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Rutland County Council

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Ladies and Gentlemen,

A meeting of the **HEALTH AND WELLBEING BOARD** will be held in the Council Chamber, Catmose, Oakham, Rutland, LE15 6HP on **Thursday, 23rd July, 2015** commencing at 2.00 pm when it is hoped you will be able to attend.

Yours faithfully

Helen Briggs
Chief Executive

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

A G E N D A

1)   **APOLOGIES**

2)   **RECORD OF MEETING**

To confirm the record of the meeting of the Rutland Health and Wellbeing Board held on the 24th March 2015 (previously circulated).

3)   **DECLARATIONS OF INTEREST**

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

4)   **PETITIONS, DEPUTATIONS AND QUESTIONS**

To receive any petitions, deputations and questions received from Members of the Public in accordance with the provisions of Procedure Rule 216.

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

Administrator 15 minutes before the start of the meeting.

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

5) TERMS OF REFERENCE

Review of Terms of Reference for the Health and Wellbeing Board
(Pages 5 - 8)

6) BETTER CARE TOGETHER: UPDATE

To receive an update from Sarah Smith, Better Care Together, Leicester, Leicestershire & Rutland Health and Social Care.
(Pages 9 - 16)

7) YOUNG PEOPLE'S MENTAL HEALTH

To receive Report No. 139/2015 from Jennifer Fenelon, Chair, Healthwatch Rutland
(Pages 17 - 32)

8) JOINT STRATEGIC NEEDS ASSESSMENT: DRAFT OVERVIEW

To receive Report No.133/2015 from the Director for People
(Pages 33 - 68)

9) ELRCCG QUALITY PREMIUM 2015/16

To receive Report No. 140/2015 from Dr Samantha Brown, NHS Arden & Greater East Midlands Commissioning Support Unit and Jane Chapman, Chief Strategy and Planning Officer (ELRCCG)
(Pages 69 - 74)

10) STEP UP, STEP DOWN - INTEGRATION PREVENTION, DISCHARGE AND REABLEMENT MODEL AND IUR2 BUSINESS CASE

To receive Report No. 138/2015 from Yasmin Sidyot, Strategy and Planning Manager, ELRCCG
(Pages 75 - 94)

11) BETTER CARE FUND: QUARTER 4 - NATIONAL RETURN

To receive Report No. 141/2015 from the Deputy Director for People
(Pages 95 - 118)

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DISTRIBUTION
MEMBERS OF THE HEALTH AND WELLBEING BOARD:

1.	The Chair	Rutland County Council
2.	Cllr Roger Begy	Rutland County Council
3.	Dr Andy Ker	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)
4.	Helen Briggs	Rutland County Council
5.	Jane Clayton Jones	Community & Voluntary Sector Rep
6.	Jennifer Fenelon	Healthwatch Rutland
7.	Katy Sagoe	Housing Rep
8.	Lou Cordiner	Leicestershire Constabulary
9.	Mike Sandys	Rutland County Council - Public Health
10.	Dr Tim O'Neill	Rutland County Council
11.	Tim Sacks	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)
12.	Trish Thompson	NHS England Local Area Team

OTHER MEMBERS FOR INFORMATION

13.	Julia Eames	Rutland County Council
14.	Mark Andrews	Rutland County Council
15.	Yasmin Sidyot	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)

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May 2013

Rutland Health and Wellbeing Board

Terms of Reference

Introduction

The Health and Wellbeing Board has been appointed by Rutland County Council as a statutory committee of the Local Authority. It will discharge directly the functions conferred on Rutland County Council by Section 196 of the Health and Social Care Act 2012 or such other legislation as may be in force for the time being.

1. Aim

To achieve better health, wellbeing and social care outcomes for Rutland's whole population and a better quality of care for patients and other people using services.

2. Key Role

2.1 Provide strategic coordination of commissioning services across NHS, Social Care, Public Health, Children's Services and other services that the board agrees impacts on the wider determinants of health.

2.2 Provide collaborative leadership that influences, shapes and drives a wide range of services and interventions that spans health care, social care and public health.

3. Responsibilities

3.1 Identify current and future health and wellbeing needs across Rutland through revising the Joint Strategic Needs Assessment (JSNA) as and when required.

3.2 Prepare and publish a Joint Health and Wellbeing Strategy (JHWS) that is evidence based (through the work of the JSNA) and supported by all stakeholders. This will set out our objectives, trajectory for achievement and how we will be jointly held account for delivery.

3.3 Develop solutions to challenges outlined in the JSNA and JHWS.

3.4 Facilitate partnership working across health and social care to ensure that services are joined up around the needs of service users. Encourage persons who arrange for the provision of health-related services in its area to work closely with the health and wellbeing board.

3.5 Join up partnership working across Rutland, particularly linking to the Safer Rutland Partnership and ensure there are appropriate links with the Local Safeguarding Children's Board and the Leicestershire and Rutland Safeguarding Adults Board.

3.6 Ensure governance arrangements, strategic partnerships and relationships are in place to progress the JHWS, address any barriers to success.

3.7 To have oversight of the use of relevant public sector resources across a wide range of services and interventions, with greater focus and integration across outcomes spanning health care, social care and public health.

3.8 Make use of flexibilities available such as pooled budgets and lead commissioning arrangements to provide more integrated commissioning across health and social care.

3.9 Focus resources on the agreed set of priorities for health, wellbeing and social care (as outlined in the JSNA and JHWS).

3.10 Ensure that Rutland County Council, East Leicestershire and Rutland Clinical Commissioning Group and Lincolnshire and Leicestershire Local Area Team for the National Commissioning Board demonstrate how the JHWS has been implemented in their commissioning decisions.

3.11 Receive reports from other strategic groups and partners responsible for delivery.

3.12 Have regard to the JHWS when exercising commissioning functions.

3.13 Accountable where applicable for outcomes and targets specific to performance frameworks within the NHS, Local Authority and Public Health.

3.14 Ensure that the work of the board is aligned with policy developments both locally and nationally.

4. Communication and Engagement

4.1 Develop and implement a Communications and Engagement plan, outlining how the board will be influenced by stakeholders and the public, and how the board will disseminate specific duties required by the board, including consultation on service changes.

4.2 Communicate and engage with local people in how they can achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing.

4.3 Represent Rutland in relation to health & well-being issues at local, regional and national level.

4.4 Ensure there is a protocol in place between the Local Children's Safeguarding Board and the Safeguarding Adults Board to outline the relationship between health and wellbeing matters and safeguarding.

5. Membership

5.1 **Minimum membership of:**
- Two representatives from the East Leicestershire and Rutland Clinical Commissioning Group (2)
- Two local elected representatives (2):
  - Portfolio holder for health and wellbeing
  - Leader of Rutland County Council
- The Director of People for Rutland County Council (1)
- The Director of Public Health for the Local Authority (1)
- One representative of the local Health watch organisation for the area of the local authority, (1)
- One representative from the Voluntary and Community Sector as nominated by the Health and Social Care Forum (1) (Non statutory member)
- One representative from the Lincolnshire and Leicestershire Local Area Team of the NHS Commissioning Board (1)
- Housing Representation (1) (Non statutory member)
- One representative from Leicestershire Constabulary (1) (Non statutory member)

and such other persons as the local authority and/or health and wellbeing board thinks appropriate e.g. other groups or stakeholders who can bring in particular skills or perspectives, such as the voluntary sector, clinicians or providers.

5.2 Housing and Community & Voluntary Sector Board members will be able to appoint a maximum of one deputy to attend meetings. Statutory member organisations will not be permitted to send a deputy with the exception of HealthWatch who will be permitted to nominate one named deputy.

6. Voting

6.1 All members of the Health and Wellbeing Board are allowed to vote (unless the County Council directs otherwise)

6.2 Rutland County Council's Meeting Procedure Rules in relation to voting apply; however it is hoped that decisions of the Board can be reached by consensus without the need for formal voting.

7. Standing Orders

The Access to Information Procedure Rules and Meeting Procedure Rules (Standing Orders) laid down by Rutland County Council will apply with any necessary modifications including the following:-

   a. The Chairperson will be an elected member of Rutland County Council or a member of Rutland County Council's Cabinet.
   b. The quorum for a meeting shall be a quarter of the membership including at least one elected member from the County Council and one representative of the East Leicestershire and Rutland Clinical Commissioning Group.

8. Meetings

8.1 Administration support will be provided by Rutland County Council.

8.2 There will be standing items on each agenda to include:

   • Declarations of Interest
   • Minutes of the Previous Meeting
   • Matters Arising
   • Updates from each of the subgroups of the Health & Wellbeing Board

8.3 Meetings will be held in public approximately every quarter (4 times a year)
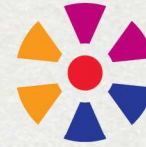
Recap: What is Better care together

- Better care together is a major change project that will reconfigure the way that health and social care is delivered across Leicestershire, Leicester and Rutland over 5 years

- It is run by a partnership of all health and social care delivery organisations supporting the region, plus the health and wellbeing boards, Healthwatch, a public and patient involvement group and members of the voluntary sector

- In essence we are attempting to transform health and social care services in Leicester, Leicestershire and Rutland from cradle to grave.

- It is a massive undertaking, but is necessary to ensure the services we all provide meet the changing needs of the communities we serve as well as addressing some of the growing health inequalities that are greatly impacting our local people.

- There is a strong case for change across the system and in the words of one of our clinical leads "We need to learn how to do today's work differently so that tomorrow's work is easier"

Status: What is the present status of BCT

- The Better care together programme we launched in 2014 has now reached its initial implementation phase, having gained formal agreement to a Strategic Outline Case from both NHS England and the Trust Development Authority.

- There are a number of changes already implemented, some planned for this year, funding permitting, and some that are planned post public consultation and so will be delivered from 2016 onwards.

- Public consultation is planned for Autumn 2015 and is presently expected to start in late November.

