Public Document Pack

Rutland County Council

Catmose, Oakham, Rutland, LE15 6HP
Telephone 01572 722577 Facsimile 01572 758307 DX28340 Oakham

Meeting:	**PEOPLE (ADULTS & HEALTH) SCRUTINY PANEL**
Date and Time:	**Thursday, 14 April 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**

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

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 18 February 2016 (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) PUBLIC HEALTH: ANNUAL REPORT 2015

To receive Report No. 72/2016 from Mike Sandys, Director of Public Health
The report will be presented by Mr Rob Howard, Consultant in Public Health
(Pages 5 - 54)

8) ORAL HEALTH PROMOTION & THE NATIONAL DENTAL SURVEY 2012

To receive Report No. 83/2016 from Trish Crowson, Senior Public Health Manager
(Pages 55 - 64)

9) CQC INSPECTION REPORTS

To receive Report No. 76-2016 from the Director for People
(Pages 65 - 66)

a) **Goldfinch Care Agency**

Inspection report published 12 January 2016
(Pages 67 - 76)

b) **Rutland Cottages**

Inspection report published 21 January 2016
(Pages 77 - 92)

c) **Wisteria House Residential Home**

Inspection report published 1 February 2016
(Pages 93 - 102)

10) ADULT SOCIAL CARE STRATEGY LAUNCH: FEEDBACK

To receive Report No. 85/2016 from John Morley, Head of Adult Social Care
(Pages 103 - 110)

11) 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.

12) ANY OTHER URGENT BUSINESS

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

13) DATE AND PREVIEW OF NEXT MEETING

Dates to be confirmed…

Items for next meeting:

1. BUDGET: Quarter 4 Performance and Monitoring Reports
   Mrs H Briggs, Chief Executive and Mr S Della Rocca, Assistant Director - Finance

2. Home Care
   Mr M Andrews, Deputy Director Services for People

3. Refugee Relocation Scheme
   Provision of support for future refugee families
   Mr P Phillipson, Director for Places (Development & Economy)

---oOo---

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

Mrs L Stephenson (Chairman)	
Miss R Burkitt	Mr G Conde
Mr W Cross	Mr R Gale
Mr A Mann	Mr C Parsons
Miss G Waller	Mr A Walters
Vacancy	

OTHER MEMBERS FOR INFORMATION

Report No: 72/2016
PUBLIC REPORT

PEOPLE (ADULTS & HEALTH) SCRUTINY PANEL

14th April 2016

DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT 2015

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

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

1 PURPOSE OF THE REPORT

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

2 BACKGROUND

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

2.2 The focus of this year's report is on the role that social and community networks have in improving the overall health and wellbeing of the population of Rutland. Social and community networks include our family, friends and the wider social circles around us and they have a significant protective factor in terms of our health.

2.3 The report uses a family of community centred approaches[1] as a framework and explores the role that communities (both place-based and where people share a common identity or affinity) can have in improving the health and wellbeing of individuals, communities and populations. By doing this it is possible to identify the ways that communities can work together to address the factors that will cause people's health and wellbeing to deteriorate. Local case studies are used to illustrate how some of these approaches are already in place in Rutland and areas where this can be further developed.

2.4 A number of local case studies have been used to illustrate how some of these community approaches are already being used in Rutland and form a basis on which to build.

2.5 The report clearly outlines the links to the Adult Social Care Strategy, People First Review, Better Care Together and fits well with the intentions described within the Adult Social Care Market Position Statement.

3 CONCLUSION AND SUMMARY

3.1 The report describes the changing demography across Rutland over the next 25 years and in this context the role that communities have in supporting health and wellbeing will become increasingly important over the next few years.

4 BACKGROUND PAPERS

4.1 A guide to community centred approaches for health and wellbeing – Public Health England & NHS England

5 APPENDICES

5.1 None

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

[1] Public Health England & NHS England. *A guide to community-centred approaches for health and wellbeing*. 48 (2014). at <https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches>

DIRECTOR OF PUBLIC HEALTH'S ANNUAL REPORT 2015/16

RUTLAND

THE ROLE OF COMMUNITIES IN IMPROVING THE HEALTH AND WELLBEING OF THE POPULATION

CONTENTS PAGE

List of Tables

List of Figures

FOREWORD

In my last annual report, I set out the case for focusing on the social and economic factors which underpin health for everyone in Rutland. These include healthy housing, access to quality lifelong education, fair and secure employment and a supportive social circle. Last year's report also set out the roles public health can play: to be a leader in areas where we have a direct influence; to be a partner working alongside others in joint initiatives; and to be an advocate or champion for health in wider spheres.

This year's report seeks to build on this work by looking at how Rutland County Council and partners across the health system can strengthen and enhance the impact that communities have on people's health and wellbeing.

As the opening section of the report sets out, people in Rutland are living ever longer lives, meaning that there are increasing numbers of older people living with long-term conditions and disabilities. It is therefore essential that we focus on preventing ill health, so that the people of Rutland not only live longer lives but also remain healthier for longer. At the same time we have to recognise that more people will need support and help with their health and care needs.

The report describes the changing demography across Rutland over the next 25 years and highlights:

- there will be an estimated 49% growth in people aged 65-84 years and 227% growth in people aged 85 years and over;
- this will be accompanied by a 10% reduction in the number of working age adults (people aged 25-64 years);
- the increase in older people will mean that across Rutland there will be more people living for longer with long term conditions and age related disabilities;
- life expectancy across Rutland is significantly better than the England average, 81 years in 2010-12 for males and 84.7 years for females;
- healthy life expectancy (the number of years lived in good health), is however much lower for males and females at 65.5 years and 70.3 years respectively.

I have included the key headline data from Rutland's Joint Strategic Needs Assessment in Appendix A.

There is a need to work together across the wider health and wellbeing economy, to focus on how we support people to become healthy older people. Communities in Rutland have a valuable role to play in tackling these pressing concerns, through empowering people to help themselves and providing extra support where it's needed. Equally importantly, being part of a strong and supportive community that works together on local issues can in itself provide an enormous boost to people's health and wellbeing.

It is important that Rutland County Council and local health organisations work together in a coordinated approach to engage effectively with communities and to build community capacity. This will help to identify specific local needs and create innovative solutions to Rutland specific issues.

The pages of this report contain some outstanding examples of work to develop healthier communities across Rutland, and my thanks go not only to everyone who has played a part in these projects, but of course to everyone who has contributed to bringing this report together.

I look forward to working with you – whether as a partner organisation or as a member of our communities – to build on this good work over the coming year.

Mike Sandys
Director of Public Health

Executive Summary

This report focuses on the role that social and community networks have in improving the overall health and wellbeing of the population of Rutland. Social and community networks include our family, friends and the wider social circles around us and they have a significant protective factor in terms of our health.

People in Rutland are living ever longer lives, meaning that there are increasing numbers of older people living with long-term conditions and disabilities. It is therefore essential that we focus on preventing ill health, so that the people of Rutland not only live longer lives but also remain healthier for longer. At the same time we have to recognise that more people will need support and help with their health and care needs.

It is possible to identify the ways that communities can work together to address the factors that will cause people's health and wellbeing to deteriorate. Communities are vital building blocks for health and wellbeing and can provide support and assistance in keeping people supported in their own home and community. At an individual level, joining social activities, connecting to others and taking part in local decisions help to keep people healthy and well. At a collective level, confident and connected communities provide the social fabric that is necessary for people to flourish. It makes economic sense, to build on the capacity of communities. Social return on investment analysis of community development in local authorities has indicated a return of £2.16 for every pound invested, with a value to volunteers of £6 for every pound invested.[16]

INTRODUCTION

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

Last year the report focused on wider determinants of health and the social and economic factors that drive health and wellbeing needs for the population, using the 1991 Dahlgren and Whitehead model of the main influences on health and wellbeing (Figure 1).[1] The basis of the model is the concept that some of the factors that influence health are fixed and others can be influenced. The factors that can be influenced are known as the wider determinants of health.

Figure 1: The Determinants of Health

Source: Dahlgren and Whitehead 1992

This report focuses on the role that social and community networks have in improving the overall health and wellbeing of the population of Rutland. Social and community networks include our family, friends and the wider social circles around us and they have a significant protective factor in terms of our health.

The report explores the role that communities (both place-based and where people share a common identity or affinity) can have in improving the health and wellbeing of individuals, communities and populations. By doing this it is possible to identify the ways that communities can work together to address the factors that will cause people's health and wellbeing to deteriorate. Confident and connected communities provide the social infrastructure that is necessary for people to flourish. Individual and community empowerment are core components to improving the population's health and reducing

health inequalities. At an individual level, joining social activities, connecting to others and taking part in local decisions help keep us healthy and well.

The role that communities have in supporting health and wellbeing will become increasingly important over the next few years. All public services across Rutland will face a very difficult financial challenge. Cuts to the Revenue Support Grant, a key source of funding for the council, mean there is an extremely challenging time ahead and this is at a time when the need for services is growing. People are living longer, which means that when they need services they need them for longer. Whilst at the moment people are working for a smaller proportion of their lives this also means that there may be more people who can volunteer and support people in communities. As retirement ages increase this pattern may change and there may be less people in the community with the time and capacity to volunteer. Identifying the support required to sustain and develop both formal and informal volunteering in this changing environment will be important in meeting this challenge and ensuring good support is available in communities.

National Drivers

In 2015, Public Health England and NHS England published ***"A guide to community-centred approaches for health and wellbeing"***.[2] This guide summarises recent research and learning on community centred approaches for health and wellbeing, based on the premise that the assets within communities (such as skills and knowledge, social networks and community organisations) are the building blocks for good health and can help to increase people's control over their health and lives. The report groups a new 'family of community-centred approaches' under four different strands (Figure 2):[2]

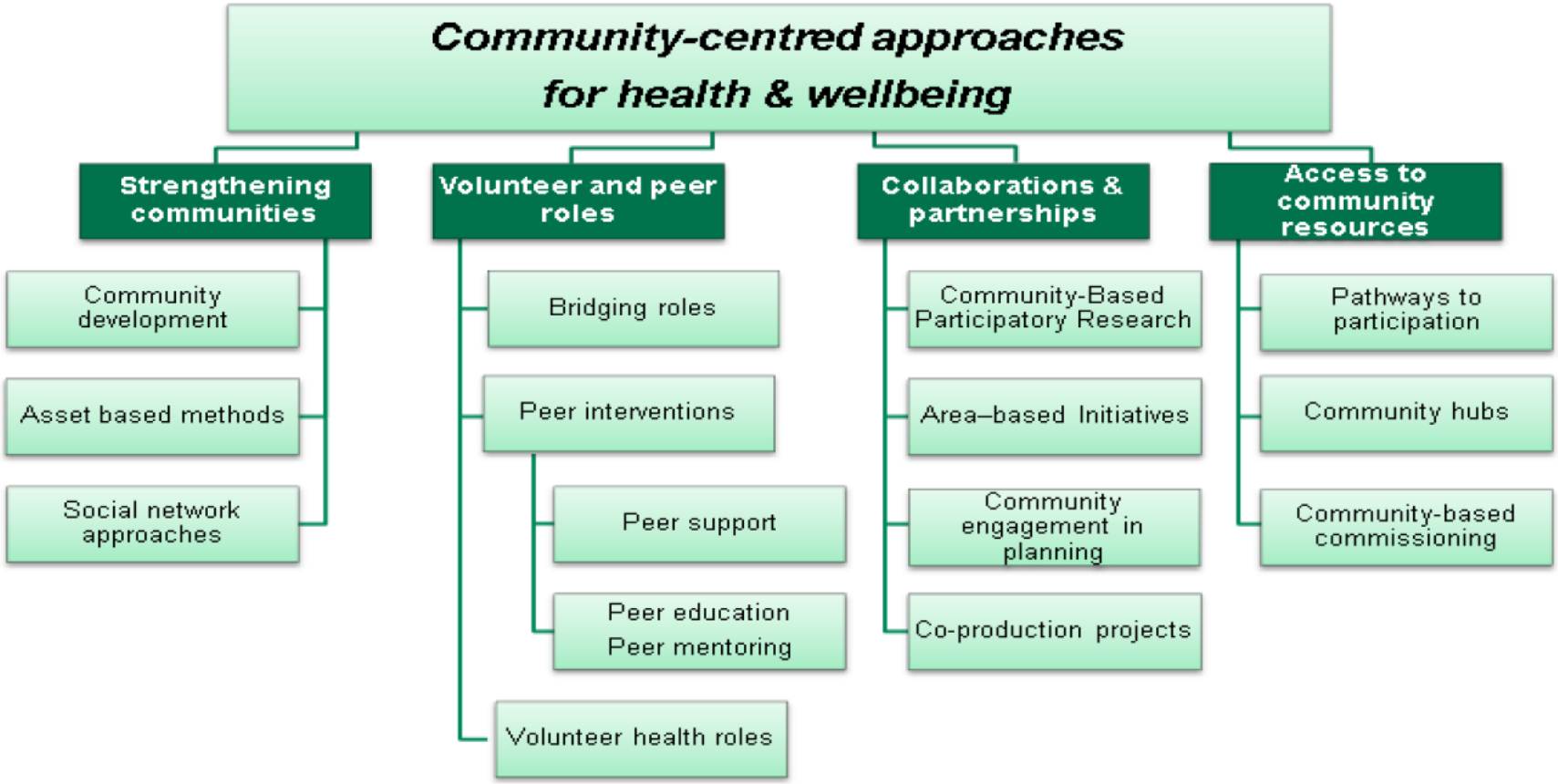
1. **strengthening communities** – building on community capacities to take action together on health and the social determinants of health;

2. **volunteer and peer roles** – enhancing individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities;

3. **collaborations and partnerships** - communities and local services working together at any stage of the planning cycle, from identifying needs through to implementation and evaluation; and

4. **access to community resources** – connecting people to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation.

Figure 2: The family of community-centred approaches for health and wellbeing



The family of community-centred approaches for health and wellbeing (South, 2014)[2]

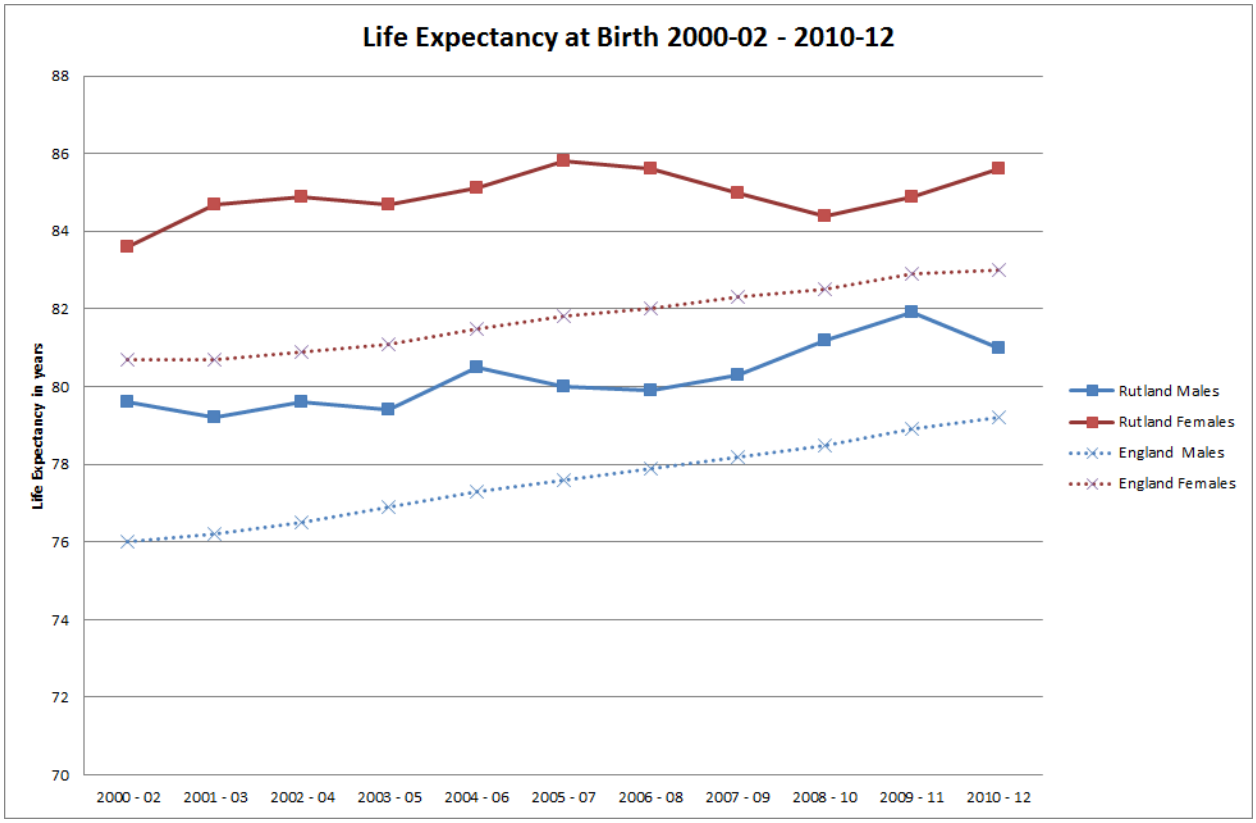
Local Drivers

The ***2015 Rutland Joint Strategic Need Assessment Overview*** describes the changing demography across Rutland over the next 25 years.[3] The key demographic drivers for Rutland are summarised below. Appendix A includes a summary of the key data within Rutland's JSNA.

The health of the people of Rutland

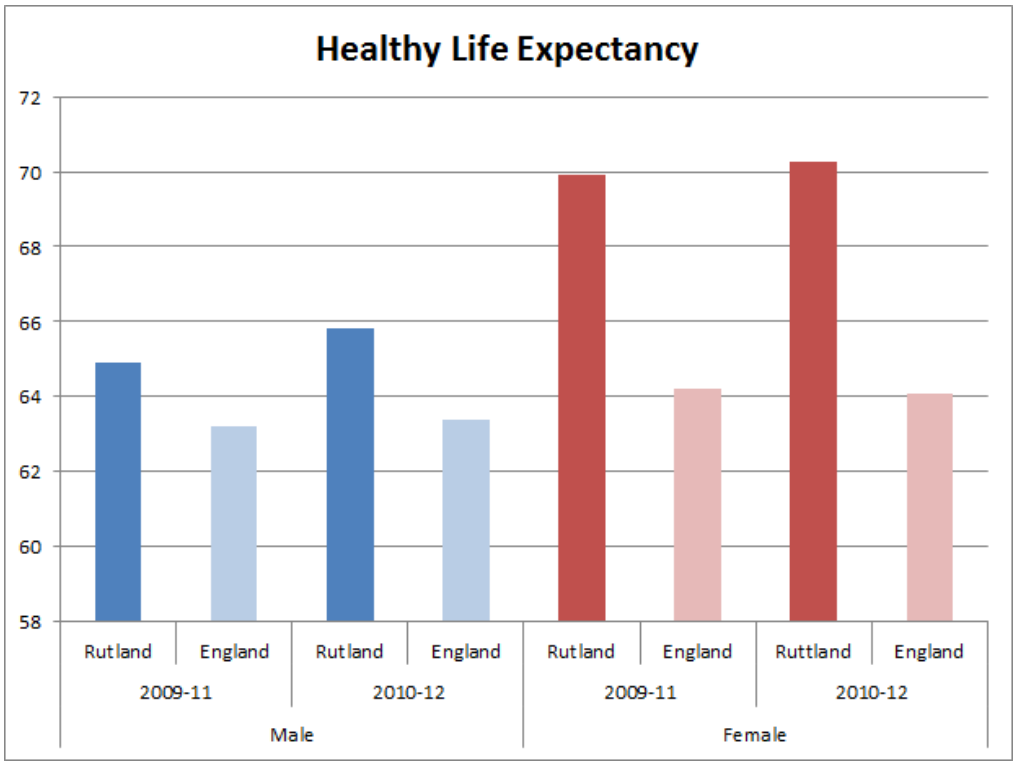
Life expectancy in Rutland continues to improve year on year and in the 10 year period from 2000-2002 to 2010-2012 there has been an increase in life expectancy of 1.4 years for men and 2.3 years for women. Life expectancy in Rutland is significantly better than the England average for both males and females at 81.0 years and 84.7 years respectively.[4]

Figure 3: Life Expectancy at Birth



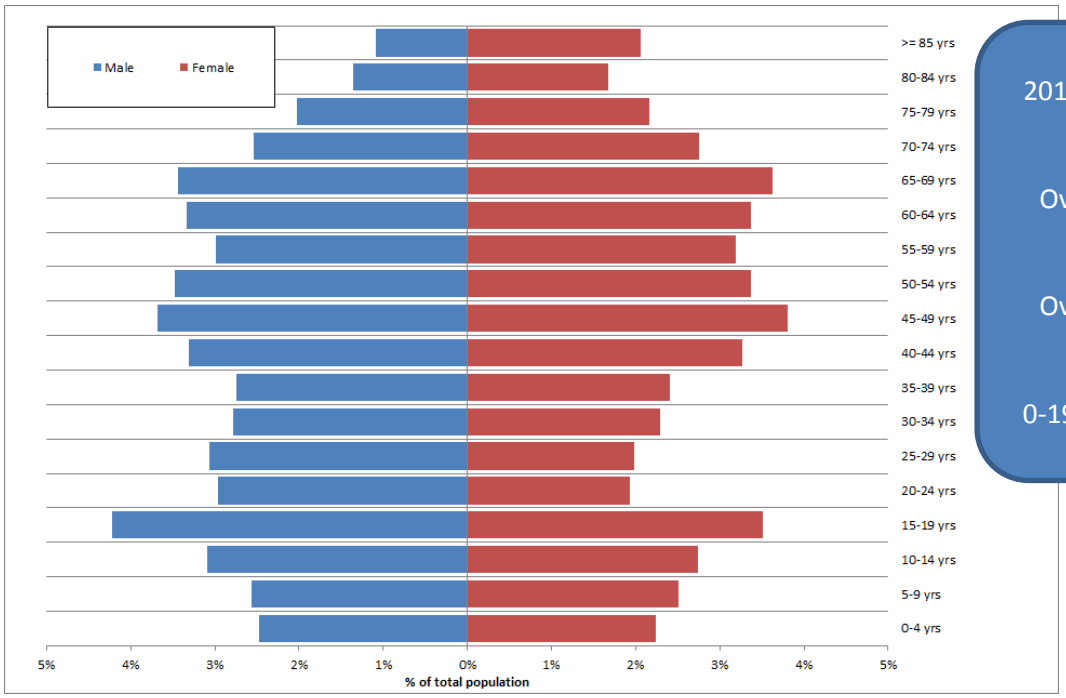
Healthy life expectancy is illustrated in Figure 4. Healthy life expectancy for 2010-12 is 65.8 years for males and 70.3 years for females. For both males and females, a significant proportion of the population will already be affected by poor health before they reach retirement age.[4]

Figure 4: Healthy Life Expectancy



The most significant driver of health needs for the Rutland population is the growing older population. In 2013, the total population for Rutland was an estimated 37,600 people. 8,540 people were estimated to be 65 years and over, and 1,180 were 85 years and over. 8,770 of the Rutland population were under 20 years of age.[5]

Figure 5: Mid 2013 Population Estimates for Rutland



2013 population – 37,600

Over 85 years – 1,180

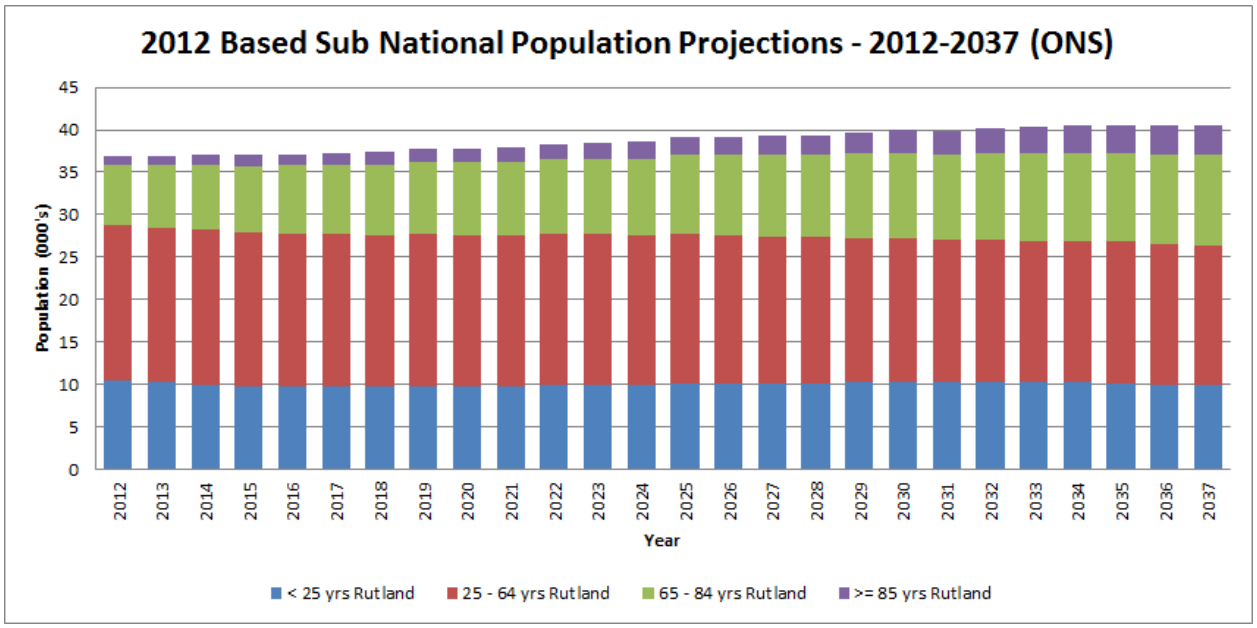
Over 65 years – 8,540

0-19 years – 8,870

The population of Rutland is growing – between 2012 and 2037 (25 years) it has been projected that the total population of Rutland will grow by 10% to over 40,800. However, this growth is not uniform across the age groups with a projected increase of:[6]

- 227% increase in people aged 85 years and over;
- 49% increase in people aged 65-84 years;
- 4% decrease in children and young people aged 0-24 years; and
- 10% decrease in the working age population (25-64 years).

