Consider means of early identifying risk and models of practice with evidence of risk mitigation	Research best practice that has evidence of risk reduction. Develop preventive framework for Leicestershire and Rutland	Procedures and Development Subgroup	March 2017	Reduction in prevalence of safeguarding referrals in this area of risk.	
Raise levels of awareness and recognition of neglect and omission and secure improvement in cross-agency responses to identified need.	Ensure that there is robust practice advice and guidance supported by staff awareness of neglect and omission. Identify workforce development needs in supporting the implementation of the above.	Review multi-agency practice advice and guidance on neglect and omission. Audit staff workforce requirements and ensure these are addressed.	Procedures and Development Subgroup Training and Development Subgroup	July 2016 September 2016	Evidence of improvement in identification, assessment and response to cases of neglect and omission. (Detail of the QAPM to be developed by the Safeguarding Effectiveness	

	Be assured that there is an appropriate and understood multi-agency service pathway related to neglect and omission. Agree a quality assurance and performance framework to test levels of improvement.	Trigger the development of the pathway. Negotiate the relevant QAPM framework	 Safeguarding Effectiveness Group	September 2016 March 2017	Group prior to April 2016)	

LSCB AND SAB

1st DRAFT

BUSINESS PLAN 2016/17

Notes: Please read!

1 **The first section of this draft business plan is configured in a conventional way – it is aimed at the Board and the Executive group.**

2 **The second section is based on the grid developed at the Board development session and is intended to provide a framework for subgroups and task and finish groups to populate their action plans, showing how the priorities within this plan will be achieved.**

3 **Between the two sections are some notes suggesting how subgroups / task and finish groups should use the second section**

4 **It is a first draft and therefore not complete.**

5 **It will require significant input from subgroups.**

6 **All of the priority 'owners' suggested are unconfirmed and have not been approached or asked.**

The consultation plan for the business plan will include:

Subgroups
The executive and Board membership
Childrens Scrutiny meetings in Leicestershire and Rutland LAs
Adults and communities scrutiny meetings in Leicestershire and Rutland
Cabinet in Leicestershire and in Rutland

Domestic Abuse	Joint Priority 1 Owner – David Sandall ?					
PRIORITY	**What are we going to do ?**	**How are we going to do it?**	**Who is responsible ?**	**When is it going to be done by?**	**Impact / what difference will it make?**	**Progress made**
A} Create Pathway for Victims, Children and Young people and seek assurance that the safeguarding elements of the pathway are robust.	Monitor the progress of the creation of the pathway by the DVSG	Ask for assurance that the work is completed and the pathway is effective; to be reported to the executive group every quarter Establish data set for performance report	Chair of DVSG via David Sandall?	March 2017		
B) Create pathway for perpetrators	Ask the DVSG to consider creating or further developing a pathway for perpetrators	Ask for assurance that the work is completed and the pathway is effective; to be reported to the executive group every quarter Establish data set for performance report	Chair of DVSG via David Sandall?	March 2017		

Mental Health	Joint Priority 2 - Owner Rachael Garton?					
PRIORITY	**What are we going to do ?**	**How are we going to do it?**	**Who is responsible ?**	**When is it going to be done by?**	**Impact / what difference will it make?**	**Progress made**
A} Suicide 40	Consider establishing a mental health sub group if this issue isn't currently within the remit of an established group. The subgroup will Review the existing local suicide prevention plan to assess it's effectiveness in relation to children, young people and adults safeguarding. The subgroup will develop an appropriate action plan to address any identified weaknesses,	This column to be determined by the subgroup / lead , in conjunction with a board officer.	Rachel Garton	March 2017 March 2017		
B) Self Harm	Consider establishing a mental health sub group if this issue isn't currently within the remit of an established group. Understand the current information and resources available to children, young people and adults on Self	This column to be determined by the subgroup / lead , in conjunction with a board officer.	?	March 2017		

	Harm. Including what to do if someone you know is self-harming.					
C) MCA DOLS	Consider establishing a mental health sub group if this issue isn't currently within the remit of an established group. For the subgroup to ensure that the workforce across both Childrens and Adults services have an appropriate understanding of mental capacity act and deprivation of liberty safeguards	This column to be determined by the subgroup / lead , in conjunction with a board officer.	?	March 2017		
D) Emotional Health and Wellbeing pathway	Consider establishing a mental health sub group if this issue isn't currently within the remit of an established group. To be assured that the safeguarding elements of the transformation plan for mental health and wellbeing effectively safeguards children, young people and adults (including transitions)	This column to be determined by the subgroup / lead , in conjunction with a board officer.	?	March 2017		
E) CAMHS	Consider establishing a mental health sub group if this issue isn't currently within the remit of an established group.	This column to be determined by the subgroup / lead , in conjunction with a board officer. 'Better Outcomes'	?	March 2017		

	To seek assurance that the CAMHS review will result in better safeguarding outcomes for children and young people.	to be agreed between the subgroup and the Board.				
F) Learning Disability pathway	Consider establishing a mental health sub group if this issue isn't currently within the remit of an established group. The LLR Health and Social Care Learning disability pathway planned within the BCT programme is being developed. The Board needs assurance that the safeguarding elements of services and pathway are robust.		?	March 2017		
Prevent - Should this be a priority or BAU		**Joint Priority 3 Owner – Jane Moore?**				
PRIORITY	**What are we going to do ?**	**How are we going to do it?**	**Who is responsible ?**	**When is it going to be done by?**	**Impact / what difference will it make?**	**Progress made**

Prevent	Seek assurance that the Prevent actions agreed by the Boards (shown on the right) are delivered effectively.	b) That the Joint LSCB/SAB section receive quarterly reports on Prevent; c) That bespoke training be offered to members of the LSCB/SAB Board, Executive and Subgroups; d) That LSCB members promote WRAP sessions to educational institutions.		March 2017		

LSCB Priority 1 Owner – Lesley Hagger and Tim O Neil ?

Child Sexual Exploitation, missing and Trafficking

PRIORITY	What are we going to do ?	How are we going to do it?	Who is responsible ?	When is it going to be done by?	Impact / what difference will it make?	Progress made
To be populated by Victor, Andy Sharp and Bally						

LSCB Priority 2 Owner – Chris Nerini **Impact of learning from SCR and other reviews**						
PRIORITY	**What are we going to do ?**	**How are we going to do it?**	**Who is responsible ?**	**When is it going to be done by?**	**Impact / what difference will it make?**	**Progress made**
Recommendations from SCR and other reviews locally and Nationally are disseminated and the impact of the learning is evidenced.	Review SCRs published nationally, Disseminate relent recommendations and learning points. Audit to test outcomes following implementation of recommendations. Hold SCR learning events.			March 2017		
LSCB Priority 3 Owner - ?? **Multi Agency awareness and understanding of Signs of Safety** **To champion and test the**						

PRIORITY	What are we going to do ?	How are we going to do it?	Who is responsible ?	When is it going to be done by?	Impact / what difference will it make?	Progress made
Improve Multi Agency awareness and understanding of Signs of Safety	Develop a multi-agency briefing session and disseminate across the LSCB partnership		??	March 2017		
Do we need an additional priority on safeguarding of increasing numbers of young refugees and asylum seekers ?						
Early Help						

Neglect						
Thresholds						

SAB Priority 1 Owner Jon Wilson

Hidden harm in the community

PRIORITY	What are we going to do ?	How are we going to do it?	Who is responsible ?	When is it going to be done by?	Impact / what difference will it make?	Progress made
Referral rates have until recently shown higher rates of referrals in relation to Care Providers (although this has levelled out.) The Board should now see an increase in community based referrals.	The Board to interrogate referral information and data. Establish if members of the public and Service Users ' know what is abuse/harm If necessary Initiate an awareness raising campaign	Survey public understanding of safeguarding adults (abuse and harm) Production of posters and leaflets	??		An increase in community based referrals	

SAB Priority 2 Owner – Jon Wilson

Thresholds

PRIORITY	What are we going to do ?	How are we going to do it?	Who is responsible ?	When is it going to be done by?	Impact / what difference will it make?	Progress made
Increase Multi agency understanding of Safeguarding thresholds	Test out how thresholds are applied. Identify gaps in knowledge about thresholds? Thresholds document updated and agreed multi-agency	Audit to establish current understanding.				
SAB Priority 3 Owner - Carmel O Brien?, or Carol Ribbins **Making Safeguarding Personal**						
PRIORITY	**What are we going to do ?**	**How are we going to do it?**	**Who is responsible ?**	**When is it going to be done by?**	**Impact / what difference will it make?**	**Progress made**
Embed principles of MSP across the SAB partnership	Increase understanding and competence in the use of Making Safeguarding Personal	Create a multi-agency task and finish group to lead on this priority				

Guidance for identified sub group Chairs for each of the Safeguarding Boards business plan priorities.

You have been requested to Chair a sub group relating to an identified priority in the 2016/17 Business plan.

As part of each priority, individual actions have been identified by the Board in order for the priority to be effectively managed and the Board to be assured of outcomes and impact.

You may identify further actions that are required to complete the work.

A Safeguarding Board member has been identified as the Board lead for each priority.

You are asked to consider the following issues when completing and reporting on actions to the Safeguarding Board.

Considerations	Notes
LEARNING AND IMPROVEMENT	➢ What should be considered from local and National reviews including SCRs, SARs, Audits . ➢ Also consider how evidence of impact can be captured.
COMPETENT CONFIDENT WORKFORCE	➢ How are staff informed about changes that are made to policy , ➢ procedure or practice as a result of your groups work.
VOICE OF THE SERVICE USER	➢ Information gathered from service user to inform your work. What do they say needs to change? ➢ How will communicate the outcomes to service users?
DATA	➢ How will the Board be assured of the outcomes and impact of your work? ➢ Consider data for the performance management report that would support improvements in performance. ➢ Consider case file audit when changes have been implemented
INFORMATION SHARING REQUIREMENTS	➢ What are the barriers (if any) to sharing information for example when someone has Mental Capacity and doesn't' want you to do anything? ➢ How do we resolve these difficulties?

JOINT PRIORITIES						
PRIORITY	**ACTIONS REQUIRED**	**LEARNING AND IMPROVEMENT** (Reviews, SCRs, SARs, Audits, Impact Evidence)	**COMPETENT CONFIDENT WORKFORCE**	**VOICE OF THE SERVICE USER**	**DATA What is needed?**	**Information sharing requirements**
1 Domestic Abuse a) Pathways for Children, young people, victims etc.	Finish and embed the DV pathway for Children and YP Assurance that Domestic Abuse Pathway considers all routes in	Draw out recommendations from DHRs locally, regionally, and nationally , and the Home Office repository for guidance To assure learning is embedded carry out Multi-agency audit, including MARAC	Test via Outcome of audits Use different Methods of communication with frontline staff Assurance about cascading of knowledge	Gather via Data from IDVAs Data from UEVA DHRs CPCs	MARAC meetings and outcomes MAPPA meetings and outcomes Use of DASH Feedback from operation encompass	DV ISA?
b) Pathways for perpetrators	Will need to be developed in partnership with DVSB for Leicestershire and Rutland		Care pathway and knowing how to act → clarity around process and procedure			DV ISA?
2 Mental Health a) Suicide	To be assured that the Suicide prevention plan includes action for preventing Children and young people suicide. Regular updates on the implementation and	Review learning from local and national SCRs Have oversight of the Suicide prevention	Build confidence on what to do following suicide. Increase knowledge and bring together staff as an expert	Feedback and engagement from service user through service user groups Multi-agency	Review what is already collected. 'Don't reinvent the wheel'. How much are we doing?	

	effectiveness of the suicide prevention Plan.	strategy.	resource hub. Provide advice, information, education	feedback and engagement needed (not just reviews)	What is the result of what we are doing? What does user think? Are staff delivering? (survey) Are we doing what we should be doing against procedures? (audit)	
b) Self-Harm	Understand the current information and resources available to children, young people and adults on Self Harm. Including what to do if someone you know is self- harming.		Provide information for staff on self harm within young people	Both Leicestershire and Rutland youth councils have asked that Self Harm be prioritised by the LSCB.	Feedback from children and young people.	
c) MCA, Dols and court of protection– embedding understanding	Receive assurance reports from MCA / DoLS and the new Transitions project		Better understanding of mental health by staff including the use of: • Thresholds • MCA	Learn from the feedback provided by Making Safeguarding Personal.		
d) Emotional Health and Wellbeing pathway	To be assured that the transformation plan for Mental Health and Wellbeing effectively	Assured that lessons from Verita report, QSG etc. are	Better Care Together providing better multi-agency	Identify the standard of how the service user is engaged /	Work more closely with BCT For BCT – having safeguarding	

	safeguards children and young people, including children and transition to adults	being addressed. Pathways have taken outcomes and evidence in new pathways of addressing gaps in assurance	approach Assured that LSCB Workforce Plan and BCT Workforce Plan informs training. Cross check with Competency Framework. Include voice of the Workforce – how competent and confident do they feel?	voice captured Different / relevant cohorts to each step of the pathway	indicators for the work streams. Seek assurance that agencies are identifying the right indicators.	
e) CAMHS 52	To be assured that the review of CAMHS continues and appropriate changes are identified . No place of Safety in UHL Child Mental Health?		Dependant on the review of CAMHS	Gain feedback directly from young people using CAMHS services.	Work more closely with BCT * Reduction in admission to Tier 4 * Crisis minimised * More shift downwards to T3, T2, T1 Reduction in use of place of safety (Section 46, PPO) 100% of children and young people – tier 4 are in the right setting K.L.O.E (Key lines of Enquiry) Demographics of population re targeting of	

					services?	
f) Learning disability pathway	??					
3 Prevent	Refresh of strategy across LLR - Making it real To be assured that the LLR prevent strategy is embedding effectively. PREVENT for Primary Schools – enabling them to 'talk about it'	To learn from the National Prevent strategy	All appropriate staff trained within the scope of the strategy	Gain feedback from Children, young people and adults on their awareness and understanding of Prevent.	% of relevant staff trained. Numbers of referrals	

ON

LSCB PRIORITIES						
PRIORITY	**ACTIONS REQUIRED**	**LEARNING AND IMPROVEMENT** (Reviews, SCRs, SARs, Audits, Impact Evidence)	**COMPETENT CONFIDENT** COMMITTED... **WORKFORCE**	**VOICE OF THE SERVICE USER**	**DATA What is needed?**	**Information sharing requirements?**
1. CSE						
2 Disseminate relevant Recommendati	Review SCRs published nationally, Disseminate relent		Use Safeguarding matters, SCR	Test impact of recommendations with groups of		

	ons from SCR and other reviews locally and Nationally and evidencing the impact of the learning	recommendations and learning points. Audit to test outcomes following implementation of recommendations. Hold SCR learning events.		learning events.	young people		
3	Multi Agency awareness and understanding of Signs of Safety	Develop a multi-agency briefing session and disseminate across the LSCB partnership		Audit M/A staff understanding of SOS	Collect feedback from Children and young people that have been present at SOS style conferences		
4	Do we need a priority on the rising number of young refugees and asylum seekers. ?						

SAB PRIORITIES						
PRIORITY	**ACTIONS REQUIRED**	**LEARNING AND IMPROVEMENT** (Reviews, SCRs, SARs, Audits, Impact Evidence)	**COMPETENT CONFIDENT WORKFORCE**	**VOICE OF THE SERVICE USER**	**DATA / AUDIT What is needed?**	**Information sharing requirements**
1. Hidden Harm in Community Referral rates have until recently shown		Local Intelligence- where are alerts coming from	Clear alert/referral pathway in place.	What are people telling us about: Understanding of what constitutes	Source of Alerts No of Self Alerts Demographics of	Sharing Information when someone has

higher rates of referrals in relation to Care Providers although this has levelled out. Do members of the public and Service Users ' know what is abuse/harm Recognition of the changes to Care at home, self directed support 55		Research Learning from themes of alerts National/Regional SAR's Data	Upskilling Home Care agencies – Using case scenarios to make it clear what we mean Communications Need to know where to target - Care Home newsletter - Safeguarding Matter - Website - Leaflets -Posters	abuse/harm Where they would get help Action- Survey – possibly HealthWatch SAB 'Listening Booth' Do you feel safe? Communications Need to know where to target - Care Home newsletter - Safeguarding Matter - Website - Leaflets -Posters	Leicestershire/Rutland Population Use data to identify gaps in service delivery/themes and hotspots	Mental Capacity and doesn't' want you to do anything
2. Thresholds	Identify gaps in knowledge about thresholds? Thresholds document updated and agreed multi-agency	Understand if thresholds is an issue within SARs.	Understand multi agency staff understanding of thresholds. Currently it is a LA threshold document, for LA to apply. Test out how thresholds are applied.	Establish what making safeguarding personal says about thresholds.		

3. Making Safeguarding Personal	Embed principles of MSP across the SAB partnership		Develop a multi agency understanding of MSP			

KEY LINES OF ENQUIRY – IMPACT – RESILIENT COMMUNITIES - *INCREASED REFERRAL - *INCREASE ADVICE AND INFORMATI

Table 6 – Children's – AS

EVIDENCE OF MATRIX

PRIORITY	LEARNING AND IMPROVEMENT (Reviews, SCRs, SARs, Audits, Impact Evidence)	COMPETENT CONFIDENT WORKFORCE	VOICE OF THE SERVICE USER	DATA What is needed?
Refugees	Balkans? Conflicts Uganda (learning from history)	Briefing and learning event for staff - Entitlement to Pubic funds High quality age assessments Consistency across areas Workforce confidence to use evidence based decision making to prevent allegations of discriminatory behaviour Linguistic and cultural issues	Community resistance balanced with welcoming new arrivals	Liaison with - Interpreter Service - Security Services - Understanding numbers and placement decisions Strategic responsibility via national?, chairs? to understand statutory position of refugees. What triage has been completed before arriving?

Notes

Add in a column for action owner and escalate to executive

Recommend the creation of a mental health sub-group – chaired by Rachel Garton?

Report No: 48/2016
PUBLIC REPORT

SCRUTINY PANEL

18 February 2016

SEXUAL HEALTH NEEDS ASSESSMENT AND DRAFT RUTLAND SEXUAL HEALTH STRATEGY 2016-19

Report of the Director of Public Health

Strategic Aim:	The overall mission of the Rutland Sexual Health strategy is, 'Empowering the population of Rutland to make informed, positive choices about their relationships and sexual health.'	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Richard Clifton, Portfolio Holder for Health and Adult Social Care	
Contact Officer(s):	Mike Sandys, Director of Public Health	Tel: 0116 305 4259 Email: mike.sandys@leics.gov.uk
	Vivienne Robbins , Consultant in Public Health	Tel: 0116 305 5384 Email: vivienne.robbins@leics.gov.uk
Ward Councillors		

DECISION RECOMMENDATIONS

That the Panel:

1. Note the Rutland SHNA and comment on the proposed recommendations.
2. Endorses implementation of the recommendations across portfolio areas (in particular CCG support, children's, substance misuse etc.)
3. Review the Rutland Sexual Health Strategy and provide feedback on the current draft.

1 PURPOSE OF THE REPORT (MANDATORY)

1.1 To update scrutiny on the recommendations and implications of the Rutland Sexual Health Needs Assessment (Appendix A) and draft Sexual Health Strategy 2016-2019 (Appendix B).

1.2 To gain feedback from scrutiny on the draft Rutland Sexual Health Strategy as part of the current sexual health consultation. Available at http://www.rutland.gov.uk/health_and_social_care/sexual_health_consultation.aspx until 15th March 2016.

2 BACKGROUND

2.1 The sexual health needs of the population are evolving. Over the past few decades there have been significant changes in relationships and how people live their lives including personal attitudes and beliefs, social norms, peer pressure, confidence and self-esteem, misuse of drugs and alcohol, coercion and abuse.

2.2 Although sexual relationships are essentially private matters, good sexual health is important to individuals and to society. The World Health Organisation (WHO), 2002 defines sexual health as '… a state of physical, emotional, mental and social well-being in relation to sexuality.'

2.3 Sexual ill health can affect all parts of society – often when it is least expected. Investment in sexual health not only improves the overall health of the population, it is also cost effective. The consequences of poor sexual health cost the NHS in 2010 an estimated £193million in unintended pregnancies and in 2012/13 approximately £630million in HIV treatment and care. National evidence also suggests that:

- Every one pound invested in contraception saves £11.09 in averted negative outcomes;

- An increase in long acting reversible contraception (LARC) usage could save £102million; and

- Increasing HIV testing among Men who have sex with Men and black African communities in England would prevent 3,500 cases of HIV transmission within five years and save £18million in treatment costs per year.

2.4 A comprehensive Leicestershire and Rutland Sexual Health Needs Assessment was completed in autumn 2015. The Rutland executive summary is attached as Appendix A. It confirms that good progress has been made on key sexual health indicators and on improving sexual health outcomes across Rutland. However, Rutland has an ageing and increasing population and sexual health services must respond. It is therefore important to consider how services evolve to meet these changing needs across the life course.

2.5 The proposed Rutland Sexual Health Strategy uses the latest evidence from the Sexual Health Needs Assessment (SHNA) to take stock of progress made so far and provides key strategic priorities for the next three years to further improve sexual health services across Rutland.

3 OVERVIEW OF THE DRAFT STRATEGY

3.1 The draft Rutland Sexual Health Strategy 2016-19 is attached to this report (Appendix B). This document outlines the eight key priorities for improving sexual health services and population outcomes across Rutland. These are briefly set out below:

3.1.1 **Coordinated approach to sexual health commissioning and partnership work.** Streamlining commissioning intentions across the system (including Peterborough) to ensure seamless patient pathways, improved quality of service and identify cost efficiencies across the system;

3.1.2 **Develop a highly skilled local workforce.** Rutland has previously experienced

recruitment problems within the service. It is therefore important, to develop both the specialist and non-specialist workforce, to make sexual health services in across Rutland an attractive place to work and progress;

3.1.3 **Strengthen the role of primary care.** General practices deliver the majority of contraception across Rutland. These services are often more accessible to the rural Rutland population than the specialist sexual health services, which are experiencing increased demand. Hence, there is a need to further equip the primary care workforce to deliver more uncomplicated sexual health services in the future;

3.1.4 **Coordinated, consistent sexual health communications.** Consistent communications have a greater impact on the population, therefore services and commissioners will develop communication approaches in partnership to ensure these have the greatest effect on population attitudes and access to sexual health services;

3.1.5 **Support schools to deliver high quality relationships and sex education (RSE).** High quality RSE is critical to empowering young people to have informed, consenting, positive relationships. Further work will be completed to build on the current Leicestershire and Rutland RSE toolkit.

3.1.6 **Utilise new technologies to support sexual health delivery.** Rutland is a rural county, therefore sexual health services need to utilise the latest technologies to increase access to the population. This includes developing a risk assessed, full STI (sexually transmitted infection) screen and utilising communication advances in service delivery, advertisements and partner notification. New sexual health interventions will also be reviewed and implemented as appropriate;

3.1.7 **Increase access to sexual health improvement and HIV prevention to at- risk groups.** In Rutland men who have sex with men are the key group at greater risk of poor sexual health. Therefore access to HIV home and community testing will be investigated and targeted to these at risk populations;

3.1.8 **Increase links between sexual violence and sexual health services.** In recent years there has been increasing national impetus on sexual violence including child sexual exploitation and female genital mutilation. Sexual health services therefore need to further embed the sexual violence prevention agenda within their services.

3.2 The Strategy is arranged into six key sections, including an introduction, current sexual health progress, cross cutting themes, the strategic approach, key activities to deliver the approach and defining how the strategy will be performance monitored. Full details are given in Appendix B.