Achievements to date

- It is acknowledged that while the support of our various regulators was being gained there has been very little engagement with staff, however change has been taking place. For example;
    - Demolition work has begun at the Leicester Royal Infirmary in preparation for its new £43.3m Emergency Department. The new facility will be the UK's first frailty friendly emergency department. It will also have a fully integrated mental health unit, state of the art imaging and dedicated rapid ambulance access.
    - Hernia procedures are now being carried out under local anaesthetic at some GP practices and health centres in Leicestershire and Rutland. Meaning people can receive care closer to home and don't have to travel to larger city hospitals.
    - A new crisis response pathway is now in place in mental health services including the opening of a new crisis house. These current changes are now being reviewed in order to assess their impact so far.
    - Improved availability of assistive technology to support people to stay out of hospital.
    - A multi-agency workshop is planned to refresh and review the dementia plan for people in Leicester, Leicestershire and Rutland to meet the needs of our changing population.

Planned for 2015/16

- There are also a number of major changes planned for 2015/16 which include:
  - Additional recovery colleges for patients with mental health issues.
  - Improvements to services for patients with learning disabilities.
  - Re-location of some intensive community support services from UHL to a community setting closer to home.
  - Changes to planned care pathways and increased level of care provided in community as opposed to acute settings.
  - Increased information sharing across primary care.
  - Public consultation for all the changes included within the Better care together programme scope.

The conversation for the Autumn

- As well as describing how care across Leicestershire, Leicester and Rutland will be improved, the Better care together engagement campaign run in the Spring of 2015 outlined a number of potentially significant proposed changes that will be discussed as part of the Consultation conversation this Autumn
- The following have already been signposted as things we need to discuss:
    - City hospitals wishing to become smaller and more specialist with more services being delivered via the community
    - Acute services being consolidated onto two sites and the clinical view being that this should be the Royal and the Glenfield hospitals
    - A different future for the General hospital
    - Community hospital hubs will be developed in hospitals that are in the best condition and location.
    - Increasing intensive community support services where patients are cared for at home
    - The options for and the future shape of maternity services
    - The options for and the future share of services to support new-borns
- A private session in September to introduce elected members to the options and discuss them from a locality impact perspective is being discussed with the council executive team

What do the public think so far?

- A public engagement campaign was run in spring of 2015 to assess the public view of the Better care together strategy.
- More than 1000 responses were received over a four week period and they confirmed the general public support for the strategic direction, including;
  – 89% (945) respondents to the questionnaire agree that health and social care needs to change the how and where it works to meet the changing population
  – 94% (999) respondents agree that we all have a responsibility to look after our own health
  – 87% (919) respondents feel that big city hospitals should focus on specialist and emergency care, with some simpler care transferring to the community hospitals/ GP services
  – When asked what is most important to people when choosing a service 44% (469) said the appointment availability/waiting times; 38% (397) said the specialist you will see
  – When respondents were asked what do you think about the proposals relating to the eight healthcare areas, the majority of people agreed with the proposals.

Some key dates

First Draft of Public facing Narrative

August

Elected Officers Engagement events

September

First Final Draft of Public facing Narrative

October

Agreed Pre-consultation Business case

Final sign Off of Material For consultation

November

Consultation Launch events

November

REPORT NO: 139/2015

Report to Rutland Health and Wellbeing Board

Subject:	Young Peoples Mental Health Project
Meeting Date:	23rd July 2015
Report Author:	Jennifer Fenelon, Chair, Healthwatch Rutland
Presented by:	Jennifer Fenelon, Chair, Healthwatch Rutland
Paper for:	Note / Approval

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:
This report describes the work done by Healthwatch Rutland over the past year in voicing and finding possible solutions to the concerns of young people in Rutland about their mental health. The project has attracted national interest because it has been led by the voices of our young people. The project has been significant both by the clarity with which the young people of Rutland have put their case and by the willingness of organisations across health, education, social care to work together to find solutions to the very serious problems identified. This report makes joint recommendations to the Health and Wellbeing Board for moving forward in Rutland.
Financial implications:
Recommendations:
That the board: 1. Notes the considerable progress made to date and endorses the next steps set out in the report.
Comments from the board:

Strategic Lead:	

Risk assessment:		
Time	L/M/H	
Viability	L/M/H	
Finance	L/M/H	

Revised Template 2011-12-13

Profile	L/M/H	
Equality & Diversity	L/M/H	

Timeline:

Task	Target Date	Responsibility

Revised Template 2011-12-13

REPORT NO: 139/2015 – Appendix A

Young Peoples Mental Health Project
Report to the Rutland Health and Wellbeing Board 23.07.15

Meeting	Rutland Health & Wellbeing Board	Agenda Item
Meeting Date	23rd July 2015	
Subject	Young People's Mental Health	
Author/Presenter	Jennifer Fenelon Chair, Healthwatch Rutland	

SUMMARY

This report describes the work done by Healthwatch Rutland over the past year in voicing and finding possible solutions to the concerns of young people in Rutland about their mental health. The project has attracted national interest because it has been led by the voices of our young people.

The project has been significant both by the clarity with which the young people of Rutland have put their case and by the willingness of organisations across health, education, social care to work together to find solutions to the very serious problems identified.

This report makes joint recommendations to the Health and Wellbeing Board for moving forward in Rutland.

NATIONAL BACKGROUND

The mental health of young people is a major cause for concern both nationally and locally.

In October 2014 the Parliamentary Health Committee published its grave concerns about provision for young people's mental health in England ..\..\House of Commons report October 2014.pdf It concluded that

"There are serious and deeply ingrained problems with the commissioning and provision of children's and adolescents' mental health services. These run through the whole system from prevention and early intervention through to inpatient services for the most vulnerable young people. "

In February 2015 the Government issued a draft response which said:-

One in four people on average experience a mental health problem, with the majority of these beginning in childhood. A report by the Chief Medical Officer in 2014 found that 50 per cent of adult mental health problems start before age 15 and 75 per cent before the age of 18.

The Government has committed to improving mental health provision and services for children and young people. The Government's 2011 Mental Health strategy, *No Health without Mental Health,* pledged to provide early support for mental health problems, and the Deputy Prime Minister's 2014 strategy, *Closing the Gap: priorities for essential change in mental health,* included actions to improve access to psychological therapies for children and young people and to publish guidance for schools on supporting pupils with mental health problems

Healthwatch England responded to this draft with evidence from across England including from Healthwatch Rutland ..\..\CAMHS\HW's comments on CYPMHW taskforce report (Jan 2015).pdf. and in March 2015 a final report "Future in Mind" was published by the Government ..\National Report March 2015\Future in Mind Childrens_Mental_Health Report March 2015.pdf.

Its Executive Summary is attached as Appendix A and key recommendations are:-

1. **Simplify structures and improve access:** by dismantling artificial barriers between services by making sure that those bodies that plan and pay for services work together, and ensuring that children and young people have easy access to the right support from the right service (Chapter 5).

2. **Deliver a clear joined up approach**: linking services so care pathways are easier to navigate for all children and young people, including those who are most vulnerable (Chapter 6), so people do not fall between gaps.

3. **Harness the power of information**: to drive improvements in the delivery of care, and standards of performance, and ensure we have a much better understanding of how to get the best outcomes for children, young people and families/carers and value from our investment (Chapter 7).

4. **Sustain a culture of continuous evidence-based service improvement** delivered by a workforce with the right mix of skills, competencies and experience (Chapter 8).

5. **Make the right investments**: to be clear about how resources are being used in each area, what is being spent, and to equip all those who plan and pay for services for their local population with the evidence they need to make good investment decisions in partnerships with children and young people, their families and professionals. Such an approach will also enable better judgements to be made about the overall adequacy of investment (Chapter 9).

On 26th May 2015 Sir Bruce Keogh wrote out to the NHS announcing a major transformation programme to implement the findings of "Future in Mind" and asking for local transformation plans prepared with input from young people and their families and aligning with " Future in mind" . CCGs will be monitored against locally set objectives.

HEALTHWATCH RUTLAND PROJECT

a. What our Young People said

In 2014 the Youth Council of Rutland told us that, of all the problems facing young people in the County today, their mental health was by far the greatest concern.

We tested this by surveying just under 1000 pupils in secondary schools across Rutland. (The survey excluded the two Rutland public schools for sheer size but these schools have kept in close touch as part of the project.)

The survey of 965 young people was carried out in late 2014 across year's 9-11 of UCC, Casterton College and Rutland County College. It was conducted by the 6 members of the Healthwatch Rutland Young People's Team most of whom are former teachers/ special needs teachers. We are indebted to the Public Health Department for help with survey design and Professor Fitchett of Leicester University for extensive pro bono analysis of the results. Key messages from the survey are attached as Appendix B.

These results were presented to an invited audience of young people and stakeholder organisations on 12th March 2015.There was unanimous agreement that the issues were serious and should be taken forward collectively by partner organisations to produce a joined up service that met young people's needs .

There was a very clear call for early intervention which could reduce later crises and long term adult ill health. The young people's messages were stark:-

- Almost half of young people (46%) taking part in the survey said that in the last 2 years they had reached a stage where they needed help coping with academic pressure.

- Over a quarter of young people (27%) said that they needed help coping with Illness (themselves or someone close).

- Almost a fifth of young people (19%) taking part in the survey said that in the last 2 years they had reached a stage where they needed help coping with Bullying.

- Significantly almost 1 in 10 young people (9%) said that they needed help coping with Social Media (bullying).
- Just over 1 in 5 young people (21%) said that they needed help coping with Loneliness.

b. Mapping current provision & identifying gaps

On 27th April 2015 the project moved on to map current services and to identify current gaps in the system. The workshop was facilitated by the young people themselves. They then went away to study the extent to which current services meet their needs and concluded that there are 10 solutions they want to see implemented immediately. These are:-

- Bring mental wellbeing on to the curriculum to enable symptoms of mental ill health to be identified.
- Hold Year Group meetings for parents led by mental health practitioners.
- Create a culture where mental health is not taboo.
- End the stigma - make it more acceptable to discuss issues
- Focus on prevention and coping strategies.
- Increase the number of counsellors in school or someone to talk to when needed.
- Student/staff forums to monitor and discuss ongoing areas of concern.
- Peer mentor training.
- Listen to the young people
- Improve young people's resilience
- Acknowledge that it is everyone's responsibility and inculcate a better understanding of what is available and how it can be accessed.
- Make sure early intervention and adolescent and child mental wellbeing is properly funded and provided.
- Publicise appropriate websites much more widely
- Educate parents, pupils and staff together to ensure that the stigma is ended and these issues can be spoken about honestly and without fear!