Figure 6: 2012 Based Sub National Population Projections - 2012-2037 (ONS)



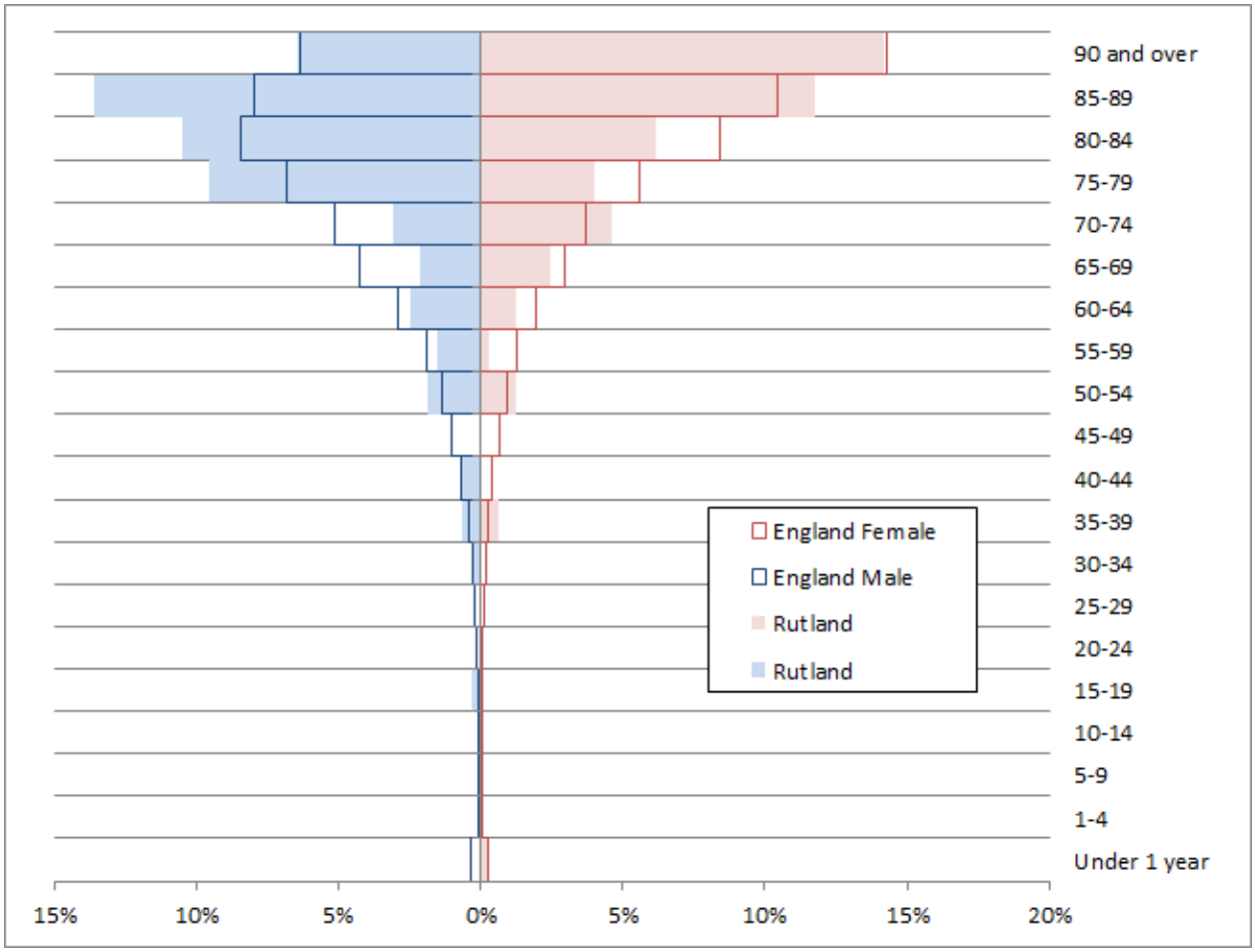
The total population is predicted to grow by 10%.
85 years + growth 227%, 1,100 to 3,600 people.
65-84 growth 49%, 7,100 to 10,600 people.
0-24 reduce by 4%, 10,400 to 10,000 people.

The 25 year time frame that we are looking at is important. The Better Care Together (BCT) Strategy 2014-19, published in June 2014, is a five year strategic plan for Leicester, Leicestershire and Rutland.[7] This five year strategy identifies the changes that are needed to make the health and social care system work more effectively in the immediate future. However, there is a need to consider the longer term care needs for the population. With an ageing population, there is a need to consider the plans that need to be put in place to

manage future health and care needs and demands in the longer term, with a focus on reducing preventable ill health, particularly in working age adults.

The population is living longer than ever before. For males, the most frequent age of death in Rutland is 85-89 years, with 26% of male deaths occurring in this age group. Overall, 75% of deaths in males are over 75 years of age and 85% are over 65 years of age. For females, the most frequent age of death in Rutland is over 90 years of age with 30% of female deaths occurring in this age group. 77% of female deaths occur at over 75 years of age and 92% of female deaths occur at over 65 years of age.[8]

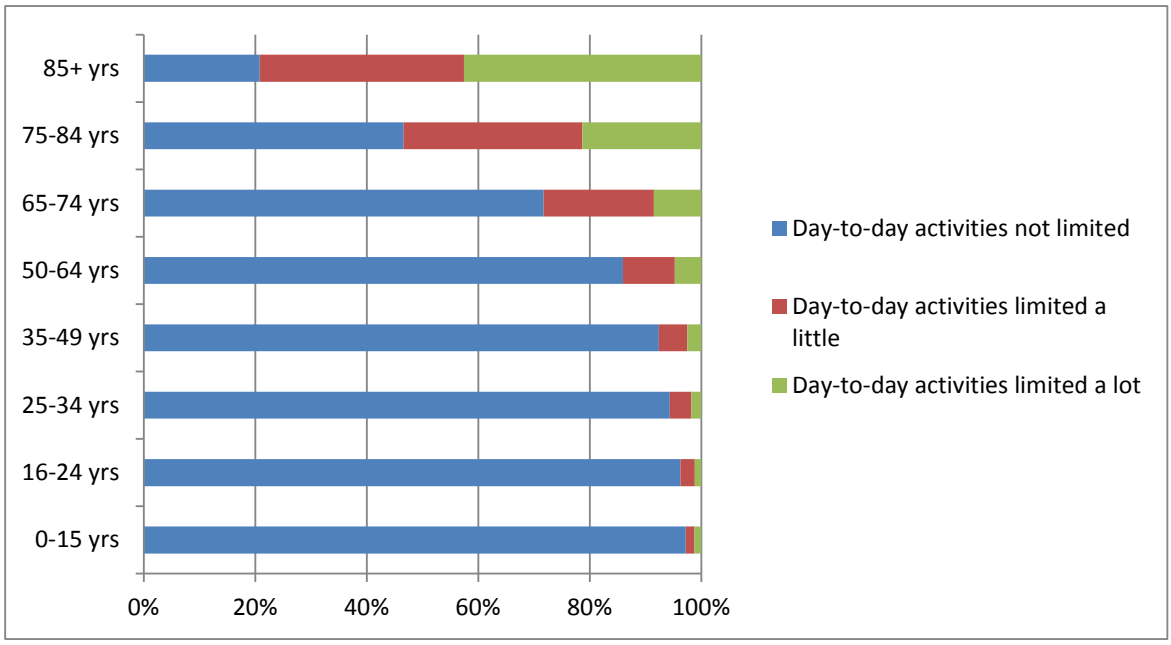
Figure 7: Deaths by Age Group in Rutland and England 2013



Health needs increase with age. The 2011 Census data for Rutland shows us that for people aged 85 years and over, only 21% of the population do not have their activities of daily living limited (ADL) by a long term health problem or disability. Over a third of this age group have their ADL limited a little and over two fifths have their ADL limited a lot. There is a clear correlation with age and as people become older their care needs linked to ADL increase. In terms of absolute numbers, the population with the highest number of people with ADL limited either a little or a lot is the population aged 75-84 years, affecting over 1,300 people. Understanding the population that have health and care needs linked to

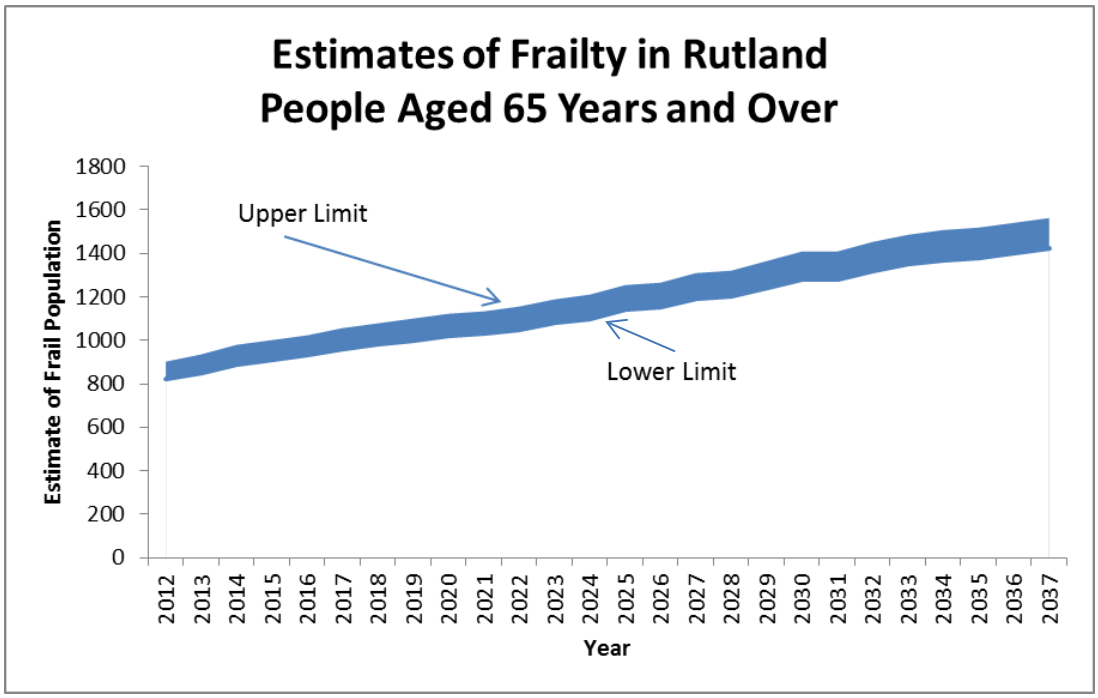
ADL is a useful way to target our preventative services to reduce longer term dependency on services.[9]

Figure 8: Long term health problem or disability by age for Rutland residents, 2011



The increasing older population will drive an increase in the number of people affected by frailty. This is illustrated in Figure 9 which applies an estimate of between 10-11% of the population aged 65 years and over affected by frailty, estimating the number of people in Rutland that are affected by frailty as between 820 and 900 in 2012 and between 1,420 and 1,560 people in 2037.[6] [10]

Figure 9: Estimates of Frailty in Rutland



The population growth patterns have implications for the provision of services for older people. There will be more older people with complex care needs who will require input from all parts of the health and social care system. This will need to be supported by people providing unpaid care through informal caring arrangements. However, the reduction in working age adults suggests that, as well as planning for the increased needs for services, there is a long term need to consider the infrastructure needed locally to support people. Carers will become increasingly significant to the wider health and care system and we will need to ensure that their health and wellbeing needs are addressed. This will be essential to maintaining independence and to support people to manage their own health and care needs with a shrinking network of informal care and support. Supporting people to live independently through appropriate housing provision is also a key enabler for the future sustainability of health and social care. Added to this and in common with many rural areas Rutland has 65% of its areas measured as deprived in terms of access to local services and this will need to be factored in to any service planning.

Rutland County Council

Rutland is changing. As the population grows older and young people with disabilities live longer, there will be additional challenges to keeping Rutland a healthy place to live.

The People First Review set a way forward for services that will meet the needs of individuals, families and our communities.[11] Taking into account the views of the public, it set the vision for the future and committed Rutland to:

- enable individuals and families within our community to achieve their full potential and be safe from harm;
- target services in particular at the most vulnerable and those who need us the most;
- integrate services more closely with the Health and Voluntary, Community and Faith (VCF) Sectors based on care pathways that support independent living;
- be clearer about what individuals, families and our community can expect;
- focus on finding different ways to do things rather than reduce or remove services; and
- adopt an early help and prevention approach.

The **Adult Social Care Strategy** sets the council's vision for everybody to have the best health and wellbeing throughout their life, and access the right support and information to help manage, reduce, prevent or delay the need for care and support.[12] Using the findings from engagement with the people of Rutland, it is clear that health and wellbeing is best promoted within people's own homes and from within people's own communities. By empowering people in Rutland to have choice and control over their lives, the council aims to maximise their wellbeing and independence in their local community, preventing and postponing the need for care and support.

The strategy is based on three themes:

1) Healthy Rutland - Healthy lifestyles are important for everyone from those with pre-existing health conditions or disabilities to those without. A healthy lifestyle will help prevent or delay the onset of long term limiting illnesses. They also prevent the recurrence of problems and reduce further deterioration and the likelihood of intensive or long-term health and social care need. In this respect, supporting people to eat healthily, manage their weight, stop smoking, increase their physical activity and reduce alcohol consumption is particularly important.

2) Independent Rutland – Using the findings from the "People First Review" it is clear that addressing an individual's needs sit within a wider network of personal and social relationships in the community. Connecting individuals with family, friends and community support networks is generally extremely important for people's wellbeing and to prevent or postpone the need for funded care and support services. The council wants to promote personal responsibility and for people to have opportunities to become a greater part of their community through increased opportunities for socialising, gaining personal recognition and building relationships, while remaining in their own homes for as long as possible.

3) A Sustainable Future – The council wants more collaborative working with health and other partners to deliver integrated community health and primary care services to improve health and social care for people. Delivering an integrated health and social care system will ensure services are best suited to local needs and circumstances, enabling people to enjoy good health and wellbeing living at home as independently as possible.

KEY FINDINGS AND RECOMMENDATIONS

Rutland County Council's People First report clearly set out how people would be at the heart of service delivery.[11] The recently published Adult Social Care Strategy and Market Position Statement determines that to achieve this people and communities will need to be engaged in the design and delivery of services.[12] [13] This report is therefore timely as it sets out a framework for developing community based approaches that can improve the health and wellbeing of the population, and provides examples of some of the initiatives that are already happening across Rutland.

The framework outlined in this report is an effective approach for providing communities with opportunities to improve health and wellbeing. However, the very nature of community led approaches means that to be most effective each community will need to be able to develop the community interventions that are most suitable for their needs. Whilst there are some good examples of community engagement in Rutland there are areas where there is less evidence of local activity or of being systematically applied across Rutland. Proposals for more joined up working and better coordination of the range of community services will help ensure a more effective and co-ordinated approach to prevention. The proposal to develop an integrated health and wellbeing service will require community approaches to be central to development and delivery.

With community-centred approaches outcomes are often connected to one another. For example improvements in mental health may have resulted from lifestyle changes. People involved in providing support through community-centred approaches are as likely to benefit from their involvement as the people that are receiving the support. This is illustrated in the case studies that have been used within this report. These links are reinforced where an intervention has worked well. The range of outcomes from each of the community-centred approaches is shown in Table 1.

The case studies presented in the report show many positive outcomes from working with communities. However, not all community-centred approaches will deliver measurable improvements in outcomes for people. Many schemes will not have sufficient evidence to draw firm conclusions or will report mixed results.

Table 1: The range of outcomes from community centred approaches

Individual	Community level	Community process	Organisational
Health literacy – increased knowledge, awareness, skills, capabilities **Behaviour change** – healthy lifestyles, reduction of risky behaviours **Self-efficacy, self-esteem, confidence** **Self-management** **Social relationships** – social support, reduction of social isolation **Wellbeing** – quality of life, subjective and objective wellbeing Health status physical and mental **Personal development** – life skills, employment, education	**Social capital** – social networks, community cohesion, sense of belonging, trust **Community resilience** **Changes in physical, social and economic environment** **Increased community resources** – including funding	**Community leadership** – collaborative working, community mobilisation/ coalitions **Representation and advocacy** **Civic engagement** – volunteering, voting, civic associations, participation of groups at risk of exclusion	**Public health intelligence** **Changes in policy** **Re-designed services** **Service use** – reach, uptake of screening and preventive services **Improved access to health and care services, appropriate use of services, culturally relevant services**

It makes economic sense, to build on the capacity of communities. Using 2011 figures the cabinet office calculated the monetary value of volunteering to the wellbeing of the volunteers as £13,500 per person per year.[14] Time banking can have a net value of £667 per person rising to £1,312 if quality of life is improved.[15] Social return on investment analysis of community development in local authorities has indicated a return of £2.16 for every pound invested,[16] with a value to volunteers of £6 for every pound invested.[16] There is definite potential to offer significant return on investment, however, poor retention of volunteers, high turnover and low levels of ownership can push costs up.

Throughout the report, case studies have been presented that cross many sectors of the community. This work is led by the different organisations that work together across Rutland to improve health and wellbeing. These organisations are collectively represented on Rutland's Health and Wellbeing Board. Support for and acknowledgement of the value and importance of community based approaches is a significant step towards identifying opportunities to work together more effectively to build community capacity. There are some really good examples of local community schemes that are delivering real benefits for local people. However, there are gaps and potential duplication in what is being delivered and opportunities to do more and coordinate more effectively. In particular, community based participatory research; community-based commissioning and co-production projects are approaches where a limited number of case studies and examples of good local practice were found. There is also scope to engage communities more actively in service planning and development.

For community based approaches to have the maximum impact for local people there needs to be good local leadership of this agenda. This will ensure that all communities are able to make best use of the opportunities to build their own local capacity. From a council perspective, there is a need to work together with other public sector agencies and the voluntary sector to increase capacity within local communities to ensure real engagement and a move away from doing things 'to' and 'for' people to 'with' or 'by' them.

Communities are vital building blocks for health and wellbeing. At an individual level, joining social activities, connecting to others and taking part in local decisions help to keep people healthy and well. At a collective level, confident and connected communities provide the social fabric that is necessary for people to flourish. An equitable health system involves people in determining the big questions about health and care and actively removes barriers to social inclusion. That is why individual and community empowerment have to be core to efforts to improve the population's health and reduce health inequalities.

RECOMMENDATIONS

It is recommended that:

1. That future programmes focus on extending **healthy life expectancy** (the number of years lived in good health) and closing the gap by targeting specific groups with worse health. This should include routine and manual workers, service families, children living in poverty and older people in greater need.

2. The development of community prevention and wellness services provides a good opportunity to measure benefits and impact of services based on a model of building community capacity and resilience to improve health and wellbeing. Mechanisms for evaluating the effectiveness of these services in achieving this should be built in to the service design from the start.

3. Cross agency working and partnerships are extended to more fully involve local people and communities as the next step to increase and improve **community engagement in planning.**

4. **Co-production models** (where service users work jointly with professionals to design and deliver services) are trialled for several projects in Rutland with the aim of developing more suitable services and reducing exclusion.

5. The Council uses a **Health Impact Assessment (HIA)/ Health in All Policies** approach to support local communities in influencing **major** developments and policies. HIA's can facilitate active engagement of local communities in the assessment process and enable consideration of the health impacts of proposals from a range of perspectives so that positive impacts can be increased, negative impacts identified and ways to mitigate these considered.

6. It is made easier for people to find out what services are on offer locally to support health and wellbeing, through better coordination and communication of prevention activities within Rutland.

COMMUNITY CENTRED APPROACHES TO HEALTH AND WELLBEING IN RUTLAND

This report uses the family of approaches, outlined in Figure 2, as a framework to review the evidence for community based working. It also provides examples of where these approaches are being used across Rutland. The report highlights the opportunities to further develop these approaches in Rutland and makes recommendations on ways that partners across the health and wellbeing system can work together to improve health and wellbeing.