4 ORGANISATIONAL IMPLICATIONS

4.1 The results of the SHNA and draft Strategy propose changes to current sexual health prioritises, commissioning intentions and service provision (including health promotion, relationships and sex education, contraception and STI screening and treatment). Specific service implications include:

4.1.1 Working with local CCGs and NHS England commissioners to reduce fragmentation across the system (including links with Peterborough). Developing a bi-annual sexual health commissioners meeting.

4.1.2 Increasing the role of primary care in delivering uncomplicated sexual health services (in particular contraception).

4.1.3 Reduction in opportunistic chlamydia screening and conversion into a full online STI screening service.

4.1.4 Providing parity across Leicester, Leicestershire and Rutland (LLR) for young people's sexual health services including development of an LLR C-Card (condom distribution scheme) and increasing access into the core integrated sexual health service.

4.1.5 Increased focus on groups at high risk of poor sexual health, especially on men who have sex with men.

5 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

5.1 Sexual health services and commissioning has become fragmented following the implementation of the Health and Social Care Act 2012. Developing a sexual health strategy that is endorsed by key partners including Clinical Commissioning Groups (CCGs), NHS England, providers and service users will set an agreed direction for sexual health commissioning across Rutland. This will streamline commissioning intentions, improving patient pathways and quality of care. The Strategy will also be aligned with sexual health strategic priorities for Leicestershire County Council and Leicester City Council to provide a wider Leicester, Leicestershire and Rutland system approach.

5.2 Undertaking consultation on the draft Strategy will ensure it meets the needs of the local population and is aligned with other key stakeholders. The sexual health consultation provides an opportunity to ensure that all stakeholders are made aware of the draft priorities and given the opportunity to make comment upon these at an early stage.

6 BACKGROUND PAPERS

6.1 Public Health England. Making It Work – A guide to whole system commissioning for sexual health, reproductive health and HIV. (2014). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf]

6.2 Department of Health. A Framework for Sexual Health Improvement in England. 1–56 (2013). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf]

7 APPENDICES (SIMPLY STATE IF THERE ARE NO APPENDICES)

7.1 **Appendix A** Rutland Sexual Health Needs Assessment, Executive Summary, October 2015

7.2 **Appendix B** Draft Rutland Sexual Health Strategy 2016-19

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

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Rutland Sexual Health Strategy

2016-2019

Introduction

The sexual health needs of the population are evolving. Over the past few decades there have been significant changes in relationships, and how people live their lives including personal attitudes and beliefs, social norms, peer pressure, confidence and self-esteem, misuse of drugs and alcohol, coercion and abuse.

Although sexual relationships are essentially private matters, good sexual health is important to individuals and to society. WHO, 2002 defines sexual health as;

*'… **a state of physical, emotional, mental and social well-being in relation to sexuality**.'(Page 5, WHO, 2002)*[i]

Sexual ill health can affect all parts of society – often when it is least expected. Investment in sexual health not only improves the overall health of the population, it is also cost effective. The consequences of poor sexual health cost the NHS an estimated £193m in unintended pregnancies in 2010 and approximately £630m in HIV treatment and care in 2012/13. Evidence also suggests[ii],[iii];

- For every one pound invested in contraception saves £11.09 in averted negative outcomes
- An increase in long acting reversible contraception (LARC) usage could save £102 million and
- Increasing HIV testing among Men who have sex with Men (MSM) and black Africans in England would prevent 3,500 cases of HIV transmission within five years and save £18million in treatment costs per year.

In terms of improving sexual health outcomes, we have made good progress across Rutland. We have been one of the first areas in the county to commission a fully integrated sexual health service, which addresses both the sexual health and reproductive needs of patients in one visit. We also perform well against many of the key sexual health indicators when compared nationally and to our local comparator authorities. However Rutland has an ageing and increasing population and it is important that we consider the changing sexual health needs across the life course.

There have also been unprecedented changes to the sexual health system since the implementation of the Health and Social Care Act 2012. This has created fragmentation across the sexual health system with three main commissioners (local authorities, Clinical Commissioning Groups (CCGs) and NHS England.) Due to Rutland's geographical position, many residents choose to access services from a range of other local areas including Leicestershire and Peterborough. This further complicates commissioning of sexual health services when national guidance suggests the need to take a patient-centred, systematic approach to sexual health commissioning around patient pathways. With key commissioners facing financial pressures, there is a need to develop strong collaborative approaches across commissioning organisations to 'pull the system back together' and ensure seamless, high quality, evidence based services are available to the local population. This strategy takes stock of progress made so far and provides key strategic priorities for the next three years to further improve sexual health services across Rutland.

Councillor Richard Clifton, Portfolio Holder for Health and Adult Social Care

Current sexual health progress across Rutland

As discussed there have been significant changes to the public health commissioning arrangements since the implementation of the Health and Social Care Act, including sexual health services. Local authorities have a statutory responsibility to provide open access sexual health services, which is a substantial proportion of the public health grant. With significant cost pressures to the public health grant in 2015/16 and predicted financial challenges over the next few years, it is important to ensure the highest quality, evidence based services are commissioned to respond to the needs of the local population. To inform this work a Leicestershire and Rutland Sexual Health Needs Assessment was completed in autumn 2015. The key Rutland headlines from this needs assessment are;

Demography of Rutland

Evidence shows that sexual health needs are greatest in young adults and often reduce with age. Rutland has an ageing population, meaning there may be less need for contraception than the England average. However there have been significant increases in numbers of over 45's presenting with STIs across Leicestershire and Rutland (59% increase between 2010-2014). With the advances in treatment, HIV has become more of a long term condition with many people living with HIV into older age. Those living in the most deprived areas of Rutland experience the poorest health (including sexual health) outcomes and are at greater risk of teenage pregnancy.

Groups at high risk of poor sexual health

Young people, men who have sex with men (MSM), black African heritage are amongst groups that are more likely to participate in risk taking sexual behaviour and consequently have poorer sexual health outcomes than the general population across Rutland. Each group has diverse requirements and therefore sexual health services need to review how they are meeting the needs of these populations. Pathways between services that address risk taking behaviours (sexual health, mental health and substance misuse) should also be further developed across service providers to address the root cause of risk taking behaviours.

Sexually Transmitted Infections (STIs)

Overall Rutland experiences lower rates of STI diagnosis than the England average and similar rates to comparator authorities. Chlamydia is the most common STI across Rutland, followed by genital warts (which has a higher rate than the England average, although this is not significant). Although lower than the national rates, there has been year on year increases in the number of STIs across Rutland, which has also been seen nationally. This may be due to increased access to STI testing or increases in STI prevalence across the counties. Certain districts have been identified as areas having higher rates of STI re-infection within 12 months. Therefore an additional priority of STI prevention and contract tracing may be beneficial in these districts, in particular with men. Young people aged 15-24 years, MSM and black Caribbean ethnic groups have been shown to have higher rates of new STIs across Rutland, which is aligned with the national picture. Increases have been seen in the proportion of STIs diagnosed in MSM across Rutland. Rutland does not perform well against the national average for Chlamydia screening in 15-24 year olds. However most comparator local authorities perform similarly, which may indicate that the overall prevalence of chlamydia is lower

than the national average. Chlamydia screening is a useful tool in normalising STI screening with young adults; therefore opportunistic screening should be increased in core sexual health services.

Increases in genitourinary medicine (GUM) attendance by Rutland residents has been seen locally and overall (including out of area contacts). This may reflect increased access due to the new LLR integrated sexual health service (ISHS), increased awareness of STI screening, but also reflects the increased STI need across Rutland. Rural access is a particular difficulty for areas of Rutland. The new ISHS has reduced out of area GUM access by 10% in Rutland between 2013 and 2014. Increasing accessibility to local services and providing alternative local sexual health service provision such as general practice and pharmacy may continue to reduce use of out of area services.

Human Immunodeficiency Virus (HIV)

There are significantly lower HIV diagnosis rates across Rutland as compared to the national and local authority comparator rates. However HIV prevalence overall is increasing locally and nationally as treatment has improved to make HIV a long term condition. There are implications for health and social care providers as the HIV positive group increases in number and becomes an ageing population with changing health needs. Early HIV diagnosis is important to improve health outcomes for the individual, reduce the risk of onward transmission and lower treatment and care costs. Rutland has higher late HIV diagnosis rates than the England average therefore increasing access to HIV testing to at risk groups maintain a priority.

Sexual Reproductive Health

Contraception is a cost effective intervention for the whole of society. Long acting reversible contraception (LARC such as coils, implants) is shown to be the most cost effective method available. Across Rutland LARC prescribing rates are above the national average for primary care, however user dependent methods (such as the combined pill, condoms) remain most widely used. Therefore additional work is needed to maintain high levels of LARC uptake and retention. There is good access to emergency contraception across Rutland provided by the ISHS, GP and local pharmacy. Consideration should be given to new forms of emergency hormone contraception (EHC or the morning after pill) such as ulipristal acetate (which has a longer effective window) and ensuring women accessing EHC are referred in contraceptive services to establish a longer term contraceptive regime.

The Natsal-3 sexual attitudes and lifestyles in Britain survey (2010-12) indicated 51% of men and 42% of women surveyed experienced sexual difficulties lasting more than three months in the past year[iv]. However no Rutland residents have access the service. Hence there is likely to be some unmet demand for psychosexual services across Rutland. With an ageing population, this demand is likely to increase. Discussions are also needed with the local CCGs to identify services for patients with sex addiction.

The under 18year conception rate continues to fall across Rutland and remains significantly lower than nationally and many comparator local authorities. The proportion of under 18 conceptions leading to abortion is not published due to small numbers. However due to emergency contraception uptake there are still significant numbers of young people who continue to take risks

and not use contraception despite not wanting to become pregnant. Therefore continued easy access to relationships and sex education and community based sexual health services is important to maintain and improve current progress. For example looked after children are a group at higher risk of teenage pregnancy. Rutland has lower abortion rates than the national average. However a fifth of women had previously had an abortion and 15% of women are accessing services at a later stage of gestation, which reduces their choice of procedure and increases risk of complications and healthcare costs. There is also limited local availability for procedures over 12 weeks across Rutland, and self-referral is only available in one Leicestershire provider. Work is needed to increase access to local abortion services and ensure that all abortion patients are supported to establish a long term contraceptive plan to avoid repeat abortions.

Sexual Abuse

Domestic abuse is a widespread issue and can take place in a range of relationships. There is a lack of understanding around what constitutes domestic abuse and signs of child sexual exploitation (CSE). It is important that staff who work in sexual health services are equipped to ask appropriate questions when seeing patients to allow disclosures to be made and appropriate referral onto specialist services.

Engagement

National data and local engagement work highlighted the critical exploration of relationships in both relationships and sex education (RSE) and in the delivery sexual health services. With the impact of social media, evolving sexual practices and a reducing age of first sex, promotion of consensual, informed and respectful relationships is important to balance against other messages. Service users value the importance of having local, community based sexual health provision. Service providers and users both highlighted gaps in information about the sexual health services that are available, how they can be accessed and how complaints can be raised. From the perspective of sexual health service providers, identified key priorities to address areas clarifying the strategy priorities for sexual health delivery across Leicester, Leicestershire and Rutland, commissioner and provider roles and responsibilities, integrating sexual health services across the system and further development of the wider sexual health workforce (including primary care and school nursing). Areas which both providers and service users highlighted including wanting more equitable and timely provision across LLR, wanting easier access in to services, seamless patient pathways, prioritising education on relationships and sex and ensuring clear information about local services. Additional Rutland specific feedback included the need to complete the needs assessment, develop the workforce, increase access to rural populations (including C-Card), school nurse EHC provision and to have parity of RSE support.

The results and recommendations for the needs assessment have provided a clear evidence base and rational for the strategic priorities and mission described below.

Our Mission: Empowering the population of Rutland to make informed, positive choices about their relationships and sexual health.

Mike Sandys, Director of Public Health

Read more

For additional information on the full sexual health needs across Leicestershire and Rutland please see the full needs assessment at XXX.

For further information on the overall needs of Leicestershire and Rutland please see the respective Joint Strategic Needs Assessments at XXX.

Cross cutting themes

The overall aim of this strategy is to empower the Leicestershire and Rutland population to have informed, positive relationships that result in reduced rates of unwanted pregnancy and sexually transmitted infections (STIs) including HIV. To achieve this vision there are a number of cross cutting themes that arose from the sexual health needs assessment. These themes should be considered across all strategic priorities and include;

- **Empowerment-** We want the local population to be well informed and empowered to make individual choices around their sexual health. This may range for information on relationships, contraception, STIs, HIV and consent to accessing local services.

- **Patient centred, integrated pathways-** Sexual health pathways must be centred on the patient and not organisational or commissioning boundaries. This creates opportunities for more integrated, joint working across the sexual health system.

- **Equitable –**Services need to available to all, but proportionate to need. The Marmot Review[v] states that to truly reduce health inequalities 'actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.' This approach is needed to sexual health services to ensure they are available to the whole population but equitable to those of greatest need. This may include targeting the most deprived wards across Leicestershire and Rutland, but also targeting groups at highest risk of poor sexual health such as young people, men who have sex with men, sex workers and black African communities.

- **Prevention focused-** Prevention is better than cure and the evidence suggests that preventative approaches to sexual health are clinically and cost effective [ii],[iii]. In times of financial pressures, a focus of prevention is needed to manage demand for services that treat unplanned pregnancies and STIs in the future.

- **Life course approach-** Leicestershire and Rutland have increasing but ageing populations. Although evidence shows that sexual health needs are greatest in young adults and often reduce with age, there have been significant increases in numbers of over 45's presenting with STIs locally. Other considerations include the advances in anti-retroviral medication that has significantly increased the life expectancy and overall numbers of people living with HIV. This has translated HIV into a long term condition, bringing with it the need to consider the increasing demands of HIV treatment and social care services.

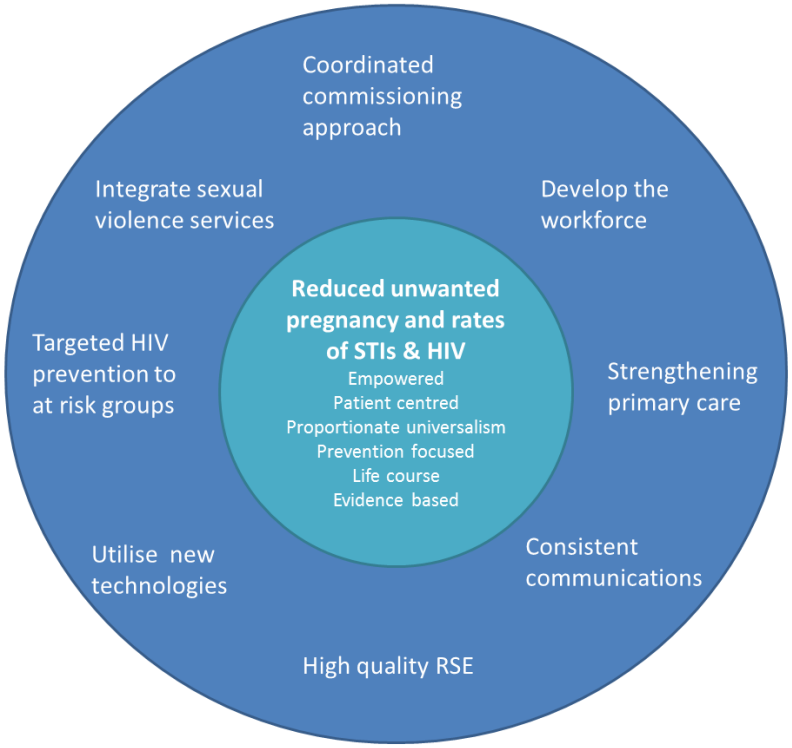
- **Evidence based-** The sexual health needs assessment will be the key resource to ensure services are commissioned to meet the local sexual health needs. All sexual health services must be commissioned using the latest national evidence and standards including National Institute for Health and Care Excellence (NICE), British HIV Association (BHIVA) and British Association for Sexual Health & HIV (BASHH). This will be supplemented with local evaluations to allow more innovative approaches to be piloted across Leicestershire and Rutland.

Our strategic approach

Across Rutland we want to deliver the highest quality, efficient sexual health system across the East Midlands/ England. This includes developing innovative ways to increase universal access to sexual health services across urban and rural locations, targeting groups at risk of poor sexual health (i.e. young people, men who have sex with men, sex workers, and black African communities.) To achieve this there are eight key themes to the strategy (Figure 1). These will be described in further detail below using the following structure;

- Where are we now?
- What do we want to achieve?
- How will we get there?

Figure 1 Summary of the key sexual health priorities across Leicestershire and Rutland



1. Coordinated approach to sexual health commissioning and partnership work

Where are we now?

Due to the implications of the health and social care act sexual health commissioning has become fragmented across local authority, clinical commissioning groups and NHS England. This has made navigating patient pathways more complex and created gaps in some services. Further work is needed to integrate sexual health commissioning intentions across all sexual health commissioners to ensure the sexual health system is responding to the needs of the local population.

What do we want to achieve?

- Joined up sexual health commissioning including joint procurements and co-commissioning of services across organisational boundaries
- Seamless sexual health patient pathways including services supporting victims of sexual violence.

How will we get there?

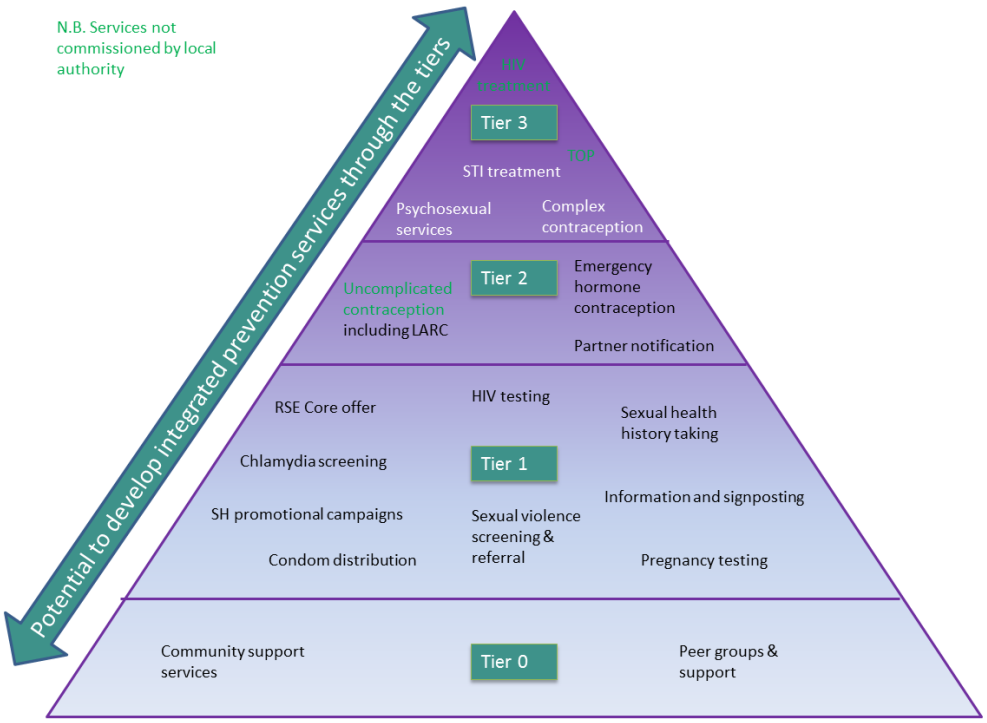
- An agreed, endorsed Rutland strategic approach to commissioning and delivery of sexual health services over the next 3 years. This will be aligned with Leicestershire County and Leicester City.
- Establish a biannual Leicester, Leicestershire and Rutland sexual health commissioners meeting to review progress on the sexual health strategic approach, share sexual health commissioning intentions and discuss the implications of these on the wider system.
- Explore co-commissioning opportunities for heavy menstrual bleeding (menorrhagia), sex addiction and cervical cytology services. Review the future possibilities of a centralised booking for abortion services, local abortion services for over 12weeks gestation and integrating HIV services into the integrated sexual health service.
- Agree a local tariff arrangements for out of area specialist sexual health services in particular Peterborough services.

2. Develop a highly skilled local workforce

Where are we now?

Across Rutland we have a highly skilled sexual health workforce ranging across all levels of sexual health prevention (Figure 2), from those working in the specialist integrated sexual health service, to primary care to those working in less traditional setting such as education, youth services etc. However sexual health services locally are struggling to recruit individuals with the correct integrated sexual health skills and increasing numbers of patients are unnecessarily being referred to the specialist service. There is also a need to develop the non-core sexual health workforce to effectively embed sexual health services into children's, substance misuse, mental health etc services.

Figure 2: Tiers of sexual health workforce training.



What do we want to achieve?

- A highly skilled, sustainable sexual health workforce across all levels of sexual health service.
- Personal development opportunities to make sexual health across Rutland an attractive place to work.
- Key sexual health messages, referral and signposting integrated into other non-core services.

How will we get there?

- Complete a Leicester, Leicestershire and Rutland (LLR) sexual health training assessment.
- Develop a tiered approach to sexual health training across LLR in collaboration with Health Education East Midlands. Prioritises for action include upskilling primary care, safeguarding and sexual violence.
- Review the current delivery model for young people's sexual health services across Leicestershire and Rutland. This includes increasing young people's access to the main integrated sexual health service and embedding a consistent condom distribution approach across LLR.
- Integrate sexual health services more effectively into non-core services e.g. substance misuse, school nursing, health visiting and midwifery.

3. Strengthen the role of primary care

Where are we now?

General practice is the largest provider and most frequently chosen first point of contact for those with sexual health concerns and contraceptive needs [ii]. In Rutland we have higher than national rates of long acting reversible contraception (LARC) prescribing in general practice, suggesting patients like the convenience of accessing their local GP for sexual and reproductive health services. However LARC rates are lower than the national average in under 35year olds and user dependant methods are still the most popular form of contraception overall. With the integrated sexual health service seeing significant increases in demand for contraceptive appointments, we need to increase the capacity and expertise of primary care to deliver sexual health services across Rutland.

What do we want to achieve?

- To increase access to sexual health services in primary care across Rutland.
- Highly skilled primary care workforce with an expertise in sexual health.
- Revised case-mix at the integrated sexual health services to ensure increased access to the specialist service for complex contraception and STI treatment.

How will we get there?

- See sexual health training priority. A specific focus will be placed on upskilling the primary care workforce on sexual health.
- Review the current delivery model for long acting reversible contraception in primary care. For example, explore a federation/ locality commissioning approach and utilising the Faculty of Sexual Reproductive Health letters of competence.
- Review options to increase delivery of less complex sexual health services through primary care. Promote the use of primary care to patients accessing the integrated sexual health service. For example encouraging repeat oral contraceptive pill consultations to take place in local general practices to release capacity within the integrated sexual health service for more complex needs.
- Undertake cost benefit analysis of increasing access to ulipristal acetate emergency hormonal contraception via pharmacy schemes locally.

4. Coordinated, consistent sexual health communications

Where are we now?

There are a number of sexual health providers and commissioners currently delivering a range of communication materials to the local population about accessing sexual health services, relationships, contraception, STI and HIV testing and treatment. However there is currently little alignment across these communications which can be confusing to the local population and reduce the effectiveness of the campaign.

What do we want to achieve?

- Shared vision about communications.
- Clear, consistent sexual health communication messages across LLR.
- Easily identifiable, coordinated LLR communications approach that utilises local insight and service identities, whilst providing greater opportunities to link into national campaigns.
- Communication approach embedded into relationships and sex education training and delivery.