Although our survey was conducted in secondary schools, we are told the same issues apply to primary schools so these recommendations apply to all ages.

c. Finding solutions

The Dragons' Den

On 22nd June 2015 we brought young people, commissioners and providers together in a light hearted but serious " Dragons Den" to explore how the young people's list could be turned into services. Chaired by the Vice Chair of the Rutland Youth Council, the "Dragons" were young people and commissioners while the "pitchers" were a wide range of voluntary and statutory providers. From this we got a picture of what services were possible.

Questioning from the young people was incisive and we are indebted to the range of providers who offered solutions and responded to tough questions.

National representatives of "Young Minds" and Healthwatch England came too. They commented that Rutland is far ahead of the rest of the country both in the extent to which the voices of young people are being heard and the level of willingness between agencies to collaborate in finding solutions.

CAMHS Services

Our Healthwatch Young People's Team was also invited to participate in the formal review of CAMHS Tier 3/4 services. We gave a range of input to this most vital stage of care. We have

also contributed our views to the Better Care Together work stream for young people's mental health and hope that the lessons learned in Rutland can be incorporated into the overall pathway of care for LLR which is being developed for consultation in the Autumn and will, doubtless, also form part of the joint CCG response to Sir Brice Keogh's request for a plan by September 2015.

4 NEXT STEPS

After the Dragons' Den, a small ad hoc group of young people and stakeholder organisations was assembled by Healthwatch Rutland to brain storm next steps.

Rutland County College volunteered to be a pilot test bed for a new approach that would support early prevention and intervention. Their only caveat being that results should start to be seen by September 2015.

Rutland County Council has agreed to support the implementation of a Pilot in Rutland County College and has offered to manage this critical stage and has established a task and finish group to help design and deliver the Pilot. This initiative by Rutland County Council is greatly appreciated. Draft terms of reference for the task and finish group for the Pilot are attached as Appendix C.

Short Term We are indebted to Rutland County Council for volunteering to support the prevention and early intervention stage of the project**.**

A large amount of provision necessary to solve the problems is already in place but it is neither well utilised nor publicised or teachers, parents etc trained in its used.

The proposed project would start initially in Rutland County College but lessons learned would then be rolled out to Casterton College and then it's linked primary School in Ryhall. In this way the solutions can be tested across the spectrum of education.

The objective is to have the basis of a trial comprehensive and integrated service in place at the pilot sites by September 2015.

Longer Term The development of pathways of care which shift the focus from crisis care at CAMHS level 3/4 towards prevention and earlier intervention is being addressed by the LLR Better Care Together Children's Group and Commissioners.

We would like to see the learning from Rutland used to help develop those pathways across Leicester, Leicestershire and Rutland before they are due to go out to public consultation in the Autumn of 2015.

FOR DISCUSSION & DECISION

The Health and Wellbeing Board is asked to note the considerable progress made to date and to endorse the next steps set out above

APPENDIX A "Future in Mind" - Executive Summary

1.1 The Children and Young People's Mental Health and Wellbeing Taskforce1 was established in September 2014 to consider ways to make it easier for children, young people, parents and carers to access help and support when needed and to improve how children and young people's mental health services are organised, commissioned and provided.

1.2 Key themes emerged which now provide the structure of this report. Within these themes, we have brought together core principles and requirements which we consider to be fundamental to creating a system that properly supports the emotional wellbeing and mental health of children and young people.

1.3 In summary, the themes are:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

The case for change

1.4 Mental health problems cause distress to individuals and all those who care for them.

1 *Children and Young People's Mental Health and Wellbeing Taskforce: Terms of Reference*. Available at: www.gov.uk/government/groups/children-and-young-peoples-mental-health-and-well-being-taskforce
One in ten children needs support or treatment for mental health problems. These range from short spells of depression or anxiety through to severe and persistent conditions that can isolate, disrupt and frighten those who experience them. Mental health problems in young people can result in lower educational attainment (for example, children with conduct disorder are twice as likely as other children to leave school with no qualifications) and are strongly associated with behaviours that pose a risk to their health, such as smoking, drug and alcohol abuse and risky sexual behaviour.

1.5 The economic case for investment is strong. 75% of mental health problems in adult life (excluding dementia) start by the age of 18. Failure to support children and young people with mental health needs costs lives and money. Early intervention avoids young people falling into crisis and avoids expensive and longer term interventions in adulthood. There is a compelling moral, social and economic case for change. We set this out in full in Chapter 3.

1.6 Evidence presented to the Taskforce also underlined the complexity and severity of the current set of challenges facing child and adolescent mental health services. These include:

i. Significant gaps in data and information and delays in the development of payment and other incentive systems. These are all critical to driving change in a co-ordinated way

The treatment gap. The last UK epidemiological study2 suggested that, at that time, less than 25% – 35% of those with a diagnosable mental health condition accessed support. There is emerging evidence of a rising need in key groups such as the increasing rates of young women with emotional problems and young people presenting with self-harm.

iii. Difficulties in access. Data from the NHS benchmarking network and recent audits reveal increases in referrals and waiting times, with providers reporting increased complexity and severity of presenting problems.

iv. Complexity of current commissioning arrangements. A lack of clear leadership and accountability arrangements for children's mental health across agencies including CCGs and local authorities, with the potential for children and young people to fall though the net has been highlighted in numerous reports.3

v. Access to crisis, out of hours and liaison psychiatry services are variable and in some parts of the country, there is no designated health
2 Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). *Mental health of children and young people in Great Britain, 2004*. A survey carried out by the Office for National Statistics on behalf of the Department of Health and the Scottish Executive. Basingstoke: Palgrave Macmillan.

3 National CAMHS Review (2008). *Children and young people in mind: the final report of the National CAMHS Review*. National CAMHS Review; HM Government (2011). *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages.* London: Department of Health; Department of Health (2012). *Annual Report of the Chief Medical Officer 2012*. London: Department of Health; CAMHS Tier 4 Report Steering Group (2014). *CAMHS Tier 4 Report*. London: NHS England.

place of safety recorded by the CQC for under-18s.

vi. Specific issues facing highly vulnerable groups of children and young people and their families who may find it particularly difficult to access appropriate services.

1.7 These issues are addressed in considering the key themes that form the basis of this report and the proposals it makes.

Making it happen

1.8 The Taskforce firmly believes that the best mental health care and support must involve children, young people and those who care for them in making choices about what they regard as key priorities, so that evidence-based treatments are provided that meet their goals and address their priorities. These need to be offered in ways they find acceptable, accessible and useful.

1.9 Providers must monitor, and commissioners must consider, the extent to which the interventions available fit with the stated preferences of young people and parents/carers so that provision can be shaped increasingly around what matters to them. Services need to be outcomes-focused, simple and easy to access, based on best evidence, and built around the needs of children, young people and their families rather than defined in terms of organisational boundaries.

1.10 Delivering this means making some real changes across the whole system. It means the NHS, public health, local authorities, social care, schools and youth justice sectors working together to:

••Place the emphasis on building resilience, promoting good mental health, prevention and early intervention (Chapter 4)

1. Executive summary and key proposals

••Simplify structures and improve access: by dismantling artificial barriers between services by making sure that those bodies that plan and pay for services work together, and ensuring that children and young people have easy access to the right support from the right service (Chapter 5).

••Deliver a clear joined up approach: linking services so care pathways are easier to navigate for all children and young people, including those who are most vulnerable (Chapter 6), so people do not fall between gaps.

••Harness the power of information: to drive improvements in the delivery of care, and standards of performance, and ensure we have a much better understanding of how to get the best outcomes for children, young people and families/carers and value from our investment (Chapter 7).

••Sustain a culture of continuous evidence-based service improvement delivered by a workforce with the right mix of skills, competencies and experience (Chapter 8).

••Make the right investments: to be clear about how resources are being used in each area, what is being spent, and to equip all those who plan and pay for services for their local population with the evidence they need to make good investment decisions in partnerships with children and young people, their families and professionals. Such an approach will also enable better judgements to be made about the overall adequacy of investment (Chapter 9).

1.11 In some parts of the country, effective partnerships are already meeting many of the expectations set out in this report. However, this is by no means universal, consistent or equitable.

A National ambition

1.12 This report sets out a clear national ambition in the form of key proposals to transform the design and delivery of a local offer of services for children and young people with mental health needs. Many of these are cost-neutral, requiring a different way of doing business rather than further significant investment.

1.13 There are a number of proposals in this report which require critical decisions, for example, on investment and on local service redesign, which will need explicit support from the next government, in the context of what we know will be a very tight Spending Review. We are realistic in this respect. At both national and local level, decisions will need to be taken on whether to deliver early intervention through an 'invest to save' approach and/or targeted reprioritisation, recognising that it will take time to secure an economic return for the nation.

The Government's aspirations are that by 2020 we would wish to see: *(The numbers in brackets refer to the proposals in and at the end of each chapter)*

1. Improved public awareness and understanding, where people think and feel differently about mental health issues for children and young people where there is less fear and where stigma and discrimination are tackled. This would be delivered by:a hard hitting anti-stigma campaign which raises awareness and promotes improved attitudes to children and young people affected by mental health difficulties. This would build on the success of the existing Time to Change campaign; (3)
1. with additional funding, we could also empower young people to self-care through increased availability of new quality assured apps and digital tools. (5)
1.
1. In every part of the country, children and young people having timely access to clinically effective mental health support when they need it. With additional funding, this would be delivered by:a five year programme to develop a comprehensive set of access and waiting times standards that bring the same rigour to mental health as is seen in physical health. (17)
1.
1. A step change in how care is delivered moving away from a system defined in terms of the services organisations provide (the 'tiered' model) towards one built around the needs of children, young people and their families. This will ensure children and young people have easy access to the right support from the right service at the right time. This could be delivered by:joining up services locally through collaborative commissioning approaches between CCGs, local authorities and other partners, enabling all areas to accelerate service transformation; (48)

having lead commissioning arrangements in every area for children and young people's mental health and wellbeing services, responsible for developing a single integrated plan. We envisage that in most cases the CCG would establish lead commissioning arrangements working in close collaboration with local authorities. We also recognise the need for flexibility to allow different models to develop to suit local circumstances and would not want to cut across alternative arrangements; (30)