1. Strengthening Communities

This group of approaches involves building community capacity to enable community action that will improve health and the social determinants of health.[2] There are a wide variety of community capacity building approaches and evidence has shown initiatives are more effective if they are shaped according to the needs and characteristics of a particular community. Taking this into account, such approaches have been shown to increase social cohesion, creating communities that feel more connected with each other and the wider services in their community.[17] [18] Benefits include the development of skills and knowledge and the building of a more united local voice with an increased sense of being able to rely on friends or relatives for support.[19] Benefits extend beyond the community group involved to the wider community as a whole.[20] Overall, community capacity building has been shown to deliver a net economic benefit.[2]

1.1 Community development

"A long term value-based process which aims to address imbalances in power and bring about change founded on social justice, equality and inclusion".[21]

A community-led approach to health improvement is concerned with supporting communities to identify and define what is important to them about their health and wellbeing; the factors that impact on their wellbeing and take the lead in identifying and implementing solutions.[22] This results in interventions which aim to bring together a group of people, who often share a common experience or characteristic, for support.[23]

Case Study - Rutland Community Agents - http://www.rutlandcommunityagents.org.uk/

The Rutland Community Agents (RCA) service has been developed as an asset based community development approach. The focus of community agents is to identify and provide support to vulnerable people of all ages building social capital. This includes older people at risk of isolation, those with mental health needs, autistic spectrum disorders or

learning disabilities.

RCA aims to promote social interaction and foster peer networks for a supportive community that improves wellbeing. The service acts as a single point of access, ensuring every contact counts and providing timely advice and local information for people on keeping safe and well and managing their long-term health conditions. This includes greater use of local individual and community solutions, resources and networks, building the resilience of those who need help before they hit crisis and diverting use from formal services.

RCA provides a variety of tailored support needs; from helping with housing, employment, legal advice and finances to holding pop-up clinics, setting-up new community groups and providing volunteer befrienders.

CA service established 24 hour online provision with 4,263 visits since April. The site provides access to online training, self-help toolkits and information on a wide range of topics including; Health, Education, Social Activities, Support, Employment and Lifestyle including support group locators and volunteering opportunities. The site also links to the Rutland Information System, enabling easy identification and access to services that meet Rutland citizens' needs.

As of the October 2015 the RCA service has:

- provided one-to-one advice / signposting to 277 Rutland residents;
- made direct contact with 848 residents through local groups and events where discussions around how the RCA's can support communities took place;
- made 246 referrals to external partner agencies;
- identified 48 new services which have been added to the RCC RIS; supporting self-help and better access to services within Rutland;
- reported 100% of individuals receiving short term advice and assistance have demonstrated progression in their overall health, well-being and quality of life assessed using the Well-being Outcome Star Tool; and
- implemented 9 new groups/events across Rutland including partner drop-in clinics and CCC (Coffee, Cake & Chat) groups in areas where isolation is identified as a core issue.

The Community Health Link Agent has made strong links with relevant partners and is now

working closely with a number of health care professionals to improve hospital discharge and prevent unnecessary admissions. Referrals are being received and support provided to patients from a number of local hospitals and Rutland GP surgeries. To date the HLA has offered advice, assistance and signposting to 83 individuals to support them to sustain their independence. Of these 46 have been supported to leave hospital or prevent a hospital admission.

1.2 Asset based methods

"In an asset based approach, the glass is half-full rather than half empty".[24]

The ethos of this approach is to value and accentuate the positive capabilities of communities, starting with strengths and focusing on local capacity, skills, knowledge, connections and potential. The focus is on building networks, promoting resilience, self-esteem and coping abilities of individuals and communities, eventually leading to less dependency on professional services.[25] The aim is to build up community groups and voluntary organisations; their informal associations and networks, their collaborative relationships, their shared knowledge and therefore their social power to make positive changes.

1.3 Social network approaches

"Outcomes include more cohesive and stronger communities, improved self-esteem and people who feel more in control of the decisions that affect them." [26] [27]

These approaches include community organised activities which strengthen social support between members. Interventions both enhance existing networks and create new ones to improve the social links between people. There are health and non-health benefits including reduced illness and premature deaths, improved mental health and resilience, reduced crime and delinquency and positive impacts on employment.[28] The results are more confident and active communities, including increased social engagement, support and more extensive networks.[2]

1.4 Summary

The community agents case study reinforces the importance of the underpinning principles of the "strengthening communities" approaches. It demonstrates the value of building networks and capacity to enable more connected and resilient communities, which can then continue to support each other.

There are also other community based projects being supported throughout Rutland which contribute to strengthening the community, some of which may not be widely known or celebrated. However, much of the available evidence of outcomes is based on small scale case studies. There is a need for a holistic approach to the development and evaluation of these approaches across different communities and partner service providers in the area. There is a gap in the evidence of the benefits of the strengthening communities approaches, both in terms of health and wellbeing outcomes and financially in terms of cost benefits and return on investment to service providers.

It is essential that more innovative approaches to the evaluation of community led approaches are developed and implemented to provide robust evidence of the benefits of these approaches.

2. Volunteer and Peer Roles

This group of approaches focuses on an individual's capacity and competence to provide advice, information and support including organising activities around health and wellbeing in communities. Volunteers or peer supporters are mainly drawn from their local neighbourhood, and receive training to enable them to undertake a health promoting role within their community. Most volunteers are unpaid and deliver this role on a voluntary basis.

There is a long history of volunteering within the UK, with research studies showing participation in volunteering is strongly associated with better health, lower premature death, better functioning, life satisfaction and decreases in the occurrence of depression.[29] Giving to others is one of the five steps to mental wellbeing with volunteering identified as one of the ways to do this.[30] Volunteers are seen as 'active citizens' and there have been a number of examples of highly successful public health volunteer projects ranging from access to contraception in the early 20th century to campaigns on disability rights.[31]

In addition to personal mental and physical health benefits, volunteers gain both formal and informal skills which can, over time increase their employability[32] as well as their confidence and self-esteem.[33] The use of peer educators or community volunteers in health improvement activities can be effective in changing certain health behaviours.[34] Involvement of volunteer led activities requires investment and funding but has been shown to have a positive return on investment.[2]

2.1 Bridging roles

These are usually carried out by volunteers (rather than 'peers') who formally signpost people to services and information, supporting them to improve their health and

wellbeing.[35]

Case study – SmokeScreen Promoter

The Tobacco Free Schools Project is developed and funded by the Public Health Grant. It is a comprehensive school-based programme to prevent the uptake of smoking by young people in Rutland.

Part of the Tobacco Free Schools project is the role of the peer mentor/ youth advocate/ 'SmokeScreen' promoter. The roles vary depending on whether they are developed within primary or secondary schools, and include supporting and advocating for smoke free environments, particularly in homes and cars. They also involve helping to promote the message that not smoking is the norm as most students don't smoke, and using this to encourage those who do smoke to stop and those who don't not to start.

A range of promotion methods are used including creating posters that will be placed around the school or college and entered into an annual poster competition. The overall outcomes of the project include:

- an increase the number of young people who seek assistance to quit smoking;
- a reduction in the number of young people taking up smoking and using tobacco; and
- a reduction in overall smoking prevalence for the population of Rutland.

2.2 Peer based interventions

These interventions aim to capitalise on the social influence of people who share similar experiences or characteristics by recruiting and training people from within the community of interest. This approach develops the capacity of volunteers or peers to become 'agents of change'.

2.3 Volunteer health roles

These are more 'formal' volunteer health roles which are often focused on reducing health inequalities. Volunteers usually receive training to undertake the role and professional support is provided. For example Voluntary Action Rutland (http://www.varutland.org.uk) supports and promotes local voluntary action by providing advice, information, support, training and consultation. They offer a wide range of services to members of the Rutland community and give priority to those most in need. They hold a database of organisations looking for volunteers and people willing to offer voluntary work for the benefit of their community.

Case Study - Breastfeeding peer support service in Rutland 'Breastfeeding Support Rutland'

Breastfeeding Peer Support Rutland offer support to mothers in Rutland. The peer supporters are mothers who have breastfed their babies, or are currently breastfeeding. They are trained to provide other mothers with support via antenatal & postnatal support and regular coffee mornings in Rutland's Children centres.

This project covers the whole of Rutland. The aim of the project is to contribute to increasing breast feeding rates at initiation and 6-8 week duration. Breast feeding peer supporters can support mothers by providing information about the benefits of breastfeeding, thus ensuring that women can make informed decisions on how to feed their baby. For those who have chosen to breastfeed, they can provide advice, support and encouragement when requested.

This project is co-ordinated by the Infant Feeding team at Leicestershire Partnership NHS Trust.

The project currently has 11 active peer supporters with a further 10 mothers who have recently been trained. Breastfeeding Peer Support contributes to an increase in the proportion of mothers breastfeeding in Rutland. A rise from 240 initiating breast feeding in 2013-14 to 282 in 2014-15.[4]

2.4 Summary

These local case studies support the evidence on the positive impact of taking part in volunteering. The evidence highlights the positive impact of volunteering for the volunteer or peer supporter, as well as for the target group or recipient of the support.

Using 2011 figures, the Cabinet Office calculated the monetary value of volunteering to the wellbeing of the volunteers as £13,500 per person per year.[14] An analysis of the value of volunteers running activities was £6 to £1 invested to employ a community development worker.[16] This demonstrates potentially a significant return on investment.

Volunteering delivers a whole range of benefits, which include:

- having a positive impact on the community and increasing the connections within that community;
- supporting individuals to make new friends and contacts;
- increasing social and relationship skills;
- improving mental and physical health; and
- improving job skills or providing career experience.

These benefits are in addition to the support that is being provided within the local community through the specific and targeted volunteer and peer roles.

3. Collaboration and partnerships

A key strand of community centred approaches is to engage and work with communities to improve planning and decision making, ensuring a greater focus on 'done with rather than done to'. Collaborative approaches that involve communities and local services working together can range from a one-off consultation to longer term participation in planning and service delivery. Partnerships with communities may include jointly identifying need, agreeing priorities and actions and planning, implementing and evaluating results.[2] There is good evidence that involving communities in the processes of planning, design, decision-making and delivery can improve health and well-being and make policy initiatives more sustainable.[34] Whilst no particular model of community engagement is thought to be more effective than any other,[36] engagement is seen to work best where it is an ongoing cumulative process enabling relationships and trust to build and strengthen over time.[37]

Community collaborations and partnerships can help to address a sense of powerlessness on the part of the community leading to a more resilient, inclusive approach and a more positive view on the way a community feel about their local area.[17] [38] In some areas of work such as social housing, communities that have owned and managed the work have performed better than local authority owned social housing.[39] Community coalitions can contribute to the effectiveness of certain community health improving behaviour change, particularly if they have been involved in the planning of the initiative.[34]

3.1 Community-based participatory research

This is where a partnership between communities, services and researchers work together to identify the needs of the community and develop programmes to meet those needs.

3.2 Area based initiatives

This refers to community based initiatives that are targeted in a particular geographical neighbourhood. This allows plans to be focused on the issues that affect a particular geographical community and that tackle multiple issues that are affecting the area in a holistic way.

Case study - 'Whissendine Good Neighbour Scheme': Local people set up a good neighbour scheme in a Rutland village

The village of Whissendine in Rutland has around 500 houses, a church, a windmill, 2 pubs, a sports club and various community groups. What is doesn't have is a post office, doctor's surgery or until recently a shop. It's a nice place to live and many choose to live there independently as long as they can. A parish plan was initiated in the village, and a questionnaire circulated asking residents how they felt about the village and how they thought it could be improved. Among other things the need for transport and befriending were highlighted. The Rural Community Council -who were assisting with the plan, suggested they set up a Good Neighbour Scheme along the lines of a scheme operating in Leicestershire. A steering group was formed, and a public meeting held where 30 people came forward to volunteer.

The Good Neighbour Scheme in Whissendine was set up in 2010. It is run by local volunteers who support people living in the village. A duty co-ordinator holds a mobile phone, and those requiring assistance ring to make a request and the co-ordinator finds a volunteer to help. Some volunteers provide transport to medical appointments or to social events in the village, others help with small DIY or gardening tasks. Some volunteers befriend, such as dropping in for a chat. The only charges made are for petrol, trips outside the village and parking. The scheme has its own website, advertises monthly in the village newsletter Grapevine, and in 2011 the scheme was awarded a Gold Award for Village Achievement from the Rural Community Council.

Feedback has been very positive, with residents saying they don't know how they managed before, and more than one person saying they feel more confident about living independently in the village in spite of increasing age.

"Most weeks I have a welcome visit from a lady from the Good Neighbour Scheme. As I spend the greater part of each day on my own, it is good to have someone call who is always cheerful, helpful and interesting to talk to."

Initial set-up costs were covered by funding from Rutland Community Spirit and Whissendine Parish Council. A Grass Roots grant via Voluntary Action LeicesterShire (VAL) was also obtained.

The Rural Community Council, who assisted at the beginning, continue to support the scheme. Rutland County Council agreed to be the umbrella organisation for DBS checks, processing them initially free of charge. Voluntary Action Rutland and VAL provided information and training.

3.3 Community engagement in planning

This is an approach that aims to involve local communities in planning and decision making with local government and the NHS. It brings in the insights of the local communities on the issues that are affecting their lives and also means that the local community has a greater sense of ownership of the plans that are developed. Public Health are developing a Health Impact Assessment / Health in All Policies approach to support local communities in influencing major developments and policies that will increase the potential positive impacts and mitigate identified negative impacts.

3.4 Co-production projects

These are projects that seek to develop equal partnerships between professionals and those using health and care services. This approach is similar to many of the other approaches but is focussed on people with established care needs.

Case Study - Health for Kids – Health for Teens

School nurses at Leicestershire Partnership Trust wanted to enable children and young people to 'help themselves' to health in a format of their choice and to provide an extension to their school nursing services. They developed a Health for Kids website: https://www.healthforkids.co.uk/ and a Health for Teens website: https://www.healthforteens.co.uk/. Children and young people were actively involved in co-designing the websites and the websites ensure that children and young people have access to good, sound, safe and accurate information.

Several separate groups of children and young people were involved in focus groups to develop the ideas and topics to be included and in particular shape how they wanted to receive the information. The children designed the characters and games used for the Health for Kids website. In its first 18 months, the Health for Kids website has had more than 39,000 visits and 175,000 page views. In the first week of a new campaign' Move it Boom!' has seen 27,000 page hits and 700 children have signed up to participate and record their activities.

School teachers in Rutland are using the site in lessons and have welcomed the emotions section as an excellent learning tool. Over eleven thousand individuals visited The Health for Teens website in its first 9 months, with 50,000 individual page views. During this time The Health for Teens twitter feed had 769 followers and these are growing steadily. Young people have continued to be involved in its development and as a result a range of additional topics, apps, videos and vlogging (video blogging) facilities are being added to the website. An editorial team of young people is being established and consultations will continue on an ongoing basis to ensure the websites stay fresh and meets the needs of children and young people and that the content and style is always driven by what children and young people want to know about. The website has recently won a communications industry award for the 'Best website' from the Association for Healthcare Communications and Marketing (AHCM). The children and young people have expressed their pleasure at seeing their ideas and views taken on board as can be seen in the video they prepared for several awards

3.4 Summary

These collaboration and partnership approaches can lead to more positive health and wellbeing outcomes and have been shown to improve a sense of belonging to a community (social capital) and to improve a sense of wellbeing. The chance to co-produce services can increase confidence and self-esteem. Using people's local knowledge and experience to design or improve services can ensure they are more appropriate, effective, cost effective and sustainable. They can encourage health enhancing attitudes and behaviours. Individuals and communities can gain a sense of increased control over decisions affecting their lives.[40] There is good evidence of the benefits of working in partnership with communities to enable better planning, decision making and delivery. For these opportunities to be used more widely and effectively statutory organisations and professionals need to be committed to sharing power and decision making and support the development of staff to have the skills, knowledge and values to work in this way.[40] Whilst there are good examples of partnerships and collaboration in Rutland, extending cross agency working and partnerships to more fully involving local people and communities

would be a next step in developing these approaches.

4. Access to community resources

The assets within communities, such as its skills and knowledge, social networks and community organisations, are building blocks for good health. It is important that we enable people and communities to participate, contribute and also access these assets in order to be able to improve their health and wellbeing.

Resources can include anything that may be community based, for example, parks and green spaces or community pharmacies. Parks and green spaces can help to address issues such as obesity, cardiovascular disease, mental ill health or antisocial behaviour.[41] There is evidence that community pharmacies can have an impact upon smoking cessation activities, cardiovascular disease prevention and management of diabetes.[42]

Access to assets can be helped through the provision of local information and services, support groups and organisations which both signpost to support or assist people in getting access to support. Examples include “community hubs” such as children’s centres, community libraries and citizens advice centres.

Using an asset based community development approach starts with the process of locating the assets, skills and capacities of residents, citizens associations and local institutions. This builds up community groups and voluntary organisations; their informal associations and networks, their collaborative relationships, their shared knowledge and therefore their social power to make positive changes.

4.1 Pathways to participation

This covers the many routes that are being developed locally to help people to access interventions that will improve their health and wellbeing. These all build on the assets that already exist within the community – be it the physical assets in the form of parks, green spaces or community centres or the assets that exist in the people that live within these communities through their own experiences and expertise and time. Local examples include “social prescribing” to activities outside of the traditional health sector, which links people up to activities in the community that they might benefit from. For example referral to green gyms or walking schemes for physical activity, food banks and welfare and debt advice.

Case Study - STEP TO IT – an inclusive dance group for girls and boys aged 12-19

"STEP TO IT" is an inclusive dance group for girls and boys aged 12-19 years old with a disability, enabling them to be part of a weekly dance session. The sessions are delivered by Rutland youth dance academy, and supported by Rutland County Council Active Rutland officers. They are held at Brightways Community Centre. The group have performed at the community dance show and even in front of royalty. This year the group won "Project of the year" at Rutland Sports awards.

The session begins with dynamic movement skills, to help refine and improve gross motor skills, and to get those body parts moving! Participants engage their creativity by moving around the room in different ways. The second part of the session is more structured with different routines being built upon every week. The session ends with 5-10 minutes of relaxation and stretching, allowing a focus on the body and spatial awareness as well as time to reflect on what the dancers have just learnt. Comments from users include:

"Step To It has been a brilliant project for me. I've never really been interested in dance or preforming, but I have loved being given this opportunity to learn hip hop/pop by a professional and then being able to perform! It's definitely helped my confidence and self-esteem as I've been able to express myself through dance and get fit at the same time; I hope this group continues and I'd recommend dance to anyone."

"Step to It is a fantastic project of 'feel good' personified! An hour in this environment is developing our daughter's co-ordination, concentration, strength and communication whilst doing something she loves with her peers - a well spent hour! With our daughter's level of learning and physical disability we struggle to find inclusive, ongoing activities that she can realistically access for long enough to experience success. Step To It provides this platform."

The programme is funded through Sport England "Sportivate" funding.

4.2 Community hubs

These are community centres or organisations focused on health and wellbeing that can provide multiple activities to address health or the wider determinants of health.

Case Study - Rutland Food Bank

23rd September 2015 marked the second birthday of Rutland Food Bank. During that time 1500 people have received emergency packs of food to last 3 days and 23.5 tonnes of food collected mostly by the generosity of local people.

In Rutland there are two Foodbanks – on Melton Road in Oakham and Uppingham Parish Church. Both provide a community hub where clients are able to share their experiences and are signposted to agencies who can offer additional help and begin to resolve any underlying problems.

All food given out by the foodbanks is donated. Often this is from schools, churches, businesses, individuals, or through supermarket collections. Supermarket collections help foodbanks engage the public. Foodbank volunteers offer shoppers a 'foodbank shopping list' and ask them to buy an extra item with their shop. This food is then handed to volunteers waiting beyond the checkout who pack it before it is taken to the foodbank warehouse for further sorting and storage. Food is sorted and stored at the warehouse, where volunteers weigh and sort the donated food according to type and 'best before date'. They also check it is undamaged and suitable for use before packing it into boxes for storage.

Professionals from statutory and voluntary organisations such as doctors, health visitors, social workers, Citizens Advice Bureau staff, welfare officers, the police and probation officers, identify people in crisis and issue them with a foodbank voucher. Clients bring their voucher to a foodbank centre where it can be exchanged for three days supply of emergency food. The list of foods in each parcel have been designed by dieticians to provide recipients with nutritionally balanced food.

4.3 Community based commissioning

This refers to a process by which local communities are involved in the commissioning cycle and includes community engagement to understand community needs, and commissioning services through third sector providers. The Council is now focussed on improving prevention and resilience (in line with current key strategies and Better Care Together and Better Care Fund),[11] [12] [13] by supporting people to help themselves, and concurrently building capacity in communities. To do this Rutland are considering using a 'Partnership' approach to commissioning that co-designs services with both providers and our communities.

4.4 Summary

Improving access to community resources has a number of health and wellbeing benefits. Using community assets innovatively increases the awareness of the assets and will generate further use. As people access the benefits of different facilities and services they will start to use treatment and support services more appropriately and to manage their non-clinical needs more effectively. The case studies presented in this section demonstrate significant benefit to people accessing community resources, both as a user of the service and as a citizen contributing to the community based approach.

FEEDBACK FROM RECOMMENDATIONS FOR 2014

In this section we highlight some of the initiatives that have taken place in the past year that are linked to the recommendations from the 2014 report.

The best start in life

- Over 40% of 5 year olds in Rutland were shown to have had experience of tooth decay in the 2012 oral health survey. This is significantly higher than national levels. A project on oral health has been undertaken to provide insight into why levels of tooth decay in children in Rutland are higher than expected and to develop an evidence-based oral health promotion programme for the future.

- Health Visiting and Children Centre staff have proactively promoted the Free Early Education Entitlement for two year olds to eligible families and a 91.6% take up has been achieved. This is expected to help to contribute towards improved School Readiness across the County.

- A multi-agency integrated antenatal, perinatal and post-natal pathway is being developed in Rutland to ensure a holistic approach to all of these services in line with the '1001 Critical Days' cross party manifesto – the goal of which is for every baby to receive sensitive and responsive care from their main caregivers in the first year of life.

Healthy schools and pupils

- School pupils in Rutland are encouraged to contribute to improving the health and wellbeing of children and young people through the use of a 'Whole School Approach' and by making use of the Leicestershire healthy school resources.

- Schools are encouraged to incorporate more physical activity in the curriculum working with Leicestershire and Rutland Sports Partnership, Active Rutland, and Rutland County Council active transport team. Active Rutland has worked with 26 schools and the active transport team supported 360 Year 5 & 6 children to take part in Bikeability Levels 1 & 2 programmes and 10 children to achieve Level 3.

- Schools are encouraged to adopt the Personal, Social and Health Education (PSHE) Association's PSHE programme of study, and that they utilise the new Leicestershire PSHE Toolkit: 'PSHE: Better than Good Enough.'

Economy and employment

- Rutland County Council has established a group on work and health for council employees, and using the National Workplace Wellbeing Charter to benchmark and assess their progress. A staff engagement and health questionnaire had a 63.7% response rate and provided the group with useful insight to inform their work. From the results 3 priority areas were identified and working groups established on mental

health, work environment and communications. This has resulted in a wide range of activity including: policies revised and updated; staff benefits packages further developed; health and wellbeing days, mindfulness taster sessions and courses on Mental Health First Aid held and staff health discussions integrated into managers meetings.

- More widely The County Council has also worked with local employers around green travel planning and provides employers with a range of support to do this including starting greener driving courses for employees who drive for work.

Strong communities, wellbeing and resilience

- Development of a unified prevention model for Rutland has continued and includes plans to further develop a network of community agents procured from the private/voluntary, community and faith sector. In the first 9 months of operation Community Agents have seen 400 individuals and prevented 60 clients admission to hospital or supported their leaving hospital.