How will we get there?

- Review the membership and ownership of a Rutland sexual health communication group. Develop terms of reference for this group to clarify their role in developing a strategic and coordinated approach for all LLR sexual health communications and how these link to out of area services such as Peterborough.
- Utilise sexual health contracts to ensure consistent, effective LLR sexual health communications.
- Consider how communications from other out of area specialist services (such as Peterborough) link into the LLR communication group.

5. Support schools to deliver high quality relationships and sex education (RSE)

Where are we now?

Across Rutland all schools are offered training on a locally developed Leicestershire and Rutland relationships and sex education (RSE) toolkit. Training equips teachers to confidently deliver RSE lessons covering relationships, consent and the law, contraception and STIs etc. Further work is needed to embed this more sustainably into the wider personal, social, health and economic education curriculum, and further education colleges as well as wider youth settings and other children's services.

What do we want to achieve?

- Empower young people to make positive choices about their relationships and sexual health.
- A long term, sustainable model to delivering high quality RSE in all schools and young people's settings.

How will we get there?

- Review, develop and implement a coordinated RSE training and support offer which meets the needs of schools, further education colleges and other young people's settings, including

strengthening links into wider personal, social, health and economic education. This includes bringing RSE training together across Leicestershire and Rutland.

- Develop a process to audit the quality and consistency of RSE delivery across schools and colleges.
- Utilise the Leicestershire and Rutland RSE group to drive these improvements.
- Specifically review the relationships and sex education received by looked after children.
- Consider what RSE material is available to support parents to discuss RSE with their children.

6. Utilise new technologies to support sexual health delivery

Where are we now?

Across Rutland we already use a range of technologies to increase access to sexual health testing, including online chlamydia screening, test not talk at the integrated sexual health service, and use of social media to target information to priority groups such as men who have sex with men. However there are further opportunities to increase access to services, especially to rural populations and improve efficiency savings by utilising additional technologies including marketing of services, online STI testing, virtual clinics and contact tracing.

What do we want to achieve?

- Increase access to sexual health services and appointment booking.
- Improved access to STI and HIV testing.
- Innovative approaches to delivering the most cost effective sexual health service including contact tracing, text, online, telephone and virtual consultations.
- Increased online presence for sexual health communications.
- Embed the latest evidence based, clinically and cost effective sexual health interventions into local service provision.

How will we get there?

- Establish full asymptomatic online STI testing using online risk assessments and postal screening kits. This includes decommissioning opportunistic chlamydia screening and converting the remaining chlamydia screening programme into a more widely accessible online full STI screening service.
- Implementation of the community and home HIV testing kits, including participating into the national HIV home kit procurement and building this into the online STI screening service mentioned above.

- Review the integrated sexual health service model to see how technology could improve access and reduce infrastructure costs of the service. For example exploring virtual clinics or telephone consultations for less complex sexual health needs.

- Utilise social media, online dating sites etc. to engage service users, advertise services to specific groups and increase the effectiveness of partner notification.

- Review the clinical and cost effectiveness evidence of new sexual health interventions including emergency hormonal contraception, self-injectable contraception and pre-exposure prophylaxis for groups at very high risk of HIV. Review whether these should be commissioned across Leicestershire and Rutland in the future.

7. Increase access to sexual health improvement and HIV prevention to at risk groups

Where are we now?

Across Rutland and Leicestershire there are a number of voluntary sector organisations that deliver key HIV prevention and testing options for groups at higher risk of STIs and HIV including men who have sex with men, sex workers and black African communities. Results from the Rutland sexual health needs assessment identified an increased proportion of STI diagnosis and high levels of HIV in these groups (in particular men to have sex with men.) Advances have also been seen in HIV home and community testing and pre-exposure prophylaxis in high risk groups (following the PROUD study.) Hence commissioning decisions will need to be made as to whether these interventions are implemented locally.

What do we want to achieve?

- Reduction of STIs in at risk groups
- Reduced HIV transmission and new diagnoses
- Lower proportions of late HIV diagnosis
- Increased access to HIV testing to at risk groups

How will we get there?

- Review commissioning and delivery protocols of home and community HIV testing for at risk groups.

- Maintain outreach clinics across LLR from integrated sexual health service to target at risk groups. For example, focus on increasing access to clinical sexual health services for sex workers and men who have sex with men.

- Considering the implications of PROUD study and pre-exposure prophylaxis to high risk groups (such as men who have sex with men and high numbers of sexual partners.)

- Regular equality impact assessment for all sexual health services.

- Consider the sexual health implications of changing patterns of legal & illegal substance use by men who have sex with men locally.

8. Increase links between sexual violence and sexual health services

Where are we now?

In recent years there has been increasing national impetus on sexual violence including child sexual exploitation and female genital mutilation. The sexual health needs assessment provided some assessment of needs and implications for services, however further work is needed to truly embed the sexual violence prevention agenda within sexual health services.

What do we want to achieve?

- Sexual violence to become an integral part of the wider sexual health system.
- Sexual health services are able to effectively respond to sexual violence needs of the population.
- Ensure sexual health and violence is considered in the commissioning of sexual and reproductive health services including sexual assault referral centre, maternity services etc.
- Integrated pathways between domestic abuse (Rutland Community Safety Team) and CSE (LLR CSE team) to ensure wider community safety issues are addressed in a timely way.

How will we get there?

- Sexual health services to attend Local Safeguarding Children Board training on safeguarding, domestic abuse and child sexual exploitation.
- Maintain sexual violence as a key theme of the sexual health action plan.
- Increased sexual health across the community safety agenda including targeted work with victims of domestic abuse and sex workers.
- Utilise the LLR sexual health commissioners meeting to highlight sexual violence implications for services.
- Explore further links between the Rutland Community Safety Team and the LLR CSE Team.

Key activities to deliver this approach

To ensure the strategic approach is delivered we will;

- **Develop new ways of working** across the sexual health system. This includes developing a Leicester, Leicestershire and Rutland sexual health commissioners meeting to ensure all commissioning intentions are aligned and task and finish groups to progress key elements of the strategic approach.

- **Keep partners informed** of progress. We will develop a detailed action plan which will be regularly reviewed and updated to track progress. Progress updates will be provided to the sexual health clinical network, commissioners meetings and directorate management teams.

- **Monitor performance** through implementation of the action plan and development of a sexual health dashboard. These will be easily accessible for all partners to view.

How will we know we have made a difference?

The key indicators to assess whether this strategy has made a difference are presented in the Public Health England Sexual and Reproductive Health Profiles. (Available online at http://fingertips.phe.org.uk/profile/sexualhealth). These include rates of specific STIs, HIV and unplanned pregnancies. This will be supplemented with local sexual health dashboards and further indicators will be developed as part of the detailed action plan. All data will be split by local authority area and compared to local comparator local authorities. Information will be collated and triangulated with local sexual health provider performance to produce an annual progress update against the action plan and how this has translated to improved sexual health outcomes across Leicestershire and Rutland.

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Leicestershire and Rutland Sexual Health Needs Assessment

Executive Summary for Rutland

October 2015

Rutland County Council

Executive Summary

1. Introduction

The sexual health needs of the population are evolving. Over the past few decades there have been significant changes in relationships, and how people live their lives including personal attitudes and beliefs, social norms, peer pressure, confidence and self-esteem, misuse of drugs and alcohol, coercion and abuse.

Although sexual relationships are essentially private matters, good sexual health is important to individuals and to society. WHO, 2002 defines sexual health as;

*'… **a state of physical, emotional, mental and social well-being in relation to sexuality**.'(Page 5, WHO, 2002)*(1)

Sexual ill health can affect all parts of society – often when it is least expected. Investment in sexual health not only improves the overall health of the population, it is also cost effective. The consequences of poor sexual health cost the NHS an estimated £193m in unintended pregnancies in 2010 and approximately £630m in HIV treatment and care in 2012/13. Evidence also suggests that;

- For every one pound invested in contraception saves £11.09 in averted negative outcomes
- An increase in long acting reversible contraception (LARC) usage could save £102 million and
- Increasing HIV testing among Men who have sex with Men (MSM) and black Africans in England would prevent 3,500 cases of HIV transmission within five years and save £18million in treatment costs per year(2),(3).

There have been unprecedented changes to the sexual health system since the implementation of the Health and Social Care Act 2012. This has created fragmentation across the sexual health system with three main commissioners (local authorities, Clinical Commissioning Groups (CCGs) and NHS England.) National guidance suggests the need to take a patient-centred, systematic approach to sexual health commissioning around patient pathways. With key commissioners facing financial pressures, there is a need to develop strong collaborative approaches across commissioning organisations to 'pull the system back together' and ensure seamless, high quality, evidence based services are available to the local population.

2. Methodology

This Leicestershire and Rutland sexual health needs assessment triangulates national and local policy with quantitative and qualitative data to understand the needs, demands and supply of sexual health services across Leicestershire and

Rutland. The needs assessment has been split into chapters to ease navigation through the document. These are

- Demography
- High risk groups
- Sexually transmitted infections (STIs)
- HIV, sexual and reproductive health
- Sexual violence
- Engagement
- Conclusion
- Recommendations

The results will be used to inform the future direction for sexual health commissioning across Leicestershire and Rutland. This summary identifies the key issues for Rutland.

3. Demography of Rutland

- Rutland has an older population than the England average. This population is expected to increase by 6.8% by 2028, with greatest increases seen in people aged over 75years.(4)
- The main ethnic group is White, being 97% of the Rutland population.(5)
- Nationally 1.6% of the population define themselves as gay, lesbian or bisexual, this equates to ~600 people in Rutland. Men are twice as likely as women to declare themselves gay or bisexual.(6)
- Overall Rutland is a very affluent county with over half of the population living in the least deprived 20% of areas in the country. However there are still pockets of deprivation.(7)

Implications for sexual health services

- Evidence shows that sexual health needs are greatest in young adults and often reduce with age. Rutland has an aging population, meaning there may be less need for contraception than the England average. However there have been significant increases in numbers of over 45's presenting with STIs across LCR (59% increase between 2010-2014(8)). With the advances in treatment, HIV has become more of a long term condition with many people living with HIV into older age. Therefore the sexual health needs across the life course must be considered including those of the older population which may entail increased demand in psychosexual, HIV treatment and HIV social care services. Services also need to be equitable to meet the needs of different vulnerable groups. For example evidence shows that black ethnic minority (BME) groups and men who have sex with men (MSM) are at higher risk of STIs and HIV. Although

proportions of these populations are not high in Rutland, they are groups with high levels of sexual health service need, meaning that culturally appropriate, targeted services are required.

- There is a social gradient indicating that those living in the most deprived areas of Rutland experience the poorest health (including sexual health) outcomes and are at greater risk of teenage pregnancy. Hence service location need to take into account deprivation and groups of high risk of poor sexual health. This includes support for teenage parents who are at significantly higher risk of not being in education, employment and training.

4. Groups at high risk of poor sexual health

- Rutland has lower estimated prevalence of opiate and/or crack cocaine users aged 15-64, alcohol hospital admission rates and deaths due to alcohol specific conditions than the England average.

- Sex workers are at greater risk of sexual violence and poor sexual health and outcomes. Evidence suggest that men paying for sex are the bridging population for STIs, hence further work is needed to ensure that sex workers and men who pay for sex have access to condoms and regular STI screening. There are currently no saunas/parlours or street work known to be operating in Rutland. However, this does not mean that there are no sex workers operating in the locality although those choosing to pay for sex may do so outside of the county.

- At least one in four people will experience a mental health problem at some point in their life. In 2013/14 0.7% of the Rutland population is diagnosed with a mental health condition. This is significantly lower percentage than the England average (0.9%).(9) Poor mental health can be both a cause and effect of poor sexual health in particular the impact of stigma and discrimination, and mental health support following sexual violence or termination of pregnancy.

- In 2012, an estimated 12.0% of 16-64 year olds in Rutland had a moderate to severe physical disability. This is a higher prevalence than the national (11.1%).(10) National data suggests that people with physical disabilities are more likely to experience forced vaginal and anal intercourse, report greater than 10 sexual partners over a lifetime and identify themselves as other than heterosexual than people without disabilities.(11) These activities contribute to people with disabilities experiencing increased rates of STIs, unintended pregnancies, and sexual violence than those without disabilities.(12)

- In 2013/14 0.4% (122) of the Rutland population aged 18 years and above were registered with a learning disability.(9)

- In 2013/14, 27 households in Rutland were categorised as statutory homeless. This is significantly lower than the national rate of homelessness acceptances.(13) Homeless people are at increased risk of STIs and unwanted pregnancies and can come under pressure to exchange sex for food, shelter, drugs and money.

- The 2013/14 rate of looked after children in Rutland was 45.1 per 10,000, which is similar to the national average of 59.8 per 10,000 population.(13) Young people who are looked after are recognised as being vulnerable to risk taking behaviour(14) including early and unprotected sexual activity, self-harming, misusing illegal and/or volatile substances and alcohol. This makes this group particularly at risk of teenage pregnancy.

Implications for sexual health services

There are a number of vulnerable groups (including those that misuse substances, sex workers, homeless, those with mental health, learning or physical disabilities, children with child protection plans or that are looked after) that are more likely to participate in risk taking sexual behaviour and consequently have poorer sexual health outcomes than the general population. Each group has diverse requirements and therefore sexual health services should regularly complete an equalities impact assessment to review how they are meeting the diverse needs of these populations. Interventions may include targeted services (for example to MSM) or tailored information (for people with learning disabilities or English as a second language). Pathways between services that address risk taking behaviours (sexual health, mental health and substance misuse) should also be further developed across service providers to address the root cause of risk taking behaviours.

5. Sexually Transmitted Infections (STIs)

- In 2014, there were 193 new STIs diagnosed in residents of Rutland (62% male and 38% female), a rate of 515.9 per 100,000 residents. These rates were significantly better than the national rate of 796.1 per 100,000 population and similar to comparator local authorities (Appendix 1).(15)

- The highest rate of STI diagnoses in Rutland were in the 20-24 age band. This was followed by the 25-34 year age band, differing from Leicestershire and England, where the 15-19 age band was next highest.(15)

- Rutland has a new diagnosis STI rate (excluding chlamydia under 25years and prisons) significantly lower than the national average. Chlamydia, followed by

genital warts, were the most prevalent STIs in 2014. From 2012 the rate of genital warts in Rutland was higher (although not significantly) than the national average.(16)

- Syphilis has the lowest rate of new STIs both nationally and locally. Rutland has a higher syphilis rate than comparator local authorities, but this is not significant due to the rate in Rutland fluctuating due to small numbers.(16)

- The rate of genital herpes nationally has increased year on year since 2009, although Rutland rates have remained continuously lower than the national rate. Rutland rates fluctuate due to small numbers involved.(16)

- Nationally, young people aged 15-24 years, MSM and black Caribbean ethnic groups have been shown to have higher rates of new STIs.

- There has been an increase in the proportion of new STIs among MSM from 5.5% (n=6) in 2010 to 7.6% (n=8) in 2013 for Rutland. Chlamydia, gonorrhoea and syphilis diagnosis is higher in MSM as compared to heterosexual men, where chlamydia and genital warts was the most dominant STI.(17)

- The majority of STI diagnosis across Rutland is found in the White population.

Chlamydia screening

- In 2014 Rutland screened a significantly worse percentage of 15-24 year olds for chlamydia (18.9%) than the national average (23.9%) and some comparator local authorities (East Riding of Yorkshire, Cheshire East, Wiltshire, Cambridgeshire, North Yorkshire and Oxfordshire, Appendix 1). The chlamydia diagnosis rate for 15-24 year olds in Rutland was 1,390 per 100,000 population, being significantly lower than the national average of 1,978 per 100,000 population. In terms of percentage positivity both Rutland had lower positivity than the national percentage of 8.3% at 7.8%. Rutland performs lower than some comparator local authorities for Chlamydia detection rates, but this is only significantly lower than East Riding of Yorkshire.(16)

- Nationally and across Rutland males age 20-24 years have the highest percentage of tests with a positive result, followed by females aged 15-19 years. Chlamydia detection rates are higher in females than males aged 15-24 years. This distinction is particularly marked in Rutland where the rate for males is 888 per 100,000 aged 15-24 years, whereas the female rate is 2,054 per 100,000 females aged 15-24 years. Interestingly positivity rates from the Integrated Sexual Health Service (ISHS) are higher in males than females across LCR.(13)

- In Rutland, the highest percentage of 15-24 year olds tested for chlamydia were in 'Other locations', GPs and GUM.(8)

- In Rutland, community sexual health services has the highest percentage positivity (17.0%) followed by GUM clinics (11.3%). It must be noted that these high positivity percentages are likely to fluctuate due to smaller numbers involved.(8)

GUM access overall

- In 2014, there were 684 first time attendees from Rutland attending any sexual health clinic in England, of these 63% were male. In 2014, the age group most frequently attending for a sexual health screen was 25-34 age band. This could indicate problems of access for younger people or reflect the Rutland population profile.(8)

- 14% of attendees were homosexual/bisexual males and less than 1% of women were homosexual or bisexual.(8)

- There was a decrease in women and an increase in men attending for a sexual health screen in 2014 in Rutland.(8) This could be a consequence of the new ISHS model.

Leicester, Leicestershire and Rutland (LLR) integrated sexual health service (ISHS)

- The new LLR integrated sexual health service model commenced from 1 January 2014 with two new hub site locations (St Peter's and Loughborough) and five additional spokes (4 in Leicestershire and 1 in Rutland). Hub opening hours have increased to 9am-8pm Monday to Friday and Saturday mornings, (spoke sites are sessional). The change of clinic sites and establishment of the new service may have impacted on activity levels in 2014 as the new service established new locations. However there was an overall increase in attendances for GUM purposes to LLR sexual health sites by 44 for Rutland.

- In 2014 there were 354 attendances to the LLR ISHS by Rutland residents for both GUM and contraceptive services. 83% of the patients attending the Leicestershire clinics were residents of Leicestershire, 1.9% were residents in Rutland and 7% lived in Leicester City. The new service has decreased the percentage use of GUM clinics outside of LLR by 10% in Rutland between 2013 and 2014. In Rutland in 2014, Loughborough Health Centre (hub and spokes) had the highest counts of patients attending a GUM, followed by Edith Cavell in Peterborough.(18)

- The highest user age band was in the 15-24 age group. The majority (73%) of attendances were female. This is likely to be reflective of attendances for contraceptive services.(18)

- The majority of attendees were of white ethnicity which is reflective of the local population.

- The percentage of male attendees identifying as homosexual or bisexual was 13.8% for Rutland and 14.2% for Leicestershire.(18)

- In Rutland 40% of the population live less than a 10 minute drive from an ISHS site and 19% have a drive of 20-30 minutes. However the Rutland clinic site is sessional and has limited capacity.(19) N.B. this assumes residents access the service via private transport as public transport were not reviewed in this docuement.

Implications for sexual health

- Overall Rutland experiences lower than rates of STI diagnosis than the England average. Chlamydia is the most common STI across Rutland, followed by genital warts. This is a similar trend to Leicestershire County. Young people aged 15-24 years, MSM and black Caribbean ethnic groups have been shown to have higher rates of new STIs across LCR, which is aligned with the national picture. Increases in have been seen in the proportion of STIs diagnosed in MSM across Rutland (and Leicestershire). This may be due to increased uptake of STI screening or higher STI prevalence. Either way targeted work must be maintained with MSM due to the high level of sexual health need.

- Rutland does not perform well against the national average and some comparator local authorities for Chlamydia screening in 15-24 year olds. This has been particularly apparent since changes have occurred in the national data collection from 2012. However all comparator local authorities perform similarly, which may indicate that the overall prevalence of chlamydia is lower than the national average. Either way chlamydia screening is a useful tool in normalising STI screening with young adults, therefore opportunistic screening should be increased in core sexual health services.

- There have been increases in GUM attendance locally and to clinics outside of LLR by Rutland residents. This may reflect increased access due to the new LLR ISHS, increased awareness of STI screening, but also reflects the increased STI need. Slightly older populations (25-29year olds) are most frequently accessing the ISHS from Rutland as compared to Leicestershire (20-24year olds) which may reflect reduced access or the demography of the population. In 2014 there was an increase in men and decrease in women accessing GUM sexual health services locally. This may be due to changes in the ISHS service model. Further work is needed to increase sexual health access to high risk groups (including MSM), female and younger populations in Rutland.

- Rural access is a particular difficulty for Rutland due to limited access to some

hub and spoke sites via public transport. The use of clinics outside of LLR by Rutland residents reflects access issues as some residents may choose to go to other open access sexual health services perhaps closer to workplaces and colleges. The new ISHS has reduced out of area GUM access by 10% in Rutland between 2013 and 2014. Increasing accessibility to local services and providing alternative local sexual health service provision such as general practice and pharmacy may continue to reduce use of out of area services.

6. Human Immunodeficiency Virus (HIV)

- In 2013 the HIV diagnosis prevalence in was 0.73 per 1,000 population aged 15-59 years for Rutland. This is significantly lower than England average of 2.1 per 1,000 population aged 15-59 years and lower than most comparator local authorities (Appendix 2).(16)

- HIV prevalence rates across Rutland (and Leicestershire) have increased over time. This is largely due to increased life expectancy as treatment has improved to make HIV a long term condition.

- In 2013 there were 15 adults received HIV related care in Rutland, 66% male and 33% female. 53% were white and 40% black African ethnicity. The likely route of infection was approximately 53% sex between men and 47% sex between men and women. There were no new diagnoses in 2013, which shows Rutland is performing better than all its local authority comparators.(20)

- In 2011-13 67% of HIV patients in Rutland were diagnosed at a later stage of infection, most of these being heterosexual. This is higher than the England overall percentage of 45%. However due to the small numbers, Rutland's overall rate of late HIV diagnosis is the best performance compared to local comparators (Appendix 1).(13)

- The uptake of HIV testing at GUM clinics was similar in Rutland (79.4%) than in England (80%). Uptake by men in Rutland was lower than the England average.(16)

- Community based testing is available for some groups in Leicestershire and Rutland. Home testing and home sampling HIV tests are now legally available and a home sampling pilot targeting MSM and black African communities is due to commence across Leicestershire and Rutland in late 2015.

Implications for sexual health

- There is significantly lower HIV diagnosis rates across Rutland compared to

the national rate and local authority comparators. However HIV prevalence overall is increasing locally and nationally largely due to increased life expectancy as treatment has improved to make HIV a long term condition. There are implications for health and social care providers as the HIV positive group increases in number and becomes an aging population with changing health needs.

- Early HIV diagnosis is important to improve health outcomes for the individual, reduce risk of onward transmission and lower treatment and care costs. Rutland has a higher late HIV diagnosis percentage than the England average. This is particularly apparent in heterosexual transmission. Therefore further work is needed to educate the heterosexual population about HIV and increase access and uptake of HIV testing, for example in Rutland males accessing GUM. Referral pathways between sexual health and HIV services must also be reviewed to ensure there are seamless pathways which prevent unnecessary delay between diagnosis and treatment. Commissioning of alternative HIV testing methods such as home testing and home sampling are important options to consider for increasing HIV testing to high risk groups including MSM and black African communities. The implications of the PROUD study on pre-exposure prophylaxis should also be considered to reduce HIV transmission to specific high risk groups.