1. transitions from children's services based on the needs of the young person, rather than a particular age. (15)
1.
1. 4. Increased use of evidence-based treatments with services rigorously focused on outcomes. With additional funding, this would be delivered by:building on the success of the CYP IAPT transformation programme and rolling it out to the rest of the country. (44)
1.
1. 5. Making mental health support more visible and easily accessible for children and young people. With additional funding, this would bedelivered by:every area having 'one-stop-shop' services, which provide mental health support and advice to children and young people in the community, in an accessible and welcoming environment. This would build on and harness the vital contribution of the voluntary sector; (16)

1. improving communications, referrals and access to support through every area having named points of contact in specialist mental health services and schools. This would include integrating mental health specialists directly into schools and GP practices. (16)
1.
1. 6. Improved care for children and young people in crisis so they are treated in the right place at the right time and as close to home as possible. This would be delivered by:ensuring the support and intervention for young people being planned in the Mental Health Crisis Care Concordat are implemented; (12)

1.   no young person under the age of 18 being detained in a police cell as a place of safety; (19)
1.   implementing clear evidence-based pathways for community-based care, including intensive home treatment where appropriate, to avoid unnecessary admissions to inpatient care. (13)
1.
1.   7. Improving access for parents to evidence-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour. With additional funding, this would be delivered by:enhancing existing maternal, perinatal and early years health services and parenting programmes. (4)
1.
1.   8. A better offer for the most vulnerable children and young people, making it easier for them to access the support that they need when, and where they need it. This would include:ensuring those who have been sexually abused and/or exploited receive a comprehensive assessment and referral to the services that they need, including specialist mental health services. (24)
1.
1.   9. Improved transparency and accountability across the whole system, to drive further improvements in outcomes. This would be delivered by:development of a robust set of metrics covering access, waiting times and outcomes to allow benchmarking of local services at national level; (36)
1.   clearer information about the levels of investment made by those who
1.

commission children and young people's mental health services; (38)

••subject to decisions taken by future governments, a commitment to a prevalence survey for children and young people's mental health and wellbeing, which is repeated every five years. (39)

10. Professionals who work with children and young people are trained in child development and mental health, and understand what can be done to provide help and support for those who need it.

Local Transformation Plans

1.14 Delivering the national ambition will require local leadership and ownership. We therefore propose the development and agreement of Transformation Plans for Children and Young People's Mental Health and Wellbeing which will clearly articulate the local offer. These Plans should cover the whole spectrum of services for children and young people's mental health and wellbeing from health promotion and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.

1.15 In terms of local leadership, we anticipate that the lead commissioner, in most cases the Clinical Commissioning Group, would draw up the Plans, working closely with Health and Wellbeing Board partners including local authorities. All these partners have an important role to play in ensuring that services are jointly commissioned in a way that promotes effective joint working and establishes clear pathways. Lead commissioners should ensure that schools are given the opportunity to contribute to the development of Transformation Plans.

1.16 To support this, NHS England will make a specific contribution by prioritising the further investment in children and young people's mental health announced in the Autumn Statement 2014 in those areas that can demonstrate robust action planning through the publication of local Transformation Plans.

1.17 What is included in the Plan should reflect the national ambition and principles set out in this report and be decided at a local level in collaboration with children, young people and their families as well as providers and commissioners. Key elements will include commitments to:

Transparency

        A requirement for local commissioning agencies to give an annual declaration of their current investment and the needs of the local population with regards to the full range of provision for children and young people's mental health and wellbeing.

        A requirement for providers to declare what services they already provide, including staff numbers, skills and roles, waiting times and access to information.

Service transformation

A requirement for all partners, commissioners or providers, to sign up to a series of agreed principles covering: the range and choice of treatments and interventions available; collaborative practice with children, young people and families and involving schools; the use of evidence-based interventions; and regular feedback of outcome monitoring to children, young people and families and in supervision.

Monitoring improvement

Development of a shared action plan and a commitment to review, monitor

1.

and track improvements towards the Government's aspirations set out in this Report, including children and young people having timely access to effective support when they need it.

Next steps in 2015/16

1.18 At a national level, we will play our part to deliver the ambition by:

••delivering waiting times standards for Early Intervention in Psychosis by April 2016;

••continuing development of new access and waiting times standards for Eating Disorder;

••commissioning a new national prevalence survey of child and adolescent mental health;

••implementing the Child and Adolescent Mental Health Services Minimum Dataset, which will include the new CYP IAPT dataset;

••continuing to focus on case management for inpatient services for children and young people, building on the response to NHS England's Child and Adolescent Mental Health Services (CAMHS) Tier 4 Report;4

••testing clear access routes between schools and specialist services for mental health by extending the recently established co-commissioning pilots to more areas;

••improving children's access to timely support from the right service through developing a joint training programme to support lead contacts in mental health services and schools. This will be commissioned by NHS England and the

4 CAMHS Tier 4 Report Steering Group (2014). *CAMHS Tier 4 Report*. London: NHS England.
Department for Education and tested in 15 areas in 2015/16. DfE will also support work to develop approaches in children's services to improve mental health support for vulnerable children;

••improving public awareness and understanding of children's mental health issues, through continuing the existing anti-stigma campaign led by Time to Change and approaches piloted in 2014/15 to promote a broader national conversation;

••encouraging schools to continue to develop whole school approaches to promoting mental health and wellbeing through a new counselling strategy for schools, alongside the Department for Education's other work on character and resilience and PSHE.

1.19 In the medium to longer term, the Taskforce would like a future government to consider formalising at least some parts of this national ambition to ensure consistency of practice across the country. This would also give a more precise meaning to what is meant by the existing statutory duties in respect of parity of esteem between physical and mental health, as they apply to children and young people.

FACT SHEET

healthwatch
Rutland

Furthering Conversations on Young People's Mental Health Experiences

On 12 March 2015 Healthwatch Rutland shared the results from their survey. This was the second phase of research committed to exploring young people's mental health experiences in Rutland. The survey was designed and administered by a group of volunteers, developed from listening booths with young people and discussions with various stakeholders (including the Youth Council of Rutland and schools). University of Leicester academics have given consultation and advice on the analysis and a review of the survey.

Who participated in the study?

965 young people attending 3 schools and colleges in Rutland, in Year 9 (26%), Year 10 (28%), Year 11 (21%) and Year 12&13 (25%) completed the survey. The survey was confidential, young people were fully informed about the survey purpose and guaranteed anonymity.

Should mental health be on the school curriculum?

7 out of 10 young people (69%) say that mental health should be on the curriculum. Young people who have received help and benefited from help when they feel under pressure are statistically more likely to say that mental health should be on the curriculum. Young people who received help from family and friends, professional health services and school services are more committed to the idea of mental health being on the school curriculum.

What are young people's reported experiences?

Academic pressure is experienced as the main issue that young people need help coping with.

  ➢ Almost half of young people (46%) taking part in the survey said that in the last 2 years they had reached a stage where they needed help coping with academic pressure.

  ➢ Over a quarter of young people (27%) said that they needed help coping with Illness (themselves or someone close).

  ➢ Almost a fifth of young people (19%) taking part in the survey said that in the last 2 years they had reached a stage where they needed help coping with Bullying.

  ➢ Significantly almost 1 in 10 young people (9%) said that they needed help coping with Social Media (bullying).

  ➢ Just over 1 in 5 young people (21%) said that they needed help coping with Loneliness.

Who would young people prefer to go to for help?

Young people rank family and friends as their most preferred source of help. School based resources and particularly teachers are their secondary preference.

Who have young people asked to help?

Young people most often have asked family, friends and teachers for help when they feel under pressure, and they report finding this help useful. The survey suggests that young people might not necessarily be aware of the professional help that is available, or that there is not enough professional help that is easily accessible when they feel under pressure.

  ➢ Just over half (52%) of young people had asked a family member for help because they felt under pressure. Almost 9 out of 10 of these (88%) felt this help was useful. Almost a quarter of young people (24%) had asked a teacher for help. Over 8 out of 10 of these (82%) felt this help was useful.

> Relatively smaller numbers of young people turn to professional health care services for help. When they do the help given is generally considered useful.

12% (117 students) had asked a counsellor for help. 7 out of 10 said this help was useful (70%). 5% of young people (50 students) had asked for help from a psychologist or psychiatrist and around two thirds (66%) said this help was useful.

6% of young people (59 students) had asked a school nurse for help and just under half (47%) said this was useful.

5% of young people (47 students) had gone to A&E for help and around two thirds (66%) said this help was useful.

8% of young people (74 students) had asked a GP for help, and three quarters (76%) said this help was useful.

4% of students (36 students) had used a Helpline, and around two thirds (69%) said this help was useful.

Do young people *consider* using drugs, alcohol, eating and self-harm to relieve pressure?

Young people who report that they have reached the stage where they felt they needed help coping are statistically more likely to report that they have considered drugs, alcohol, eating and/or self-harm to relieve pressure than those who have not reached a stage where they felt they needed help coping.

> Of those young people reporting that to relieve pressure they have considered Taking drugs, Drinking alcohol, Eating (too much or too little) or Self-harm (n=410) 55% said they had considered the risks, 38% said they had not considered the risks and 7% did not answer the question.

> Over a third of young people (35%) said that they had considered Eating too much or too little to relieve pressure in the last two years. 153 young people in our sample (16%) said that they had considered Self-harming to relieve pressure in the last two years. 122 young people in our sample (13%) said that they had considered drug use to relieve pressure.

For further information contact: Dr Ann Williams, Healthwatch Rutland

APPENDIX C
Rutland Young People's Mental Health and Emotional Well-Being Task & Finish Group

Terms of reference 26/06/15
Purpose of the task and finish group:

- To create a project plan that will address three overarching objectives:
    - To improve access to early mental health and emotional well-being support for young people in Rutland
    - To support and build capacity amongst front line practitioners working with young people; with a particular focus, in the first instance, on those working within education settings.
    - To support and build parental resilience.
- Oversight and input into the framework to be used during the pilot.
- Review progress of the pilot and provide an evaluation report including recommendations for future work based on the learning generated.