- A Falls Summit was held in Rutland as part of the Better Care Fund and included a wide range of participants from public, voluntary and community agencies. This identified that whilst there was already significant activity, there were gaps and there was a need for better coordination, publicity and a clear pathway. These findings are now being used to develop falls prevention work further. Greater integration across health and social care services in Rutland have been achieved by the REACH re-ablement service where occupational therapists, physiotherapists and nurses have worked as a team using individual care plans to maximise independence and wellbeing. This has resulted in less people going into residential care and seen a small drop in hospital admissions.

Active and Safe Travel

- An Active School Travel Health Needs Assessment is being developed for Leicestershire and Rutland. The aim is to understand the perceptions of road safety and road traffic injuries associated with active school travel and how closely these match the real risk in terms of road traffic accidents occurring on the school commute and the benefits in terms of increased physical activity in children.

Access to green and open spaces and the role of leisure services

- The Active Rutland team, supported with Public Health funding, held Rutland Walking and Cycling Festivals, and the Rutland Round. 2015 saw over 300 people participate in week long programme of walking events across Rutland's green spaces. There are 2 Walking for Health accredited groups. The Oakham group has around 20 walkers and the Ketton group has 50-60 walkers each week. 3 additional run leaders have been starting up new sessions for people across the county including programmes for

beginner runners. The established Rutland Water Parkrun averages around 100 participants each week, and to date has seen 720 different runners.

- The Sports Arena held at the annual Rutland Day celebrations based at Sykes Lane had over 5,000 people attend. Local clubs put on sessions for the public to try a new activity and promoted what is on offer across Rutland for people to get involved in.

Warmer and safer homes

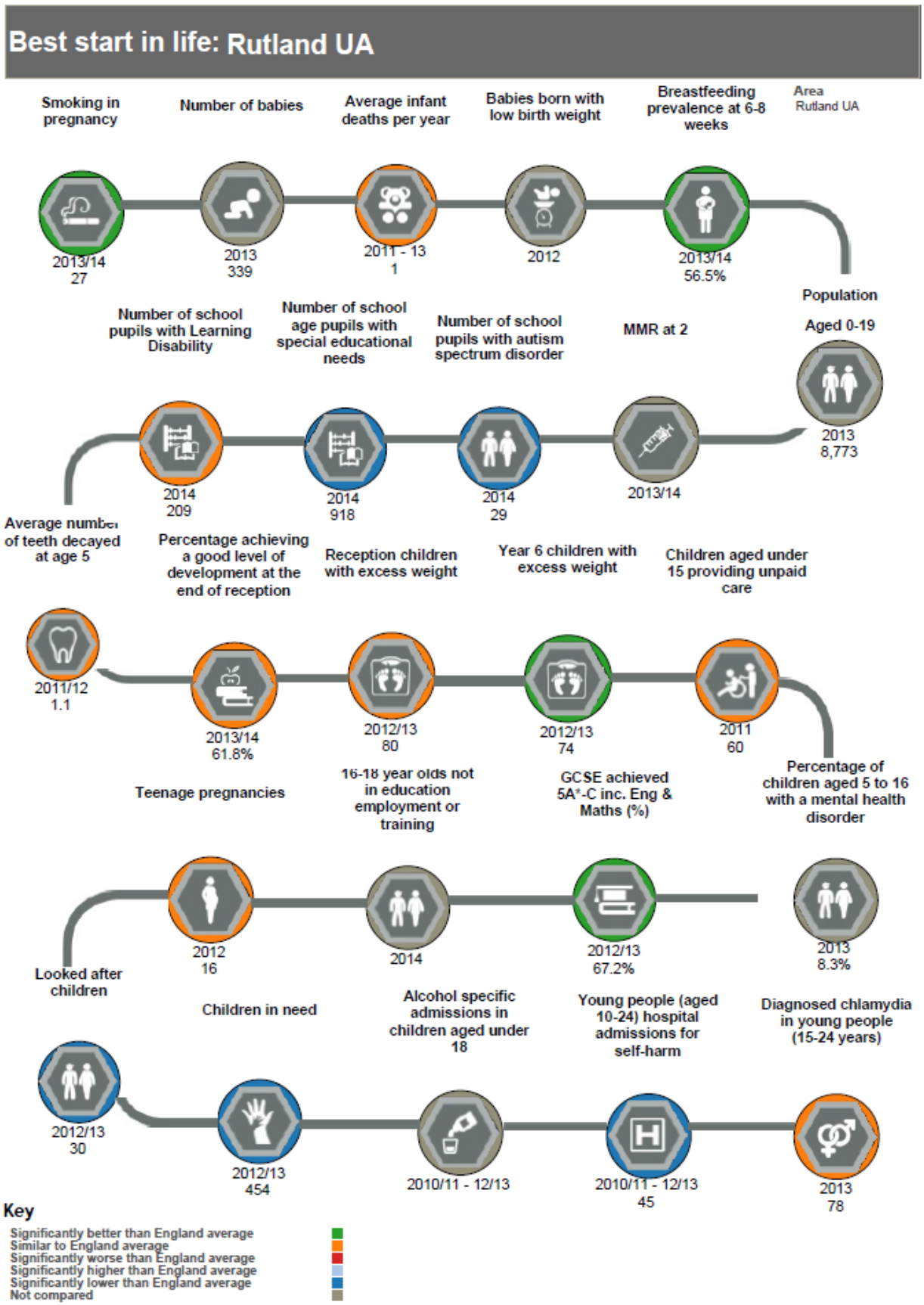
- Rutland Better Care Fund resourced the delivery of the Falls Management Exercise (FaME) programme. This is being evaluated externally through funding from CLAHRC (Collaboration for Leadership in Applied Health Research and Care) funded project. There is also a falls prevention action plan in place.

- In 2014/15 Rutland County Council funded a third party provider to carry out energy audits and advise residents with options to make their homes warmer. Between January 2015 and June 2015 152 visits were carried out within Rutland.

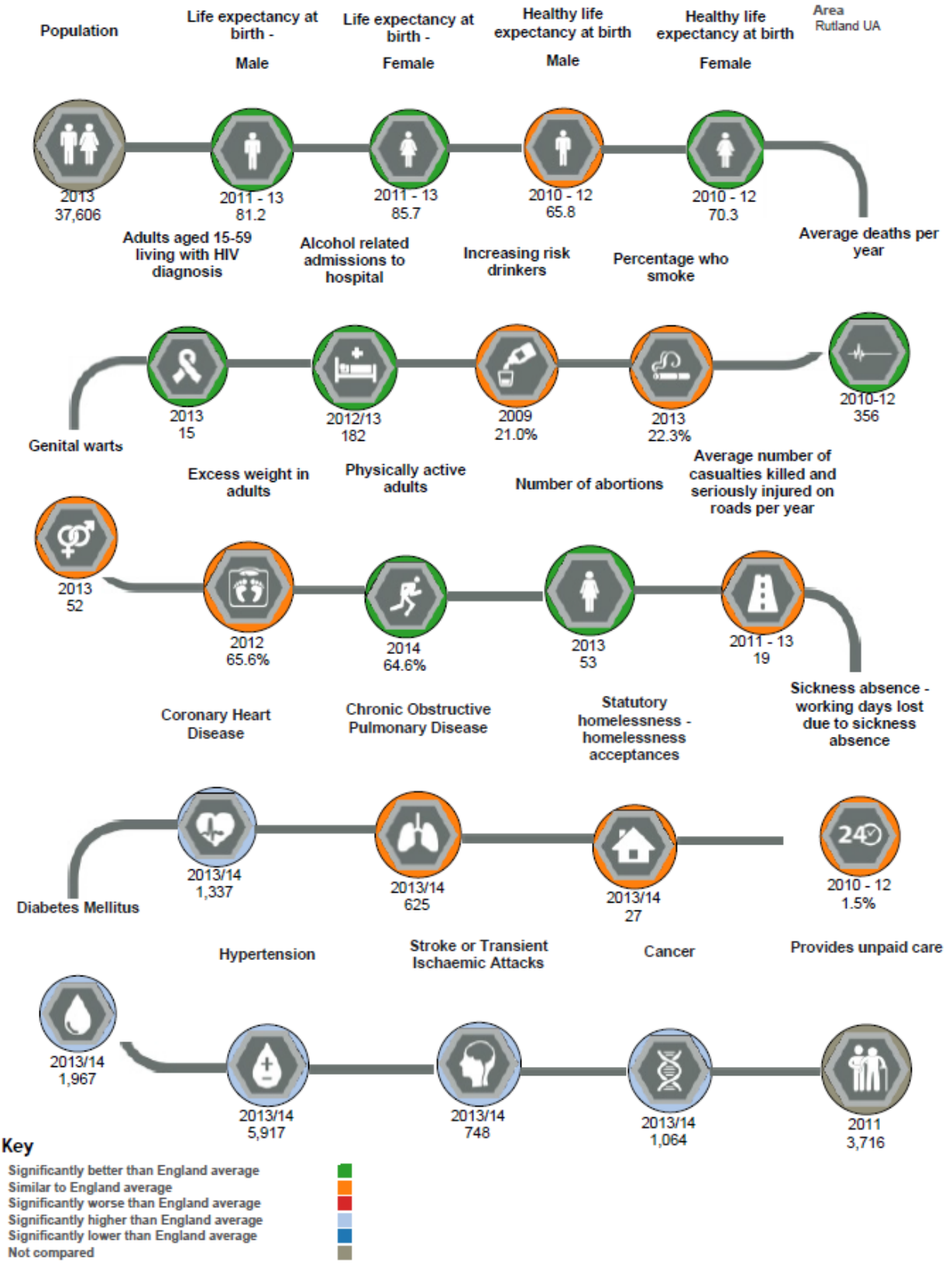
Public Protection and Regulatory Services

- A number of programmes are commissioned to encourage and promote healthy food choices and alternatives to fast food. In Rutland this includes the Family Lifestyle Club (FLiC) and Lifestyle Eating Activity Programme (LEAP). These services are being redesigned to ensure an appropriate model of delivery for Rutland.

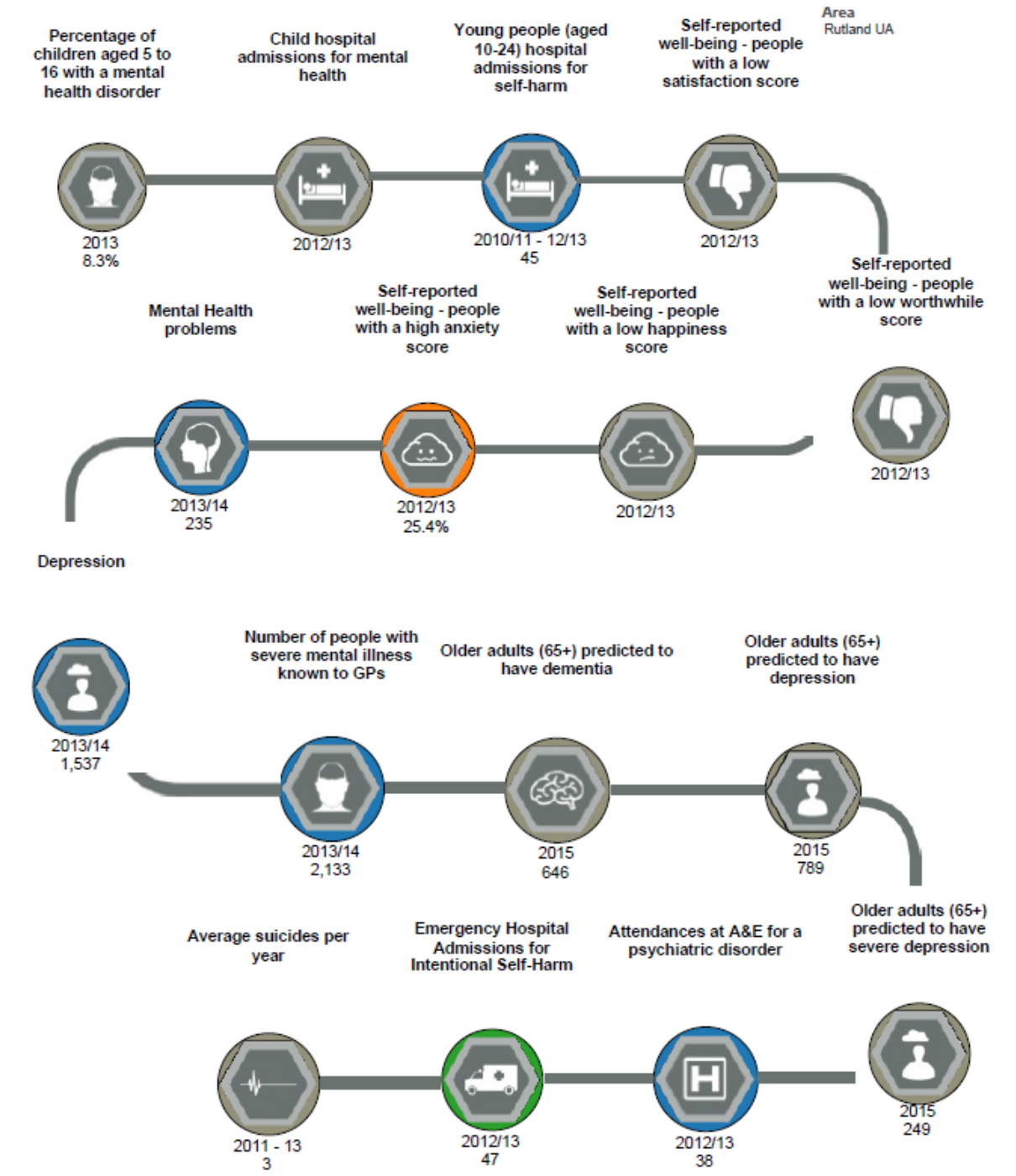
APPENDIX A: RUTLANDS JSNA HEADLINES


Best start in life: Rutland UA
Smoking in pregnancy
2013/14
27
Number of babies
2013
339
Average infant deaths per year
2011 - 13
1
Babies born with low birth weight
2012
Breastfeeding prevalence at 6-8 weeks
2013/14
56.5%
Area
Rutland UA
Population
Aged 0-19
2013
8,773
MMR at 2
2013/14
Number of school pupils with autism spectrum disorder
2014
29
Number of school age pupils with special educational needs
2014
918
Number of school pupils with Learning Disability
2014
209
Average number of teeth decayed at age 5
2011/12
1.1
Percentage achieving a good level of development at the end of reception
Reception children with excess weight
Year 6 children with excess weight
Children aged under 15 providing unpaid care
2013/14
61.8%
Teenage pregnancies
2012/13
80
16-18 year olds not in education employment or training
2012/13
74
GCSE achieved 5A*-C inc. Eng & Maths (%)
2011
60
Percentage of children aged 5 to 16 with a mental health disorder
2012
16
Looked after children
Children in need
2014
Alcohol specific admissions in children aged under 18
2012/13
67.2%
Young people (aged 10-24) hospital admissions for self-harm
2013
8.3%
Diagnosed chlamydia in young people (15-24 years)
2012/13
30
2012/13
454
2010/11 - 12/13
2010/11 - 12/13
45
2013
78
Key
Significantly better than England average
Similar to England average
Significantly worse than England average
Significantly higher than England average
Significantly lower than England average
Not compared

Health and wellbeing of adults: Rutland UA



Mental health: Rutland UA

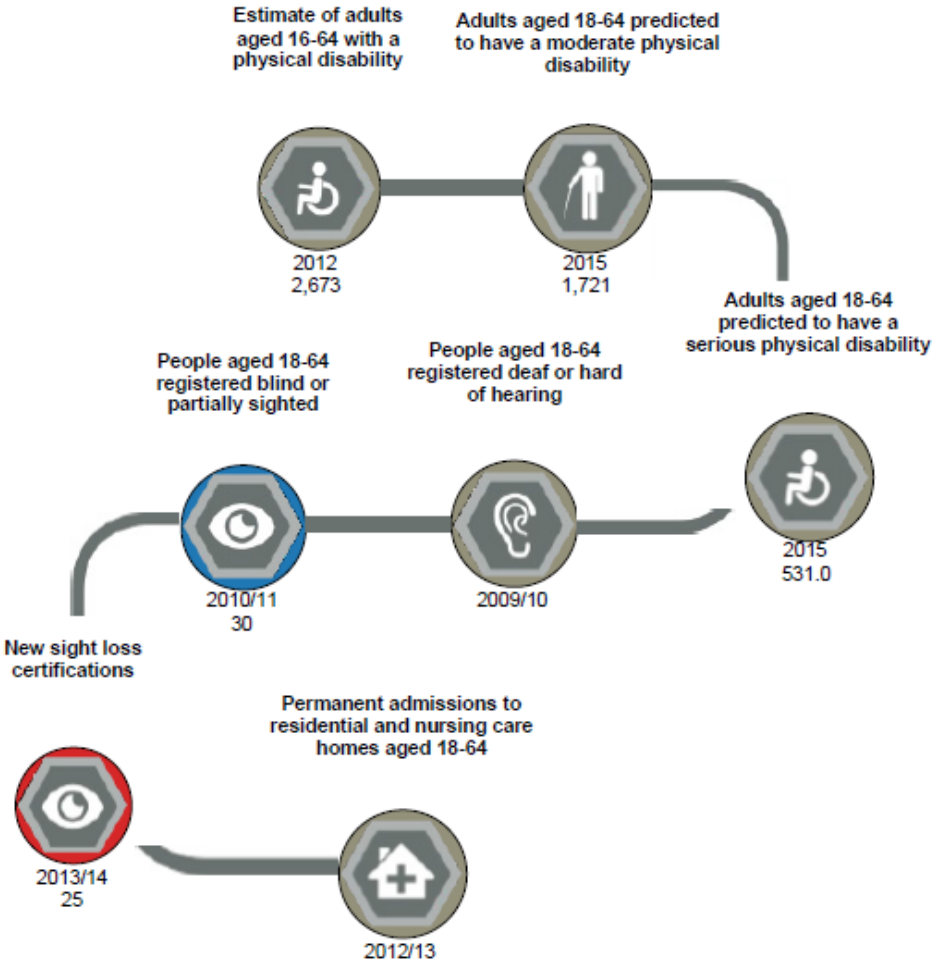


Key

- Significantly better than England average
- Similar to England average
- Significantly worse than England average
- Significantly higher than England average
- Significantly lower than England average
- Not compared

Physical and sensory disabilities: Rutland UA

Area
Rutland UA

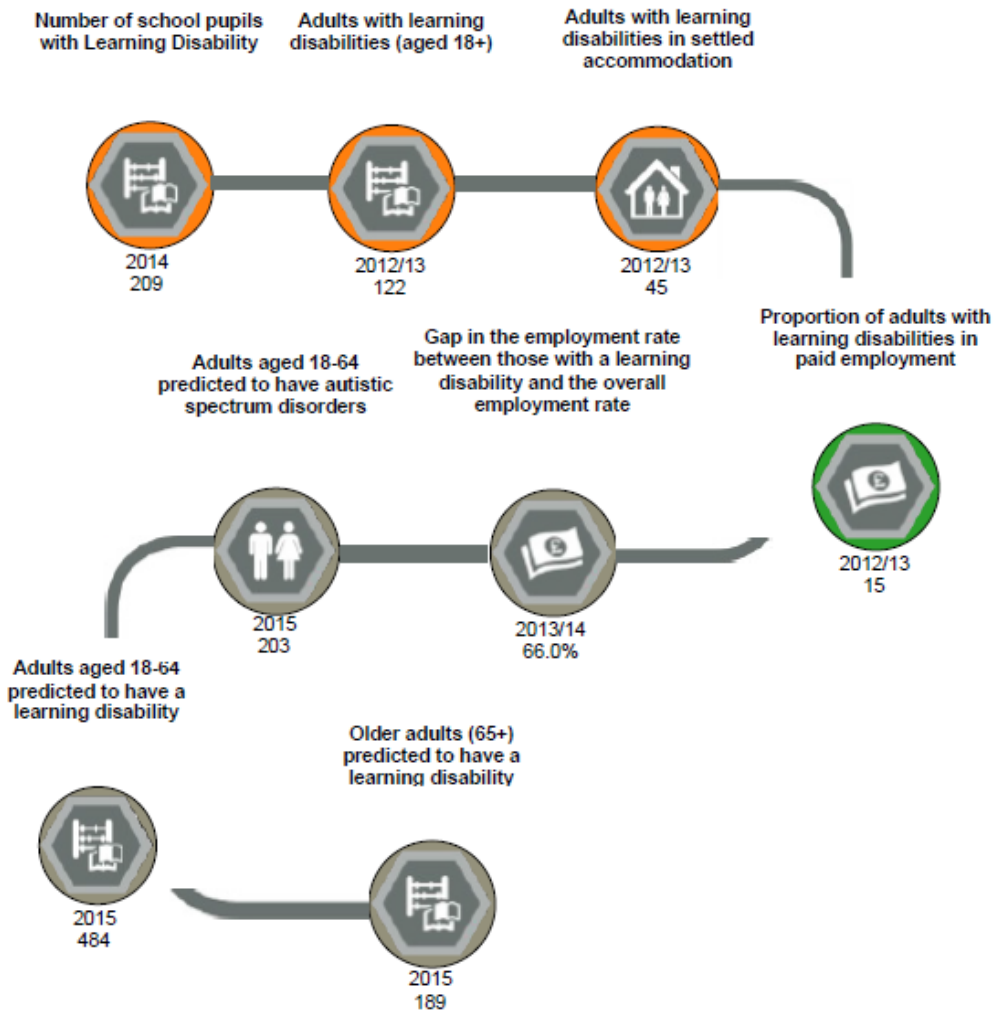


Key

- Significantly better than England average
- Similar to England average
- Significantly worse than England average
- Significantly higher than England average
- Significantly lower than England average
- Not compared