7. Sexual Reproductive Health

Contraception

- It is estimated that on average, women have a 30 year time period in which they will need to avert an unintended pregnancy.
- Contraception is cost saving, with £11 saving for every £1 spent. NICE guidance identifies that LARC methods such as contraceptive injections, implants, the intrauterine system (IUS) or intrauterine device (IUD) are more effective at preventing pregnancy than user dependent methods(e.g. oral contraception, condom).
- Contraception is available from specialist open access sexual health services and from general practice. It is estimated that 80% of contraception is delivered through general practice (GP).
- In 2013, 193 Rutland residents attended specialist sexual health services for contraception.(17)
- In specialist contraceptive services across LCR, user dependent methods of contraception (UDM) were most frequently prescribed for all ages except for the

35-44 year age group, who were most frequently prescribed LARC methods. In 2013, similar or lower proportions of LARC were prescribed overall compared to the England average in all age groups except for the 18-19 and 25-34 year age groups in Rutland.(17)

- For Rutland residents, LARC represents 46% of contraceptive provision from specialist sexual health services and 15% from general practice.(17)
- LCR has a higher rate of LARC prescribing from primary care compared to the national average. The rates in 2013 were 76.1 per 1,000 women aged 15-44 years for Rutland as compared to 52.7 for England and compared to local comparator local authorities. There has been a small increase in the proportion of LARC delivered across Rutland in primary care between 2013 and 2014.(16)
- 4 practices provide contraceptive implant fitting and activity levels vary across practices. In 2014/15 there were 157 implant insertions and 104 implant removals.
- 4 practices provide inter uterine devices/ systems (IUD/S) fitting and activity levels vary across practices. 183 IUD/S fits were completed in 2014/15.
- Retention of LARC methods is an important factor. LARC methods are cost effective even at one year's use compared to user dependent methods such as the contraceptive pill. Retention rates are difficult to calculate as women may attend different services for fits and for removal.
- The IUS is also used for non-contraceptive purposes e.g. control of heavy menstrual bleeding. This is the commissioning responsibility of Clinical Commissioning Groups. The number of fits for this purpose is difficult to determine from available data sources.
- Approximately 60% of practitioners delivering LARC services across LCR currently hold national FRSH Letters of Competence. Ongoing training is required to maintain competencies of practitioners to provide IUD/S and SDI in primary care.

Emergency Contraception

- It is important to access emergency contraception (EC) as early as possible after unprotected sex or contraceptive failure so good access to local services is important.
- There are different types of EC available. There are two types of Emergency Hormonal Contraception (EHC), LNG and UPA (EHC) and also Cu IUD.
- All forms of EC are available from the ISHS and General Practice. EHC (LNG) is available from 5 pharmacies in Rutland, 84 pharmacies in Leicestershire and from some school nurse clinics.

- In 2014-15 there were 190 EHC consultations in Rutland Pharmacies. Rutland residents also use Pharmacy services outside of Rutland. Across LCR, the majority of users were in the 19-24 age group. The most frequently stated reasons for accessing EHC were split condom (almost 50%) and no contraception used (40%). The number of patients referred on to sexual health services for further sexual health/contraceptive advice increased between 2013-14 and 2014-15.(21).

Psychosexual services

- There have been no known referrals for psychosexual services for residents of Rutland.

- The Natsal-3 sexual attitudes and lifestyles in Britain survey (2010-12) indicated 51% of men and 42% of women surveyed experienced one of more sexual difficulties lasting more than three months in the past year, including lack of interest in having sex, feeling anxious during sex, pain during sex, vaginal dryness and problems getting or keeping an erection.(22)

Teenage Pregnancy

- In 2013, the under 18 conception rate per 1,000 female aged 15 to 17 years was 9.2 in Rutland, while in England the rate was 24.3. Between 1998 and 2013, Rutland achieved a 45.6% reduction in the under 18 conception rate. Nationally the rate reduced by 47.9% throughout this time. Rutland has the lowest under 18 conception rate when compared to comparator local authorities.(16)

- In Rutland, the rate of under 18 conceptions has remained consistently lower compared to all Leicestershire districts over time. Rutland saw an increase in their conception rate 11.7 per 1,000 15-17 aged females in 2010-12 to 12.3 per 1,000 in 2011-13.(23)

- Since 2008-10, Rutland has witnessed a year on year decrease in the percentage of under 18 conceptions leading to abortions from 50.0% in 2008-10 to 30.0% in 2011-13.(23)

Abortion

- Nationally an estimated one in six of pregnancies were unplanned, two in six were ambivalent and three in six were planned. This gives an annual prevalence estimate for unplanned pregnancy of 1.5%. Pregnancies in women aged 16–19 years were most commonly unplanned (45.2%) however, most greatest proportion of unplanned pregnancies were in women aged 20–34 years (62.4%).(24)

- There were 55 abortions for Rutland residents in 2014.(25)

- In 2014 the abortion rate for Rutland was 9.5 per 1,000 female population. This is significantly better than England average of 16.5 per 1,000 female.(25)
- The highest abortion rate was for the 20-24 year population. Note this is different to Leicester City where the highest abortion rate is in the 25-29year olds.(25)
- In 2014, 21.4% of women in Rutland had had a previous abortion, while in England the proportion was higher at 27.0%. This increases to 37% for Rutland in the over 25 age group, however this is aligned with the England proportion at 45.6%.(25)
- In 2014 85.2% of Leicestershire women accessing abortion were under 10 weeks gestation at time of procedure, which is higher than the England average of 80.4%. Rutland has the highest performance compared to comparator local authorities (Appendix 1).(25)
- In 2014 in Rutland, 8% women accessed an abortion procedure at 13 weeks or more gestation. This was similar to National average of 9%.(25)
- In 2014, approximately a third of all abortions in Rutland were surgical procedures compared to approximately half in England.(25)
- There are two providers of abortion services commissioned for LLR population. There is limited local availability of procedures over 12 weeks. Self-referral is not available for both providers.

Implications for sexual health

- Contraception is a cost effective intervention for the whole of society. LARC is shown to be the most cost effective method available. Across Rutland LARC prescribing rates are above the national average for primary care, however contribute to a lower proportion of total contraception use. Therefore additional work is needed to maintain the level of GP provision and increase the proportion of LARC procedures completed in the ISHS. This will include working with GPs to increase the proportion of LARC fitters accredited via the national Letter of Competence and to undertake an audit to gain a better understanding of how long LARC devices are being retained by women.
- It is important to maintain easy access to emergency contraception (EC) to allow women to access services as soon as possible after they have had unprotected sex. There is good access to EC across LCR provided by the ISHS, GP and local pharmacy. Consideration should be given to new forms of EHC such as UPA (which has a longer effective window) and ensuring women accessing EHC are referred into contraceptive services to establish a longer term contraceptive regime (in particular LARC).

- The Natsal-3 sexual attitudes and lifestyles in Britain survey (2010-12) indicated 51% of men and 42% of women surveyed experienced sexual difficulties lasting more than three months in the past year.**Error! Bookmark not defined.** Hence there is likely to be some unmet demand for psychosexual services across Rutland due to no current attendances within the ISHS. With an aging population, this demand is likely to increase. Therefore commissioners should consider increasing awareness of the existing service and increasing the activity levels in the future. Discussions are also needed with the local CCGs to identify services for patients with sex addiction.

- The under 18year conception rate is significantly lower than national average And comparator local authorities. The proportion of under 18 conceptions leading to abortion, is reducing and is lower than the England average. However conceptions leading to abortion and numbers of young people accessing emergency contraception, suggests that there are still young people who continue to take risks and not use contraception despite not wanting to become pregnant. Therefore continued easy access to relationships and sex education, including provision in independent schools, and to community based sexual health services is important to maintain and improve current progress. Training around teenage pregnancy and related issues is important to ensure a high quality children's workforce who feel competent to discuss a range of issues and support young people's access of health services.

- Teenage parents experience barriers in accessing education, employment or training. This will impact on their lifelong opportunities, which will impact on the health and wellbeing of both themselves and their child. Therefore a co-ordinated response to the support of young parents is important to ensure a range of needs are addressed.

- Rutland has a lower abortion rate than the national average. However a fifth of women had previously had an abortion and some women are accessing services at a stage of later gestation, which reduces their choice of procedure and increases risk of complications and healthcare costs. There is also limited local availability for procedures over 12 weeks across Leicestershire and Rutland and self-referral is only available in one provider. Therefore additional work is needed to increase access to local abortion services and ensure that all abortion patients are supported to establish a long term contraceptive plan to avoid repeat abortions.

8. Sexual Abuse

- In 2013/14, there were 14 reported sexual offences in Rutland. In this year, the rate of sexual offences in Leicestershire was 0.38 per 1,000 population. This rate is lower than the national rate of 1.01 per 1,000 population. Since 2011/12, the rate for sexual offences in Rutland has decreased year on year.(13)

- Natsal-3 found that 1 in 10 women and 1 in 71 men said they had experienced non-volitional sex since age 13 (median age for males was 16 and for females was 18). People with poorer physical, mental and sexual health, including treatment for depression or another mental health condition in the past year, a long-term illness or disability, and a lower sexual function score were more likely to report non-volitional sex.(26)

- In 2014, the estimated numbers of people the adult population aged 18-64 who report having been sexually abused during their childhood was 735 females and 1,600 males in Rutland. These numbers are estimated to decrease slightly in Rutland over the next fifteen years.(27)

- Over the past three years referrals to the LLR Child Sexual Exploitation (CSE) team have increased from 54 in 2012/13 to 165 in 2014/15. Prevention, identification and support for victims of CSE remains a key priority for sexual health services.

Implications for sexual health services

- Domestic abuse is a widespread issue and can take place in a range of relationships. There is a lack of understanding around what constitutes domestic abuse. The national coverage on historic abuse and current approaches to raise awareness about CSE are likely to lead to lead to increases in the number of victims coming forward and seeking help. It is therefore important that staff who work in sexual health services are aware of the prevalence of domestic abuse and CSE and are equipped to ask appropriate questions when seeing patients to allow disclosures to be made and appropriate referral onto specialist services.

9. Engagement

- As part of this SHNA a range of stakeholders and service users have been consulted. This includes 2 sexual health stakeholder events consulting over 100 stakeholders and 7 focus groups consulting with 94 people from May to September 2015. Specific Rutland groups that were engaged included the Oakham Youth Group, and Learning Difficulties and Disabilities (LDD) Partnership Group. Rutland specific feedback included the need to complete the needs assessment, develop the workforce, increase access to rural populations (including C-Card), school nurse EHC provision and to have parity of RSE support. LLR historical research findings on HIV prevention services, Relationships and Education, young people's knowledge, attitudes and experience of sexual health and access to LARC and have also been summarised.

- National data and local engagement work highlighted the critical exploration of relationships in both Relationships and Sex Education (RSE) and in the delivery sexual health services.
- There continues to be a lot of confusion over how contraceptive methods work and myths about their reliability and use.
- Services need to take account of the role the media plays in influencing decisions about sex and relationships and make attempts to counter negative or unhelpful overt messages with positive ones e.g. promotion of consent, how to access confidential services and what a healthy relationship looks like.
- Service users value the importance of having local, community based sexual health provision.
- Service providers and users both highlighted gaps in information about the sexual health services that are available, how they can be accessed and how complaints can be raised.
- Additional messages from local stakeholders and professional included the need to clarify the sexual prioritises and commissioning responsibilities across the system to develop a truly integrated LLR sexual health system. Particular feedback was gained on the need to provide equitable and timely access to services, develop the wider sexual health workforce (including primary care) and develop seamless pathways across organisations and services.

Implications for sexual health

- National data and local engagement work highlighted the critical exploration of relationships in both RSE and in the delivery sexual health services. With the impact of social media, evolving sexual practices and a reducing age of first sex, promotion of consensual, informed and respectful relationships is important to balance against other messages.
- Services need to take account of the role the media plays in influencing decisions about sex and relationships and make attempts to counter negative or unhelpful overt messages with positive ones e.g. promotion of consent, how to access confidential services and what a healthy relationship looks like.
- Service users value the importance of having local, community based sexual health provision. Service providers and users both highlighted gaps in information about the sexual health services that are available, how they can be accessed and how complaints can be raised. Clear and consistent information is required to ensure practitioners and service users know which services they can access and how they do this.

- Despite there being a wider choice of contraception available, there continues to be a lot of confusion over how contraceptive methods work and myths about their reliability and use. Messages about relationships and sex (in school and beyond) need to include clear and concise information about contraceptive methods. In order to promote the LARC methods it is important that the benefits and implications of these methods are understood and communicated to the women who choice to use them.

- From the perspective of Sexual Health Service Providers, key priorities to address are clarifying the priorities for sexual health delivery, commissioner and provider roles and responsibilities, integrating sexual health services across the system and further development of the wider sexual health workforce (including primary care and school nursing). Areas which both providers and service users highlighted including wanting more equitable and timely provision across LLR, wanting easier access in to services, seamless patient pathways, prioritising education on relationships and sex and ensuring clear information about local services.

10. Conclusion

Overall Rutland is meeting the majority of the sexual health needs of the local population. This is evidenced by continuing lower rates for all STIs (including HIV), under 18 conceptions and sexual abuse than the England average and many local authority comparators (see Appendix 1 and summary dashboard Appendix 2). Nevertheless absolute numbers of some STIs (including gonorrhoea) and patient led demand is increasing across Rutland. This is consistent with the national picture, where more people are accessing specialist sexual health services. However locally this increase is also likely to be linked to the improved access created by the new integrated sexual health service and community based contracts, which have increased numbers and proportions of residents accessing local services across Rutland. (Although there is still significant use of specialist sexual health services outside of LLR by residents of Rutland.) STI screening and contraception uptake are part of a prevention approach to enable people to maintain good sexual health. Further work is on-going to establish high quality relationships and sex education across all secondary schools; this supports young people to develop positive, healthy relationships.

Each section above (demography, high risk groups, STIs, HIV, sexual reproductive health, sexual violence and engagement) provides specific implications for sexual health services following the review of evidence of need. When triangulating these sections together key areas for improvement across Leicestershire and Rutland include bringing together the sexual health commissioning system, prioritising prevention and access to vulnerable groups (including young people, men who have sex followed by sex workers, black African communities and people with physical

disabilities) and developing the sexual health workforce (including non-specialist provision such as primary care, school nursing and substance misuse). The recommendations from this triangulation are set out below. These will be translated into a sexual health strategy for Leicestershire and Rutland and reported to local authority departmental management teams, Health and Wellbeing Boards, health scrutiny, Cabinet and other appropriate meetings for approval and implementation.

Key strengths of the needs assessment include the breadth and depth of validated quantitative national data sources that deliver reliable accurate data on service utilisation. This is a good reflection of need for contraception and STIs that have symptoms, however is less effective for symptomless or latent STIs such as chlamydia and HIV. Although recent media interest may increase presentation, there is also likely to be underreporting for psychosexual issues and sexual abuse including FGM and CSE. High quality information on specific vulnerable groups (e.g. sex workers, MSM, FGM etc.) was difficult to ascertain. Due to small numbers in many indicators (especially for Rutland) numbers can fluctuate widely across years, making trends more difficult to interpret. There were also different time lags in data sources which must be considered when comparing sections. Qualitative feedback with nearly 200 people was also completed as part of the needs assessment to add additional local detail and identify themes from the results, however fully validated thematic analysis using NVivo was not completed. The consultation with representatives from services was undertaken at a time of year that made it difficult for certain sectors to be involved e.g. teachers and representatives from education and the service user consultation was quite targeted being mainly with individuals under 25. Wider consultation with the general population would provide a broader perspective of views and this will be completed as part of the consultation on the needs assessment and strategy. Results from the needs assessment may be similar to that seen in other affluent counties across England, however is less generalisable to more urban cities.

The Rutland sexual health needs assessment provides commissioners with a clear evidence base on sexual health need, supply and demand. With increasing and aging populations, changing sexual health needs across Rutland and increasing pressure on public sector budgets. It is therefore necessary to evolve innovative integrated service models to meet this demand within constrained budgets across the local health and social care system.

11. Recommendations

The following section summarises the key recommendations for sexual health commissioners and service providers across Rutland; N.B. these have been categorised to develop the key themes in the draft Rutland Sexual Health Strategy 2016-19.

11.1 Sexual Health Commissioners

1. **Development of a sexual health strategy for Leicestershire and Rutland**. Ensure that this engages and integrates the whole sexual health system, has clearly defined priorities, roles and responsibilities and considers sexual health across the life course.

2. **Explore co-commissioning opportunities to integrate sexual health patient pathways across commissioning organisations.** For example, with CCGs for primary care, menorrhagia, sex addiction, abortion services and NHS England for HIV services (including the implications of the PROUD study). Also consider how sexual health services can be further integrated into other local authority services such as substance misuse, school nursing, health visiting and social services (for HIV positive patients).

3. **Monitor demand for psychosexual services** and potentially increase provision as awareness and need increases with an aging population.

4. **Identify service provision to support people with sex addiction**. Work with CCG mental health commissioners to consider appropriate access to treatment for sex addiction across LCR.

5. **Development of an LLR sexual health marketing and communications strategy** to promote consistent brands and messages about healthy relationships, reducing stigma and how to access services. Additional service promotion is needed to target groups and areas at higher risk of poor sexual health including young people, MSM, sex workers, black African communities. The implications of late HIV diagnosis should be raised with the heterosexual population. N.B. This should consider links to out of area services such as those accessed in Peterborough.

6. **Assess the cost effectiveness of UPA emergency hormonal contraception** by completing a cost benefit analysis of increasing access to UPA locally. This should then inform future emergency contraception provision across LCR.

7. **Undertake an audit of LARC retention rates in primary care and ISHS** to ascertain how well informed women are of the implications of these methods and how long women are retaining them for. This should focus particularly on younger women aged 15-34years.

8. Consider **locality priorities to address the differing trends in teenage pregnancy** across the 7 Districts in Leicestershire and in Rutland.

9. Additional work is needed with the police to **understand the causes of the increases in sexual offences** in Leicestershire and interventions to help reduce these offences.

10. **Rutland commissioners to consider agreeing a local tariff arrangement with Peterborough sexual health services** due to the number of GUM attendances within this area.

11. Consider the **sexual health needs of the military barrack populations in Rutland.** This should form part of a wider health needs assessment on these defined populations.

11.2 Sexual health services

12. **Equality impact assessment should be completed in all sexual health services** to ensure the services are meeting the needs of whole population including those with protected characteristics as determined in the 2010 Equality Act. Particular attentions should be placed on sexual orientation, BME (including Asian populations that have under representative STI diagnosis), English not as a first language and people with learning and physical disabilities.

13. **Investigate the current barriers to accessing sexual health services from General Practice**, in particular by young people, LGBT and Sex Workers.

14. **Increase chlamydia screening as part of the core ISHS** (i.e. GUM and CSHS) due to high positivity rates and prioritise opportunistic screening to sources of highest positivity such as preventex postal kits.

15. Explore more **innovative models of ISHS service delivery to improve access particularly in more rural areas** including Melton and Rutland .e.g. implementing virtual clinics, online testing etc. Priority should be given to increasing access to sexual health screening to men across Leicestershire and women and those aged 20-24years in Rutland.

16. **Improvements are needed to the appointment booking system for ISHS**. The service should continue to offer both appointments and drop-in appointment options.

17. **Develop effective and efficient pathways between sexual health services and domestic abuse, substance misuse and mental health** services to address the root causes of the risk taking behaviour.

18. **Ensure sex workers and men who pay for sex have access to condoms and regular STI screening** to reduce bridging of STIs into the wider population.

19. **Increase access to community and home based HIV testing for specific groups at higher risk of HIV** (MSM, sex workers, young people, African heritage.) This includes developing robust protocols and pathways for local HIV testing to ensure rapid access to support and treatment for people with reactive

test results. Attention should also be given to increasing HIV testing within ISHS for men in Rutland.

20. **Health and social care providers should consider future needs of HIV positive population.** This includes implications of an ageing HIV population and assurance for patients that confidentiality is maintained as the group of care providers extends beyond specialist HIV care providers.

21. **Maintain good access to emergency contraception**, particularly for young people and Asian women. Improve pathways between emergency contraception providers and other sexual health services to ensure longer term sexual health needs are met.

22. **Improve information and access to range of contraception methods to young women aged 15- 25years**, including LARC. This includes reviewing the current model of LARC delivery in primary care to reduce the proportion of women using user defined methods through GPs and ensuring community provision is available for young people.

23. **Increase access to abortion services by developing a single point of access for LLR** (including self-referral) to improve the proportion of women accessing services under 10 weeks gestation. Consideration is also needed to improve local access to abortion services over 12 weeks gestation.

24. **Review of the specialist teenage pregnancy and community midwifery service pathways** to identify opportunities for further integration with sexual health services and to determine the extent to which they are meeting current need.

25. **Review the support needs of teenage parents and mothers in particular those aged 19-21** to ensure that they can positively progress into education, employment and training at a point that is timely for them and their families.

26. **All sexual health services should support the LLR CSE strategy.** Consultation with the CSE Team and if possible, victims of CSE needs to explore to what extent the current SHS offer meets the needs of this vulnerable cohort

11.3 Training

27. **Complete a sexual health training assessment to develop a workforce plan** to improve all levels of sexual health competencies across LCR. LARC provision and primary care is a key priority for this plan.

28. **Ensure high quality RSE training/ provision is delivered across LCR** to ensure young people can make informed choices about their sexual health. Materials should give greater emphasis on healthy relationships, consent, domestic abuse, how to seek help, all contraceptive methods and the links

between alcohol and risk taking sexual behaviour. RSE materials to support parents should also be considered.

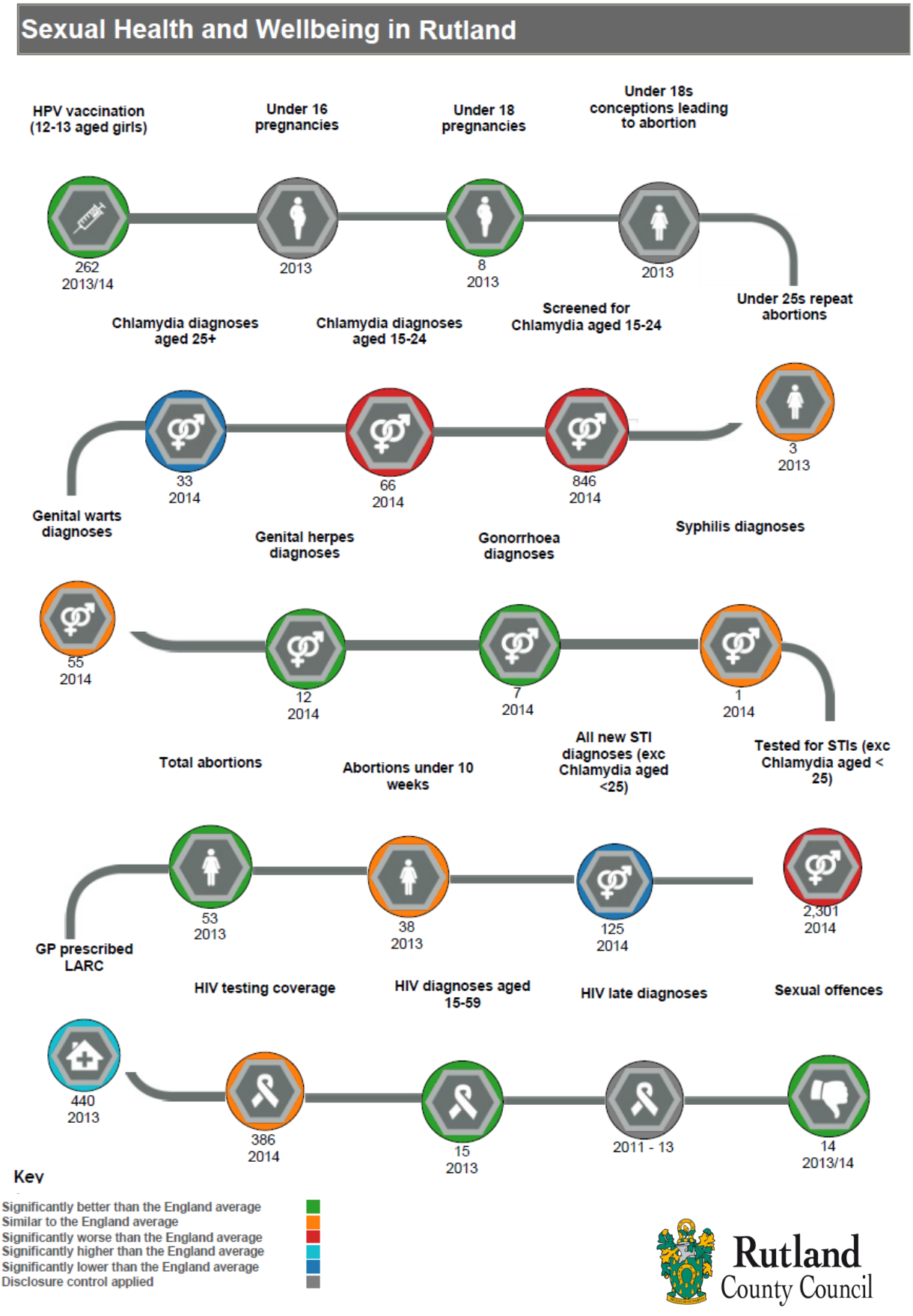
29. **CSE and domestic abuse training should be accessed by key staff from all sexual health providers** to ensure that practitioners can identify and understand local support pathways available.