Membership:

The Task and Finish Group will be chaired by Rutland County Council's (RCC) Early Intervention Health and Wellbeing Development Officer. The membership shall comprise of representatives with the skills and understanding of young people's mental health and emotional needs as well as the knowledge of the services available to address these. Partners on the Task and Finish Group should ensure that their representative has a clear remit and accountability to address issues raised and respond to actions identified.
Membership to include:

- Health & Wellbeing Development Officer (RCC)
- Two Young People's representatives
- A parent representative
- A member of Healthwatch
- Inclusion Development Worker - Mental Health
- Children's Community Liaison Nurse
- Director of sixth form – Rutland County College or Student Manager
- Principal Educational Psychologist

Governance and reporting
Rutland's Health & Wellbeing Board.
Families Support - Early Intervention Head of Service RCC

Meetings:

- 2-3 initial meetings of the task group held at Rutland County College with actions being worked on between meetings.
- Subsequent bi-monthly progress meetings for the duration of the pilot to capture and reflect on progress to inform the final evaluation report.
- Chair - Health & Wellbeing Development Officer

Deliverables:

- A project plan with clear outcomes, actions and timescales and leads identified to take to the Health and Wellbeing Board July 2015.

- A pilot project implementation plan that identifies a programme for the pilot schools and identifies who will deliver the project, when and any resources needed. September 2015
- A proposed training and development plan for those working with young people in schools or other community settings.
- An evaluation report including recommendations for future work.
- This Task and Finish group will operate for no more than 2-3 months to full implementation of the pilot project at which point bi-monthly progress meetings will take place for the duration of the Pilot. The pilot project is expected to last approximately 6 months.

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REPORT NO: 133/2015

<u>Report to Rutland Health and Wellbeing Board</u>

Subject:	Joint Strategic Needs Assessment
Meeting Date:	23rd July 2015
Report Author:	Karen Kibblewhite, Head of Commissioning
Presented by:	Karen Kibblewhite, Head of Commissioning
Paper for:	i) Comment on the JSNA Overview
	ii) Comment on and agreement of the detailed chapter subjects and the timescales for completing them.

Context, including links to strategic objectives and/or strategic plans:

Strategic Objectives

- Meeting the health and wellbeing needs of the community

Background

Rutland's last Joint Strategic Needs Assessment was completed in mid-2012 and the data contained therein is now largely out of date. We also need to develop a clear strategy for commissioning in Rutland, which is contingent on having an up-to-date understanding of what the population's needs are.

JSNAs should be designed to be a user friendly document, which encompass a wide range of indicators to inform need. They are a means of capturing the key data in one place and designed to elucidate levels of need across communities – they are not designed to provide solutions to needs levels.

Approach

As agreed by the Health & Wellbeing Board in February 2015, we are creating a JSNA format which is stored as a series of online data and documents, and which can be refreshed as new data becomes available. This approach was agreed by the Health & Wellbeing Board in February 2015 and will enable us to make clear, evidence based decisions. The overall JSNA will be structured as follows:
a) Overview document
b) Online tableau data
c) Online detailed chapters covering specific themes

Overview - The Overview document is a concise report of the key headlines from this online data, with explanatory narrative. This will create a user-friendly document that then directs people to the more detailed data available on any given area in the tableau. It will provide the evidence base upon which the Commissioning Strategy will be developed. The draft Overview report is attached for comments.

Online Tableau Data - The Public Health Team have put together an online 'tableau' for data, which will allow any partner to access the most recent data available across a range of Public Health, Adult Social Care, Children's and other local indicators. This data will be refreshed on an ongoing and periodic basis as new data becomes available.

Detailed Chapters - The key issues identified within the Overview document will form the basis each drill-down detailed chapter. The detailed chapters will be developed so that they can be used as stand-alone documents as well as part of the JSNA. They will use nationally comparable data, local datasets, and key stakeholder consultation to inform recommendations about needs and future provision. The themes for the chapters will be approved by the Health & Wellbeing Board and timetabled to be undertaken over a period of two years.

Consultation

A working draft of the JSNA Overview was shared with internal stakeholders and CCG colleagues for comments in June. Following the initial comments, a further draft has been shared with wider stakeholders. The deadline for these comments was 21st July.

A draft was also presented at People (Adults & Health) Scrutiny on 9th July for comments and feedback.

Financial implications:
The JSNA will inform future commissioning of services by ensuring that services are targeted to meet our identified needs. By identifying our priority areas, it should enable the Council and other partners to make best use of their resources. The costs of undertaking the JSNA itself are within existing workloads and resources .

Recommendations:

That the HWB:
 	
  1. Comment on the JSNA Overview.
 	
  2. Comment on and agree the detailed chapter subjects and the timescales for completing them.

Comments from DMT/SMT:
DMT approved the document. SMT approved the document with some additions.

Strategic Lead:	Karen Kibblewhite	
Does the report need to go to informal cabinet?		Y

Key decision:	N	**Has portfolio holder been briefed?**	Y

Risk assessment:

Time	M	The timetable proposed is viable. The requirement to have something in place is key to ensuring there is a basis for our commissioning moving forward.
Viability	L	This is reliant on capacity within the Public Health Intelligence Team and at RCC. This will be mitigated by the timetabling of the detailed chapters.
Finance	L	There are no additional financial implications of undertaking the JSNA itself – the work is within existing resources and workload.

Profile	M	The JSNA is a key document which drives the Health and Wellbeing Board's work.
Equality & Diversity	L	An Equality Impact Assessment (EIA) screening has been completed. A full Equality Impact Assessment (EqIA) has not been completed because the JSNA cover a range of different groups in Rutland, including those with protected characteristics, and the impact of this needs assessment will be better targeting of services to those who need them most. As individual chapters are completed they will be subject to an EIA screening.

Proposed JSNA Chapters

It should be noted that the JSNA is an iterative document and will be added to as more data becomes available. It is therefore suggested that whilst an initial timetable for the chapters is agreed, that this is reviewed periodically to ensure that any emerging issues can be added and priorities be brought forward.

It is envisaged that three to four months will be needed per chapter for data collection, analysis and drafting depending on the scope of each, prior to consultation and sign-off. Where work has already started or is aligned to other workstreams, there may be some overlap.

Chapter	Timescale
Children and Young People's Mental Health	Started May 2015
Substance Misuse	Started June 2015 (aligned with re-procurement of services)
Sexual Health	Started July 2015
Learning Disabilities	Started July 2015 (part of BCT workstream – 6 month timescale)
Residential and Domiciliary Care	August 2015 (aligned to re-procurement)
Children's health provision 0-19 years (aligned with the transfer of Health Visiting)	October 2015
Frequent attendees to Primary Care	November 2015
Children's oral health	December 2015
Special Educational Needs and Disability	March 2016 (to follow Learning Disabilities)

REPORT NO: 133/2015

Rutland County Council

MULTUM·IN·PARVO

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Joint Strategic Needs Assessment

Overview 2015

Version 2 – 6th July 2015

CONTENTS

1. What is a JSNA?

The Joint Strategic Needs Assessment (JSNA) is the means by which we assess the current and future health healthcare and wellbeing needs of the local population in Rutland. It is an assessment of local, current and future health and social care needs that could be met by the local authority, the Clinical Commissioning Groups (CCGs), and other partners. It will inform Rutland's Joint Health and Wellbeing Board, which has a duty and responsibility to identify key priorities to improve the Health and Wellbeing for people living in Rutland. The Health and Wellbeing Board produces a Joint Health and Wellbeing Strategy which is based on the needs identified within the JSNA, and agrees priorities on which to focus.

The JSNA includes a range of quantitative and qualitative evidence looking at specific groups, like hard to reach groups, as well as wider issues that affect health such as crime, community safety, education, skills and planning.

The information within the JSNA is essential to establish:

- the needs of the whole community including how needs vary for people at different ages, and may be harder to meet for those in disadvantaged areas or vulnerable groups who experience inequalities, such as people who find it difficult to access services
- the wider social, environmental and economic factors that impact on health and wellbeing - such as access to green space, air quality, housing, community safety, employment.

Rutland's JSNA was last refreshed in 2012.

2. Our Approach

The public health strategy for England, Healthy Lives, Healthy People 2011 proposed that a life course approach is taken for tackling the wider social determinants of health. The life course approach aims to understand and address how experiences in childhood and adolescence influence socio-economic position and the risk of disease later in life.

Over the life course, the health and wellbeing needs and requirements of the population change. Many needs are relevant in just one stage of the life course, whereas others are relevant over many stages. This makes presenting information over the stages of the life course complicated. The data provided here has therefore been divided into overarching areas, as well as focusing on children and young people and adults

In common with many other local authorities, Rutland is moving to an electronic JSNA which can be updated more frequently. The detailed datasets available and the hyperlinks to them are detailed in Appendix 1. This core dataset is based on nationally available data - and therefore provides comparators against regional, national and similar areas. Alongside this summary document providing the overview of key areas, there will be a number of detailed chapters developed. These chapters will be published as they are written and enable key areas to be interrogated in detail, using additional local data and the input of key stakeholders in each area, and will updated as new data becomes available.

This summary document will inform both the areas chosen for detailed chapters, and the Health & Wellbeing Board's refreshed Strategy.

3.   Our Vision

The reason we are here is to serve our children, families, vulnerable adults and communities to the best of our ability. The culture that we will develop is one where we will regularly ask ourselves "Would this be good enough for my child, my parent or me?"

Ultimately the needs assessments we develop will be used to influence our strategy and commissioning decisions, directing the services we deliver to residents both in-house and through external providers. Our aim, underpinning all of this work will be the delivery of quality services that meet our communities' needs in the most effective way and at the right time.