Learning disabilities and autism: Rutland UA

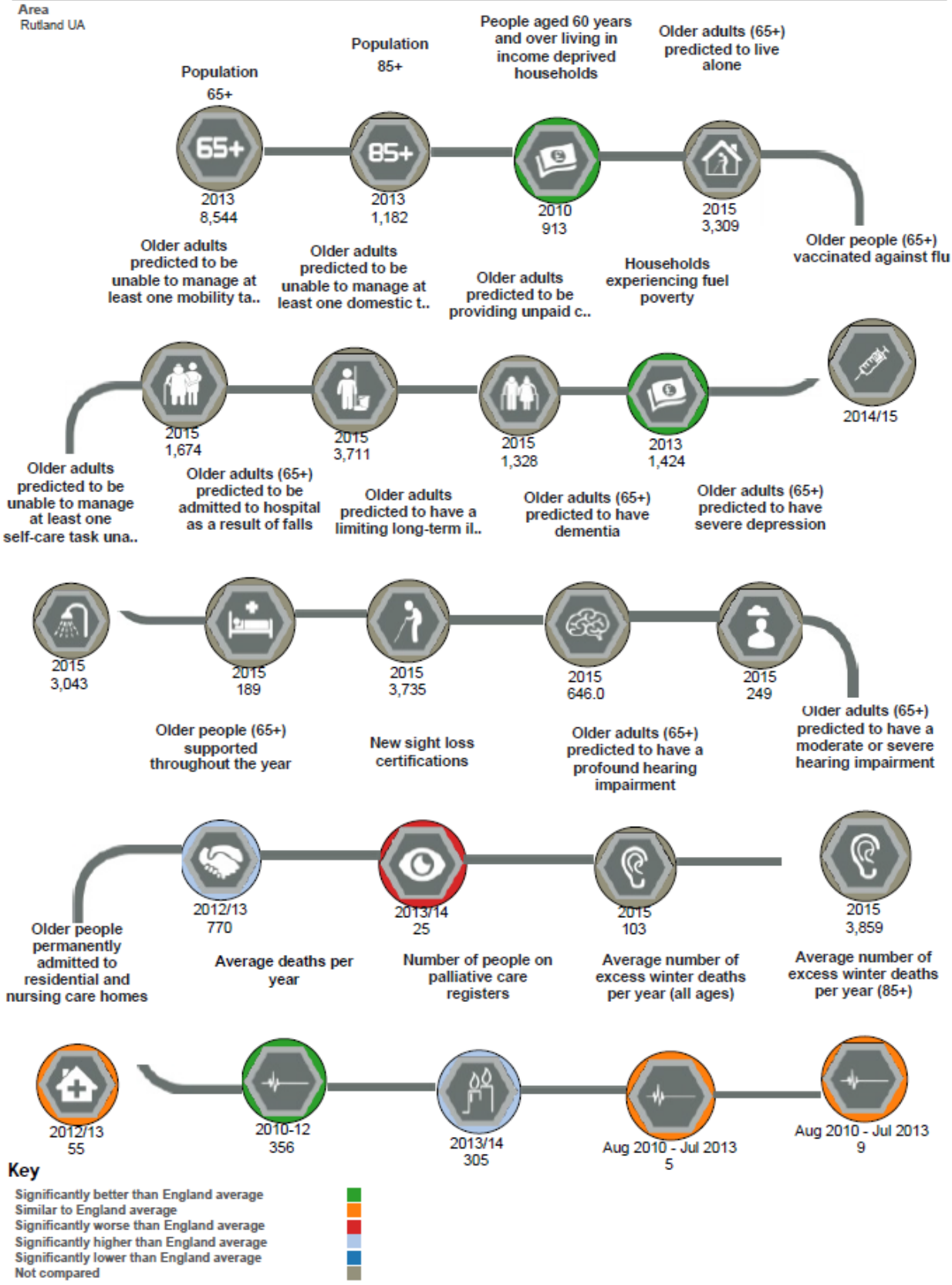
Area
Rutland UA



Key

- Significantly better than England average
- Similar to England average
- Significantly worse than England average
- Significantly higher than England average
- Significantly lower than England average
- Not compared

Issues specific to ageing: Rutland UA



LIST OF ABBREVIATIONS

BCF	Better Care Fund
CCC	Coffee, Cake & Chat
CCG	Clinical Commissioning Group
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
DBS	Disclosure Barring Service
DIY	Do it Yourself
FaME	Falls Management Exercise
FFLP	Food For Life Partnership
FLiC	Family Lifestyle Club
GP	General Practice or General Practitioner
HIA	Health Impact Assessment
JSNA	Joint Strategic Needs Assessment
LEAP	Lifestyle Eating Activity Programme
LPT	Leicestershire Partnership Trust
NHS	National Health Service
PHSE	Personal Health and Social Education
RCA	Rutland Community Agents
RIS	Rutland Information System
UK	United Kingdom
VAL	Voluntary Action LeicesterShire
VCS	Voluntary and Community Services

REFERENCES

1. Dahlgren, G. & Whitehead, M. *Policies and strategies to promote social equity in health*. (1991).

2. Public Health England & NHS England. *A guide to community-centred approaches for health and wellbeing*. 48 (2014). at <https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches>

3. Rutland County Council. Rutland County Council Joint Strategic Needs Assessment Overview 2015. (2015).

4. Public Health England. Public Health Outcomes Framework. (2014). at <http://www.phoutcomes.info/>

5. Office of National Statistics. ONS Mid-2013 Population Estimates. (2014). at <www.statistics.gov.uk>

6. Office for National Statistics Population Projections Unit. *2012-based sub-national population projections*. (2014).

7. Better Care Together. A Partnership of Leicester Leicestershire and Rutland Health and Social Care. Better Care Together Plan 2014. (2014). at <http://www.bettercareleicester.nhs.uk/the-bct-plan/>

8. Office of National Statistics. *VS3 MORTALITY BY CAUSE* - 2013 REGISTRATIONS TO 2013 BOUNDARIES DEATHS TO PERSONS RESIDENT IN: LOCAL AUTHORITY*. (2014).

9. Office of National Statistics. Census 2011 - Nomis. *Crown Copyright* (2013). at <http://www.nomisweb.co.uk/census/2011>

10. Fried, L., Furrucci, L., Darer, J., Williamson, J. & Anderson, G. Untangling the concepts of disability, frailty and co-morbidity: implications for improved targeting and care. *Journals Gerontol.* **Series A: ,** 255–263 (2004).

11. Rutland County Council. *People First Final Report - People First Review January to July 2014*. (2014). at <http://www.rutland.gov.uk/pdf/Report No. 202-2014 People First Appendix A.pdf>

12. Rutland County Council. *Adult Social Care Strategy 2015-2020 Healthy and Independent Lives – A Sustainable Future*. (2015). at <Adult Social Care Strategy 2015-2020 Healthy and Independent Lives – A Sustainable Future>

13. Rutland County Council. *Adult Social Care Market Position Statement 2015*. at <http://www.rutland.gov.uk/pdf/Rutland ASC Market Position Statement 2015-20.pdf>

14. Fujiwara, D., Oroyemi, P., McKinnon, E., Oroyem, i P. & McKinnon, E. *Wellbeing and civil society. Estimating the value of volunteering using subjective wellbeing data*. (2013).

15. Knapp, M., Bauer, A., Perkins, M. & Snell, T. Building community capital in social care: is there an economic case? *Community Dev. J.* **48,** 313–31 (2013).

16. nef Consulting. *Catalysts for community action and investment: A Social Return on Investment analysis of community development work, based on a common outcomes framework. Executuive Summary.* (2010).

17. Cairncross, L., Morrell, C., Darke, J. & Brownhill, S. *Tenants managing: an evaluation of tenant management organisations in England.* (2002).

18. Popay et al. *Community engagement in initiatives addressing the wider social determinants of Health A rapid review of evidence on impact, experience and process.* (2007).

19. Winters, M. & Patel, K. *The Department of Health's Black and Minority Ethnic drug misuse needs assessment project.* (2003).

20. Grimsley, M., Hickman, P., Lawless, P., Manning, J. & Wilson, I. *Community Involvement and Social Capital.* (2005).

21. Lifelong Learning UK. *National Occupational Standards for Community Development*. (2009).

22. Daily, J. & Barr, A. *Understanding a Community-led Approach to Health Improvement*. (2008). at <http://www.scdc.org.uk/media/resources/what-we-do/mtsc/Understanding a community-led approach to health improvement.pdf>

23. Elliott, E. *et al. Connected Communities - A review of theories, concepts and interventions relating to community-level strengths and their impact on health and well being*. (2011).

24. Foot, J. & Hopkins, T. *A glass half-full: how an asset approach can improve community health and well-being*. *Improvement and Development Agency* (2010). at <http://www.local.gov.uk/c/document_library/get_file?uuid=fc927d14-e25d-4be7-920c-1add80bb1d4e&groupId=10171>

25. Morgan, A. & Ziglio, E. Revitalising the evidence base for public health: an assets model. *Promot. Educ.* **Suppl 2,** 17–22 (2007).

26. Wallerstein, N. *What is the evidence on effectiveness of empowerment to improve health?*. (2006).

27. Woodall, J., Raine, G., South, J. & Warwick-Booth, L. *EMPOWERMENT AND HEALTH & WELL-BEING: Evidence Review*. (2010).

28. Fisher, B. *Community Development in Health – a Literature Review*. (2011).

29. Jenkinson, C. *et al.* Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers. *BMC Public Health* **13,** (2013).

30. NHS. Five steps to mental wellbeing. *2014* at <http://www.nhs.uk/Conditions/stress-anxiety-depression/Pages/improve-mental-wellbeing.aspx>

31. Laverack, G. Health activism. *Health Promot. Int.* **27,** 429–434 (2012).

32. Seyfang, G. & Smith, K. *The time of our lives: Using time banking for neighbourhood renewal and community capacity building*. (2002).

33. Boyle, D., Clark, S. & Burns, S. *Hidden work: Co-production by people outside paid employment.* (2006).

34. Swainston, K. & Summerbell, C. *The effectiveness of community engagement approaches and methods for health promotion interventions. Rapid Review Phase 3*. (2008).

35. Eng, E., Parker, E. & Harlan, C. Lay health advisor intervention strategies: a continuum from natural helping to paraprofessional helping. *Heal. Educ. Behav.* **24,** 413–417 (1997).

36. O'Mara-Eves, A. *et al. The effectiveness of community engagement in public health interventions for disadvantaged groups: a meta-analysis*. (2015).

37. Community Planning Toolkit - community engagement. at <www.communityplanningtoolkit.org>

38. Tunstill, J. *et al. Implementing Sure Start local programmes: An in-depth study*. (2005).

39. Goodlad, R., Docherty, I. & Paddison, R. Responsible participation and housing: Restoring democratic theory to the scene. in *Housing Studies Association, Autumn Conference.* (2003).

40. National Institute for Health and Clinical Excellence. Community Engagement NICE Guidelines [PH9]. *NICE guidelines [PH9]* (2008). at <https://www.nice.org.uk/guidance/ph9>

41. Pevalin, D. & Rose, D. *Social Capital for Health: Investigating the links between social capital and health using the British Household Panel Survey*. (2003).

42. Public Health England. Consolidating and developing the evidence base and research for community

pharmacy's contribution to public health: a progress report. in *Task Group 3 of the Pharmacy and Public Health Forum* (Public Health England, 2014).

Report No: 83/2016
PUBLIC REPORT

SCRUTINY PANEL

14 April 2016

ORAL HEALTH PROMOTION & THE NATIONAL DENTAL SURVEY 2012

Report of the Director of Public Health

Strategic Aim:	Meeting the health and wellbeing needs of the community	
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):	Trish Crowson, Senior Public Health Manager	Telephone 01572 758268 email: trish.crowson@leics.gov.uk

DECISION RECOMMENDATIONS
That the Panel: 1. Notes the findings and actions identified in the attached report; 2. Endorses the approach taken to development of the action plan and engagement with community partners and settings in promoting good oral health; 3. Makes suggestions for any further actions.

1 PURPOSE OF THE REPORT

1.1 To inform the Panel on the findings of the National Dental Health Survey 2012 on oral health of five year olds in Rutland and the actions taken to better understand the reasons for the levels of tooth decay amongst children in Rutland.

1.2 To set out the proposed actions for developing targeted oral health promotion in Rutland.

2 BACKGROUND

2.1 Oral health is an integral part of a person's overall health and wellbeing and has been improving for both adults and children. However, recent data shows that dental caries is the most common reason for children to be admitted to hospital; with nearly 26,000 admissions last year[i]. The most common dental diseases are dental caries (decay) and periodontal (gum) disease. Dental decay can progress to causing severe pain and sepsis. Toothache may result in time off work; times

lost in school, sleepless nights and have a general impact on the individual's ability to function.

2.1.1 There is a direct relationship with material deprivation and oral health, and although the number of people accessing NHS dentistry has been increasing since 2008 (NHS England) many vulnerable groups receive limited support in terms of treatment, care and prevention.

2.1.2 A major factor in the development of dental caries is the frequent intake of refined sugar, which also contributes to the development of other health problems such as obesity. Dental caries is therefore a major risk factor for poor diet.

2.2 Dental Public Health Intelligence Programme Dental Surveys

2.2.1 The Dental Public Health Intelligence Programme (DPHIP) is a national programme of dental surveys co-ordinated by Public Health England (PHE). DPHIP surveys are conducted annually, usually over academic years and are carried out on randomised stratified samples or wider surveys e.g. census surveys, subject to additional samples being commissioned.

2.2.2 Rutland County Council has procured Community Dental Service CIC to undertake surveys on the Council's behalf, as part of a joint specification with Leicestershire County and Leicester City local authorities. This commenced in August 2015.

2.2.3 The surveys undertaken for 2012 and 2013 both focused on children: the 2012 on five year olds and the 2013 on three year olds. The data from these indicated the need for further work on children's oral health in Rutland, and this is detailed below.

2.2.4 The current survey work for 2015-16 is related to older people in extra care housing. The surveys are conducted according to a national standard protocol and examiners are trained and calibrated to a national standard. The findings of this survey will be published nationally (to allow for comparison between areas) in Summer 2017.

3 RUTLAND'S RESULTS OF THE 2012 AND 2013 SURVEYS

3.1 Rutland is a healthy place. Most measures indicate good general health and life expectancy is higher than the national average. Levels of socio-economic deprivation in Rutland are amongst the lowest in the country.

3.2 Oral health is integral to overall health. Data from the three year olds and five year olds oral health surveys has shown levels of tooth decay in Rutland to be higher than the national average. In England, 27.9% of five-year old children had experience of some dental decay (caries) in the 2011/12 national survey. This compares to 40.3% in Rutland. Of those children that had some decay, the average number of teeth affected in England was 3.38, compared to 2.71 in Rutland. Appendix A contains the data tables for both surveys.

3.3 Further analysis of the data was requested and undertaken by Public Health England Knowledge and Information Team on Rutland's behalf and showed that

levels of tooth decay are not uniform within Rutland. Forty-six percent of 5 year olds in Rutland were included in the sample. The wards in which children aged 5 had more than 50% decayed, missing or filled teeth were Uppingham and combined wards of Exton, Langham and Whissendine. (These were combined in the analysis to preserve anonymity of the survey). Appendix B shows a map of indicating levels of decay of five year olds.

3.4 Given that dental decay is usually associated with higher levels of deprivation and tooth decay in Rutland is higher than would therefore be expected it is important to ascertain what the reasons for this might be, to gain a greater understanding and to identify the most appropriate actions to tackle the problem.

4 ORAL HEALTH INSIGHT WORK

4.1 Rutland County Council received specific funding from Public Health England to commission a project to gather insight into what the reasons for the higher levels of tooth decay might be, and to ascertain whether there are modifiable risk factors that we can address, such as dietary habits, oral hygiene practices, beliefs, knowledge or attitudes that are different to other, lower prevalence areas.

4.2 In addition, some routine activity ran concurrently with work to improve data and intelligence. This included: training for health visitors and children's centre staff; promotion of oral health messages by health visitors; and information in 'the red book' personal child health record' given to all new parents with information targeting messages at key stages of child development. Dental practices in the county have also been able to access training on delivering better oral health in line with national guidance.

4.3 The Oral Health Insight work commenced in September and involved three components:

- A desk exercise examining the statistics relating to poor oral health in the area and a review of wider practice to promote children's oral health.
- Consultations with stakeholders including pre-school childcare /childminders/ nursery staff, dental staff, children's centre staff and the health visiting team.
- Engagement with parents of children under 5 to try and ascertain why rates of tooth decay are so high, and in particular the behaviours that underpin the problem.

4.4 Findings

4.4.1 <u>Professionals – awareness and recognition</u>

i) Amongst the childcare providers, most were not aware of the higher incidence of dental decay in Rutland when compared with the national average. Most were surprised by this. They had expected that with the area being affluent and rural, parents would be conscientious about looking after their children's teeth.

ii) A small number of childcare workers were not surprised when we made them aware of the higher incidence of decay. Interestingly,

these tended to be those that worked in settings where parents brought in their children's drinks, snacks and lunch.

"The snacks they bring are lot more chocolate-based and sweet-based, a lot of them seem to have the juice, whereas years ago you used to have more milk."

iii) All settings/ professionals said they would be happy to help out with future oral health initiatives, with some feeling they should do more.

iv) Having had some time to consider the higher incidence of dental decay in Rutland, most felt that parents in the area did not lack the knowledge to promote good oral health for their children. Busy lives for parents were seen as a driver for unhealthy options, with sugary drinks and snacks being viewed as an easy option.

4.4.2 Issues to Explore

A number of issues emerged that were identified by the consultees as worth exploring further with parents. These were:

i) Awareness of free sugars in drinks and snacks, including so called 'healthy snacks' like dried fruit

ii) Using sweets as rewards for good behaviour and to assist parents with busy lives

iii) How often juice is given to children and why it is given instead of milk and water

iv) The time children had for their teeth to recover from them coming into contact with sugar

v) The availability of dental places and experiences in finding one

vi) When parents take their children to the dentist for the first time

4.4.3 Engagement with parents

i) Engagement with parents involved face-to-face surveys with 84 parents and in-depth conversations with 35 parents.

ii) Parents who participated were generally interested in oral health, aware of most (but not all) of the issues relating to good oral health practice, motivated to take action on them and felt confident they had all the information and advice they needed to do so.

iii) All of the parents knew about brushing twice a day and described how they supervised brushing, with the vast majority finishing brushing to make sure their children's teeth were clean. A lot did this

in spite of their children's reluctance to brush, with a significant proportion having to battle to get it done.

iv) Parents did not appear aware of the need to give children a break from sugar and to follow guidance recommending limiting sugar intake to four times a day. During the depth conversations we also discovered many would exceed this limit as result of their children grazing on snacks throughout the day or having drinks with sugar in them.

v) Another issue parents did not appear to be aware of was when to take their children to the dentist for the first time. On the basis of this work we would conclude that a child going to the dentist when their first tooth appears is more down to luck than awareness.

vi) Many stakeholders and parents believed it was tricky to find a dentist, yet in reality most people interviewed did have an NHS Dentist. More promotion of the availability of places is required.

vii) A significant proportion of parents gave their children a drink of milk in bed after brushing. This was an issue which most parents knew was not recommended, but still did at a time when it is important to them to settle down their children and get them to sleep.

4.4.4 In light of the findings from the conversations with parents, a range of factors that encourage or discourage both desired and problem behaviours have been identified. With this behavioural analysis in mind, there are number of things that will be considered that incentivise desired behaviour and dis-incentivise problem behaviours in relation to children's oral health. These might include:

i) Raise awareness of the risks of frequent snacking and grazing

ii) Encourage parents to set a time for snacks (avoid grazing throughout the day)

iii) Promote messages that children's teeth need plenty of time between food and juice drinks

iv) Show how five-a-day and good oral health can work in practice

v) Give hints and tips on how to make brushing fun

vi) Promote availability of free fluoride varnish from dentists

vii) Highlight that children will drink milk or water if other options aren't available

viii) Encourage parents to only offer water/milk on demand

ix) Highlight other routines apart from grazing

x) Raise awareness of the need for a dental check-up once their first tooth appears

xi) Highlight availability of dental places in the area

xii) Give parents advice on 'other ways to get their child to sleep' (apart from a bottle in bed after brushing)

xiii) Raise awareness of risk of some 'healthy food', e.g. dried fruit

xiv) Question the importance of drinking *something* (where child resists water or milk)

xv) Raise awareness of consequences of tooth decay

4.4.5 The full report on oral health insight for Rutland is available on request.

4.5 Next Steps

4.5.1 A small internal working group has been established to develop an action plan to address children's oral health, taking into account the findings of the insight work. The plan will include the following recommended areas:

4.5.2 Harnessing existing community assets - work with locally-based organisations/settings (Children's Centres, other childcare providers) and a range of staff (Health Visitors, Community Nursery Nurses, Dentists) who are in touch with parents of young children. Most are already aware and convinced by the importance of promoting good oral health and are willing to help take action to prevent tooth decay in the future. They represent key assets that can be mobilised or further built on.

4.5.3 Training for staff and parents - a training package will be developed to help improve knowledge and support staff and volunteers to communicate with parents of young children about oral health. Oral health promotion training for staff, and sessions for parents delivered in settings have been well received and this needs to be rolled out more widely with regular refreshing. It should go beyond a focus on brushing and pick up on key issues that have emerged in Rutland e.g. snacking / grazing, drinks with free sugar and getting to the Dentist when the first tooth appears. Training will incorporate an element of behaviour change and simple motivational interviewing techniques to empower staff to hold conversations with parents. This is similar to the 'Making Every Contact Count Training' offered to front line staff in some parts of the country. Many parents also spoke about 'battles' over cleaning teeth. Training and supporting staff to provide supervised tooth-brushing in pre-school settings would help make tooth-brushing more fun and instil it as a routine for the children.

4.5.4 Adapting and providing promotional materials - Rutland has access to the Healthy Teeth Happy Smiles materials that are used elsewhere across Leicester and Leicestershire. In general they cover many of the issues highlighted in the Insight work and some (with very minor amendment) would be appropriate to use more widely in Rutland. Further supplies will be printed and circulated more widely to community settings to support the work of frontline staff in encouraging parents to adopt good oral health behaviours. Additionally providing health visitors with a 'first toothbrush and toothpaste pack' to give to a parent at the four month contact would provide a good opportunity for the health visitor to raise the issue of oral

health and evidence from elsewhere shows this to be effective and that parents recall this.

4.5.5 Developing new resource materials and loan equipment – a resource and briefing pack will be developed to ensure that all stakeholders understand the key messages, the role they have to play, and the materials available to support them. Briefing packs have proved very important in ensuring public health campaigns are effective, particularly when it's been necessary to encourage a range of stakeholders to be communicating consistent messages. Materials should include a focus on key issues highlighted from the insight work e.g. giving children's teeth time to recover after snacks and drinks (other than water), to discourage grazing, teeth friendly snacks. Consideration will also be given to the logistics of providing a resource library of teaching materials and equipment that could be used by a range of pre-school and school settings in promoting oral health.

4.5.6 Single contact point for finding a dentist - making it easier for parents to find a dentist to see their child will help support the drive to get children to a check-up once their first tooth appears, attending a dentist regularly and provision of fluoride varnish on a twice yearly basis. NHS Choices does provide information on availability, but there is sometimes a lag in the information getting updated.

4.5.7 A detailed action plan including timescales and responsibilities for each aspect of work is in the process of being developed by the working group who will also be responsible for ensuring effective roll-out.

4.5.8 Updates on the action plan and progress made on addressing children's oral health will be taken to Health & Wellbeing Board.

4.6 Measuring impact of the oral health programme

4.6.1 A number of indicators will be used to assess progress. These will include both outcome and output measures:

i) Use of annual, national survey data on the numbers of decayed, missing and filled teeth, where a drop in prevalence would indicate a positive outcome.

ii) The numbers of community and health professionals (e.g. school nurses, health visitors, teachers, children centre staff, nursery assistants, dental nurses) trained in delivering oral health promotion.

iii) The numbers children involved in oral health programmes. e.g. depending on the actions agreed for the plan numbers might include number of supervised tooth brushing programmes offered and number of children involved.

iv) Public awareness/ knowledge of oral health promotion messages

4.6.2 Whilst it is important to measure the impact that will be made by this work, it is important to recognise that there may be limitations on this with potentially new cohorts of families being surveyed each time.

5 ORGANISATIONAL IMPLICATIONS

5.1 The 2012 Health and Social Care Act conferred responsibility for oral and general health improvement to local authorities and specifically requiring them to provide or commission oral health promotion programmes to improve the health of the local population and to provide or secure oral surveys.

5.2 Given the findings of the 2012 survey identifying higher than average numbers of five year olds in Rutland to have tooth decay it is the responsibility of Rutland County Council to take action to reverse this position. This report outlines what has been done to date and proposals for further work.