Appendix 1 Rutland Sexual and Reproductive Health performance compared to comparator local authorities. (Data PHE Sexual and Reproductive Health profiles, data as of November 2015. N.B HIV data has been updated from the full needs assessment).

Indicator	Buckinghamshire	Cambridgeshire	Central Bedfordshire	Cheshire East	East Riding of Yorkshire	North Yorkshire	Oxfordshire	Rutland	West Berkshire	Wiltshire	Worcestershire	Rutland rank (1 best)	Polarity (is L or H good)
Abortions under 10 weeks (%)		74.60	82.40	78.96	80.17		76.24	**85.19**	83.19	81.55	76.99	1	H
All new STI diagnoses (exc Chlamydia aged <25) / 100,000	575.77	481.32	508.41	551.21	448.07	397.57	776.91	**538.93**	512.18	473.10	567.83	7	L
Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02)	4237.51	4713.74	3944.60	5175.80	6003.10	5043.97	3530.27	**4332.37**	2844.18	5123.84	4774.39	7	H
Chlamydia proportion aged 15-24 screened	19.13	24.94	16.05	23.21	21.67	22.93	20.86	**17.82**	10.86	19.62	17.96	9	H
Gonorrhoea diagnosis rate / 100,000	25.00	17.24	21.55	19.85	14.88	12.28	50.74	**18.61**	17.38	19.39	21.85	5	L
GP prescribed LARC rate / 1,000	56.94	72.41	63.18	52.61	74.07	100.57	65.02	**90.30**	74.00	82.76	63.42	2	H
HIV diagnosed prevalence rate / 1,000 aged 15-59	1.39	1.09	1.32	0.91	0.41	0.59	1.13	**0.48**	0.75	0.70	0.76	2	L
HIV late diagnosis (%) (PHOF indicator 3.04)	53.73	52.81	45.71	43.90	47.83	55.00	44.44		0.00	40.63	67.50	1	L
HIV testing uptake, total (%)	79.60	83.60	76.40	61.80	63.00	75.70	81.90	**77.90**	80.50	78.20	70.10	6	H
New HIV diagnosis rate / 100,000 aged	5.67	5.85	5.00	6.08	1.40	2.96	3.43	**0.00**	2.37	2.26	5.41	1	L

15+													
Population vaccination coverage - HPV (%) (PHOF indicator 3.03xii)	88.37	91.84	91.25	93.12	89.31	83.77	92.51	**93.57**	85.07	87.98	86.39	1	H
Sexual offences rate / 1,000 (PHOF indicator 1.12iii)	1.18	1.17	0.81	0.92	1.19	1.16	1.33	**0.98**	1.20	1.23	1.54	3	L
Syphilis diagnosis rate / 100,000	1.55	2.37	2.65	5.37	2.08	3.82	3.00	**2.66**	2.57	1.46	2.62	8	L
Under 18s conception rate / 1,000 (PHOF indicator 2.04)	17.21	16.14	19.86	19.31	20.34	17.12	16.54	**9.18**	18.48	19.49	25.09	1	L
Under 18s conceptions leading to abortion (%)	55.09	47.40	58.70	61.11	49.59	53.55	48.37		61.40	46.89	50.40		L
Under 25s repeat abortions (%)		19.44	24.25	25.19	16.61			**21.43**	26.32	25.06	23.01	3	L

Appendix 2 Summary of sexual health indicators across Rutland (Data as of October 2015)



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Report No: 54/2016
PUBLIC REPORT

SCRUTINY PANEL

18 February 2016

REDUCING SUBSTANCE MISUSE HARM IN RUTLAND: PROPOSAL FOR COMMISSIONING COMMUNITY TREATMENT

Report of the Director of Public Health

Strategic Aim:	'Creating a safer community for all' and 'Meeting the health & wellbeing needs of the community'.	
Exempt Information	None	
Cabinet Member(s) Responsible:	Cllr Richard Clifton	
Contact Officer(s):	Mike Sandys, Director of Public Health	0116 30 54239 Mike.Sandys@leics.gov.uk
	Julian Mallinson, Consultant in Public Health	0116 30 54262 Julian.Mallinson@leics.gov.uk
Ward Councillors	N/A	

DECISION RECOMMENDATIONS

That the Panel:

1. Notes the future vision for reducing substance misuse harm in Rutland and the shift towards prevention, early help and recovery tailored for Rutland.

2. Notes the most viable option for the Interim Service as being an exemption from the Council's Contract Procedure Rules to directly award a contract to the provider of the new Leicester City and Leicestershire service.

3. Notes the funding envelop for the Interim Service and the associated contribution towards the Council's Medium Term Financial Plan.

1 PURPOSE OF THE REPORT

1.1 Drug and alcohol misuse causes avoidable harm to people, families and communities in Rutland. As considered by Cabinet on 16 February 2016, this report sets out the current approach and future vision for reducing substance misuse harm in Rutland, describes the various dimensions of local need and proposes options for procuring community treatment from 30 June 2016 when current contracts end.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 'Substance misuse' refers to the harmful use of alcohol and psychoactive drugs for non-medical purposes, which causes avoidable physical, social and/or psychological harm.

2.2 Since April 2013, Rutland County Council (RCC) has been responsible for improving public health through its population focus, local leadership and commissioning substance misuse services.

2.3 Reducing substance misuse harm requires a comprehensive approach, which recognises that different levels of intervention are appropriate for addressing different levels of need. The balance of the current programme is towards the higher levels of intervention.

Levels 0 and 1	Health improvement for general population and low risk drinking.
Level 2	Early identification and brief advice for increasing/higher risk substance misuse.
Level 3	Specialist treatment and recovery for substance misuse dependency, including clinical interventions

3 SUBSTANCE MISUSE IN RUTLAND

3.1 Local needs were assessed based on expert opinion from research, information on service use, benchmarking against other areas and consultation with staff and service users.

3.2 Substance misuse has far reaching impacts on individual health, families and communities. Evidence- based interventions to reduce harm have the co-benefits of improving health and wellbeing, cutting crime and saving money. Treatment services should be recovery-orientated, compliant with national guidance and person-centred.

3.3 Key measures that describe need at different levels include[1]:

- Number of young people participating in college-based initiatives (2014/15) = 450.
- Number of people receiving a NHS health check, including alcohol screening (2014/15) = 1,193.
- Number of adults screened for alcohol misuse in primary care (2014/15) = 1,831.
- Number of brief interventions in primary care (2014/15) = 53.
- Population aged 18-64 predicted to have alcohol dependence (2014) = 1,243.

[1] Restrictions on disclosure apply to small numbers of less than five. National Drug Treatment Monitoring System (NDTMS) performance reports are classified as Restricted Statistics. At the time of writing this report, 2014/15 activity was subject to publication restrictions.

- Population aged 18-64 predicted to have drug dependence (2014) = 702.
- Estimated prevalence of opiate and/or crack cocaine users aged 15-64 (2011/12) = 45.
- Number of adults in drug and/or alcohol treatment (2014/15) = 97-114.
- Number of young people in drug and/or alcohol treatment (2014/15) = <5.
- Number of alcohol-related hospital admissions (2013/14) = 127.
- Alcohol related mortality (2013) = 12.
- Number of assessments by hospital-based alcohol liaison team (2014/15) = 23.
- Number of users in inpatient detoxification (alcohol) (2014/15) = <5.

3.4 Based on estimated prevalence and numbers in treatment, alcohol misuse is likely to be more of a problem in Rutland than drug misuse. In absolute terms, the number of people currently accessing support for substance misuse is small. However, prevalence estimates and GP screening would suggest that there are many others who would benefit from support. Overall, Rutland performs well against England, the East Midlands and its statistical neighbours. Efforts to reduce substance misuse harm should be organised through local partnerships. The wider Council has a role in addressing social and economic issues that relate to substance misuse. A comprehensive harm reduction programme should include school-based prevention, innovative approaches and treatment services that are accessible, visible and responsive to the distinct needs of children and adults.

4 FUTURE VISION

4.1 Within a comprehensive harm reduction programme, our vision is to shift the balance from treatment to prevention, early help and recovery and from public service provision to self-help and organised community support.

4.2 To realise this vision, there will be a planned approach to shifting from current community treatment services to;

- Interim Service - that will provide integration and continuity of substance misuse treatment after current contracts end on 30 June 2016 through to 31 March 2017 and the commencement of longer term arrangements below.

- Integrated Wellness Service - (Level 2 substance misuse alongside other health, social and economic needs) from 1 April 2017, likely supplemented by specialist substance misuse treatment (Level 3) purchased on a spot-basis.

4.3 The remainder of this report focusses on the procurement of the Interim Service. The Integrated Wellness Service, and any future specialist provision, will be the subject of a future Cabinet report.

5 COMMUNITY TREATMENT SYSTEM

5.1 The system of community treatment is currently made up of three services that provide information, brief advice and liaison, harm reduction, clinical and psychosocial interventions and recovery support. Their total contract value is £201,300 per annum, which is 95% of the substance misuse budget and 16% of the 2015/16 Public Health Grant. The remainder of the substance misuse budget is allocated to screening and brief advice in primary healthcare and inpatient detoxification. Other schemes funded outside the substance misuse budget, which contribute to prevention and early help for substance misuse, include the Teenage Health Worker and NHS Health Checks programme.

6 PROCUREMENT OPTIONS FOR INTERIM SERVICE

6.1 There are five options for procuring the Interim Service, which have been fully appraised against a range of considerations. These options are;

- **Option 1. Delegate** - to a commissioner of the new integrated substance misuse service for Leicester City and Leicestershire County.
- **Option 2. Direct award** - to the new Leicester City and Leicestershire County service.
- **Option 3. Out of area** - direct award to an established neighbouring provider, in consultation with the respective commissioner.
- **Option 4. Mini competition** - light-touch competitive process, restricted to selected providers in order to expedite timeline.
- **Option 5. Do nothing** - not replacing current contracts after they expire.

6.2 Given the profile of the service and the clinical risk of withdrawing treatment, 'doing nothing' (Option 5) was deemed to be unacceptable to service users and stakeholders. A discrete Rutland service, procured through a mini-competition process (Option 4) for an interim period, may not be attractive to providers and would not offer choice to services users or economy of scale. The option of procuring an out of area provider (Option 3) may be feasible, but less flexible if already established and dependent on support from the out of area commissioner.

6.3 The two options receiving the highest scores (Options 1 and 2) both involve the new Leicester City and Leicestershire service. This new service has been designed locally, is aligned with related health and social care and could include Rutland from the start of mobilisation. Although delegation to Leicester City Council or Leicestershire County Council would have the advantage of leveraging the provider to deliver in Rutland through an existing contract and relationship, it may not be feasible to establish a robust arrangement for delegation (underpinned by section 101 of the Local Government Act, 1972) within the timeframe of this procurement. The direct award to the new Leicester City and Leicestershire service would give RCC direct control over contract negotiation and management, alongside the benefits of economy of scale, flexibility for service users and

continuity of care. This option would require a nine-month exemption to be sought under the Contract Procedure Rules and would provide a tailored service specifically for Rutland.

7 PROPOSED LEVEL OF INVESTMENT

7.1 Given the apparent unmet need in Rutland, the capacity of the current service should be at least maintained.

7.2 Once the exemption from the Contract Procedure Rules has been approved, it is recommended that contract negotiation with the new provider of the Interim Service is based on a funding envelop of £80,000 per annum. This figure is based on the estimated unit cost of Leicestershire's new service (from financial contribution to new contract divided by 2014/15 number in structured treatment) and the number of Rutland users in structured treatment in 2014/15.

7.3 The estimated unit cost of structured treatment is less than Public Health England's estimate of the average cost (£1,758) of one hospital admission that is wholly and partially attributable to alcohol[2], bearing in mind that the needs and associated costs of service users will vary.

7.4 This procurement is intended to improve the value for money of the service and realise savings from the Public Health budget. As such, the procurement will contribute to the ambition of the People First Review (2014) and to RCC's Medium Term Financial Plan savings target for Public Health of £200,000 per annum. As the new service would commence on 1 July 2016, there would be a part-year effect on savings in 2016/17.

7.5 Compared to current provision, an integrated service with Leicester City and Leicestershire would also increase choice of provision for service users, continuity of care across the treatment system and responsiveness to emerging trends and concurrent needs, including mental illness.

8 CONSULTATION

8.1 In July 2015, RCC collaborated with Leicestershire County Council, Leicester City Council and the Office of the Police and Crime Commissioner on a soft market test and public consultation regarding community substance misuse treatment. These exercises tested ideas around the integration of services across geographical areas (Leicester, Leicestershire and Rutland), service user groups (adults and young people) and settings of care (criminal justice and other community). In addition, a stakeholder event was held on 12 October 2015 to raise awareness of substance misuse services and to gather information on substance misuse needs in Rutland.

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[2] Assuming national tariff cost (2013/14) and average length of stay (5.2 days) for all admissions in England 2011. In Public Health England (PHE) Business Case Template (2013) [accessed 23/11/2015). http://www.alcohollearningcentre.org.uk/_library/Alcohol_Liaison_Service_Business_Case_Template_-final.docx

8.2 The Cabinet member responsible, Cllr Richard Clifton, has been consulted on this proposal. The proposal also reflects feedback from People DMT, SMT and Informal Cabinet.

9 ALTERNATIVE OPTIONS

9.1 Five alternative options for procuring the Interim Service were fully appraised against a range of considerations. These options are summarised in Section 6 above.

10 FINANCIAL IMPLICATIONS

10.1 Although the final contract value is not known at this stage, there is an expectation that the contract negotiation will deliver some savings towards the financial savings target of £200k per annum for Public Health.

11 LEGAL AND GOVERNANCE CONSIDERATIONS

11.1 The formal exemption from the Contract Procedure Rules will be in line with Part 11 of the Constitution.

12 EQUALITY IMPACT ASSESSMENT

12.1 People who misuse drugs and alcohol are a particularly vulnerable group who often have concurrent health, social and economic needs. This service has the potential to make a positive contribution by supporting recovery in relation to these various needs.

13 COMMUNITY SAFETY IMPLICATIONS

13.1 Substance misuse has far reaching impacts on individual health, families and communities. A broad programme of evidence- based interventions to reduce harm has the co-benefits of improving health and wellbeing, cutting crime and saving money.

13.2 Reducing substance misuse harm in Rutland will contribute to the Council's strategic priorities 'Creating a safer community for all' and 'Meeting the health & wellbeing needs of the community'. The proposed vision will also be reflected in the 2016 refresh of the Safer Rutland Partnership strategy.

14 HEALTH AND WELLBEING IMPLICATIONS

14.1 See ‘Community Safety Implications’ above.

15 ORGANISATIONAL IMPLICATIONS

15.1 Environmental implications – Not applicable.

15.2 Human Resource implications - Arrangements are in place regarding pensions and TUPE for staff transferring from current services across Leicestershire, Leicester City and Rutland to the new Leicestershire and Leicester City service. There will be no residual impact on the interim Rutland service in relation to pensions and TUPE. Dedicated RCC resource will be needed to negotiate the direct award with the interim provider, given the vested interests of Leicestershire and Leicester City commissioners.

15.3 Procurement implications – As set out in this report. The direct award of contract will be negotiated by the relevant Chief Officer (or their nominated representative) to ensure best possible value and that Rutland needs are met. The formal exemption from the Contract Procedure Rules will be in line with Part 11 of the Constitution.

16 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

16.1 Substance misuse has far reaching impacts on individual health, families and communities. As such, efforts to reduce substance misuse harm should be organised through local partnerships, including the Rutland Health and Wellbeing Board and the Safer Rutland Partnership.

16.2 Recovery-orientated community treatment is an essential component of a comprehensive, evidence- based harm reduction programme.

16.3 The new service model will cost less than current provision and will achieve more in terms of visibility, ease of access to specialist treatment and outcomes for service users, families and communities.

16.4 The longer-term vision for reducing substance misuse harm in Rutland is to shift towards prevention, early help and recovery, tailored for Rutland and integrated with other Council work, including through an overall Rutland ‘wellness’ service.

17 BACKGROUND PAPERS

17.1 There are no additional background papers to the report.

18 APPENDICES

18.1 There are no appendices to the report.

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Report No: 43/2016
PUBLIC REPORT

SCRUTINY PANEL

18 February 2016

PEOPLE CONTRACTS AND FUTURE COMMISSIONING DIRECTION

Report of the Director for People

Strategic Aim:	Meeting the health and wellbeing needs of the community	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr R Clifton, Portfolio Holder for Health and Adult Social Care Mr R Foster, Portfolio Holder for Safeguarding Children and Young People	
Contact Officer(s):	Karen Kibblewhite, Head of Commissioning	01572 758127 kkibblewhite@rutland.gov.uk
Ward Councillors		

DECISION RECOMMENDATIONS
That the Panel: 1. Endorses the approach for future commissioning relating to People Directorate contracts and makes suggestions for the future vision.

1 PURPOSE OF THE REPORT

1.1 This report provides Scrutiny with an overview of the proposed vision for future commissioning within Rutland and on the implications for current contracts of this proposal, and an opportunity to comment and make suggestions.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 Commissioning in Rutland needs change to be fit for purpose in the future. Significant work has been undertaken over the past eighteen months to review commissioning arrangements and processes, and assess existing contracts against local communities' needs.

2.2 In addition, work has been undertaken to align our procurement processes with the Public Contract Regulations 2015 which came into force in March last year, and to ensure contracting activity is compliant with this and out internal processes. All this work coupled with the wider review of the voluntary sector and how best it

can be developed and made use of in Rutland has led to the proposed approach for future commissioning.

2.3 Currently, there is no coherent overarching structure underpinning the service delivery model for either Adults or Children's contracted services. A paper was tabled at Cabinet in December 2015 to propose a new approach to commissioning a number of services which will enable the needs of the community to be placed at the heart of contracts and focus on quality outcomes, and to make savings against current spend. This approach was agreed by Cabinet.

2.4 In order to achieve a new model of commissioning and undertake the procurement, a number of existing contracts were extended or renewed for up to 12 months, whilst the procurement is undertaken.

3 THE FUTURE APPROACH

3.1 The key tenets of the proposed future approach to commissioning, which Scrutiny are invited to comment on, are:

3.1.1 A whole life approach, from cradle to grave, to ensure that service users are not viewed in isolation, but in the context of their carers, their families and their communities. Not all services will be appropriate for all ages, but the artificial barriers between children's and adults' services create difficulties in transition and separation.

3.1.2 Improve prevention and resilience (in line with our current key strategies and Better Care Together and Better Care Fund), supporting people to help themselves, and concurrently building capacity in communities.

3.1.3 Reduce service barriers and reduce duplication. Make it easier for individuals to identify the service they need and access it, without getting caught in complicated service structures or multiple referral points.

3.1.4 Make use of joint commissioning opportunities where appropriate, maintaining services that are right for Rutland, and maintaining key statutory and safeguarding services in-house under our direct control.

3.2 A number of elements of this work are Council-wide, and not limited to People Directorate contracts, these should be developed corporately to influence all commissioning activity:

3.2.1 Social Value –the positive impact gained beyond the direct contract requirement

3.2.2 Supply chain –development of the markets in Rutland and encourage use of local businesses

3.2.3 Quality and Outcome Based contracts – improving quality and focusing on what services achieve for people's lives, rather than on quantitative numbers of outputs

3.2.4 Contract payment methodology – using contract structures such as Payment by Results to incentivise positive impact and innovation.

3.3 This future approach will require a fundamental change in the way services have been commissioned up until now. It requires a complete re-design of service

structure against the needs of local communities and taking into account both provider and service users views, and enabling joined-up and outcomes-based commissioning, rather than developing separate contracts for individual, specific services.

4 THE PROCUREMENT APPROACH

4.1 With advice from the Welland Procurement Unit, a procurement process has been designed which is in line with the procurement regulations and RCC's Contract Procedure Rules. The procurement process enables the co-design of services with providers to ensure that services commissioned provide a coherent pathway for service users, with easy entry points to services and smooth transition between them.

4.2 The procurement exercise itself will be used to design the final services with a range of providers. The procurement will be undertaken in two phases: the first phase of co-design will require providers to submit bids and meet a minimum set of criteria in order to join the co-design. The co-design will involve a number of meetings to design and refine the service structures, based specifically on Rutland's local needs.

4.3 Once the services have been co-designed, the second phase will be a further competition for providers who have participated in the co-design to submit bids to deliver the specific services. The contracts will then be held for each service with individual providers or consortia and be contract managed with each responsible provider.

4.4 Although the approach is new, it is based on previous procurement approaches which are proven. The timescale for this procurement will enable new contracts to be awarded and the redesigned service structure to be in place by 1st April 2017.

4.5 If during the co-design phase, the commissioning model does not appear to be delivering as envisaged, there is the option to close the process and go through separate open tender processes for the services against specifications drawn up by RCC. Depending on the size of the contracts, this would take between 6-9 months, with the procurements for each contract running concurrently.

4.6 In line with the Council's Contract Procedure Rules, further reports to Cabinet seeking approval will be submitted during the procurement process.

5 IMPLICATIONS FOR EXISTING CONTRACTS

5.1 There are a number of existing contracts which would fall within the parameters of this approach, and consequently interim measures are needed, to ensure service continuity is maintained and to enable the procurement to be undertaken. A number of contracts have therefore been extended until 31st March 2017 to enable this, a summary of those contracts is in Appendix A.

5.2 Those contracts which are funded via the Better Care Programme are subject to approval by the Health & Wellbeing Board prior to extension.

6 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

6.1 There is a clear need to commission differently in the future to ensure that services are fit for purpose and outcome driven. The recommendations to support this new approach and use the new procurement process to co-design and procure re-structured services will lead to high quality, needs-led provision and improved outcomes for Rutland residents.