4.   Rutland's Population
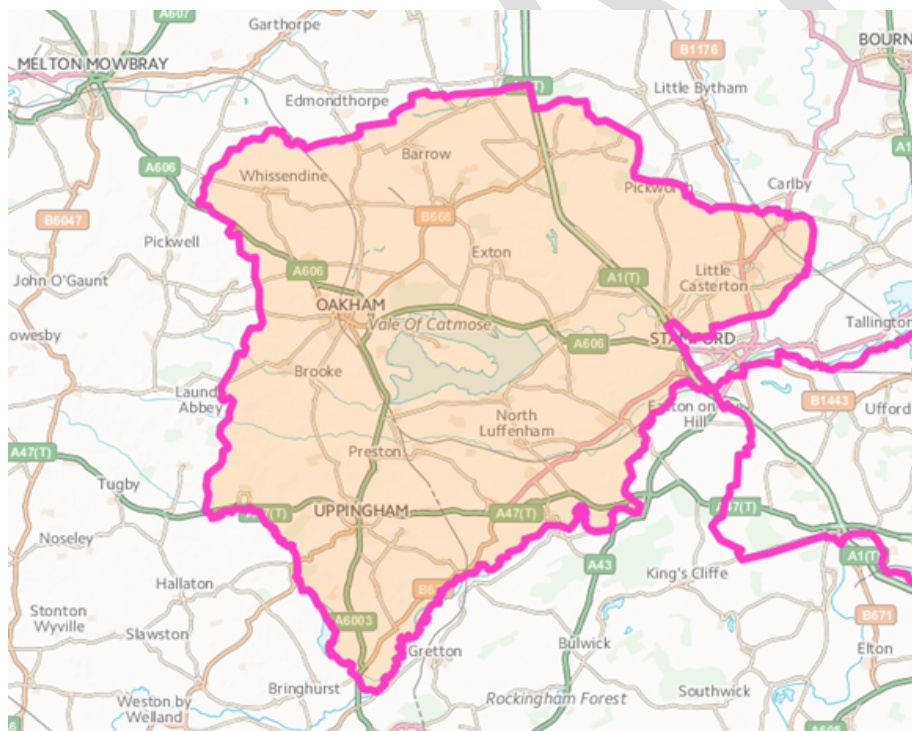
There are 16 wards in Rutland.

There is a total of 15,002 households with an average density of 1.00 persons per hectare; the ward with the highest density is Oakham North East with 24.20 persons per hectare, the lowest density is Braunston and Belton with 0.30 persons per hectare.

4.1 Demographics

The population of Rutland as at the 2013 mid-year estimate was 37,600, comprising 19,200 males and 18,400 females.

The breakdown by age of the population is:
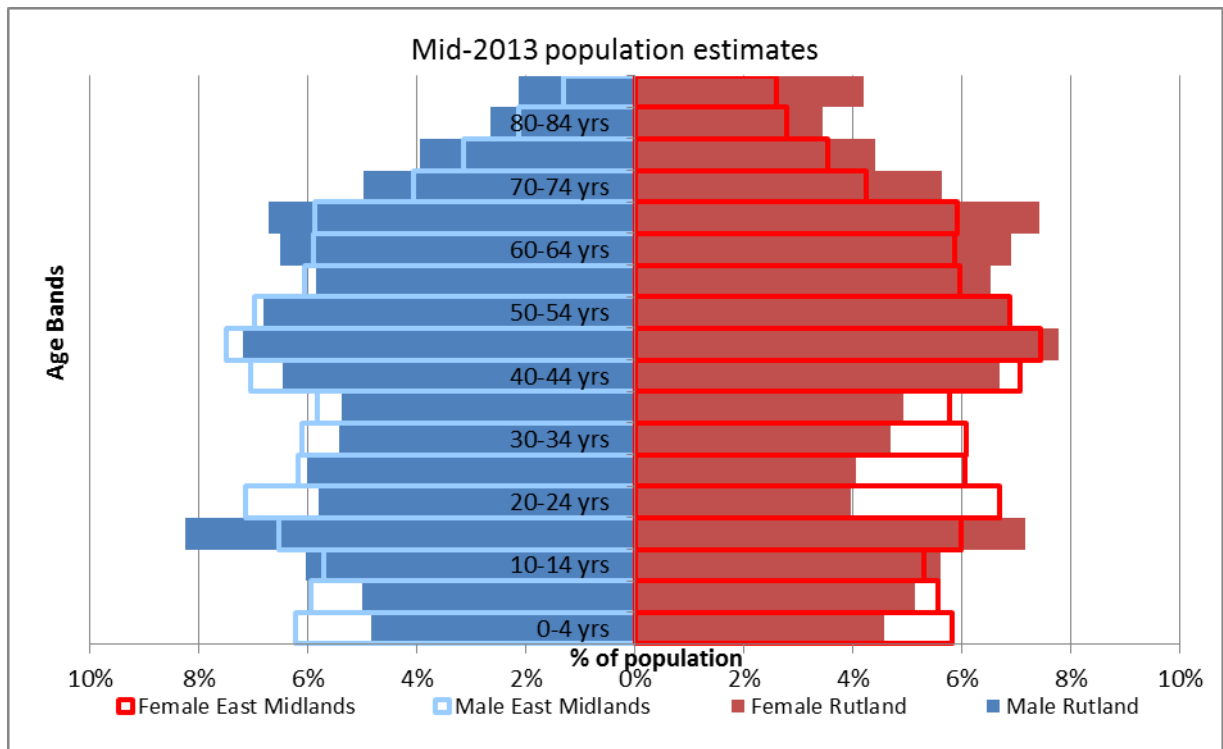
There is a particular spike in the population aged 15 to 19 years, and this is especially pronounced for males. This runs contrary to the regional trend. The next age banding of 20 to 24 years shows a significantly lower population that the previous age group and the regional picture, suggesting that young people are migrating away from Rutland in their twenties. There is an overall widening of the pyramid between the 45-49 year group and the 65-69 year age group – again, for the latter this is contrary to the regional picture. With life expectancy set to increase it is expected that the elderly population is set to increase significantly over the next 20-30 years.

The distribution of males to females is fairly even up to the age of 19, whereafter the number of males compared to females almost doubles for the next ten years to the age of 30, although it remains higher. From 40 onwards, the numbers of men and women becomes more even again, with the proportion of females increasing compared to males with age, reflecting the linger life expectancy of females.

4.1.1 Ethnicity
As at the 2011 Census, the majority of Rutland residents were White British (97%) with the remaining 3 % of the population made up of 1% Mixed/multiple ethnic group; 1% Asian/Asian British; and 1% of Black/African/Caribbean/Black British and other ethnic groups. This compares with a BME population of 10.7 per cent for the East Midlands region and 14.6 per cent for England. The ward with the highest proportion of BME residents is Greetham at 9.0 per cent.

Less than 1% of the population in Rutland report that they cannot speak English well, or at all. This compares with 1.6 per cent for the East Midlands region, and 1.7 per cent for England. The ward with the highest proportion, and number, of households with no adults that have English as a main language is Oakham North East, with 0.20%. This compares with 3.60% for the East Midlands, and 4.40% for England.

4.1.2   Sexual Orientation
There are no specific statistics relating to the sexual orientation of the Rutland population. 1.6% of adults in the UK identified themselves as gay, lesbian or bisexual in 2013. This comprised of: 1.2% of adults who identified as gay or lesbian; and 0.5% of adults who identified as bisexual [25] If this rate is applied to the population of Rutland, it means that there were approximately 520 people in the county who identified themselves as gay, lesbian or bisexual in 2013. This may be slightly in the high side, as the rate for the region as a whole for 2013 was 1.4%.

4.2   Deprivation

Out of 149 Upper Tier Local Authorities in 2010, Rutland ranked 148 (with 1 being the most deprived, and 149 being the least deprived) (Indices of Deprivation: 2010 by County Council). In the last three years of Health Profiles released by Public Health England (2013-15), Rutland has ranked first in the 10 best performing local authority districts for deprivation.

4.2.1   Housing
Affordability and access to housing is a major issue for Rutland. The lower quartile house price (where a quarter of houses are below that price) in Rutland was £150,000 in Q2 of 2013 (CLG Table 583 at 10/6/15). This was the joint third highest figure in the East Midlands and 20% higher than the England figure.

In 2013/14 in Rutland, 27 people were accepted as in housing need, a rate of 1.8 per 1000 compared to the England average of 2.32 per 1000.[20]

Radon
Rutland is an area of high radon, a naturally occurring radioactive gas, which can lead to increased risk of lung cancer with prolonged exposure. The risk is also higher for those who smoke.

4.2.2   Unemployment & Wages
Unemployment rates in Rutland are extremely low in comparison to both regional and national averages.

Data for 2014 indicates that 17,200 people in Rutland are economically active and of these 16,600 (79.7% of the population) were employed. In May 2015, 126 people were claiming Job Seekers Allowance, 0.6% of the working age population compared to 1.7% for the East Midlands and 1.8% for Great Britain as a whole. Of these, 100 had been claiming for up to 12 months, and the remaining 25 for a period of over 12 months. A further 1,150 people were of working age and claiming key benefits as at November 2014.

The average gross weekly pay for males, and females, in Rutland is slightly above the regional average, but falls short of the national average by 5% for males, and 9.4% for females. The wage difference between males and females is 4% wider than the national average.

4.2.3   Fuel Poverty
In 2012 the number of households in fuel poverty in England was estimated to be 2.28

million, which represents approximately 10.4 per cent of all households. This was a fall on the numbers published for the previous year which estimated 2.39 million households to be in fuel poverty. Almost 10,000 Winter Fuel Payments were made to the elderly over the winter of 2012/13 in Rutland, a figure of around £2.2 million.   This can be expected to rise to £3.7 million by 2030 given the projected population increases (not taking into account inflation over the next 15 years).

In 2012, the percentage of households in Rutland experiencing fuel poverty was 11.9%. This is better than the East Midlands percentage of 13.2%, but worse than the England value of 10.4%.[20]

4.3   Births

In 2013 there were 339 live births in Rutland, this is a general fertility rate of 9.0 births per 1,000 women aged 15-44 years. This is lower than the England average (12.3 per 1,000 women).[4]

4.4   Life expectancy

The average life expectancy of Rutland residents, particularly female residents, places Rutland within the top 10% of all Upper Tier Local Authorities nationally – with men expected to live 2 years longer on average, and women expected to live 1.7 years longer to 81 and 84.7 years respectively. Residents can also expect to spend a greater proportion of their lives in good health than compared to the national average: for men, this is an average of 2 years longer at 65.8 years compared to a national average of 63.4 years; and for women, an average of 6 years longer in good health, 70.3 years compared to 64.1 years nationally. The Local Authority Health Profiles indicate that in 2015, Rutland had the fifth highest healthy life expectancy for females of all Local Authority District areas.

There are variations in life expectancy within the county: Oakham North West has the lowest life expectancy at birth for males at 76.0 years and Uppingham has the highest life expectancy at birth for males at 82.4 years. Ryhall and Casterton has the lowest life expectancy at birth for females at 80.0 years and Oakham South East has the highest life expectancy at birth for females at 96.8 years.

4.4.1   Premature Mortality

There were 324 deaths in Rutland in 2013; 172 (53%) males and 152 females. In 2010-12 in Rutland the all age, all cause mortality rate was 861.7 per 100,000 population (n = 1069 deaths). This is significantly lower than the England average value of 988.3 per 100,000 population [5].