6 FINANCIAL IMPLICATIONS

6.1 Rutland County Council applied for and received non-recurrent funding from Public Health England to undertake the insight work and to implement recommendations for oral health promotion for this.

6.2 Future oral health promotion work, not subsumed within this action plan, will continue to be funded from the Public Health Grant.

7 CONCLUSION AND SUMMARY

7.1 Further analysis of the survey data and insight work has identified areas where levels of tooth decay where higher and some behaviours that would go some way to explaining why this should be the case.

7.2 This intelligence is being used to help shape an action plan which will involve a wide range of professionals and community organisations who are well placed to promote good oral health with children and their parents and carers.

8 BACKGROUND PAPERS

8.1 Dental health of five year old children – Rutland – Dental Health Profile. Public Health England – available at: http://www.nwph.net/dentalhealth/5yearoldprofiles/East%20Midlands/Rutland%20LA%20Dental%20Profile%205yr%202012.pdf

9 APPENDICES

9.1 Appendix A -Data Tables from the 2013 Three Year Olds Survey and 2012 Five Year Olds Survey

9.2 Appendix B - Map of decay experience of five year olds in Rutland

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

Appendix A. Data Tables from the 2013 Three Year Olds Survey and 2012 Five Year Olds Survey

The data tables below show data for both three and five year olds and compare Rutland to the England average, and several other local areas for further comparison.

Oral health survey of three-year-old children 2013 Data Table Rutland[1]

	% pop with decay	mean d3mft	% d3mft > 0	Mean d3mft > 0
Rutland	46.4	0.33	14.9	2.22
Leicestershire	16.0	0.39	18.6	2.09
East Midlands	9.1	0.45	15.8	2.85
England	8.1	0.36	11.7	3.08

Based on fewer than 30 children with decayed teeth

Oral health survey of five year-old children 2012 Data Table Rutland[2]

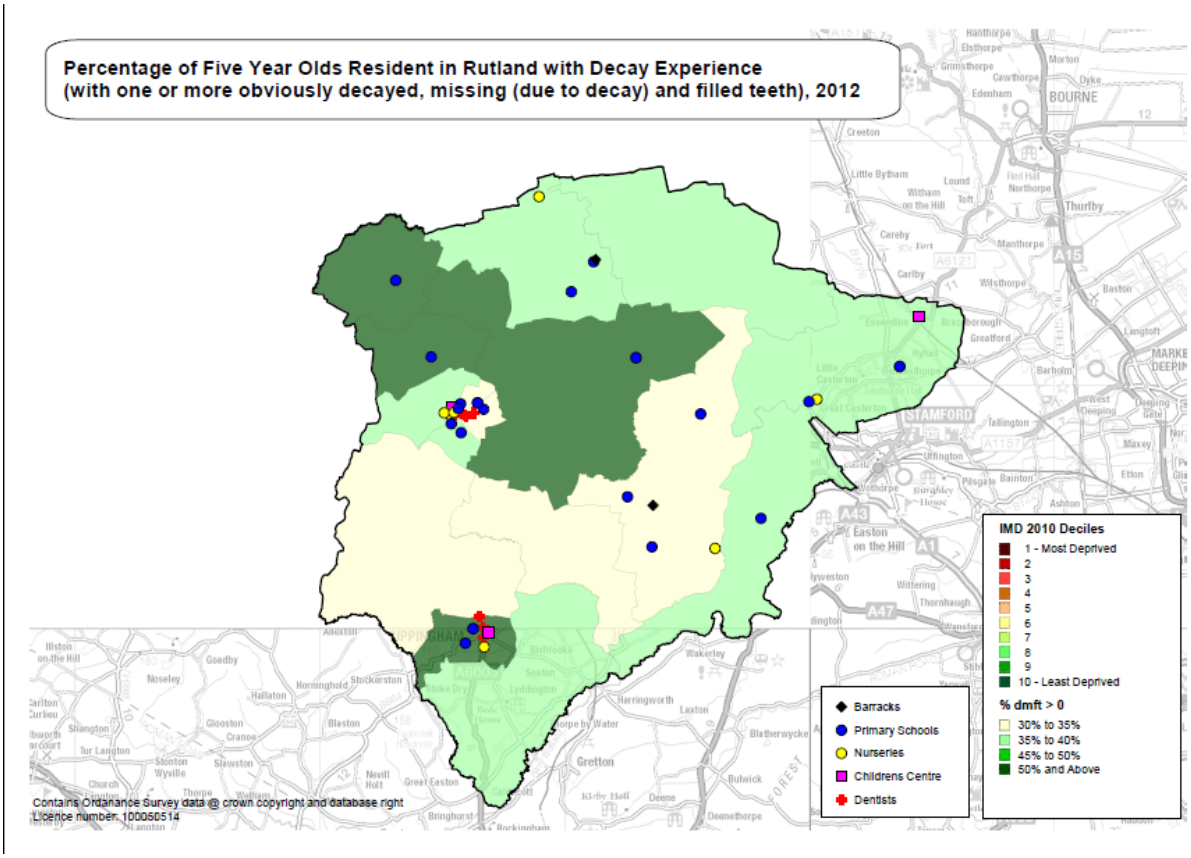
	% pop	mean d3mft	% d3mft > 0	Mean d3mft > 0
Rutland	46	1.09	40.3%	2.71
Leicester	10	2.06	53.2%	3.88
Leicestershire	20	0.95	37.1%	2.56
England	21	0.94	27.9%	3.38

[1] Public Health England. National Dental Epidemiology Programme for England: Oral health survey of three-year-old children 2013. A report on the prevalence and severity of dental decay. 2014

[2] Public Health England. National Dental Epidemiology Programme for England: Oral Health Survey of Five-Year-Old Children 2012. A report on the Prevalence and Severity of Dental Decay. 2013

Appendix B. Map of decay experience of five year olds in Rutland

Percentage of five year olds resident in Rutland with decay experience (with one or more obviously decayed, missing (due to decay) and filled teeth) 2012



The areas shaded dark green have levels of decay 50% and higher. It should be noted that these figures are combined to protect patient identifiable information and therefore not all areas shaded dark green may have very high levels of tooth decay.

Report No: 76/2016
PUBLIC REPORT

SCRUTINY PANEL

14th April 2016

CQC INSPECTION REPORTS

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 and Care Agency reports.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 There have been three CQC reports published since the last Scrutiny Panel which are for:

a) Goldfinch Care Agency – Inspected 19th November 2015 report published 12th January 2016

b) Rutland Cottages (Prime Life) - Inspected 9th December 2015 report published 21st January 2016

c) Wisteria House Residential Home – Inspected 23rd November 2015 report published 1st February 2016

2.2 All of the above reports showed an overall rating of good.

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

3 CONCLUSION

3.1 The latest CQC reports give assurance of the standards at the above CQC regulated services being maintained in 5 of the 5 areas looked at by the inspectors in regards Rutland Cottages and Wisteria House. Goldfinch Care Agency are needing improvement in one area on this occasion which is “The service had not completed assessments of peoples capacity to make informed decisions about their care in line with The Mental Capacity Act 2005”.

4 BACKGROUND PAPERS

4.1 CQC inspection reports dated 12th January 2016, 20th January 2016 and 1st February 2016.

5 APPENDICES

5.1 none

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

Mrs. Pauline Ruth Butchart

Goldfinch Care Agency

Inspection report

31 Firs Avenue
Uppingham
Oakham
LE15 9RE
Tel:1-971649977
Website:www.goldfinchcare.co.uk

Date of inspection visit: 19 November 2015
Date of publication: 12/01/2016

Ratings

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

Overall summary

We carried out the inspection on 19 November 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in available. This was the first inspection of the service since it registered in 2013.

The service is a home care agency that provides live-in carers to people. The carers provide personal care to people in their own homes. At the time of our inspection 10 people used the service.

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.'

People told us that they felt safe in their own homes?. Risks were assessed and managed to protect them from harm. Staff understood what to do in an emergency.

67

Summary of findings

Staff had received training to meet the needs of the people who used the service. People received their medicines as required and medicines were managed and administered safely.

Staff respected people's homes. People's independence was promoted and choice making encouraged. People remained part of the wider community if they wished to and links with people important to them were maintained.

Some people had the capacity to make decisions about their care and the support they received. These people were involved and their opinions sought and respected. Where people required support to make decisions, the service did not follow the requirements of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The registered manager and staff team were unclear of their role in ensuring best interest decisions were made for people.

The registered manager had assessed the care needs of people using the service. Staff had a clear understanding of their role and how to support people who used the service as individuals. Where people had more complex needs these were being met and support was tailored to people's changing needs.

Staff knew people well and treated them with kindness and compassion. People received a consistent level of support. Where additional staff were required to support when regular staff members were not able to these staff were also well known to people.

People were supported to maintain their health and wellbeing. Systems were in place to monitor the health and wellbeing of people who used the service. People's health needs were met and when necessary, outside health professionals were contacted for support.

Staff felt supported by the registered manager. The registered manager supervised staff and regularly checked their competency to carry out their role. People who used the service felt they could talk to the registered manager and had confidence that they would address issues if required. Family members found the registered manager to be approachable.

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 safe

People told us they felt safe and the staff team knew how to keep people safe from harm. Risks were assessed and managed to protect them. Staff understood their responsibility to protect people from harm and report concerns. The service had robust recruitment and training policies which were followed to ensure staff members were safe to work and trained to provide safe care to people.

Good

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

We saw that staff received appropriate training to enable them to meet the requirements of their role. We saw that the service had not completed assessments of people's capacity to make informed decisions around aspects of their care in line with the Mental Capacity Act 2015

Requires improvement

Is the service caring?
The service was caring

People were encouraged to make choices and independence was promoted. Staff treated people with kindness, dignity and respect.

People's privacy was maintained and staff sought people's consent to provide care. People were supported by staff that they felt comfortable with and who they knew well.

Good

Is the service responsive?
The service was responsive

Feedback from people who used the service and their relatives was actively sought. People were aware of the complaints procedure and felt able to raise any concerns. Where concerns had been raised these had been dealt with in a timely manner.

We saw that the registered manager reviewed the care that people received monthly. Where people's needs changed this was reflected in their support. Staff were available to offer support to people at times that they needed it and were flexible to meet people's preferences.

Good

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

The service had a statement of purpose. Staff had a clear understanding of the aims and objectives of the service. People using the service or their relatives were clear on the service they should expect to receive.

Good

Summary of findings

Staff felt supported by the registered manager and that they could be contacted at any time. People using the service felt able to contact the registered manager and discuss any issues with them.

Goldfinch Care Agency

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.

The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. We spoke to two people who used the service and four relatives of other people who used the service.

We looked at the care plans of three of the people who used the service at the time of our inspection. After the inspection we spoke with six care workers employed by the service. We looked at three staff recruitment files to see how the provider recruited and appointed staff. We also looked at the records the registered manager provided concerning their procedures for monitoring the quality of the service and evidence of staff training.

Before the inspection we reviewed notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law.

Good

Is the service safe?

Our findings

People told us that they felt safe. One person told us "Yes everything is safe. If it wasn't I would talk to [registered manager]." A relative of someone who uses the service told us "We feel safe with the current girl, yes." Another told us "Yes, everything is safe."

Staff were aware of how to report and escalate any safeguarding concerns that they had. We saw that there was a policy in place that provided details of how to report safeguarding concerns and all staff had access to this policy when they were working. Staff had received training about their responsibility to keep people safe. Staff told us that they felt able to report any concerns. We saw that there were systems in place to help prevent and protect abuse, for example staff were required to maintain clear records around the use of people's finance.

We saw that the service had a recruitment policy in place which was followed to ensure that all relevant checks were carried out on staff members prior to them starting work. We looked at the recruitment files for three staff members. We found that all relevant pre-employment checks had been carried out before staff commenced work.

Risks associated with people's care had been assessed and assessments were reviewed. Staff were required to sign these to show that they understood them and were able to follow the guidelines to keep people safe. Staff had access to these risk assessments at all times while they were working. Risks associated with the environment were also assessed to ensure that staff and people using the service were safe. Staff were required to contribute to maintaining the safe environment by carrying out health and safety checks such as weekly fire alarm tests.

We saw from records held at the service that people were supported to access emergency health professionals if required. Staff had access to emergency contact telephone numbers and were clear on how to summon help if required.

People could be assured that they would receive their medicines as prescribed by their doctor. One person told us "The meds are on time, very much so. She's [staff member] always got things organised." Staff receive training to enable them to give people their medicines safely. We saw that clear records were kept to enable staff to know when and how to help people take their medicines.

We were told that suitable staff were available to ensure people remain safe and supported by people who understood their needs when their regular carer was unavailable either due to planned breaks or sickness.

Accidents and incidents were recorded and the registered manager was made aware of these in a timely fashion. We saw from records that when an accident had occurred staff had responded appropriately to the situation such as contacted emergency health professional help but also that they had looked to seek a longer term solution to prevent further occurrences. We saw that a risk assessment and care plan had been amended to reflect a 'near miss' incident.

Requires improvement

Is the service effective?

Our findings

People were supported to have sufficient to eat and drink. One person told us "[Carer] does top quality cooking." We were told by a staff member that they supported a person using the service to receive their nutrition via PEG feeding. PEG feeding refers to a medical procedure in which a tube (PEG tube) is passed into a patient's stomach to provide a means of feeding when oral intake is not adequate. The regular staff member that supports that person along with additional staff who may be called upon to provide planned or emergency cover had received training. This training ensured that the person's nutritional needs were being met.

We saw that people were being supported to maintain good health. The records that the service kept on people were clear and in depth. They reflected the wishes of the person and what was important to them. Staff were clear on the information within these records and used them to ensure that people received the care they required.

Staff told us that they received training when they started working at the service that enabled them to understand and meet people's needs. This included manual handling and health and safety training. Staff confirmed that they had completed manual handling training and shadowed more experienced staff members before they had been allowed to support people on their own. We saw training records that confirmed this.

The staff training records showed that staff received regular refresher training and ongoing learning. Staff told us that they had attended courses such as, dignity in care, safeguarding and some practical sessions with the hoist and slings. We saw that the registered manager had attended a course which then enabled them to carry out training in that subject, known as a train the trainer course. The registered manager then provided the training in those areas for other staff at the service.

We saw that staff's understanding of the training materials had been assessed. Staff were required to complete understanding based evaluations after they completed training sessions. The registered manager confirmed that there had been an occasion when a newly employed staff member had received induction training however did not demonstrate that they were competent to implement all their learning. As a result the registered manager did not offer the staff member any work placements.

The Mental Capacity Act 2015 (MCA) and Deprivation of Liberty Safeguards (DoLS), is legislation that protects people who are not able to consent to their care and support. It ensures people are not unlawfully restricted of their freedom or liberty. We found that the registered manager was not able to demonstrate that the service was following the legislation. Where people had the capacity to understand and consent to their treatment we found that they had done so and been actively involved in decisions around their care. Where people did not have the capacity to consent to care and treatment the necessary assessments to confirm this and ensure that the person received the care that took into account their specific needs and wishes had not been made as required by the legislation.

Staff had not received training with regard to the Mental Capacity Act and did not fully recognise where people were at risk of being deprived of their liberty. We were told of forms of monitoring such as pressure sensor mats that had been put in place to prevent harm but that people had not expressly consented to. Some people's relatives had applied for and been granted Power of Attorney. Power of Attorney describes the legal process that allows someone to make decisions on behalf of another person when they are no longer able to do so themselves. Where this was the case staff were aware but were not clear on the specific circumstances under which relatives could make decisions on behalf of people using the service. The registered manager assured us that they would develop and implement a policy which addressed the requirements of the Mental Capacity Act 2015 and Deprivation of Liberty Safeguards.

Good

Is the service caring?

Our findings

People told us that the service they received was caring. People who used the service felt that the service took into account their needs for dignity and respect and that they received care that reflected this. One person said “Care is different things to different people, they leave me completely alone for a period if I ask.” another said “I'm not encroached on at all by having her here. There's a plan and she knows what to do, or not do. She knows me.”

There was clear guidance for people who used the service as to the standard of care that they should expect. The statement of purpose for the service stated that people who used the service should be supported with respect at all times and that independence should be encouraged. Family members of people who used the service told us “[Staff member] does keep [family member] independent as much as possible.” One staff member told me “I follow [person using the service], to know what she is comfortable with, I don’t push my standards on her”

People using the service were treated with dignity and respect. The staff members that we spoke to understood that they were visitors in people’s homes. They were aware of the need to give people space and respect their privacy. Staff understood the need to support people at a pace that suited them. One of the relatives of a person using the service told us “We can't rate [staff member] highly enough, as she's tried to activate his mind, does quizzes with him and rings people he knows to come around, visit and have coffee.”

People told us that staff got to know them and their needs well. When staff changed or another staff member was required to cover breaks or sickness the new staff member was given opportunities to meet and work alongside the existing carer so that they could help with the introduction and ensure that continuity of care was maintained. The registered manager told of one staff member who worked alongside the existing staff for three days before they were required to support a person on their own. The staff member confirmed this and that it had helped them to feel confident to support that person and that the person had been given the opportunity to start to develop trust in the staff member.

Family members told us that their relatives were able to remain independent and relaxed due to being cared for in their own homes. Relatives were involved in helping staff to understand significant events in people using the service’s lives. This meant that staff could engage with them about the things that were of interest to them. The registered manager told us how the use of music from a particular time had helped one person to remain calm and settled during the period of the day when they had previously displayed signs of anxiety.

Good

Is the service responsive?

Our findings

People told us that they felt that the service was responsive to their individual needs. One person told us "I have a buzzer which I press and they come in two minutes." A relative told us "[Staff member] knows exactly what to do next, we have all the equipment we need." We asked the relatives of some of the people who used the service if they felt that the care their relative received met their needs. One told us "Yes, I think so, this carer particularly is very useful." Another said "I can't fault them."

People's views were sought and listened to. One person told us "[Registered manager] came out and discussed with me and we agreed on what I wanted." Another person told us "Yes, I was fully involved in planning what I wanted my care to be." One relative told us "We'd go to the agency and speak to [registered manager] if we needed anything changing" another said "If we had a complaint, we'd go to [registered manager].People using the service and their relatives were made aware of the service complaints procedures. People felt that the registered manager was approachable and that they would respond to their concerns. One person told us "I did go to [registered manager] with a concern once." They told us that the concern was about staff compatibility with other members of the household. When asked how things were resolved, the person using the service told us that the registered manager had changed the staff member and that they were happy with the solution.

Staff were responsive to people's changing needs. We saw from care records that when a person using the service was experiencing poor health, staff and the registered manager were quick to involve health professions and relatives. As the person's support needs changed these were assessed and new support plans implemented. We saw that plans were reviewed and updated to reflect changing needs three times over a six month period for one person.

Staff employed by the service reviewed the care notes, medication records and other person specific reports on a monthly basis and compiled a report. This enabled the registered manager to see if the service was meeting people's needs. We were able to see from these reports that one person using the service had benefited from improved mental health. This was attributed to the encouragement and support of the staff member in helping the person access the community more.

The registered manger met with people who used the service regularly. They also conducted surveys with people who used the service and their relatives to find out if the service was meeting their needs and expectations. People were encouraged to feedback and we saw that changes had been made to people's care packages as a result of the feedback.

The records that the service maintained were detailed, respectful and took into account the individual preferences of people. For example a person who used the service was supported to access their preferred hair dresser in the community and maintain links with people they had known for years. People were supported to access their preferred place of religious worship.

The registered manager was able to demonstrate that they understood the implications of change of staffing to people who use the service and implemented systems to ensure that change was managed as smoothly as possible. These systems empowered the people using the service to feel involved in the process of change. People using the service or their relatives were provided with staff profiles so that they could see the staff's skill set and interests. This helped them to make an informed decision about if they wanted that staff member to support them.

Good

Is the service well-led?

Our findings

People told us that they thought that the service was well led. One person said "It's a very well run service, small but very well run." A family member said "We can contact [registered manager] whenever - we have a mobile number, office number and e-mail and [registered manager] is normally very, very prompt in getting back to us." Another family member told us "it's excellently run. I can't fault it." We saw email exchanges between the registered manager and the family members of people who used the service.

The registered manager was clear on the aims of the service and told us that staff were expected to "Exercise dignity and respect at all times." Staff confirmed that they were clear on their role and the expectation of the registered manager as well as people who use the service and their families. This was reflected in the service statement of purpose.

The registered manager met with all people who were interested in receiving support from the service. Their needs were assessed and the manager ensured they or their relatives were clear on what service they would receive and what they would expect from the care staff. The registered manager also explained to people and their family members the role of the carer staff and the expectation that they would receive their allotted breaks and that their living facilities met their needs. We were told that this helped to ensure that all parties understood what was expected of them. People or their relatives were required to sign contracts outlining the specifics of the support to be provided.

The registered manager maintained their own learning and we saw that they had recently accessed training courses on advanced care planning and dementia care. They had also received some training specific to the care needs of one person who used the service so that they were able to step in and support this person in case of an emergency. We saw that the registered manager had actively sought alternative forms of training for their staff and that they took into account different people's learning styles. One example was the use of media to reinforce a topic. A training feedback form had recently been implemented to enable the registered manager to review the effectiveness of the training.

Staff told us that they felt supported by the registered manager and would be confident to discuss issues as and when they arose. The registered manager conducted regular supervision and observations of practice with staff members. The registered manager maintained contact with staff via phone calls, messages and emails. One staff member told us "[registered manager] is a great communicator." Most staff told us that they felt that the level of support that they received suited their needs and we saw that some staff received more contact than others dependent on their needs. One staff member told us that they had informed the registered manager that they felt that they did not feel comfortable offering support to a person using the service. The registered manager took these comments on board and arranged cover for the person using the service. The staff member was offered an alternative assignment that better suited them.

The registered manager was aware of the requirements upon them to notify the Care Quality Commission or other agencies of significant events within the service.

Prime Life Limited

Rutland Cottages

Inspection report

Huntsman Drive
Barleythorpe Road
Oakham
Rutland
LE15 6RP

Tel: 01572722350
Website: www.prime-life.co.uk

Date of inspection visit:
09 December 2015

Date of publication:
20 January 2016

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected the service on 9 December 2015. We gave the provider 48 hours' notice of our inspection.

Rutland Cottages are a grouping of 24 cottages across the road from Rutland Care Village which is also a service run by Prime Life Limited. People who live in the cottages have the option of receiving care and support from staff working in Rutland Care Village. At the time of our inspection one person had been using the service for the last six months.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

The provider had procedures for supporting people to be safe in their home. Staff understood their responsibilities under those procedures.

The provider had robust recruitment procedures that ensured as far as possible that only people suited to work at the service were employed. Staff were suitably deployed so that there were enough staff with suitable skills, knowledge and experience available to support people using the service.

Only staff who had satisfactorily completed training in medicines management and who were assessed as competent to administer people's medicines did so.

Staff received relevant training and support to be able to deliver people's care needs.

The provider had procedures for implementing the requirements of the Mental Capacity Act (MCA) 2005. Staff we spoke with understood their responsibilities under the MCA. They sought people's consent before performing personal care routines and proving support.

People were supported with their nutritional needs. Staff monitored the health of people using the service and involved health services, for example, people's GP, when necessary. The provider cooperated with providers of specialist services if people required additional specialist support.

Staff were caring. They developed caring relationships with people they supported and involved then in decisions about their care. Staff treated people using the service with dignity and respect.

People's care plans were person centred and focused on their individual needs. Care plans were regularly reviewed.