7 BACKGROUND PAPERS

There are no background papers.

8 APPENDICES

8.1 Appendix A – Contracts extended to enable the new procurement approach

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Appendix A. Contracts extended to enable the new Procurement Approach

Provision	Current Contract	2015/16 Value per annum	Proposed action
Voluntary Sector Support and Community Transport Services	VAR Service Level Agreement. Expires 31st March 2016	£73,296 core services + £18,768 on community transport	Extend for 1 year – reducing and focusing the requirement.
Community Agents Scheme	Spire Homes BCF funded. Expires 31st March 2016	£155,553	Extend for 1 year as a single contract with sub-contracting arrangement.
Community Agents Dedicated Handyman Scheme	Home Straight Ltd BCF funded Expires 31st March 2016	£4,500	
Community Agents Dedicated Information and Advice	Citizen's Advice BCF funded Expires 31st March 2016	£10,500	
Community Agents Dedicated Befriending Support Scheme	Age UK BCF funded Expires 31st March 2016	£4,200	
Support & Advice Services for visually impaired people	Vista Expires 31st March 2016	£24,407	Extend for 1 year
Dementia services in the community for individuals and their carers	Alzheimer's Society Expires 31st March 2016	£49,998	Extend for 1 year, revising the requirement in line with need.
Management and development of support services to older people	Age UK Expires 31st March 2016	£38,000	

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Report No: 42/2016
PUBLIC REPORT

SCRUTINY PANEL

18 February 2016

BETTER CARE FUND PROGRAMME 2015-16 AND 2016-17

Report of the Director for People

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

DECISION RECOMMENDATIONS

That the Panel:

1. Notes the update and performance of the Better Care Fund 2015-16.
2. Notes the proposals for the Better Care Fund 2016-17 and makes recommendations for any improvements to the programme.
3. Notes the additional update provided on the Community Agents Scheme, as requested by Scrutiny.

1 PURPOSE OF THE REPORT

1.1 The 2015-16 Rutland Better Care Fund (BCF) plan is currently three quarters of the way through implementation, and planning is underway for the 2016-17 period. This report sets out the performance and impact thus far of the Rutland Better Care Fund Programme (BCF) and sets out the proposals for next year's BCF programme.

2 BETTER CARE FUND 2015-16

2.1 The Better Care Fund was established nationally to support transformation in integrated health and social care. It was designed to incentivise the NHS and local government to work more closely together around people, placing their wellbeing as the focus of health and care services, and shifting resources into social care

and community services for the benefit of the people, communities and health and care systems.

2.2 The current programme in Rutland started in April 2015, with the aim to "deliver important improvements to the way we collectively offer care and support to local citizens so that avoidable pressure on hospital care is reduced, and community options and support are increased."

3 PROGRESS IN THE 2015-16 PROGRAMME

3.1 The BCF programme has proactive governance arrangements via the Integration Executive meeting and Section 75 Partnership Board, and reporting into the Health & Wellbeing Board. Plan progress is measured bottom up through qualitative reporting and tracking outputs and outcomes, and top down by monitoring change in five key national metrics and one locally defined one. A more detailed overview of current performance is provided in Appendix A.

3.2 There has been good progress on integrated, cross-sector working. Closer working between community health services and social care has impacted positively on reablement outcomes and to reduce delayed discharges. In addition, the closer ties between GP surgeries and social care through the care coordination role have ensured that patients with growing needs are offered a wider range of services than purely health. This approach to integration will continue to be built on into next year.

3.3 The highest priority of the current programme has been to reduce the burden on acute care by: avoiding emergency admissions wherever possible; ensuring prompt hospital discharge; and avoiding readmission through reablement.

3.4 New day and night crisis response approaches have been introduced and have avoided around 25 emergency admissions since September 2015. This has involved considering alternative urgent care options such as night nursing to manage the crisis instead of defaulting to hospital admission. This change in approach has been particularly valued in end of life cases. It is possible that there is more capacity to avoid admissions going forward, to ensure greater consistency of response day and night and also to intervene sooner to prevent people reaching crisis point.

3.5 The Integrated Discharge Team has deployed additional resources and developed pathways to facilitate prompt discharge from hospitals in and out of the area (with a particular emphasis on Peterborough Hospital which currently handles over half of Rutland's non-elective admissions and where we now have both dedicated nursing and social care personnel to facilitate discharge), with parallel changes to the delivery of reablement services helping people to remain at home through a reorganisation of Rutland County Council's adult social care services and closer working with community health colleagues.

3.6 Adult social care staff now work regularly from Rutland Memorial Hospital alongside their health colleagues and are an integral part of 'Ward and Board' rounds where patient plans are discussed. Through training, there is also now a greater crossover in terms of the skills of community health and social care colleagues thereby increasing efficiency as staff can take on a wider range of tasks for each other when they are in a service user's home.

3.7 Within the long-term conditions priority, the falls prevention and dementia schemes have both taken time to build momentum, but are now well placed to deliver tangible outcomes. A number of falls prevention projects are now underway, notably: enhanced falls training for professionals; a preventative exercise programme for people at risk; a communications campaign; and, a series of falls 'fetes' across the County to boost falls prevention awareness. For dementia, a range of services have been commissioned helping dementia sufferers and their carers and families, in parallel with developing dementia friendly communities through the 'Dementia Friends' scheme. A memory advisor is in place, driving forward work with Healthwatch and other partners to better coordinate dementia services locally and ensure they respond effectively to real needs.

3.8 The Assistive Technology scheme has provided people with technological solutions to help them to manage challenges they face due to age or ill health (e.g. through falls monitors, medication managers, GPS tracking devices and video calling technology). Home adaptations have also been delivered under the programme. Finally, the 'integrated care coordinator' approach has also provided a new bridge between primary and social care meaning that people who need more than health support are identified sooner and that local GPs are now more aware of the wide range of local non health services that can support their patients.

3.9 Underpinning the programme, has been work on enablers including: workforce development through staff training and reorganisation of Adult Social Care Teams to better respond to future needs; IT systems and the delivery of a new social care case management system; and information sharing. From April 2016, the Council will use NHS numbers as the primary patient/service user indicator to facilitate information sharing across social care and health.

3.10 There was also significant work undertaken as part of the programme to secure Care Act compliance. This work was successful and, again, opportunities to further develop aspects such as the Rutland Information Service for information and advice will continue to be built upon moving forward.

4 BETTER CARE FUND PLANNING 2016/17

4.1 To be able to meet the development timetable, provisional work on the 2016-17 Better Care Fund plan started in November 2015, although - at the time of writing - full national guidance on the new BCF programmes and confirmation of budgets is still awaited. Therefore the programme presented here is provisional and may be subject to change.

4.2 The new draft plan is presented as Appendix B. This was tabled at the Health and Wellbeing Board on 26th January for initial views, where the direction of travel was strongly supported. The Health and Wellbeing Board noted that the plan should be more ambitious in what Rutland wants to achieve through this work. The Plan has been revised accordingly.

4.3 The initial draft plan sets out how the new programme was developed and what factors have been taken into account in shaping it. Strong continuity is proposed with the current BCF programme, but with changes to build on the progress and learning secured during the current year.

4.4 The proposed aim of Rutland's 2016/17 programme is that: "By 2018 there will be

an integrated social and health care service that is well understood by users, providers and communities and used appropriately, has significantly reduced the demand for hospital services and puts prevention and self-management at its heart, including by building on community assets."

4.5 Four priorities are proposed, summarised below (set out in more detail in the Draft Plan):

- **Unified Prevention** - broadened across the work areas rather than scheme based, with opportunities for more coordinated responses through a new commissioning model;

- **Long Term Condition Management** – as a key opportunity to reduce health and social care demand, expanded beyond falls and dementia and strengthened through proposals for enhanced complex case management and community health and social care integration;

- **Crisis response, transfer and reablement** - consolidation of progress to date - including with key acute services outside LLR - is the focus to reduce non-elective admissions and delayed discharges; and

- **Enablers** - including IT; information sharing; and joint commissioning.

4.6 Rutland is expecting a similar level of funding to the current financial year, although this has yet to be confirmed.

5 NEXT STEPS

5.1 The current BCF Plan continues to be monitored for the remainder if this financial year.

5.2 It is anticipated that the final revised plan will be presented again to the Health and Wellbeing Board for their approval on 22nd March 2016, subject to the national timetable.

6 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

6.1 Performance data shows that the current BCF Programme is having an impact in Rutland, and although there are areas for improvement, we are cognisant of these and they will be built on into next financial year.

6.2 Planning for next year's programme is well underway and has been supported by a number of key stakeholders, including the Health and Wellbeing Board. The draft Programme is line with the national guidance.

7 BACKGROUND PAPERS

7.1 There are no additional background papers to the report.

8 APPENDICES

8.1 Appendix A – 2015/16 BCF Performance Report

8.2 Appendix B – Draft 2016/17 BCF Plan

8.3 Appendix C – Update on the Community Agents Scheme

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Appendix A – Current Performance

Attached

Appendix B – Draft 2016/17 Better Care Fund Plan

Attached

Appendix C – Update on the Community Agents Scheme

1 INTRODUCTION

1.1 The Community Agents Scheme was established to provide an initial point of access for people within their own communities to support them to help themselves and to signpost on to support services where needed.

1.2 The initial model involved Spire Homes and the Rural Community Council working as a single team to deliver this. During the year, it was agreed the 'split' the Scheme so that Spire concentrated on providing the individual Agents themselves, and the Rural Community Council – with separate funding they secured via Big Lottery – delivered community activities designed to reduce social isolation.

1.3 In addition, there were four smaller partners to the Scheme:

- Rutland Citizens Advice: providing dedicated face to face support on a range of issues within communities;
- The Bridge: providing specific training and employment support;
- Age UK: developing befriending within communities where this has been identified as an issue;
- Home Straight: delivering minor 'DIY' and repairs where individuals cannot afford to pay someone and it enables them to remain or return home.

1.4 During the course of the year, The Bridge had an internal restructure and so ended their specific involvement with the Scheme. They continue to provide education, training and employment support in Rutland and the Community Agents are able to signpost into that.

2 PERFORMANCE

2.1 Contract monitoring is undertaken with Spire as the lead provider on behalf of all the providers involved on a monthly basis.

2.2 The Scheme started slowly following recruitment issues, but has been fully staffed since August and has gradually been building up both contacts within communities and the numbers of people seen.

2.3 The latest performance report to end of December indicates 400 individuals seen since the Scheme started in April, with 112 individuals receiving longer-term support (more than three sessions). The Scheme is building month on month, with December alone seeing 32 self-referrals to the Agents, demonstrating the impact the scheme is now having. The majority of service users are over the age of 67 years, and there is a fairly even split between men and women. Referrals have been received from all wards.

2.4 For those individuals who need longer-term interventions, the Community Agents undertake an Outcome Star to identify individuals' needs and measure whether they have reduced following an intervention. The support needs identified most

frequently are: 'living environment' and 'looking after yourself'; and therefore further development next year both within this Scheme and the wider BCF will look at how support for people to help themselves can be improved for both of these.

2.5 There have been two aspects that weren't initially expected with the Scheme:

2.5.1 The Agents are spending longer with individuals than initially anticipated, which has had an impact on capacity. This suggests that people need more support to help themselves, including identifying how to access support services, and also much of this support is to assist people in co-ordinating the services they do, and could, receive.

2.5.2 There have been fewer volunteers than initially expected to support with areas such as home visits and access to social activities. This is partly due to the length of time the Scheme took to be fully staffed and therefore establish itself, and the providers have been requested to review how this can be improved going forward.

2.6 Given the current performance of the Scheme, it is anticipated that next year the Scheme will work with c650-700 people minimum across the county, building particularly in those areas where there are currently low proportionate referrals.

3 Funding

3.1 The funding for this year was £185,920, comprising:

£155,535	Spire Homes (including start-up costs)
£ 10,500	Rutland Citizens Advice
£ 11,185	The Bridge (contract ended in year)
£ 4,200	Age UK
£ 4,500	Home Straight

The forecast spend is lower due to the Bridge contract ending in year.

3.2 The allocation within the budget for Community Agents is currently indicative as the programme has not yet been agreed for next financial year, pending the national guidance. However, it is expected that the contract value will be reduced in next financial year to reflect the costs included this year for start-up of the scheme, and anticipated to be in the region of £148-150,000. The funding released from the reduced contract value will support other BCF work to develop prevention – as yet to be agreed by the Health and Wellbeing Board.

3.3 Using the data from April to the end of December, the average full year cost of the Scheme is c£335 per person supported. In terms of value for money, there are still further improvements to make. However within the context of reducing hospital or care home admissions and supporting return home, the cost per person supported by the Scheme equates to less than one week's cost of residential care or three day's delayed discharge from hospital. The expected increase in people supported next financial year will improve the 'cost per person' and the overall value of the Scheme.

4 Future Developments

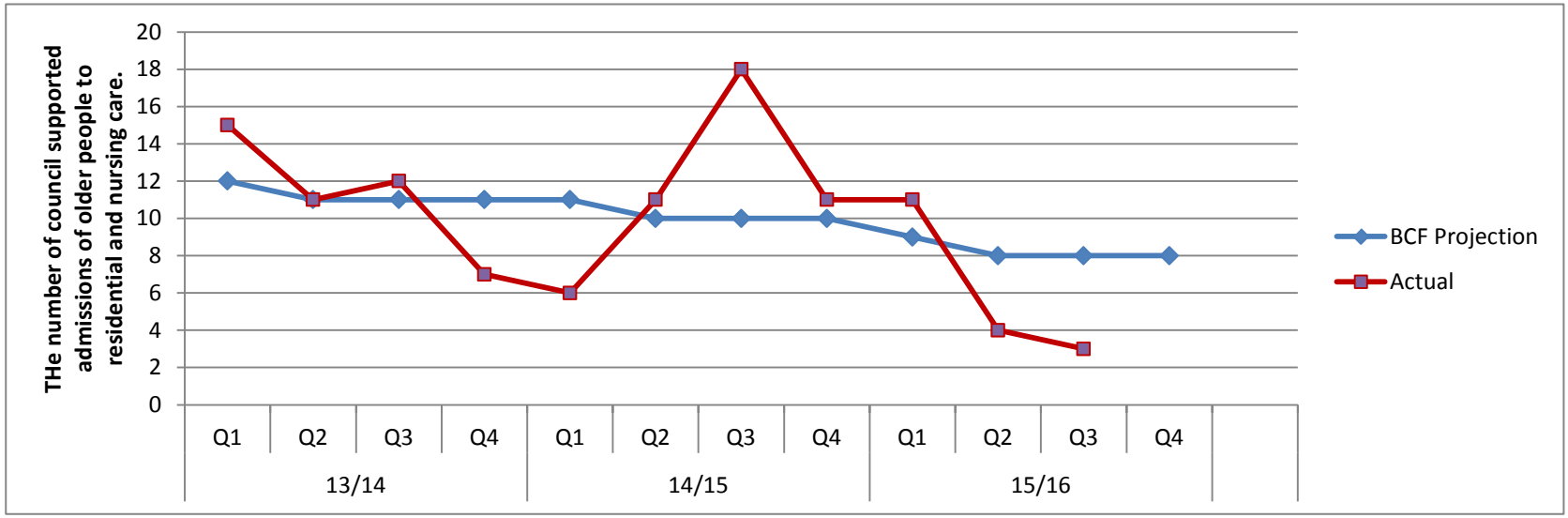
4.1 Whilst the Scheme was initially designed to provide signposting only, it has become clear that the Agents themselves have spent longer supporting people to remain in their homes or return home after hospital than originally envisaged.

4.2 The Scheme is focussing on developing community capacity next year and building work with other organisations to create volunteer networks - as well as continuing individual support - so the service focuses on those who need it most, to enable the average length of time that they spend supporting individuals to be reduced and more individuals to be supported and signposted on. In addition, the continually improving links within communities will enable a greater focus on identifying those who are currently vulnerable but unknown to services. Next year's BCF programme, has taken this into consideration and the development of the unified prevention priority will see a broader focus on both the prevention itself, and on the communication of information and advice to enable people to support themselves and make it easier to navigate services with less overall support.

Metric 1 - Residential Admissions

GREEN: The number of permanent residential admissions fell again in Q3 of 2015-16, putting it at the lowest level seen in the last 11 quarters. The programme is on target for this metric.

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



Outcome Sought:

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

Rationale:

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

Definition:

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

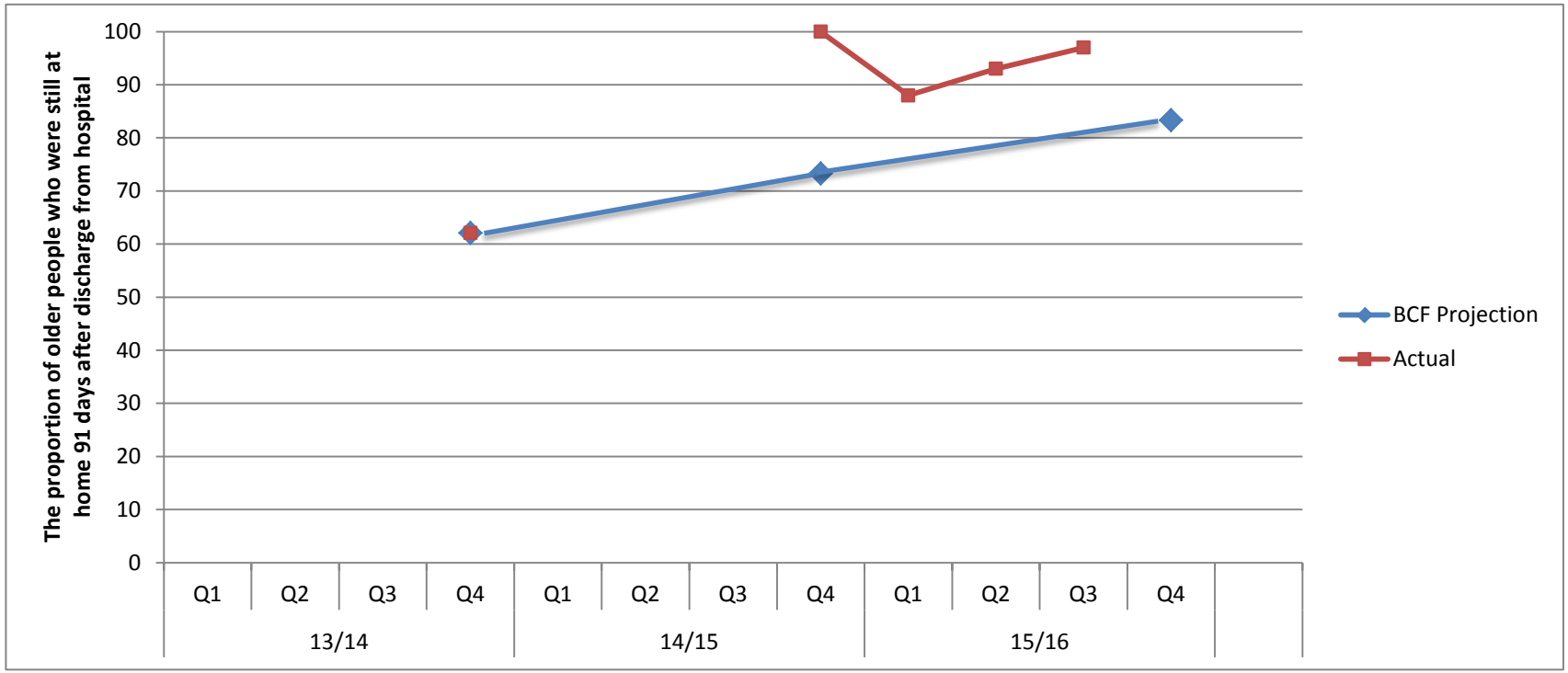
Reporting Schedule:

Metric will be reported quarterly. Next update late Feburary 2016.

Metric 2 - Reablement

GREEN: The pattern of people remaining home 91 days after discharge remains positive. The Q3 rate was an improvement over the last two quarters at 97%, exceeding the BCF Projection target and improving on Q1 and Q2, whcih were both above target. Formal BCF reporting will be based on whether people discharged between 1 Oct and 31 Dec 2015 are still at home 91 days later.

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services



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

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

Definition:

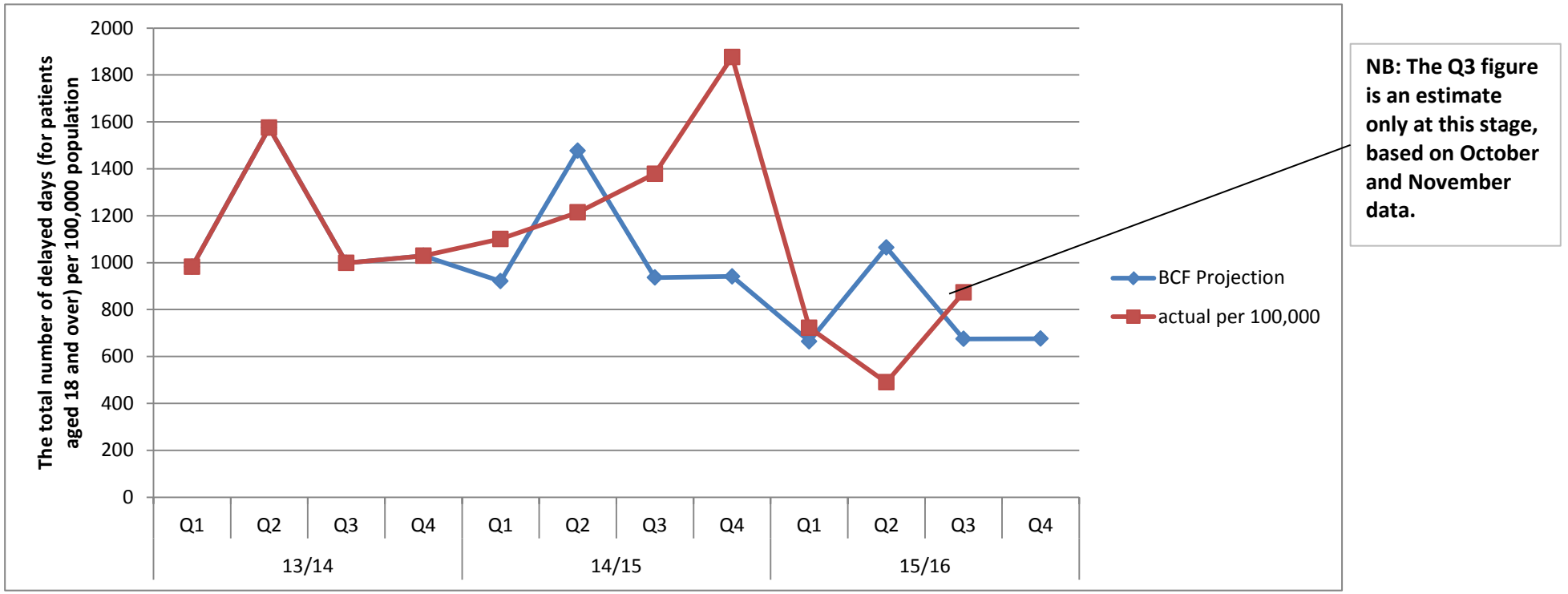
This measures the number of older people aged 65 and over discharged to their own home or to a residential or nursing care home during a 3 month period (October-December), who are at home or in extra care housing or an adult placement scheme setting three months (91 days) after the date of their discharge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

Reporting Schedule:
Formally, the metric is updated annually, based on two sets of 3 months data. The number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital is collected **1st October to 31st December** for the relevant year. Same individuals are then checked 91 days later (i.e. January to March). Next full quarter update March 2016.
Local updates are calculated alongside this for more frequent insight. Next update February 2016.