Premature deaths from cardiovascular disease in Rutland were - at 45 per 100,000 population - at a similar rate to the England average of 33.2 per 100,000 population for 2011-13. Cardiovascular disease includes heart disease and stroke. However, the rate is significantly better for premature deaths from cancer: a rate of 119.3 per 100,000 population compared to the England average rate of 144.4 per 100,000 population (n = 131). There is no data for mortality by respiratory or liver disease due to the low numbers.

5. The Best Start in Life

In 2013 there were an estimated 8,773 children and young people under the age of 20 in Rutland.[4]

In 2012, 4.2% of all babies in Rutland had a low birth weight . This is significantly better than the England average value of 7.3%.[8]

The conception rate for females aged under 18 was similar in 2012 to the England average at 18.8 per 1,000 population. [11]

In 2012, the conception rate for females aged 13-15 was 6.4 per 1,000 population (43 conceptions). This is similar to the England average value of 5.6 per 1,000 population. Caution should be exercised when using this figure however, as it is the value for Leicester and Rutland combined. [11] Data for the termination of teenage pregnancies is suppressed due to low numbers.

The Local Authority Health Profiles show Rutland as performing best out of all Local authority district areas for teenage pregnancy (under 18s) in 2013, and sixth in the top 10 best performing in 2015.

5.1 Children in poverty

The proportion of children under 16 years old living in poverty in Rutland in 2011 was 8.4%, decreasing to 8% of young people under 20 years. This is significantly better than the England average values of 20.6% and 20.1% respectively, and reflective of the deprivation levels in the county more generally. [6]

The Local Authority Health Profiles indicate that Rutland was ranked 7th of the best performing 10 local authority districts for child poverty in 2013, but didn't rank within the top ten during 2014 or 2015. It is unclear whether this is due to Rutland's performance declining, or other local authority areas improving at a greater rate.

5.2 Infant mortality

The infant mortality rate (deaths under 1 year) for the county was 3.0 per 1,000 live births between 2010 and 2012. In this time period, there were 3 infant deaths, averaging approximately 1 death per year. [6] The rate of infant mortality has been inconsistent over the past fifteen years, from a rate of 5.4 per 100 in 2000-02 (similar to the England rate of 5.3 per 1000), and at a peak in 2004-06 of 5.5 per 1000 and a low of 1.9 per 1000 in 2007-09; however with such low numbers, a small change will impact more greatly on the overall rate.

5.3 Smoking in pregnancy

The proportion of mothers smoking at the time of delivery was 8.4% in 2012. This is significantly better than the England average value of 12.0%.[6]

5.4 Breastfeeding

In 2013/14, the proportion of mothers initiating breastfeeding was 81.1%. This is significantly

better than both the East Midlands rate of 71.9% and the England rate of 73.9%. [6] The proportion of those continuing to breastfeed at 6-8 weeks remained good, with 56.5% of mothers' breastfeeding.

5.5   Immunisations and Vaccinations – *to be inserted when data is available.*

5.6   Healthy weight in children

Data for 2012/13 indicates that the number of children in Reception classified as overweight or obese was 23.0%, and as underweight was 0.9%, both similar to the England averages of 22.2% and 0.9% respectively. By Year 6 (age 10-11 years), those classed as underweight remains in line with England values, but those classified as overweight was significantly better at 24.1% compared to 33.3%[12]

5.7   Tooth decay

In 2011/12, the average number of teeth per aged 5 child sampled in Rutland which were either decayed or had been filled or extracted was 1.1. This is similar to the England average value of 0.9 per child.[6] The proportion of children aged 5 with one or more decayed, missing or filled teeth was 40.3%, significantly higher than the East Midlands rate of 29.8% and the England rate of 27.9%. Therefore although the level of decay was comparable to the England average, the number of children experiencing that level of decay was much higher. [9]

5.8   Unintentional and deliberate injuries

The rate of hospital admissions for children aged 0-4 years was 73.5 per 10,000 population in 2013/14, this is significantly better than the England rate of 140.8 per 10,000. Similarly for children aged up to 14 years the rate remains well above the England average at 78.4 per 10,000 compared to 112.2, and second best in comparison to statistical neighbours. For young people aged 15 to 24, the rate for Rutland is similar to the England average at 118 compared to 136.7.

5.9   Education

Data for 2012/13 indicates that the percentage of children achieving a good level of development at the end of reception was 57.3%. This is significantly better than the England average value of 52.3%. The percentage of children achieving the expected level in the Year 1 phonics screening check was 71.8%. This is similar to the England average value of 67.1% [6] The number of pupils aged 14-16 achieving 5A*-C in GCSE examinations was 318 (67.2%). This is significantly better than the England average value of 60.8%.[11]

The number of half days missed in primary schools in 2012/13 was 32,751 (4.0%). This is significantly better than the England average value of 4.7%. The number of half days missed in secondary schools was 41,076 (4.7%), again significantly better than the England average value of 5.9%.[10]

In Rutland, in 2013, the number of 16-18 years olds not in education, employment or training was 20 (1.8%). This is significantly better than the England average value of 5.3%, and puts Rutland first in comparison with statistical neighbours. [6]

5.9.1   Children with special educational needs
In Rutland, in 2014, the number of school age pupils with a special educational need (SEN) was 918 (12.1%). This is significantly lower than the England average value of 17.9%. Of

these, 5.0% were classified on school action compared to the England average value of 8.7% and 3.6% were classified on school action plus compared to the England average value of 5.6%.[10]

However, the proportion of school-children with a SEN statement was 3.3%, significantly higher than the England average value of 2.8%.[10]

Overall the proportion of school pupils in Rutland with behavioural, emotional and social support needs, with speech, language and communication needs, or with autism spectrum disorder is significantly lower than the England average values at 1.1%, 0.9% and 0.4% respectively, compared to 1.7%, 1.7% and 0.9% respectively.

5.10   Children at risk of poor health

The risk factors associated with poor health for children are lower in Rutland compared to England averages: the number of children under 16 living in poverty in 2011 was 500 (8.4%). The total number of dependents under 20 living in poverty that year was 565 (8.0%). Both were significantly better than the England average value of 20.6% and 20.1%.[6]

Nineteen applicant households with dependent children or pregnant woman were accepted as unintentionally homeless and eligible for assistance in 2012/13. This equates to a rate of 1.3 per 1,000 households. This is similar to the England average value of 1.7 per 1,000 population.[10]

The number of lone parent households as at the 2011 Census was 714 (4.8%); the number of households with dependent children with one person with a long term health problem or disability was 456 (3.0%); and the number of households with dependent children with no adults in employment was 235 (1.6%); all of which were significantly better than the England average values of 7.1%, 4.6% and 4.2% respectively. [10]

In 2013, there were 11 young people from Rutland aged 10-18 years who entered the youth justice system. This equates to a rate of 241.1 per 100,000 population. This is similar to the England average value of 440.9 per 100,000 population.[10]

In 2012, the estimated number of children aged under 17 who required Tier 3 CAMHS was 145. [10]

5.11   Hospital admissions and mortality

Rates of hospital admissions in 2012/13 were similar or significantly better than England average values:

- for children aged 0-14 years for unintentional and deliberate injuries: 79.6 per 10,000 population (7,574 admissions) similar to the England average value of 103.4 per 100,000 population [6];
- for young people aged 15-24 years for unintentional and deliberate injuries was 94.4 per 10,000 population (43 admissions) significantly better than the England average value of 130.7 per 10,000 population.[6]
- for asthma for children aged under 19 years was 94.6 per 10,000 population (8 admissions) significantly better than the England average value of 221.4 per 100,000 population.[9]

The rate of children killed or seriously injured in road traffic accidents was 15.1 per 100,000 population (3 children) for 2010-12, this is similar to the East Midlands average of 20.5 per 100,000 and the England average value of 20.7 per 100,000 population.[9]

In 2010-12 the mortality rate for children aged 1-17 years was 12.7 per 100,000 population (3 children). This is similar to the England average value of 12.5 per 100,000 population.[9]

5.12 Children in need

In 2012/13, 372 children in need referrals were made in Rutland; this equates to a rate of 452.8 per 10,000 population. This is significantly better than the England average value of 520.7 per 10,000 population.[10] The proportion of these referrals with a completed initial assessment was 70.4% - similar to the England average of 74.4%, although there are some concerns over data quality issues with this indicator.

During the same period, a total of 454 children under the age of 18 in Rutland were classified as children in need and of these cases, 245 were new. This equates to a rate of 552.6 per 10,000 population. This is significantly better than the England average value of 645.8 per 10,000 population.[10] The proportion of children in need due to abuse, neglect or family dysfunction was 45.6%, and again, this is significantly better than the England average value of 65.3%.

The proportion of children in need for over two years for the same year of 2012/13 was 31.3%. This is similar to the England average value of 34.2%.

5.13 Looked after children

In 2012/13, 30 children under the age of 18 were classified as looked after in Rutland, which equates to a rate of 38.0 per 10,000 population compared to the England average value of 60.0 per 10,000 population.[10] In addition, the rate of those looked after in foster placements was 100%, again significantly better than the England average of 74.7%.

In 2013, 12 (81.0%) of eligible looked after school aged children had an emotional and behavioural health assessment. This is similar to the England average value of 71.0%. All looked after children under the age of 5 had up-to-date development assessments, and 75% had an annual health assessment. [10]

However, the rate of children leaving care during this period was 12.8 per 10,000 population, significantly worse than the England average value of 24.9 per 10,000 population.[10] It is worth noting that this rate may be skewed by the very low numbers in Rutland however.