People were supported to raise concerns and their opinions and their feedback was acted upon. The views or people using the service and their relatives were sought and acted upon. Staff had opportunities to be

involved in developing the service. They were supported to raise concerns. They told us they were confident their concerns would be acted upon.

The provider had effective arrangements for assessing and monitoring the quality of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff understood and practised their responsibilities to protect people from abuse and avoidable harm.

Staff were effectively deployed to ensure people received the care they required.

People were supported with their medicines at the right times.

Is the service effective?

Good

The service was effective.

People were supported by staff with the right knowledge and skills. Staff understood their responsibilities under the Mental Capacity Act 2005.

People were supported with their nutritional and health needs.

Is the service caring?

Good

The service was caring.

Staff developed caring relationships with people they supported.

People had opportunities to be involved in decisions about their care.

Staff respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People using the service and their relatives had opportunities to contribute to the planning of care. Delivery of care was personalised.

People were using the service had access to the provider's complaints procedure.

Is the service well-led?

Good

The service was well led.

Staff had opportunities to be involved in developing the service.

People using the service and their relatives were able to contact the registered manager.

The provider had effective arrangements for assessing and monitoring the quality of the service.

Rutland Cottages

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 checked 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 9 December 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service to one person; we needed to be sure we would be able to speak with them.

The inspection was carried out by a single inspector.

We reviewed the information we had about the service. This included notifications made to the Care Quality Commission and feedback we received from relatives of people using the service.

We spoke with the one person using the service and two of their relatives. We spoke with a support worker from another provider who supported the person. We looked at the person's care records and spoke with two care workers who provided care and supported. We spoke with the registered manager of the service and the team leader who managed care workers who supported people in Rutland Cottages. We looked at a recruitment file and training records to assess how the provider recruited and trained new staff. We looked at records associated with the provider's procedures for monitoring and assessing the quality of the service.

Good

Is the service safe?

Our findings

The person using the service told us they felt safe when they received care and support in their home. They told us they felt they could raise any concerns because they had what they described as a good relationship with the care workers that supported them. Both relatives we spoke with told us they had no concerns about the person's safety.

The staff that supported the person using the service came from Rutland Care Village, a residential care home complex across the road from Rutland Cottages. We spoke with two of those care workers. Both demonstrated an understanding of their responsibilities to keep people safe and protect them from avoidable harm. They knew the types of abuse recognised by the Health and Social Care Act and were familiar with the provider's procedures identifying and reporting any safeguarding concerns. They told us how they would recognise signs that a person was at risk of abuse, for example changes in behaviour, posture, sleeping and eating patterns, appearance an signs of unexplained cuts or bruises.

When a person begins to use the service, the team leader assesses a person's needs and dependencies and also assesses any environmental risks in the person's home. People are advised about how to keep safe in their homes. This included arrangements for visitors to the cottages which protected people from visitors unknown to them.

The staff we spoke with told us they received safeguarding training. A training schedule we looked at showed that most staff had attended the training or were scheduled to do so. Both staff were confident that if they raised any safeguarding concerns they would be taken seriously by the team leader and registered manager. We saw evidence that the registered manager, deputy manager and team leader encouraged staff to report concerns. They did this at staff meetings and supervision meetings. We saw evidence that reports of concerns and incidents were investigated. The provider had robust arrangements for reporting concerns to the Care Quality Commission and the local authority adult safeguarding team. People using the service and relatives could be confident that the provider had robust arrangements for ensuring delivery of care that was safe and protected people from harm.

People living in Rutland Cottages were supported by care workers whose main role was to work in one of the staff teams in Rutland Care Village. The provider had arrangements to ensure as far as possible that people living in the cottages were supported by a core team of care workers who were known to the people. No care worker supported a person living in the cottages without first having been introduced to the person; who then had a say in whether they wanted to be supported by that care worker. The person using the service told us that had been their experience. This was important because receiving care and support from care workers chosen by a person contributed to their sense of safety.

Before care workers supported people they were required to read people's care plans so that they understood people's needs and preferences about how they wanted to be cared for. People's care plans included risk assessments associated with their personal care routines. These included information for care workers about how to support people safely and in ways that avoided a risk of injury.

The provider had robust arrangements for the reporting and investigation of accidents and injuries experienced by people using the service and staff. Reports were investigated by senior staff for the purpose of identifying why and how an incident had occurred and steps were taken to reduce the risk of a similar incident occurring in Rutland Cottages and Rutland Care Village.

People living in the cottages who required personal care experienced the same standards of support with their medicines as people in Rutland Care Village. Only care workers who were trained in medicines management and assessed as competent to administer medicines did so. People's medicines were securely stored in their home. The team leader ensured that people in the cottages received their medicines at the right times. The person using the service told us that was the case. They also told us they were confident that care workers knew what the medicines were for and that they administered the medicines as prescribed by their doctor. They told us, "They (care workers) explain what my medicines are for." They also told us that they were given painkillers when they needed them.

Good

Is the service effective?

Our findings

The person using the service told us they felt they were supported by staff with the right skills and knowledge. A relative expressed their view of the staff. They told us, "They are generally pretty good. They do their best."

Care workers we spoke with told us they felt well supported through supervision, appraisal and training. One told us, "My induction was good, it was helpful." All new staff had induction training that covered essential subjects such as safeguarding, consent, moving and handling and an introduction to the service and wider organisation. Care workers also received training about medical conditions that people using the service lived with. This meant that people received care and support from care workers with relevant knowledge about their needs. The person using the service told us, "The staff know what my needs are."

The provider linked with other providers to support staff with specific guidance. For example, support workers with specialist skills in supporting people with visual and hearing impairments provided support and guidance to care workers supporting people who lived in the cottages. They advised care workers about how to communicate with people with those impairments. A support worker from another provider told us, "When I've seen the (provider) staff, they have on the whole done what I advised."

The provider had a training plan for all staff that was monitored by the registered manager and deputy manager. This ensured that staff received updated and refresher training and training that had been identified in supervision and appraisal as relevant to their role. A care worker we spoke with told us, "The training I've had has been useful." Another care worker told us, "I'm happy with the support I get."

The Mental Capacity Act (MCA) 2005 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. We checked whether the service was working within the principles of the MCA.

All staff had either received or were scheduled to attend training about the MCA. The provider had a MCA policy which care workers we spoke with were aware of. All staff had a staff handbook when they joined the service which referred them to this and other policies and procedures. Care workers we spoke with understood the relevance of the MCA to their roles. They explained that the MCA protected people who were unable to make decisions about their care. They understood that they were required to obtain a person's consent before they provided personal care and support. They told us they always explained to a person why they were in their home and asked a person if they wanted to support with personal care. The person using the service told us that care workers sought their consent before supporting them. They told us, "They ask me before they help. If I didn't like it I'd say." Care workers we spoke with told us they respected a person's choice about whether they wanted support with personal care and would make a record if a person declined.

Under the MCA a person must be assumed to have mental capacity unless there is evidence to the contrary. The provider's policy and procedures for assessing a person's mental capacity were in line with the MCA.

The team leader told us that when they observed care workers supporting people one of the things they monitored was whether they sought a person's consent. Those observations were more regular during a care workers induction and probationary period, but they continued after probationary periods on an ad hoc basis.

The person using the service did not have complex nutritional needs nor did they require support when eating and drinking. However, under their care plan the person was supported to have breakfast or meals either in their home or in the dining room of the care home across the road if they preferred. The person using the service told us, "I enjoy the food. The carers make my breakfast. If I ask for anything they make it." The person had the same choice of meals that people living in Rutland care Village had. They had a choice of healthy nutritional food. They told us, "I eat everything put on the plate in front of me." Relatives told us they were satisfied with this aspect of the care though there had been an occasion several months ago when they had to arrange for the person to have a meal. On that occasion staff in Rutland Care Village had overlooked that the person required a meal. The team leader took steps to ensure all staff were aware of the arrangements to support people in Rutland Cottages.

The provider had effective arrangements for supporting the health needs of people who chose to use the service. Care plans were designed to record information about people's health needs and how care workers were required to support people with those needs. Care plan documentation included forms for monitoring people's health and identifying any changes. When we looked at the care records of the person using the service we found that care workers monitored the person's health and had arranged for a GP to visit when it was appropriate to do so. Care workers informed the family when they arranged a GP visit. The person using the service told us, "I'm quite well." When we spoke with care workers who supported the person they were aware of the person's health needs and it was evident they had an awareness of the contents of their care plan and delivered care and support in line with that plan.

Good

Is the service caring?

Our findings

The person using the service told us that staff were kind. They said, "All the care workers are very nice to me. The staff ask me how I am and if I need anything else." A relative added, "[Person using service] gets on well with all the staff that come over. The team leader is fond of [person using service] and the staff are nice. That's an important thing for us."

The care plans developed by the provider included information about a person's life, what was important to them and their likes and dislikes. Care workers we spoke with were familiar with the information in the care plans and they used this develop caring relationships with people. We saw that was the case in relation to the person using the service. Care workers added to their knowledge of the person through their daily interactions with them. The person told us, "Staff chat with me."

Care workers described how they communicated with the person. They had sought support from a specialist provider to understand how best to communicate with the person. Staff followed the guidance that had been put in place. This meant that staff were able to communicate with the person using techniques that enable the person to understand them. Staff sought to help the person feel they mattered by providing care and support the way the person wanted. One of the person's medications required particular attention to detail when it was administered. The person and their relatives were comforted that this was done correctly as it mattered a lot to them.

We saw evidence in care records that care workers responded promptly to signs a person was in discomfort. This included helping the person to be more comfortable when they were seated and calling for a GP if the person was unwell.

The provider had procedures to involve people in decisions about their care and support. The person using the service and their relatives told us they had been involved. A relative told us that they had discussions with the service about aspects of the way care was delivered and that the service made changes.

The provider gave people using the service information about the support they received in an information pack. Information about their individual care was available in their care plans which they were able to discuss at reviews which took place monthly. The person using the service did not have a care plan in their home, but this did not appear to matter to them. We discussed this with the registered manager who told us that an `easy to read' version of the care plan would be offered to the person to have in their home. A relative told us they would prefer to have more involvement. We discussed this with the registered manager and they told us they would invite the relative to the next review of the care plan.

The provider ensured that information about people using the service was securely kept and accessible only to people authorised to see it.

Every person living in Rutland Cottages lived in the privacy of their homes. Home care visits were made only at times that were agreed with the person.

The person using the service told us that staff were respectful towards them. Care workers we spoke with told us they always asked the person how they could support them with everyday things like what to wear. All care workers received training about dignity and respect in a care setting. We could see from staff information boards and posters that the provider promoted privacy, dignity and respect. This aspect of care was monitored by the registered manager through everyday observation of care workers and senior managers when they visited the service.

Good

Is the service responsive?

Our findings

The person using the service and their relatives were involved in the planning of care and support. They told us, "The staff do things the way that suits me. The staff know what my needs are. They do everything they should do. I've never felt that anything has been lacking in my care." The person told us about how care workers supported them and the times they visited. They told us that care workers visited them at times they wanted. A relative told us they were involved in decisions about how care was delivered. This included discussions about when medicines were given administered and arrangements for meals.

The provider ensured that care plans included information about people's needs and how staff should provide care and support that met a person's needs. The care plan we looked contained information about the persons needs and how they wanted to be cared for and supported. Care workers we spoke with told us they referred to the person's care plan and that it was a useful source of information and guidance about how to support the person. They were able to answer questions we asked them about the contents of the person's care plan.

The person using the service told us they enjoyed other people's company. They were supported in that regard because when they wanted they were taken to a dining room in Rutland Care Village for lunch. They told us, "I sit with other people at lunch, different people. I enjoy that." They also had access to an activities room in Rutland Care Village where they could participate in communal activities and meet other people. They had opportunities to attend faith services at Rutland Care Village. A relative pointed out that the person sometimes needed to be reminded of those opportunities in order to participate in them. We discussed this with the provider who told us they would use reviews of care plans to inform the person about activities and arrange how to support the person to participate in activities of interest to them.

The provider had procedures for reviewing care plans every month. We saw this had happened. The reviews included seeking the person's views and resulted in amendments to the care plan. A relative, who was also the person's representative, told us they would like to be involved in reviews. We passed this request to the registered manager who told us they would liaise with the relative.

The provider worked with specialist providers and collaborated with them to provide care and support. We saw that the provider worked with a charity specialising in supporting people with restricted vision and hearing. The provider acted on advice from the charity. For example, they arranged for the person to have a `talking clock' in their home, which helped them because they had a visual impairment.

The person using the service and their relatives knew how to raise concerns. The person told us, "I feel I could let them know of any concerns." A relative told us that the provider responded appropriately to a concern they raised 12 months before.

The provider had arrangements for receiving feedback from people using the service and relatives. These included daily contact with the person using the service, regular visits from a team leader, care plan reviews and contact with relatives.

The provider had a complaints procedure that was accessible to people using the service and their relatives. The procedure advised people who they could refer their complaint to if they were not satisfied with a response to a complaint.

Good

Is the service well-led?

Our findings

The provider operated a home care service for older people living in the Rutland Cottages. At the time of our inspection, and for at least six months before then, only one person required the service. Because of the small scale the service was operating at, it was run from the neighbouring Rutland Care Village. The care workers providing personal care to people living in Rutland Cottages also worked in Rutland Care Village.

The person using the service and their relatives were aware of how the service was organised. Their main point of contact was a team leader in Rutland Care Village, and they knew who the registered manager was. Concerns and suggestions they raised 12 months before were acted upon by the provider. Relatives told us they felt comfortable about raising concerns if the need arose.

Staff were supported to raise concerns. They could do so through the provider's whistle-blowing procedure. We saw notices on display about the procedure. Care workers we spoke with were aware of the procedures and they told us they would use them in what they thought was a very unlikely event of their manager not acting on any concerns they raised. The care workers told us that they could discuss concerns at any time with their manager.

The provider had clear expectations and standards with regard to staff conduct and how they supported people with dignity. These were included in a staff handbook and were covered in staff induction training, safeguarding training, supervision meetings and staff meetings. The registered manager monitored the day to day conduct and behaviour of staff through observation and feedback from visitors and relatives.

Management of the home care service was delegated to a team leader in Rutland Care Village who reported directly to the registered manager. Both were aware of a statutory requirement to report incidents such as serious injuries and allegations of abuse to the Care Quality Commission and the relevant local authority adult safeguarding teams.

The registered manager and staff had a shared understanding of the challenges facing the service. These were discussed in team meetings. A practical challenge was that the needs of people living in Rutland Cottages were not overlooked or overshadowed by the much bigger service operating in Rutland Care Village. That risk was minimised because a core team of five care workers working in Rutland Care Village had additional responsibilities for Rutland Cottages.

The provider's procedures for monitoring and assessing the quality of the service operated at two levels. These procedures were based on 11 `key indicators of performance'. The registered manager carried out a range of scheduled checks and monitoring activity to provide assurance that people received the care and support they needed. They reported their findings to a regional manager who carried out their own checks to verify the registered manager's findings. The regional manager's reports were reviewed by the provider's operational board. This meant the most senior managers in the provider organisation knew how the service was performing.

Mr & Mrs G Kirk

Wisteria House Residential Home - Rutland

Inspection report

9 Ayston Road
Uppingham
Oakham
Leicestershire
LE15 9RL
Tel: 01572 822313

Date of inspection visit: 23 November 2015
Date of publication: 01/02/2016

Ratings

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

Overall summary

The inspection took place on 23 November 2015 and was unannounced. At our last inspection on 10 October 2013 the service was meeting the regulations in force at the time.

Wisteria House Residential Home – Rutland provides care and support for older people. The service can accommodate a maximum of 13 people. At the time of our inspection 10 people were using the service.

There is a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

People felt safe at the service and were happy with the care and support they received. People told us they were able to do the things that they wanted to do and where they were able to they could access the community independently when they chose to do so.

People were treated with dignity and respect. People were supported by staff who understood their needs and knew about people's likes, dislikes and preferences. There were enough staff to keep people safe and meet their needs.

Staff had a good understanding of the various types and knew how to report any safeguarding concerns. Staff received a thorough induction and regular training to ensure that they had the right knowledge to understand and meet people's needs. Staff did not always receive regular supervisions or have regular staff meetings to ensure that they were supported effectively within their roles.

People's medicines were managed safely and people were supported to access healthcare services as required.

The registered manager and deputy manager had a good understanding of the Mental Capacity Act 2005 and knew how and when they would need to use it.

People were supported to maintain a balanced diet. They were complimentary about the food and enjoyed mealtimes. People were able to choose where they ate their meals.

People's care needs were assessed and care plans were developed with people and their relatives where appropriate to ensure that people's needs were met. Where risks associated with people's care had been identified risk assessments had been carried out and control measures to reduce the risks had been put in place. These were regularly reviewed.

The registered manager and staff members had a consistent understanding of the services visions and aims. The service provided a homely environment for people where they were able to do the things that they wanted to do and enjoy things that were important to them.

The provider had procedures for the monitoring of the quality of the service. These included holding meetings with people that used the service and sending out annual quality assurance questionnaires.

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 safe.

People told us they felt safe. Staff had a good understanding of the various signs of abuse and knew how to report any concerns. There were enough staff to keep people safe and meet their needs. People received their medicines as prescribed.

Good

Is the service effective?
The service was effective.

Staff received training to enable them to meet people's needs. Staff felt supported in their roles. The registered manager and deputy manager had a good understanding of the Mental Capacity Act 2005 and knew how and when they would need to use it.

Good

Is the service caring?
The service was caring.

Staff were kind and caring towards people. Staff offered people reassurance when they needed it and took action to ensure that people were comfortable. Staff respected people's privacy and dignity.

Good

Is the service responsive?
The service was responsive.

People contributed to discussions about their care. People received care and support that met their individual needs. People felt able to raise any concerns. Staff supported people with a variety of activities to meet their needs.

Good

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

People were involved in the development of the service. The registered manager and staff members had a consistent understanding of the services visions and aims. The provider had procedures for the monitoring of the quality of the service.

Good

Wisteria House Residential Home - Rutland

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. At our previous inspection carried out on 10 October 2013 the service was meetings the regulations in force at the time.

This inspection took place on 23 November 2015 and was unannounced.

The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, their area of expertise was for older people with dementia.

We reviewed notifications that we had received from the provider. A notification is information about important events which the service is required to send us by law. We contacted the local authority who had a contract with the provider.

We spoke with six people that used the service and two people that were visiting relatives at the service. We spoke with the registered manager, the deputy manager, a senior staff member, two care workers and the housekeeper.

We looked at care records of the two people that used the service and other documentation about how the service was managed. This included policies and procedures, three staff recruitment records and records associated with quality assurance processes. We looked at records relating to medication and carried out a stock check of medicines that were used by people at the service.

Good

Is the service safe?

Our findings

People were protected from abuse. People told us that they felt safe. One person told us, "I feel safe and I can't believe how lucky I am to be so well looked after." When asked if they felt safe another person told us, "Of course I do – I've got a buzzer if I need anything."

Staff were familiar with safeguarding procedures. They knew what signs to look out for to identify whether a person was at risk of abuse and knew how to report any concerns to their manager. They knew they could contact the local authority adult safeguarding team and Care Quality Commission to report concerns. The provider's safeguarding policy included details of how to report to both.

We saw that risks associated with people's care and within the environment were assessed. We saw found control measures had been put in place to ensure that the risks were reduced. For example, for one person regularly accessed the outside area independently. A control measure had been introduced for staff to carry out a check of a check of the environment before the person went out. This was to ensure that the environment was free from any trip hazards.

We saw that accidents and incidents were recorded and contained details of how the injury had occurred, details of any injuries sustained and the treatment that the person had received. These were all reviewed by the registered manager. This enabled the registered manager to maintain an oversight of the incidents and identify any themes and trends.

There were emergency evacuation plans in place that provided information about people's requirements and needs should the service need to be evacuated. There was a business continuity plan in place that provided information about how that service would be managed in the event of an untoward event or emergency. A full range of health and safety checks had been undertaken regularly. There were also checks carried out equipment to ensure that it was safe to use. We found that the local authority compliance had recently identified an issue with the window restrictors at the service. The provider had taken immediate to ensure that this had been rectified and replaced all of the window restrictors on the first floor.

There were enough staff to keep people safe and meet their needs. One person told us, "There are always four or five [care staff] in the morning and evening rush – the whole thing works to perfection." Throughout the day of our inspection there were plenty of staff around who were helping people in a calm and unhurried manner. We found that staffing rotas demonstrated the staffing levels during our inspection were consistent with other days at the service.

We looked at three staff files and found that all required pre-employment checks had been carried out. The provider followed safe recruitment practices to ensure that staff were suitable to work in social care before employing them as a member of the staff team.

People told us that staff supported them with their medicines. One person told us, "When I go down for my breakfast they watch me take my tablets." Another person told us, "[the staff member] watches you to see you've taken your tablets."

There was a policy and procedure in place for managing and safe handling of medication. We discussed medicines with a staff member who talked us through the process of administering medicines. This was consistent with the policy and procedure. The majority of people's medicines were supplied in a monitored dosage system (MDS). A MDS provides a separate compartment for each dosage time of the day and reduces the risks associated with the administration of medicines. We looked at medication administration records, we saw that these were completed in line with the medication policy. We carried out a spot check of a medicine that was not supplied in this system and we found that the recorded amount of tablets was consistent with what was in stock. We found that the people were supported to receive their medicines safely.

Good

Is the service effective?

Our findings

People told us that staff knew how to meet their needs. Staff members told us that they received sufficient training to enable them to meet people's needs. We saw that staff had attended training courses and undertake relevant qualifications. The registered manager told us how it was a requirement for new staff at the service to complete the Care Certificate as part of their induction. The Care Certificate is based on 15 standards and aims to equip health and social care support workers with the knowledge and skills which they need to provide safe, compassionate care. Each standard is underpinned by full learning outcomes and assessment criteria. A staff member who had recently started at the service confirmed this. We also saw that the manager had introduced some of the workbooks to existing staff to enhance their knowledge in particular areas. Staff received effective induction and training to enable them to meet people's needs.

Staff told us that they felt well supported in their roles. They also told us that they could speak to any other staff members, including the registered manager or deputy manager if they needed any support. One staff member told us, "We all work as a team." The manager told us that due to the size of the service they regularly had informal staff meetings where staff were provided with general updates about the service but the last recorded staff meeting had been approximately six months prior to our visit. We saw that staff received supervisions and appraisals but the frequency of these varied. We discussed this with the registered manager who advised us that this was something that they would address. Staff told us they were satisfied with the frequency and felt able to talk to the registered manager for support at any time.

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.

People told us that staff provided them with choices in relation to the care and support. We saw that staff provided people with day to day decisions about their care, such as what they wanted to eat and where they wanted to sit. Staff told us that they always ensured that they had people's consent before assisting them with their care and support. We found that the registered manager and deputy manager had a good understanding of the MCA and how and when they would need to use it. Other staff member's knowledge was not so detailed but they explained that they would always approach a more senior member of staff for advice. We saw that the service did have an MCA assessment form in place that was ready to be used should the need arise, for example when they had reason able doubt that a person was unable to consent to their care.

Staff were aware of the people that had do not resuscitate orders in place, but there was no system in place to identify when these needed to be reviewed. We found that one person's should have been reviewed approximately one month prior to our visit but this had not been identified by staff. We discussed this with the registered manager who advised us that they would look into this.