Metric 3 - Delayed Transfers of Care

AMBER (from GREEN): Considerable attention is being dedicated to reducing delayed transfers of care. However, performance remains variable. Finalised Q2 figures were favourable and meant that the pay for performance payment was achieved. As December 2015 figures have not yet been relased, the Q3 figure below is an estimate extrapolated fromOctober and November data. This estimate shows DTOCs rising again from the last quarter's low. DTOC issues relating to Peterborough hospitals have been a particular focus across November/December, with managment and operational meetings to identify and address potential system issues. A new approach was also used over Christmas/New Year (commissioning short-term space in residential homes at short notice to avoid discharge delays, with local follow through). Looking to 2016-17, national guidance recommends each area agrees a local action plan for DTOC reduction.

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



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

Rationale:

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

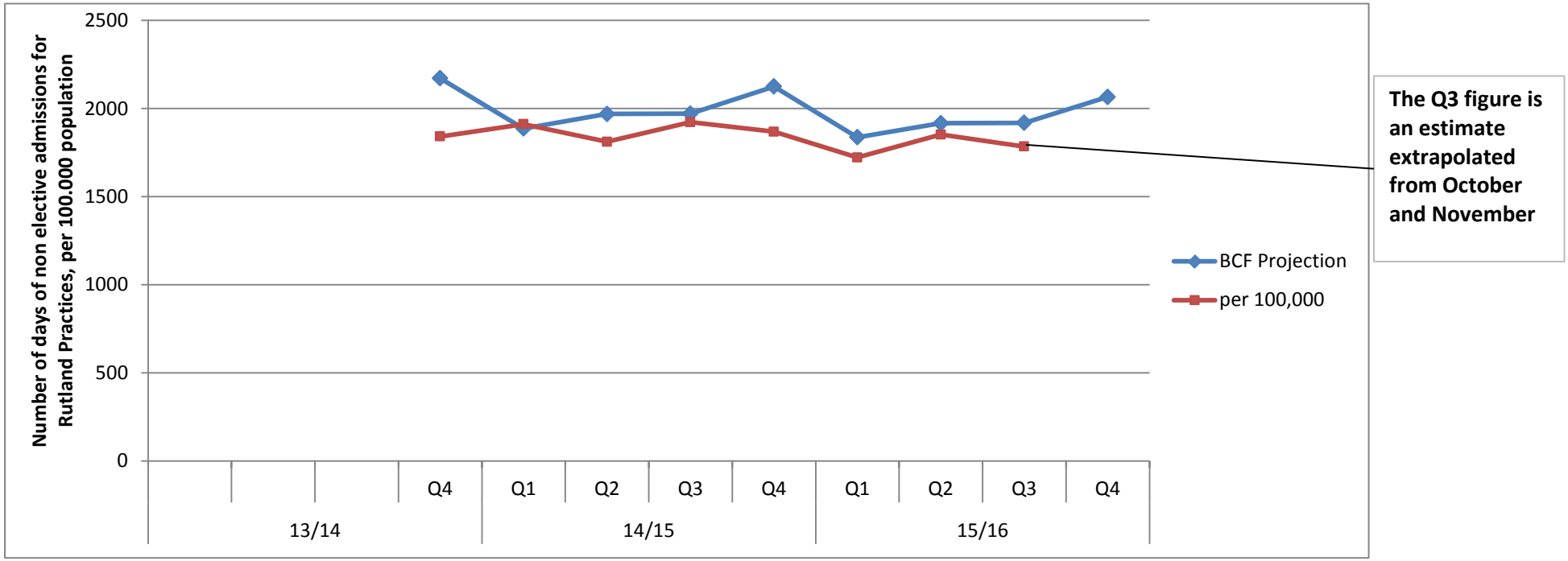
Definition:
Delayed transfer of care per 100,000 population per month.

Reporting Schedule:
Full Q3 figures anticipated before the end of January 2016.

Metric 4 - Non-Elective admissions (general and acute) - Pay for Performance metric

AMBER: Rutland met its pay for performance target for non-elective admissions (NELs) in the first two quarters of this calendar year. December NEL figures are not yet available, so the Q3 figure below is an estimate based on October and November's figures. Although the estimated figure is below the projection, it is not possible to be confident that the NEL pay for performance target will be met, hence the Amber rating. The CCG have also indicated that, in general, they are seeing a trend of rising emergency admissions. Some deeper analysis was requested at the December Integration Executive, to be coordinated by the CCG, to confirm whether there may be areas of work which could help to reduce non elective admissions in Rutland.

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



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

Rationale:

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

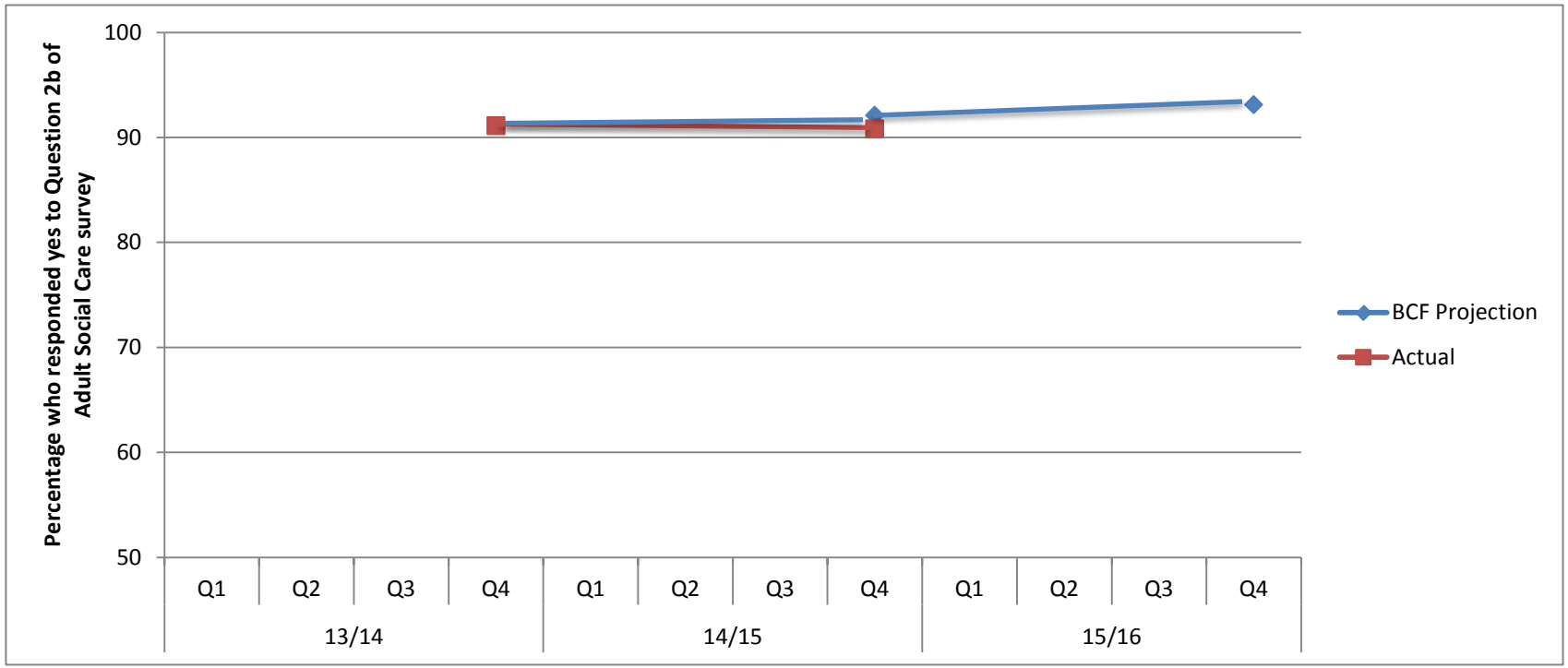
Definition:
Non-Elective admission data are derived from the Monthly Activity Return, which is collected from the NHS. It is collected by providers (both NHS and IS) who provide the data broken down by Commissioner.

Reporting Schedule:
Updated quarterly from non elective admission statistics for Rutland practices supplied by GEM CSU (Greater East Midlands Commissioning Support Unit). Full quarter figures expected by end January 2016.

Metric 5 - Patient/Service User Experience

No RAG rating - this is an annual statistic and not yet available. Target was missed by just over 1% in 2014-15.

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



Outcome Sought:

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

Rationale:

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

Definition:

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

Reporting Schedule:

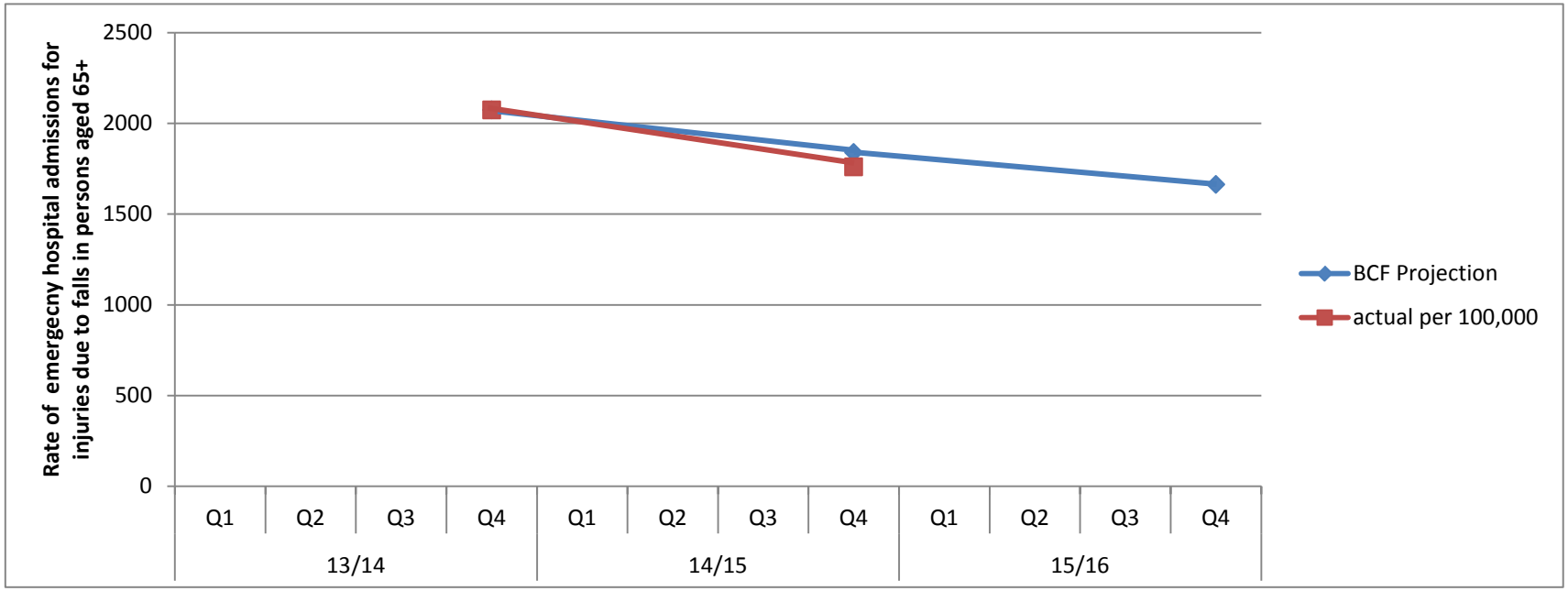
Data reported from annual Adult Social Care users survey. Next update will be March/April 2015.

Metric 6 - Local Metric

There is no formal RAG rating as currently this is annual Public Health data.

The 2014-15 Public Health England figure is now in for falls (see chart). For the most recent GEM CSU update on falls patterns up to the end of September 2015, see Falls highlight report.

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



Outcome Sought:
To reduce the number of admissions for injuries due to falls

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

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

Reporting Schedule:
Sourced from Public Health Outcomes Framework, last update 14/15. Currently discussing more timely release of data with local health partners and referring to proxy data in the interim from Health.

Better Care Fund – Provisional proposal for the 2016-17 programme v1.0

Sandra Taylor, Health and Social Care Integration Manager, Rutland County Council
Version: 1.0
15 January 2016

Contents

Introduction

This paper sets out proposals for a new Rutland Better Care Fund programme for 2016-17. These proposals have been developed in advance of national BCF guidance, which is due out in early January. Therefore, the proposals must be seen as provisional.

The proposals have been informed by:

- The **interim evaluation of the 2015-16 Rutland Better Care Fund programme** and the inputs of the Rutland Better Care Fund partnership to this exercise, including through the peer review discussion held at the 3 December Integration Executive.
- **Programme monitoring up to December 2015**, including performance against metrics and regular highlight reports.
- **New project workshops** held on 23 November (Oakham) and 1 December (Uppingham).
- **Relevant Rutland strategies**, including the Health and Wellbeing strategy and Adult Social Care strategy.
- **National BCF announcements** to date, including confirmation that the minimum mandated budget will be similar to 2015-16.
- **National NHS planning guidance** 'Delivering the Forward View', released in December 2015.
- New and revisited **health and social care research** relevant to the programme and the circumstances of Rutland.

Interim Evaluation of the 2015-16 programme

An interim evaluation exercise was undertaken in November/December 2015, with a core methodology adapted from a framework issued nationally by the national Better Care Support Team. The evaluation involved three main elements:

- reviewing top-down achievements as captured in the programme's key indicators,
- scheme level evaluations, which were then discussed at a special Integration Executive meeting to establish a 'moderated' view of performance across the programme and to agree key directions to progress further in the next programming round, and
- undertaking two new projects workshops, which partners were invited to attend and which provided a space to discuss new or additional directions of work.

Progress against indicators

There is a lag time in key indicator updates, but most indicators have been going in the right direction overall up to the end of quarter 2 (September 2015), notably reablement (the proportion of people who remain at home 91 days after discharge from hospital), avoided admissions to residential care and delayed transfers of care (but with some volatility in the latter case).

Days of non elective admissions were also sufficiently below the target threshold in the first two quarters of 2015-16 for the pay for performance payments to be made. However, ELR CCG has indicated that this latter indicator is unlikely to be on target in the third quarter as the wider trend for non elective admissions is rising. Analysis has been commissioned to better understand these patterns and to identify any opportunities to impact on this trend (eg. considering whether admissions of longer duration are arising from to exacerbation of existing conditions that could be stabilised through pre-emptive care at home).

It is more difficult to comment on performance in relation to the local indicator, falls, as up to date comparable data is limited, with a lag time in the issuing of Public Health England falls statistics (the 2014-15 figure is not as yet available). Even with falls prevention projects taking time to come on stream, falls prevention is believed to have been a tangible outcome of many parts of the programme, however, evidenced through scheme highlight reports and the evaluations detailed below (eg. reablement, assistive technology, DFGs, care coordination, dementia care). However, local health data indicates that it is likely that the number of falls remains high relative to targets. Levels of falls would, however, probably have been higher still without the BCF interventions.

Finally, the customer satisfaction survey is undertaken annually in the spring, so it is not possible to gauge performance directly against this. More could potentially be done to capture user satisfaction ongoing, using unified tools, to feed back into informing the programme.

Scheme level evaluations

For this stage of the evaluation, scheme leads worked with their stakeholders to complete a questionnaire which captured:

- the scheme rationale, achievements to date and outstanding plans for 2015-16,
- a score based assessment of performance in a set of key areas (eg. the extent to which the scheme is addressing an important issue, delivering as planned, building integration capacity, progressing early help or self help and supporting end users),
- an assessment of the extent to which the scheme had progressed the 'six domains of integrated care' (see below), presented via a SWOT analysis (identifying strengths, weaknesses, opportunities and threats),
- the lessons learned to date and recommendations for the scheme's future development, and

The six domains of integrated care (proposed by the Better Care Exchange)

1. **Leadership/**management of a successful Better Care implementation
2. Delivery of **excellent on the ground care, centred around the individual**
3. Developing underpinning, integrated **datasets and information systems**
4. **Aligning systems** and **sharing benefits and risks**
5. **Measuring success** (metrics, feedback, evaluation)
6. **Workforce and culture** - developing organisations to enable collaborative health and social care working relationships

The scheme level evaluations are summarised in **Appendix 1**. Overall, this stage of the evaluation demonstrated that the programme has been progressing well in the main with clear connections being drawn between most of the schemes and desired outcomes as measured by the programme's metrics.

The programme has positive and proactive governance and there has been good progress on integrated, cross-sectoral working, preparing the way to take integration further in the next programme (eg. closer working between community health services and social care has impacted positively on reablement outcomes and reduced delayed discharges, while closer ties between GP surgeries and social care through the care coordination role have ensured that patients with growing needs are offered a wider range of services than purely health). Some schemes took time to get off the ground due to procurement or recruitment processes, and scheme performance has also been

affected in some cases by staff turnover or competing demands. The resilience and consistency of systems is something to work on going forward.

The highest priority aspect of the current programme has been to reduce the burden on acute care, by avoiding emergency admissions wherever possible, ensuring prompt hospital discharge and avoiding readmission through reablement. New day and night crisis response approaches have been introduced and have reduced emergency admissions. It is possible that these could be used more extensively and could be more joined up. Additional resources have been deployed and pathways further developed to facilitate prompt discharge from hospitals in and out of the area (with a particular emphasis on Peterborough Hospital which currently handles over half of Rutland's non elective admissions), with parallel changes to the delivery of reablement services helping people to remain at home (including through a reorganisation of Rutland County Council's adult social care services and closer working with relevant community health colleagues).

Turning to long term conditions, the falls prevention and dementia schemes have both taken time to build momentum for a variety of reasons (eg. procurement or recruitment time), but are now well placed to deliver tangible outcomes contributing to programme metrics. To further evolve the local health and care system, the programme's focus on long term conditions could usefully be broadened out from dementia and falls, building on the care coordination work, as many more conditions are challenging for people to manage and impact on both their quality of life and demand for health and social care services. There is also scope to increase the person-centredness of approaches, addressing the whole person and in ways tailored to them (mental and physical, health issues and issues impacting on health, the individual and the circle of support around them), also responding in a coherent way around life events (retirement, significant diagnosis, bereavement, downsizing) and making it easier for people to take a greater role in shaping and maintaining their own wellbeing. An important aspect of the changes is to facilitate closer working by community health care and social care. Other aspects that there is scope to build up include support for carers. Users could also be more involved in helping to shape services and in feeding back on whether new approaches are working in practice for them.

Looking at the broader prevention landscape, there have been positive opportunities to increase the role played by VCF organisations, for example through the Community Agents scheme, dementia work and falls prevention projects. This builds up individual and community capacity. The introduction of new services such as assistive technology and falls prevention training and awareness raising alongside well established interventions such as Disabled Facilities Grants has broadened out the options helping people to stay independent for longer.

Underpinning the above changes, work has been done on enablers including workforce development (eg. training enabling staff to work to the health and social care protocol, reorganisation of Rutland social care into team structures better responding to future needs, new job descriptions), IT systems (procurement and delivery of a new social care case management system, ability for workers to access their own information resources directly across all the main health and social care buildings), information sharing (the council has obtained NHS numbers which will be used from April 2016 as the primary patient/service user indicator). There was significant work done under the programme to secure Care Act compliance. This work was successful but some systems require ongoing development (eg. further developing the Rutland Information Service for information and advice) and this needs to be factored in. There is also work to do on other enablers,

particularly around the care records which underpin the work around patients and the ability to coordinate effectively.

New projects workshops

The two BCF new projects workshops, held on 23 November and 1 December were an opportunity for a wider range of stakeholders to work together to generate new ideas for projects or areas of work that could be progressed under the 2016-17 Rutland BCF programme, either as identified new schemes or through competitive calls for bids once the programme was underway. A summary of the outcomes is provided through a set of slides in **Appendix 2**.

In practice, the workshops tended to generate ideas to further develop or evolve existing areas of activity, rather than proposing whole new areas of work that had not yet featured locally. This is in a way encouraging – there was agreement that the programme was already doing broadly the right things but that there was scope to enrich this.

Key areas where ideas were generated were:

- **Communication.** It was agreed that more work could be done on communications locally, building on existing communications channels, so that the plethora of support available was communicated coherently and was easy to understand and stay up to date with, both for professionals and end users. This is addressed in the unified prevention priority of the new programme.
- **Further developing established services.** A range of ideas came forward to further evolve some existing schemes, notably assistive technology and home adaptations, which also have the potential to be coordinated together. In terms of technology, ever more older people have access to smart phones and are increasingly confident with technology – does this mean there is more potential to supplement or enrich care using these tools?
- **Partnership building.** There was further potential to further build the partnership, both between health and social care and eg. working differently with providers. It is anticipated that the Council's new 'innovation partnership' approach to commissioning will have an impact here. There was also scope to engage and involve end users more in shaping services – we are currently low down on the 'engagement ladder', doing things to and for end users, not yet with them.
- **Enhancing prevention services, making it easier to keep well.** GP surgeries were recognised as key trusted focal points in the community. More services could wrap around these, making it easier for patients to access a wider range of 'whole person' support and freeing up GP capacity in the process to focus on more complex health cases.
- **Long term conditions.** The existing interventions were welcomed, but there was scope to broaden out. Half of GP appointments are long term condition related. Mental health is also a part of this picture, including for younger people. We could join up local insights about long term conditions to bring more benefits.
- **Enablers.** IT was also recognised as a blocker.

Revisiting the original Rutland BCF aim and priorities

The Rutland 2015-16 BCF plan sets out its overall medium term aim as follows:

> "By 2018 there will be an integrated social and health care service that has significantly reduced the demand for hospital services and puts prevention at its heart."

This high level aim summarises the main direction of travel nationally for health and social care and remains key in Rutland. Given good progress to date, we propose that the aim to achieve the objective by 2018 offers a good balance of challenge and realism. To emphasise the critical role of individuals in managing their own health journey, the importance of appropriate healthcare choices and the contribution of communities to health, it is proposed that the following underlined changes would be worthwhile additions to the main programme objective.

> "By 2018 there will be an integrated social and health care service that is <u>well understood by users, providers and communities</u> and <u>used appropriately</u>, has significantly reduced the demand for hospital services and puts prevention <u>and self management</u> at its heart<u>, including by building on community assets</u>."

The 2015-16 Rutland BCF plan anticipated working towards this objective via operational plans in four thematic areas, supported by a fifth 'enabling' workstrand:

1. Unified prevention services
2. Integrated urgent response
3. Hospital discharge and reablement
4. Long term conditions
5. Enablers (notably IT, Information Governance, information and programme management)

These high level priorities remain relevant to Rutland's needs. They are also consistent with the main proposed areas of activity of neighbouring authorities for 2016-17, which is helpful when working in a health economy in which many organisations cover a wider area than Rutland.

There is scope for the programme to evolve, however, within the detail of these priorities to progress Rutland to the next stage of its health and social care transformation. It is proposed that urgent response and hospital discharge and reablement should be consolidated into a single priority and that the priorities should then be reordered as follows:

1. **Unified prevention services**
2. **Long term condition management**
3. **Crisis response, transfer and reablement**
4. **Enablers**

This sets out a logical hierarchy of universal and more targeted prevention services, complex management of long term conditions, then, at the apex of the pyramid, services around acute care. Activiities span the classic pyramid of preventative measures, the lower levels having universal scope, and the higher levels a smaller target population but with greater needs:

- Help people to remain well whenever possible through primary prevention activities, removing risk factors before they have done the harm (eg. quitting smoking, losing weight, having flu jabs so they do not become ill at all).