People were supported to maintain a balanced diet. People were complimentary about the meals. One person told us, "There's a lot of very good home cooking". People were able to choose where they ate. One person told us, "I have my breakfast and tea here in my own room". The registered manager told us that people were encouraged to eat their main meals in the dining room to make it more of a social dining experience however they reiterated that people did not have too.

People enjoyed the dining experience. People told us that the food was good and that they enjoyed mealtimes. At lunchtime we saw that there were three tables set for the meal with tablecloths, placemats, napkins, cutlery and salt and pepper. Each person had their own personalised napkin ring. There was also a weekly menu available in the middle of each table. Tables were served all together and accompaniments for the meal were served in separate dishes in the middle of the table to enable people to help themselves to as much as liked. Staff encouraged people to have seconds and ensured that everyone had finished

Good

Is the service effective?

before they removed any food. There was choice of desserts offered visually to people and the meal was finished off with the offer of either tea or coffee. Weekly menus showed that people were supported to eat a balanced diet.

A variety of drinks were offered to people throughout the day. We saw that people had access to snacks as required. One person who had a bowl of fruit in their room told us, "I prefer fruit because I don't eat chocolate." They went on to tell us, "I take my bowl downstairs when it's empty and they fill it with a lovely selection of fruit." People were supported to eat and drink throughout the day.

We saw that where the service identified concerns about a person's swallowing they contacted the Speech and Language Team and followed their advice. They had a care plan in place to ensure that around their eating requirements which provided guidance for staff to follow. We saw that the person was provided with food in line with their care plan on the day of our inspection.

A relative of a person told us, "Since [my relative] had been here it's been miraculous. Within two-three days she was a different person." They went on to tell us how their relative received input from an occupational therapist and how staff continued to support their relative with the exercises the occupational therapist had advised. A relative also told us that staff supported people to attend hospital appointments if required. We saw from people's care records that they were supported to access healthcare services as required however the outcome of these visits was not always clearly documented.

Good

Is the service caring?

Our findings

People told us that the staff were kind and caring. One person told us, “The staff are marvellous.” Another person told us, “They’re all very kind to us.” A relative told us, “They’ve always got time for you as a person.” We saw that staff were kind and caring with people. They always explained what they were doing and offered people reassurance when they needed it.

We saw feedback about the service that stated ‘The staff are aware of people’s needs.’ The majority of the staff team had worked at the service for a long period of time so they knew people that used the service well. They were able to recognise when people were uncomfortable and responded promptly to their needs. For example, a staff member saw that the sun was shining through the patio doors into a person’s eyes. They immediately asked the person if they would like the blinds closing and responded by closing the blinds.

We saw that staff complimented people on their appearance. For example, we heard a staff member saying, “I do like that colour on you [person’s name], it’s lovely.” We saw that person was very pleased with this comment and responded by saying, “Thank you very much.” Later in the day one person was coughing we saw a staff member respond by empathising with the person and saying, “Oh dear [person’s name], would you like a drink.” Staff showed concern for people’s wellbeing and developed positive relationships with them. We observed staff laughing and joking with people.

Staff knew details about people’s life histories and knew people’s relatives. They were able to tell us about people’s likes, dislikes and preferences. We saw that when a person asked a staff member for help, the staff supported the person as soon as they had finished the task that they were completing.

We saw that people were involved in their care plans. They included details of people’s usual daily routines and things that were important to them. A relative of a person told us how they had been involved in the development of their care plan.

People told us staff treated them with dignity and respect. One person told us, “They treat me with respect.” Staff told us how they respected people’s privacy and dignity while they were providing care. For example, by ensuring that they always knocked on doors and closed curtains if lights were on. We observe that staff always knocked on people’s doors and waited for a response before entering. People told us that they were able to be as independent as they wanted to be. One person told us, “I look after myself.” People told us that staff enabled them to do as much for themselves as possible and that staff assisted them to wash bits that they couldn’t reach. Staff told us how they promoted people’s independence by allowing them to do as much for themselves as possible. They explained how they encouraged people to do as much for themselves as possible while assisting people with their personal care.

The service was a very homely environment. Efforts had been made to try to create a ‘home from home’ feel with home cooked food, comfortable sitting areas and drinks served from teapots into cups and saucers. People’s bedrooms were personalised and people had brought things that were important to them into the service, such as cabinets and ornaments.

People told us that friends and family could visit at any time. We looked at the signing in book which showed that people visited at various times. There were no undue restrictions on visiting hours.

Good

Is the service responsive?

Our findings

People told us that the service was responsive to their needs. People told us that they or their relatives, if they preferred, had contributed to discussions about their care and with the development of their care plan. The registered manager told us how they carried out an initial assessment of people's needs before they moved into the service to ensure that they were able to meet people's needs. They went on to tell us how after a person had moved into the service they would develop a care plan with them after the first week to ensure that it included all of the relevant information about how they would like the service to meet their needs. This included talking involving family members and discussing people's likes, dislikes and preferences. Relatives that we spoke with confirmed this. We saw that these were recorded in people's care plans along with information about their usual routines. Staff were knowledgeable about them. Care plans were regularly reviewed to ensure that they continued to meet people's needs.

One person told us, "I'm free because they give me my freedom." People were able to access the community if they wished to do so. One person told us how staff assisted them to go shopping and out for a coffee as this was something that they enjoyed. We saw that people were supported to access the local church. Two people told us how they regularly accessed the community independently through their own choice and told us how they enjoyed doing so. Two people told us how they preferred their own company and spent a lot of time in their rooms. One person told us, "I'm very happy with my own company." They went on to tell us how they enjoyed listening to their talking books and listening to the radio. This was respected by staff. Staff told us how they spent time with people in their own rooms if people wanted some company.

People told us that they enjoyed the activity sessions at the service that took place. During our inspection we saw armchair exercises, dominoes and ball and parachute games taking place. One person told us, "I went to the exercises because I know what I can get out of them." They went on to tell us, "I really like the atmosphere here – it's very positive." Staff offered people alternative actibvities. A person who chose not to participate in the dominoes session was offered a magazine to read. A care worker sat next to them and engaged in conversation about the magazine articles. During the afternoon we saw that some students from a local school visited the service and spent talking with people and playing board game. The registered manager told us that this was something that took place each week. One person that we spoke to about this told us how much they enjoyed and looked forward to the students visiting. People from the service were also invited to attend events at the local school which they were supported to do by staff members and enjoyed.

We saw that meetings were held with people that used the service where people were provided with feedback about the service and asked for their views and suggestions of activities that they may like to do. The last meeting had been held over six months prior to our visit. We saw that two of the last suggested activities had been followed up but we saw that people had requested that a trip to seaside take place. This had not occurred. We discussed this with the registered manager who advised that this did not take place because a few people at the service had been unwell over the summertime but this would be something that they would plan for the following year.

People told us that they could talk to the staff about anything. One person told us, "I love it here, they're extremely nice and I have no complaints." Another person told us, "I've no complaints whatsoever." The service had a complaints policy that was available in welcome packs in people's rooms. This contained information about how to make a complaint with details about how it would be investigated and where people could refer their complaints to if they were not satisfied with the provider's response.

We saw that a quality assurance survey had been sent out to relatives of the service in June 2015. Relatives were generally very positive about the service and their comments included, "The staff are aware of the resident's needs," and "I have never seen anything but kind and professional care given to either [my relative] or another resident." However some relatives commented that they did not know where the complaints procedure was. We saw that this had been addressed and a letter had been sent out to relatives to explain where the complaints procedure was, on display in the reception area of the service. We saw that an action that was required following a recent contract monitoring visit from the local authority had been completed. This showed that the service took action in response to the feedback that they received.

Good

Is the service well-led?

Our findings

People were involved in developing the service through care plans reviews and discussions about their care where they were able to make suggestions about things at the service that they would like to see in place. People told us that could discuss anything with the registered manager or staff at the service. Staff told us that the registered manager had an open door policy and they were able to discuss anything with them or the deputy manager in their absence.

The registered manager provided hands on care throughout the day to support staff and enable her to keep under review practices at the service. The registered manager had a caring approach to people and this reflected on how other staff interacted with people. Staff members told us how they enjoyed their work. One staff member told us that this was because they were never rushed. They went on to tell us that the registered manager had said 'take whatever time necessary to help people', and this was evident during our inspection. Staff were not rushed and they spent time with people.

Staff and the registered manager shared a vision of the service. It was to create a homely environment where people's care needs were met and they were able to do the things that they wanted to do and enjoy things that were important to them. For example, cups of tea were made in a teapot and served to people in china cups and saucers. People enjoyed the atmosphere at the service and homely environment.

We looked at the feedback that had received from the last quality assurance questionnaire. We saw that comments made by relatives about the registered manager included, "The registered manager] is fantastic, very happy that she is in charge," and "the leadership is very good and [the registered manager] is always available to family members." This opinion was echoed by staff members. Staff went on to tell us that the registered manager would address any issues with them and support them to ensure that they were put right.

The registered manager at the service was aware of the requirements and responsibilities of their role. We had received some notifications from the service as required. The registered manager was going revisit the CQC guidance to ensure that we were notified as required about all events at the service.

The provider had procedures for monitoring and assessing the quality of the service. This included seeking relative's views of the service through an annual survey. A survey was completed in June 2015. Relative's responses were positive. They said they [people using the service] were safe, that their needs were met, that staff were kind and that the service was well led. We saw that feedback was sought in meetings that were held with people that service. For example people were asked if there were enough drinks made available to them and if they were happy with the food. People's feedback at the meetings was positive about the service and this was our findings during the inspection.

Report No: 85/2016
PUBLIC REPORT

SCRUTINY PANEL

14 April 2016

ADULT SOCIAL CARE STRATEGY LAUNCH FEEDBACK

Report of the Director for People

Strategic Aim:	Meeting the health and wellbeing needs of the community	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr R Clifton, Portfolio Holder for Health and Adult Social Care	
Contact Officer(s):	John Morley, Head of Adult Social Care	01572 758442 jmorley@rutland.gov.uk
	Emmajane Perkins, Service Manager Adult Social Care	01572 720917 eperkins@rutland.gcsx.gov.uk

DECISION RECOMMENDATIONS
That the Panel: 1. Notes the content of the report and the feedback received; 2. Comments on additional steps that may be undertaken to further engage stakeholders and raise awareness

1 PURPOSE OF THE REPORT

1.1 To provide feedback on the first launch events of the Adult Social Care Strategy 2015-20 and the publicity undertaken thusfar, and to update Scrutiny on the next steps.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 Rutland County Council's Adult Social Care Strategy 2015-20 was consulted on during 2015, including presentation at Adults and Health Scrutiny on 1st October 2015. A number of comments were made during the consultation and these were reflected in the final version, which was approved by Cabinet on 17th November 2015.

2.2 The Strategy sets out our vision adult social care to 2020, outlining our overall aim to enable and encourage people and communities to live healthier, more independent lives and to do this in a way that means they have to rely on us less. It sets out six goals:

- Enable individuals and families within our community to achieve their full potential and be safe from harm
- Target services at the most vulnerable and those in greatest need
- Integrate services more closely with the Health and Voluntary, Community and Faith (VCF) Sectors in a way that supports independent living
- Be clearer about what individuals, families and our community can expect
- Focus on finding different ways to do things rather than reduce or remove services
- Adopt an early help and prevention approach

2.3 The Strategy sits alongside a number of complementary strategies such as the Better Care Together programme and Rutland's Better Care Fund plan, which are working to integrate social care with health services to help people to remain well and independent for longer.

3 LAUNCH EVENTS FOR THE STRATEGY

3.1 A launch event to present the strategy to key stakeholders was held on the morning of 7th March at Oakham Rugby Club. The delegates represented areas from across a broad spectrum of the voluntary and community sectors, together with public sector partners such as the emergency services, prison and health services.

3.2 Invitations were issued to the faith sector, but regrettably were not taken up on this occasion. The sector is an important element of Rutland's community and future engagement plans will include opportunities for further invitations to be issued so as not to unintentionally isolate any of the parishioners. Direct contact will be made with faith leaders so as to ensure the sector is aware of why they are being invited and that their contributions are valued and welcome.

3.3 A similar event took place on the 23rd March at the Showground to engage with operational staff from the adult social care workforce, including health colleagues.

3.4 Both events were very well received and welcomed as an opportunity to hear first-hand the vision for Adult Social Care in Rutland. Feedback from 7th March is shown as Appendices B & C at the end of this report.

3.5 There was strong positive engagement about both launch events on social media, with updates from the launch events seen in excess of 4,300 times by Twitter users.

4 FEEDBACK ON THE STRATEGY

4.1 Overall the feedback on the Strategy was positive, with stakeholders expressing the benefits of a joined-up approach. The main areas within the Strategy commented on were:

4.1.1 The continuing need for individuals to understand what is available to them and how to access it;

4.1.2 The importance of service user choice, and ensuring that inequalities for individuals are reduced;

4.1.3 The need to ensure realistic future funding for services to ensure they are maintained and sustainable.

4.2 Stakeholders also raised the importance of greater clarity on joined up working and how various organisations can contribute to the overall Strategy. It was noted that some stakeholders felt they did not understand how they could support the delivery of the Strategy.

4.2.1 This may be indicative of a misinterpretation that an adult social care strategy relates solely to adult social care, as opposed to being relevant to the integration of health and social care in its broadest sense. Further work is being undertaken across all teams and with partners through the Integration Executive to ensure a consistent understanding and develop understanding and to clarify how joint working supports delivery.

5 PUBLICITY

5.1 Information about the Adult Social Care Strategy and the current public consultation around charging for adult social care has been widely distributed through libraries, sports centres and GP practices in the county in addition to being sent directly to current service users. Other examples of outlets requested to hold information are Citizens advice, Healthwatch Rutland, Rutland Memorial Hospital.

5.1.1 A set of Frequently Asked Questions (FAQ) are also available on the RCC website (Appendix A)

5.2 In addition to the launch events, various publicity has been undertaken to raise awareness of the Strategy:

5.2.1 It has been publicised on the RCC website and through the RCC Twitter account, together with details as to how to obtain a copy or to speak with someone about it.

5.2.2 The Rutland Mercury carried a front page article, with further articles in the Rutland Times and the Leicester Mercury. Their respective websites also carried the article.

5.2.3 Councillor Richard Clifton was interviewed on Rutland Radio about the Strategy and what it means for local people.

6 NEXT STEPS

6.1 The events and feedback have highlighted a number of opportunities for further work:

6.1.1 Joined up working with wider professionals who have access to people's homes to help identify those who may be vulnerable and

6.1.2 Continued publicity and awareness raising through local communities, using parish fora, Community Agents and community groups to ensure as wide a reach as possible to potential service users;

6.1.3 Direct engagement with the faith sector to identify their role in supporting vulnerable people within the community.

6.1.4 Preventative services could be enhanced through effective engagement with the local business sector, helping to identify and potentially support vulnerable people.

7 BACKGROUND PAPERS

7.1 Adult Social Care Strategy 2015-20

8 APPENDICES

8.1 A: Adult Social Care Strategy FAQ

8.2 B: Stakeholder Event 7th March 2016 Delegates' Feedback Forms Comments

8.3 C: Stakeholder Event 7th March 2016 Delegates' Feedback Forms Responses

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

Appendix A. Adult Social Care Strategy FAQ

Adult Social Care Strategy Frequently Asked Questions

The following FAQ has been produced to help answer any questions you may have about Rutland County Council's new Adult Social Care strategy:

What is Adult Social Care?

Adult social care services provide help and support for some of the most vulnerable people in our community – those with needs arising from illness, disability, old age or hardship.

Who is responsible for providing this care in Rutland?

Adult Social Care is provided by a range of public, private and voluntary sector organisations, as well as individual carers. Rutland County Council has overall responsibility for ensuring the needs of adults living in the County are met. This responsibility became a legal requirement following the introduction of the Government's Care Act 2014.

What is the Council's new Adult Social Care Strategy?

The Strategy is a document that sets out our ambitions for social care for the next five years – right up to 2020. It also sits alongside a number of complementary strategies such as the Better Care Together programme and Rutland's Better Care Fund plan, which are working to integrate social care with health services to help people to remain well and independent for longer.

Why do we need a strategy?

As our population grows older and young people with disabilities live longer, there will be additional challenges to keeping Rutland a healthy place to live.

By 2033 the total population of Rutland is expected to reach 46.4 thousand – an increase of almost 22% from 2008. The greatest change will be in the over 65 age bracket and in future years more than a third of our population will fall into this category. Around 1,700 people aged over 75 in Rutland were predicted to live alone in 2010 but this number is expected to rise to 3,800 by 2030. Furthermore, the total number of people aged 65 and over who have a significant health problem is predicted to double between 2010 and 2030.

Rutland's population at the recent 2011 Census was 37,369. Further statistical data for Rutland can be found online at: http://www.rutland.gov.uk/council_and_democracy/statistics_and_census_informat.aspx

All of this means we need a radical shift in the way we deliver Adult Social Care in Rutland and a refocusing of available resources.

How has this strategy been produced?

The Strategy follows on from the Council's People First Review – a wide-reaching consultation which took place in April 2014 to help us plan for:

- Demographic pressures posed by an ageing population with a high incidence of dementia
- Major changes in national policy with the introduction of the Care Act 2014
- An unprecedented financial environment in which the Council needs to deliver significant savings
- The need for a collaborative approach with health partners, to develop more seamless care and support

The review recommended a way forward for services that would meet the needs of individuals, families and our communities and has helped form the basis of the new Adult Social Care Strategy.

What is going to change as a result of this?

Our overriding aim is to enable and encourage people and communities to live healthier, more independent lives and to do this in a way that means they have to rely on us less. Our goal is to:

- Enable individuals and families within our community to achieve their full potential and be safe from harm
- Target services at the most vulnerable and those in greatest need

- Integrate services more closely with the Health and Voluntary, Community and Faith (VCF) Sectors in a way that supports independent living
- Be clearer about what individuals, families and our community can expect
- Focus on finding different ways to do things rather than reduce or remove services
- Adopt an early help and prevention approach

When will these changes be introduced?
Work is already taking place to make sure people in Rutland receive the right care, in the right place, at the right time. This will continue over the next five years as we look to introduce further changes that will help people lead healthy, independent lives and make services more sustainable for the future.

Who will this affect?
Even if you are young and healthy now you may need these services in future so this strategy affects the vast majority of adults living in Rutland. It also affects carers, individual service users and various partner organisations. To make sure services are sustainable we are looking to work more closely and effectively with partners in the health, voluntary, community and faith sectors, while we also aim to change the way that we commission services to meet specific needs.

Why has the Council increased council tax to fund Adult Social Care?
Social care services are some of the most important services we provide and take up an increasingly large proportion of our overall budget. While the number of people in Rutland who rely on us for care is increasing as our population grows and elderly people live longer, Central Government has made major cuts to the funding it gives local Councils. Instead, the Government has as given Unitary Councils like Rutland the power to increase council tax by 3.99% in each of the next four years and assumes we will act accordingly to close this funding gap and pay for local services.

Appendix B. Adult Social Care Strategy 2015-2020 Stakeholder Event 7th March 2016 Delegates' Feedback

1	I like the new way of working strategy going forwards. A holistic approach will surely benefit the community as a whole
2	Good mix of organisations represented
4	Plenty of services available but people need to know where to get it Info needs to be given out at the right time and not randomly – not just info for info sake Health can = negative for many – being told what can and cannot do – need to use wellbeing more – might get better buy in ☺
5	We cannot fault the service we have had from the Council for our son following his stroke
8	It was interesting to hear other sectors views on all that we covered this morning
9	Very useful information morning. Thank you.
10	We had a wide variety of sectors represented on our table. I think it would be beneficial in the future to discuss solutions by sector e.g. care homes, home care, voluntary sector etc.
11	It would have been nice to have completed some focus groups prior to this event and shared the headlines. This could have provided additional (and very relevant) information to focus the table discussions. It wasn't clear how RCC would work with other stakeholders, which is why I scored neither agree nor disagree, i.e. / NHS England, CCGs, PHE and Health and Wellbeing board
12	Consideration given to the knowledge that is already there, the skill set of the organisations already delivering the services.
13	Important to emphasise health and wellbeing to help people understand the broader implications of strategy. Keep the group engaged as part of communication
16	Great event with a variety of partners. Hope to have a follow up in the future
18	Great networking event and community engagement and detailed discussions on tables was informative. Overall, session was well structured, informal and enjoyable. Thank you.
20	Excellent morning looking at the needs of local communities. For planning – should have users having their say in what they want – but needs to be targeted at people who will access services – to deal with inequalities. Consider how this strategy will be applied to deal with health inequalities and ageing population within prison health
21	A well organised event with some useful recommendations made for the benefit of our community
22	Useful to be informed and involved. The proof of effectiveness will be in the breaking down of barriers between service providers to ensure the service user knows that providers understand the full spectrum of services that are available, and/or they know where to go for information (team/individual provision)
24	Ensure future funding is realistic that services can achieve the goals
27	Well run
28	The value of volunteering for all ages is paramount to well-being. This is especially so for the elderly and newcomers to any community. Loneliness is a vital element in needing social care. All future consultations would value from input from Parish Councils, Churches (all denominations) community shops and other community groups
29	Please don't overload voluntary groups – 'signposting' is too easy it needs to be used with caution and consideration of whoever the client is signposted to. Working together does work! E.g. parking directorate accommodating the needs of the voluntary group
30	Vital to establish a more level playing field across the wider partnership in tackling these issues. How do we do that?
33	Always remember there are still some people with Learning Disabilities who will benefit from support in a residential type setting. Our intentional community is different from typical residential care
35	Excellent speakers. Engaging. Good interaction/delegate participation

Appendix C. Adult Social Care Strategy 2015-2020 Stakeholder Event 7th March 2016 Delegates' Feedback Form Responses

46 people received a feedback form. 35 completed and returned on the day

	Strongly Agree (a)	Agree (b)	Neither (c)	Disagree (d)	Strongly disagree(e)
This event has helped me to understand the Council's new Adult Social Care Strategy	6	27	2		
I have a clear understanding of what the Council hopes to achieve with this new plan	8	22	5		
It is clear why a new strategy is needed and why this is important	13	19	3		
This strategy is right for Rutland and will meet the health and well-being needs of our community	5	22	8		
I understand how I can help to support the delivery of this plan	3	25	7	1	
I would like to be involved in future development work	14	18	2		1
My expectations of today have been met	4	28	3		

The respondent who would not like to be involved in future development work is 'Parent'

The respondent who does not understand how they can help to support the delivery of this plan is from ELR CCG

Areas represented

Active Rutland, Age UK Leics, Alzheimer's Society, Barchester Healthcare, Barleythorpe Parish Council, Barrowden Parish Council, Bluebird Care, British Red Cross, Carers UK / OHCR, Cathedral Home Care; Rutland Citizens Advice, ELR CCG, Healthwatch Rutland, Home Straight Home Care, Leics Fire & Rescue Service, Lodge Trust, LPT, NHS/Prison Healthcare, Oakham Drop-in Centre, Parent, PoHWER, Police, Prime Life (Rutland Care Village), Public Health, RCC Adult Learning & Skills, RCC ASC, RCC Contracts, RCC Finance, RCC Housing, Royal British Legion & 'Hear For You' emotional support & wellbeing, Rutland Access, Sailability, Service user, Spire, VISTA