- Use secondary prevention to diagnose disease early and delay its progress (eg. reducing high blood pressure or cholesterol or delaying the development of Alzheimer's symptoms).
- Where people do have symptomatic health issues, to undertake tertiary prevention, mimimising the symptoms or reducing their impact so people stay as well as they can for as long as they can, including through reablement to maintain mobility, for example.
- Then, wherever possible, for patients suffering greater ill health, avoiding the health crises that can lead to hospitalisation and, if people do need to be taken into hospital, ensuring a transfer of care back home or to local providers as soon as possible to avoid deconditioning and secondary infections, etc, as well as reducing demand for acute services.

2016-17 themes	Proposal	Impact on service users
Unified prevention services	Make it easier to find out what services are on offer locally to support health and wellbeing, by further developing the Rutland Information Service as a joint platform for the public, professionals and advocates. Bring prevention services in Rutland communities into a more coherent, consistent offer, including housing expertise and support to carers, including by using a new commissioning model. Provide better coordination and communication of this offer in communities and via trusted primary care settings so that local people have easy access to information, help and advice. Build community capacity so that communities are more self sufficient.	• People keep themselves well and know where to go to get information and advice if needed about what is available in their communities. • People feel supported to live independently at home. • Delaying the need for invasive and costly care packages. • Equipment provides peace of mind for users. • Patients can manage their own care. • More self sufficient, self sustaining communities, tackling social isolation.
Long term conditions	This priority addresses the support offered by primary and community health and social care for patients with long term conditions and the frail elderly, including through: • Enhanced approaches to care management and support planning (building on the care coordinator approach), including anticipating and reducing needs. • A review of care pathways. • An integrated system spanning primary care and community based health and care services in and out of hours. • Consolidating, integrating and extending a number of Rutland's community health based services into one 24/7 service operating across health and social care – to focus on maintaining independence in the community for as long as possible.	• Care services are effectively coordinated around the patient, reducing duplication and increasing effectiveness. • Service users feel in control of their care. • Service users feel supported and that their needs are understood. • Service users are better able to manage their condition(s). • Service users are able to stay as well as possible for as long as possible.

Crisis response, transfer and reablement	• Rapid response services avoid unnecessary hospital admissions and residential care for those needing urgent assistance. • Significant improvements in the timeliness and effectiveness of discharge pathways from hospital, especially for frail older people by consolidating new coordinated approaches to transfers of care. • Optimised independence and recovery when returning home.	• Reassurance for the service user and their family that there is effective support closer to home reducing likelihood of being admitted to hospital. • If they do have to be hospitalised, patients return sooner to a community setting, rather than deconditioning in hospital. • People can more easily resume their normal lives on their return home, maintaining independence. • Choice for end of life patients who may want to remain at home. • Acute beds are freed up for acute needs.
Enablers	IT and Information Governance facilitate integrated care rather than being a barrier to it. Integrated commissioning is progressed as an important transformational enabler.	• Health and social care systems will be aligned/joined up with a common dataset so patients are asked less often to tell their story and can receive improved service. • Joint commissioning drives integration and reduces duplication, reducing overall costs of care.

The BCF priorities and schemes

The proposed actions to be supported under each of these four priorities are described in more detail below. The overall thrust is one of continuity, but with some reshaping that builds on progress to date and aims to progress more concerted integration.

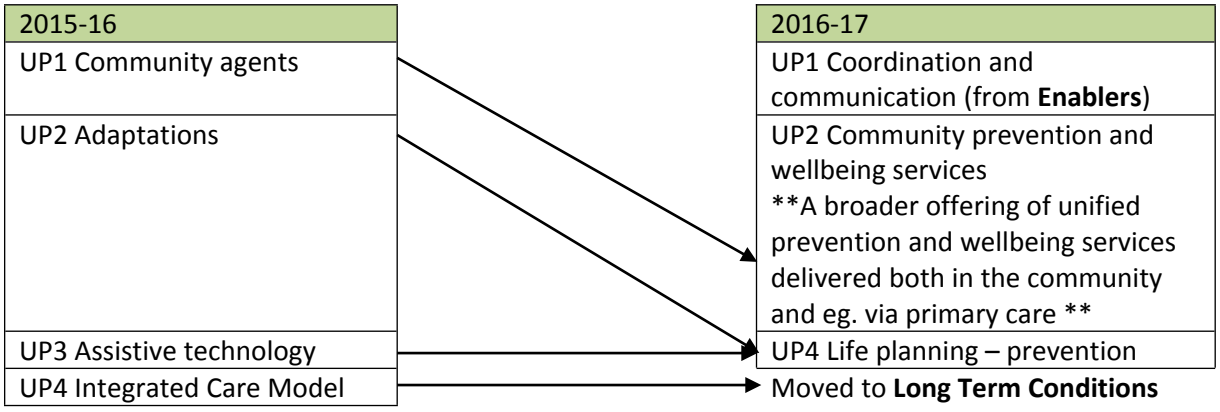
The priorities are described in more detail below. Each section summarises the rationale for the proposed changes, sets out how the 2016-17 proposals relate to 2015-16 schemes, and summarises each scheme and its potential to contribute to the programme's key metrics (assuming these remain the same as in 2015-16):

Programme metrics
1. Avoided admissions to residential care
2. Reablement (people still at home 91 days after discharge from hospital)
3. Delayed transfers of care reduced
4. Reduction in non elective/emergency admissions to hospital
5. Patient satisfaction (agreement that services have improved quality of life)
6. Reduction in admissions due to falls

1. Unified prevention

Main prevention activities have been positive but potentially too scheme focussed and largely divorced from prevention activities taking place in parallel outside the BCF programme (eg. as led by Public Health). While there have been clear benefits, it is difficult to say, therefore, that we have reached the point where there is a 'unified' prevention offer. A key aim needs to be to consolidate the valuable services developed and offered in 2015-16 (within the programme and in parallel with it), and at the same time to reach more people more easily with prevention messages.

Mapping – Unified prevention schemes – 2015-16 to 2016-17



Unified prevention - schemes

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
UP1	Coordinating and communicating the offer	Further developing the Rutland Information Service as a common/collective online information platform that partners and users believe is an effective, easily navigable, up to date view of what activities and services are available in local communities. Partners will be working together to streamline and improve information, making life easier for providers, advice givers and advocates and making self help easier to achieve. This will also help involved organisations to position their offer relative to the wider picture.	Y			Y	Y	Y
UP2	Community prevention and wellbeing services	As part of the prevention strategy, there is a continuing need to work with 'harder to reach' people and those who are below the threshold for social care directly in their communities, and to increase community capacity, including by building on existing community assets. Therefore, community based advice and community capacity building would continue, largely via the Community Agents scheme and their associated services and networks. In parallel, to increase the reach and take-up of prevention services, supporting people to help themselves, the proposal is for a wider range of tangible services including some offered by the Voluntary Community and Faith sector and public health (so not just information and advice) to be accessible via GP surgeries. This gives a 'whole person' response via a service that people trust,	Y	Y	Y	Y	Y	Y Y

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
		helping individuals to tackle life issues and behavioural risk factors more easily. This complements the CCG's proposed healthcare GP wraparound, boosts prevention, keeping people well for longer, and increases GP resources for more complex case management (research indicates that around 20% of GP time is spent on health issues whose cause or solution lies outside medicine (eg. money problems, social isolation, stress, housing (Citizens Advice , 2015)). This could include offering access to Public Health and VCF prevention services via or from GP surgeries (eg. around smoking, debt, housing, stress). During 2016-17, RCC is developing a commissioning model in which a partnership will be established via a procurement who then work together to co-design and develop models of delivery. The activities under this scheme would be in scope. There is also potential to coordinate the CCG's VCF commissioning into this picture.						
UP3	Life planning – preventative services	This brings together a range of schemes offering tangible support to help people stay independent for longer. Some of these services map to the social care 'front door'. From the current programme, they would include the Disabled Facilities Grants, assistive technology, falls prevention projects such as the FaME exercise programme and the next stage of the 'lifelong design' scheme for accessible homes. The possible benefits of the latter to the health service were underlined in a recent study for Public Health England which found that, nationally, simple improvements to the homes of older people could save the NHS £600m per year (BRE Group, 2015). This is also an opportunity to draw together a broader range of services and support addressing different types of prevention activity helping people to retain their independence, so that these are easier to access. The priority's name highlights that it is about getting people to plan ahead, not just delivering for urgent need. The scheme could include a small projects fund. It is important that delivery here continues to explore new	Y Y Y	Y Y Y			Y	Y Y Y

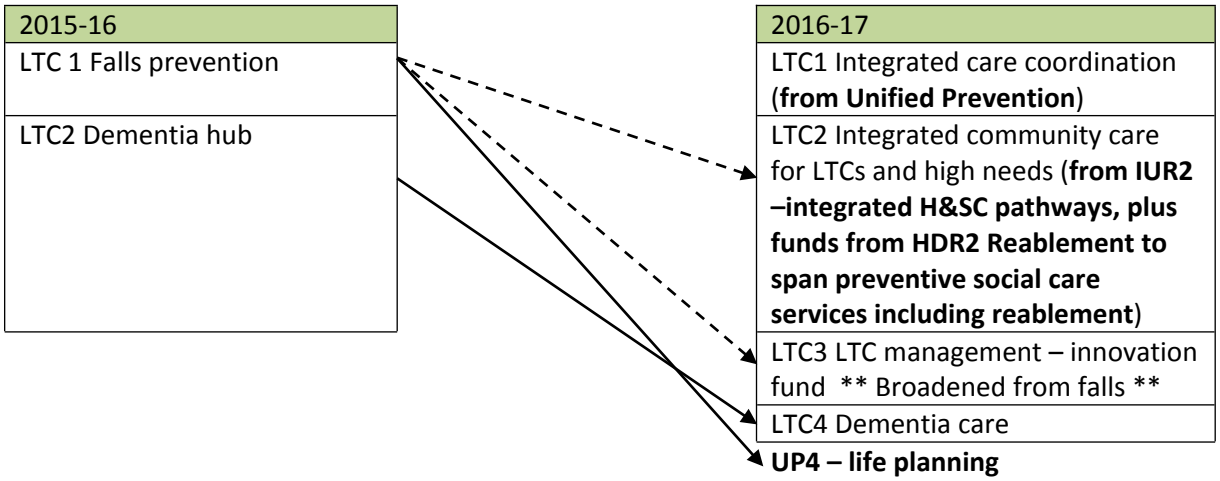
Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
		areas (cf. the Speakset pilot that allows video calling to/by service users). A number of other potential changes in approach were identified during the evaluation eg. new DFG purchasing choices where they offer benefits to users and reduce overall costs. (The capital budget for DFGs would need to be ringfenced, and may therefore need to be managed and reported on as a separate scheme.)						

2. Long term condition management

In the 2015-16 Rutland BCF programme the focus of the long term conditions priority was on two specific issues: dementia management and falls prevention. While these remain important issues in the County, this focus left little room to address one of the biggest causes of demand on health services locally and nationally: the difficulties posed in managing the health of individuals with multiple long term conditions. The proposal here is therefore to strengthen the Long Term Condition management priority to respond to this, as this broader aim has further potential to reduce non elective admissions in particular and to help people remain living at home. A core part of this priority is to build up an integrated community health and social care service that is well coordinated and tailored to local needs.

Dementia is a growing issue given Rutland's ageing population, so it is proposed that the Rutland dementia scheme should continue. Falls prevention will no longer be a stand-alone scheme but, as illustrated in the table below, will continue to be progressed under a number of other headings and tracked via the local falls indicator if this is retained. The current falls projects would be progressed, if still ongoing, under the 'Unified Prevention' priority. Given people's reluctance to seek an early diagnosis for dementia, the dual focus of this scheme should continue: developing dementia friendly communities on the one hand (at the same time ensuring more people are more informed about the condition) and helping sufferers of the condition and their carers on the other.

Mapping – Long term condition management – 2015-16 to 2016-17



Long term condition - schemes

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
LTC1	Integrated case management for LTCs	The Integrated Care Coordinator previously worked under the prevention priority, reviewing whether people with complex health needs (as identified by GPs using risk models) have other unmet needs (eg. in social care), that, if addressed, could help keep them well. To further enrich the local approach to helping people manage their long term conditions, it is proposed that the care coordinator role be moved to the LTC priority and that, to further strengthen the LTC management response in Rutland, the focus shifts towards 'integrated case management'. Additional specialist medically trained case manager capacity would be created that could lead on specialist support planning and prevention, creating a small team that can take this activity to the next level. These specialist prevention services would draw on the integrated community health and care services covered under LTC 2 below. This shift would also help to drive forward support planning and the use of Personal Health Budgets and would support Continuing Health Care assessment and management. This scheme would focus on those with chronic health problems (so, those with multiple long term conditions (including mental health) and/or frailty and who are having	Y	Y		Y Y Y	Y	Y Y Y

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
		difficulty managing their situation). It could also address mental health and end of life planning. There remains a need for good coordination and linkage with other prevention schemes, notably UP2 Integrated prevention and wellbeing (especially as some of this activity would be tightly associated with primary care). The shift in emphasis also helps to articulate a clearer distinction between community prevention services and integrated case management.						
LTC2	Integrated community health and care services for LTC and high needs	**Community health services** (including ICS and district nursing) and **social care teams** (particularly the long term and reablement teams) already work closely to support people in the community who have health and/or social care needs. This scheme aims to further integrate and enrich this approach. The scheme, effectively another aspect of the GP patient 'wraparound', would provide follow through on coordinated person-centred support planning, reduce duplication in overlapping areas `of care and offer scope for the effective deployment of prevention services to people at risk eg. making more use of reablement therapies to sustain health. There is also likely to be increased scope to intervene before developing issues become urgent care needs. A further aspect is coherent support for the planned care journey. This scheme would support any developments which were needed to drive forward integrated working, for example coordinating job descriptions and terms and conditions, developing shared posts and processes, joint commissioning of services. The health and social care protocol which allows trained social care professionals to undertake health-related tasks is an enabler to this integration. This scheme would be further supported through a proposal to collocate health and social care teams at the Rutland Memorial Hospital and to establish integrated leadership.			Y	Y		Y Y
LTC3	LTC	This scheme offers scope to innovate locally in how long term	Y	Y	Y	Y	Y	Y

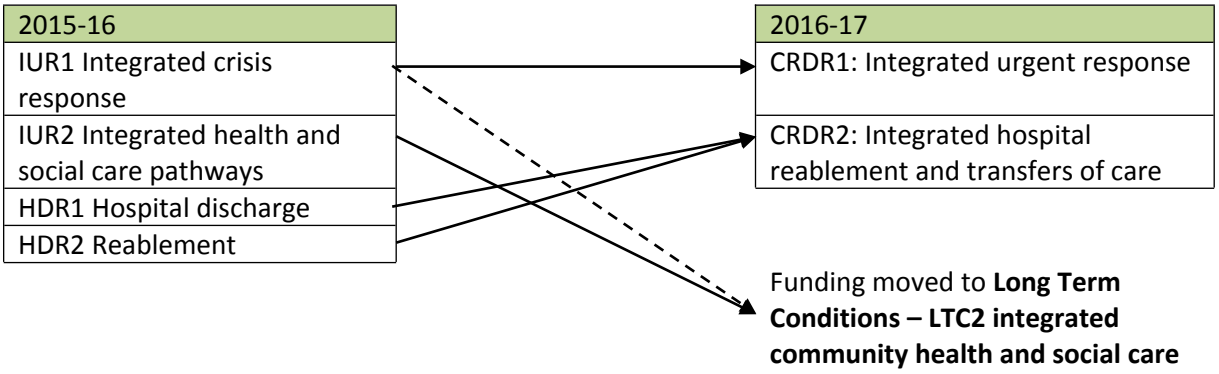
Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
	management – innovation fund	conditions are managed, including through patient activation and self care. This would allow scope for the case managers anticipated in LTC1 to progress pilot projects trialling approaches that are new in Rutland. Successful interventions could offer scope to reduce health and social care demand while improving individual quality of life. There is potential to work more closely with patients to co-design approaches to improved condition management which could include eg. telehealth pilots for self-monitoring and enhanced responses to the mental health impacts of living with illness. It would also be helpful to understand what factors help patients to take a proactive role in managing their own health and how to encourage these.						
LTC4	Dementia care	The dual focus of this scheme should continue: i. developing dementia friendly communities, and ii. services to help sufferers of the condition and their carers. Healthwatch work confirms that the wider awareness work remains important to reduce the stigma around dementia and to give people the confidence to take early action should this condition affect their lives directly. Continuing with a scheme focussed on a specific condition provides a test bed in which lessons can be learned about shaping services across multiple sectors that can then be applied to other contexts where there is a need for coordinated working across all sectors around a specific health challenge.	Y		Y Y Y	Y	Y	Y

3. Crisis response, discharge and reablement.

This priority needs to be continued as it is at the 'sharp end' of the immediate need to reduce the burden on health's acute services. However, it is proposed that the priority's funding should be rebalanced to more accurately reflect the proportion of local activity that relates to directly avoiding hospital admission and managing hospital discharge and reablement. Activity that is instead longer term community based care for patients/service users and has a preventative aspect will be reflected under the LTC heading.

This priority will continue to work to avoid people in crisis being hospitalised and, if they do need to be taken to hospital, getting them home again as soon as possible and enabled. New approaches here will be continued and consolidated, with further integration. A key challenge is to build up resilience and consistency, both of which are challenging in small systems reliant on small numbers of staff, particularly where staff turnover affects continuity. This includes 24/7 consistency.

Mapping – Crisis response, transfer of care and reablement – 2015-16 to 2016-17



Crisis response, transfer of care and reablement schemes

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
CRDR1	Integrated urgent response	2015-16 established 24:7 services to ensure that people in a health crisis are offered assistance other than hospitalisation, if hospitalisation is not the best option for them. 2016-17 will be focussed on consolidating these services. Night and day services operate differently: • Night: Single Point of Access and night nurses. Participation in the wider Leicestershire night nursing scheme (the most cost effective approach given low volumes of demand locally). • Day: Ensuring that integrated ICS and Reach activity is able to respond to crisis, preventing hospitalisation wherever this would not be the best course of action. Service Level Agreements would help to ensure activity and performance was captured regularly and consistently, helping to better understand patterns of use and impact and the scale of demand/need. Currently, numbers of avoided admissions feel low relative to the overall patterns of emergency admissions - as a ratio, they represent less than 5%				Y Y	Y	Y

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
		of all emergency admissions locally.						
CRDR2	Integrated hospital reablement and transfer of care	This addresses hospital discharge pathways 1, 2, 3 (1 = straight home with existing support, 2 = home with some new or additional support, 3 = complex transfers of care where the individual is unable to go straight home and needs an interim stage of care). There is potential for Rutland to progress further along the 'maturity scale' for discharge planning and management, including by boosting resources for transfers of care. More than 50% of admissions are now out of LLR, so the distribution of resources to support the return home needs to continue to map to this pattern and be able to respond if the pattern changes. This scheme involves the In-reach team, ICS and Reach. The In-reach team could be further embedded. There is also scope for further change eg. co-commissioning of the independent sector, person centred planning of the pace of reablement, readmission risk management. Residential reablement needs to address discharge to assess and continuing healthcare issues.		Y Y Y	Y Y Y		Y	Y Y Y

4. Enablers.

A main focus of the 2015-16 programme Enablers priority was Care Act 2014 compliance. As compliance has been achieved, this priority no longer needs to figure in the programme. There is a continuing need for programme management. In addition, there is further work to do on 'enablers' for change. This is reflected in the proposed structure of this priority (below).

Mapping – Crisis response, discharge and reablement – 2015-16 to 2016-17

2015-16	2016-17
E1 Care Act enablers	E1 Enablers
E2 IT and data sharing	E2 Programme support and comms
E3 Programme management	

Enablers schemes

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
E1	Enablers – revenue	Comprises actions relating to: • facilitating secure and appropriate information sharing through sharing agreements and training, and securing use of the NHS number as primary identifier, • IT systems supporting integrated care, • whole system leadership, culture and workforce development, also development of the provider workforce, and developing new ways to work with the community, voluntary and faith sector, • customer profiling and targeting, • user engagement and increasing the person centredness of delivery, and • analytics and evidence-based decision-making (including further development and exploitation of the LLR-wide Health and CareTrak system). There is a key need to meet mandatory requirements around use of the NHS number and ability to share case information. Alongside this, some of the other enablers merit attention as they will help to unlock progress on integration. These would benefit from more oxygen & visibility eg. leadership development and increasing the role of service users in informing service and system design. If there is capital spend for the enablers, this may need to be managed as a separate line.						
E2	Integrated commiss-ioning	This scheme addresses joint commissioning across health and social care in Rutland to help to drive change in the other three priorities. A planning stage is needed that confirms the potential scope of this activity. Candidates include commissioning of care homes, domiciliary care and residential reablement. This scheme will benefit from lessons learned from the CCG's joint commissioning activities with Leicestershire County Council during the current financial year. It offers opportunities to tailor services directly to Rutland. Defining a separate commissioning workstrand will help to ensure clear leadership of commissioning versus operational change and bring greater visibility to commissioning as a						

Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
		transformational activity. There is no dedicated budget here for this activity – budgets being committed are reflected, where relevant, elsewhere in the programme. If joint commissioning is undertaken for budgets not yet included within the BCF section 75 agreement, the option is available to establish stand-alone section 75 agreements for risk and benefit sharing. This avoids bundling jointly commissioned spend into the BCF agreement where this may not fit well in terms of timescales and governance.						
E3	Programme support and comms	Although programme support is presented as a separate line in the budget for transparency, this capacity not only supports the administration and governance of the programme but is also engaged in working with the partnership to shape the programme and progress the enabling workstrands.						

Draft budget allocations

The budget below is indicative and will be subject to change following confirmation of budget allocations and full technical guidelines. In this indicative allocation, around 20% of the BCF budget is allocated to unified prevention, a third to long term condition management and 40% to crisis response, transfer of care and reablement, with the remainder of the funding allocated to enablers. In the long term conditions, crisis response and discharge areas, this redistribution of funding shown here aims to reflect more meaningfully the actual distribution of resources and effort across the programme's priorities, rather than signalling a review and reorganisation of associated posts.

At a next stage, as well as adjusting to actual amounts available, a further round of checks will be done to align budgets so that they can be managed efficiently (eg. so that whole posts and contracts are managed under single cost centres).

Priorities and schemes	**%**	**In BCF programme (£k)**	**From/ Lead**
1. Unified Prevention Services	19	429	
UP1 Coordination and communicating the offer	1	30	RCC
UP2 Community prevention and wellbeing services	8	190	RCC
UP3 Life planning – preventative services	5 5	104 105	DFG Capital RCC
2. Long Term Condition Management	35	795	
LTC1 Integrated case management for LTCs	2 4	40 100	RCC CCG
LTC2 Integrated community health and care services for LTCs and high needs	18 4	405 100	CCG RCC
LTC3 LTC management – innovation fund	2	50	RCC
LTC4 Dementia care	4	100	RCC
3. Crisis response, transfer of care and reablement	42	936	
CRDR1: Integrated urgent response	4 5	100 115	RCC CCG
CRDR2: Integrated hospital reablement and transfer of care	24 2 6	536 50 135	RCC RCC CCG
4. Enablers	4	90	
E1 Enablers	2	39	RCC
E2 Integrated commissioning			CCG
E3 Programme support and communications	2	50	RCC
Total	100%	2249	