5.14 Safeguarding of children

Thirty-five children were subject of a child protection plan in Rutland in 2012/13. This equates to a rate of 42.6 per 10,000 population. This is similar to the England average value of 37.9 per 10,000 population.[10] The spend on safeguarding children and young people's services was a rate of £1,364,978 per 10,000 population. [10]

6.   Staying Healthy

The 2011 Census collected data on people's self-reported health and activity, for Rutland:

-   18,828 people reported that they were in very good health (50.4%); 12,718 reported that they were in good health (34.0%); 4,532 reported that they were in fair health (12.1%); 1,008.0 reported that they were in bad health (2.7%); and 283 reported that they were in very bad health (0.8%). [4]

-   2,194 people in Rutland reported that their daily activities were limited a lot by a long term condition or disability (7.2%) and 3,418 reported that their daily activities were limited a little by a long term condition or disability (11.1%).[7]

6.1   Tobacco

The overall smoking prevalence for adults in 2013 was 22.3%, similar to the England average of 18.4%. However, the prevalence for adults in the 'routine and manual' cohort was 47.5%, significantly worse than the England average value of 28.6%, and putting Rutland eleventh in comparison to its statistical neighbours – the best performing local authority being Central Bedfordshire at 22.4.[13]

In 2013/14, the rate of successful quitters who were CO validated at 4 weeks was 6,949.7 per 100,000 population (282 quitters). This is significantly better than the England average value of 2,471.9 per 100,000 population.[13]

Despite this high level of smoking, during 2009-11, the rate of lung cancer registrations was 42.1 per 100,000 population (n = 50), significantly better than the England average value of 75.5 per 100,000 population [13] and during the following two years - 2011-13 - the rate of deaths from lung cancer was also significantly better at 32.3 per 100,000 population (n = 40) compared to 60.2 per 100,000 population.[13] The rate of oral cancer registrations during 2009-11 was 6.7 per 100,000 population (n = 8). This is similar to the England average value of 12.8 per 100,000 population.[13]

During 2011 - 13, the rate of deaths attributable to smoking was 197.2 per 100,000 population (148 deaths). The rate of deaths from chronic obstructive pulmonary disease (COPD) was 29.0 per 100,000 population (37 deaths). This is significantly better than the England average value of 51.5 per 100,000 population.[13] This is significantly better than the England average value of 288.7 per 100,000 population.[13] The rate of smoking attributable deaths from heart disease was 31.9 per 100,000 population (24 deaths). This is similar to the England average value of 32.7 per 100,000 population.[13] The rate of smoking attributable deaths from stroke was 10.4 per 100,000 population (8 deaths). This is similar to the England average value of 11.0 per 100,000 population.[13]

6.2   Obesity

In 2013/14, GP recorded obesity in the over 16s was – at 9.9% – similar to the England rate of 9.4%, and better than the regional rate of 10.4%. In 2013, the number of adults achieving the recommended 150 minutes of physical activity per week was 314 (65.9%). This is significantly better than the England average value of 56.0%, and the best performance compared with statistical neighbours.[6] Conversely, those achieving less than 30 minutes of

physical activity per week was only 126 (19.7%). Again, significantly better than the England average value of 28.3%. [6]

6.3   Long-term Conditions

In Rutland, in 2013/14, the number of adults aged between 40 and 74 who were offered an NHS Health Check was 2,463 (20.5%). This is significantly better than the England average value of 18.4% [6]. Of those offered an NHS Health Check, the number receiving the Health Check was 1,684 (68.4%), also significantly better than the England average value of 49.0%.[6]

The number of adults diagnosed with diabetes in 2013/14 was 1,967 (6.8%). This is worse than the England value of 6.2% and the East Midlands value of 6.6%.[15]

The number of people diagnosed with coronary heart disease in 2013/14 was 1,337 (3.7%). This is significantly lower than the England average value of 3.3%.[15]

Rutland has the lowest gap in the employment rate between those with a long-term condition and the overall employment rate in comparison with statistical neighbours, with a rate of -5.3.

6.4   Substance Misuse

In 2011/12 in Rutland the rate of adults in alcohol treatment was 1.9 per 1,000 population. (50 adults). This is significantly lower than the East Midlands average value of 2.7 per 1,000 population.[17] In 2011-12 in Rutland the rate of alcohol-related admissions to hospital was 485.8 per 100,000 population (182 adults). This is significantly lower than the East Midlands average value of 645.7 per 100,000 population.[17]

For 2010-12, the alcohol specific mortality rate for males in Rutland was 5.3 per 100,000. This is similar to the England average value of 1.1 per 100,000 population.[18]

The rates of adults and of young people in structured drug treatment are lower or similar than the East Midlands average. There were no recorded parents in treatment as at September 2014, although this may be due to unrecorded data or to a genuine lack of parental substance misuse. [17]

The Local Authority Health profiles show Rutland as ranking fifth best performing local authority district area for drug misuse overall in 2015.

6.5   Avoidable injury

The rates of those killed or seriously injured on the roads between 2011 and 2013 was 52.2 per 100,000 population (n = 58 people), similar to the England average [6].

The rate of hospital admissions for self-harm for 2011/12 was significantly better than the England average at 133.8 per 100,000 population (n = 47) compared to 188.0 per 100,000 population.[19]

For the same period the rate of mortality from causes considered amenable to healthcare was 64.3 per 100,000 population, similar to the England average of 86.8 per 100,000 population.[19]

6.6 Workplace health

The data available indicates that the impact of ill health on working during 2010-12, were similar to the England average values for both proportion of workers who had one or more days off sick, and rate of working days lost due to ill health [6]

6.7 Sexual health

In 2013, the rate of GP prescribed Long Acting Reversible Contraceptives (LARC) for Rutland was 76.1 per 1,000 population (n = 440 people). This is significantly better than the England average value of 52.7 per 1,000 population [11].

In 2013, the rate of abortions was 9.0 per 1,000 population (n = 53). This is significantly better than the England average value of 16.6 per 1,000 population.[11] Of those, 76.0% of abortions were performed under 10 weeks gestation, similar to the England average value of 79.4%.[11]

6.7.1 HIV
In 2013 in Rutland, the HIV diagnosed prevalence rate was 0.7 per 1,000 population (15 people). This is significantly better than the England average value of 2.1 per 1,000 population.[11]

6.7.2 Sexually Transmitted Infections
In 2013, the diagnosis rates for genital herpes was 37.8 per 100,000 population and genital warts was 140.5 per 100,000 population both are similar to the England rates of 58.8 per 100,000 population and 133.4 per 100,000 population.[11] In 2013 in Rutland, the diagnosis rate for gonorrhoea was 18.9 per 100,000 population. This is significantly better than the England average value of 52.9 per 100,000 population.[11]

In 2013, the detection and treatment rate for chlamydia for males aged 15-24 years was 952 per 100,000 population, compared to the England average of 609.7 per 100,000 population.[6] For females the same age, the detection and treatment rate was 2659 per 100,000 population compared to the England average of 1997.4 per 100,000. The overall rate for Rutland being worse than England and East Midlands' averages at 1713 per 100,000 population in comparison to 2016 and 2171 respectively.

7.   Ageing Well

In the 2011 Census, 2,194 people reported that their daily activities were limited a lot by a long term condition or disability (7.2%) and 3,418 reported that their daily activities were limited a little by a long term condition or disability (11.1%).[7]

In 2010, 8.8% of people aged 60 years and over were classed as living in income-deprived households. This is significantly better than the England average value of 18.1%.[20] In 2011/12, 97.6% of people aged 65 years and over were receiving winter fuel payments. This is significantly better than the England average value of 64.1%.[20]

7.1   Flu Vaccinations

In 2012/13, the percentage of people aged 65 years and over that were vaccinated against flu was 72.7%. This value is estimated from the former Primary Care Trust covering the county. This is significantly worse than the England average value of 73.4%.[6]

7.2   Winter Deaths

Between August 2011 and July 2012 , there were 8 excess winter deaths for people aged 85 and over. This gives an excess winter deaths index of 12.6. This is similar to the England average value of 22.9.[6]

In Rutland, in Aug 2008 - Jul 2011, the excess winter deaths index was 25.0. This is significantly better than the England average value of 64.1.[20]

Rutland was the second best performing local authority district for excess winter deaths in the 2015 Local Authority Health Profiles.

8. Social care

8.1 Enhancing quality of life for people

The social care-related quality of life score for the county in 2013/14 was 18.9 out of 24, this measure is calculated using a combination of responses to the Adult Social Care Survey, which asks how satisfied or dissatisfied users are with indicators of quality of life, such as personal cleanliness and safety. Rutland's score is in line with the England average and with the regional East Midlands' score. [20]

In 2013/14, the proportion of people aged over 18 years who used services who have control over their daily life was 75.1%. This is significantly better than the England average value of 76.1%.[20]

In 2012/13, the proportion of people aged over 18 years who received self-directed support was 68.2%. This is significantly better than the England average value of 56.2%.[20]

The proportion of people aged over 18 years who received direct payments was during the same period was 19.1%, again significantly better than the England average value of 16.8%.[20]

In relation to mental health services, for 2012/13, the proportion of people aged 18-69 years in contact with mental health services who were in settled accommodation was 27.8%, significantly worse than the England average of 58.5%.[20] However, the proportion of people aged 18-69 years in contact with mental health services who were in employment was similar to the England average value of 8.8%, at 9.3%.[20]

The proportion of people supported to manage their long term condition during 2010/11 was 86.9%, significantly better than the England average value of 77.6%.[20] and for the last quarter of that year, the proportion of vulnerable people supported to maintain independent living was - at 98.5% - the same as the England average [20].

The rate of clients receiving direct payments/personal budgets on 31st March 2013 was 325.1 per 100,000 population (n = 95 people). This is similar to the England average value of 274.1 per 100,000 population.[20]

At the same date, the rate of adults receiving community support was 1,403.1 per 100,000 population (n = 410 people). This is significantly lower than the England average value of 1,704.6 per 100,000 population.[20]

During 2012/13 the rates for Rutland were significantly higher than the England averages for:

- adults receiving day care services: 410.7 per 100,000 population (120 people) compared to 335.5 per 100,000.[20]
- adults who received direct payments: 462.0 per 100,000 population. (135 people) compared to 352.0 per 100,000 population.[20]
- adults who received equipment and adaptations: 1,505.8 per 100,000 population (440 people) compared to 887.1 per 100,000 population.[20]
- adults who received home care: 1,368.9 per 100,000 population (400 people) compared to 1,152.7 per 100,000 population.[20]
- adults who received any community based support: 3,268.3 per 100,000 population (955 people) compared to 2,619.8 per 100,000 population.[20]

In comparison, for the same period the rate of adults who received short term residential care (not respite) during the year was 0.0 per 100,000 population (0 people), significantly lower than the England average value of 156.1 per 100,000 population.[20]

8.2   Delaying and reducing the need for care and support

In 2013/14, only 35.8% of adult social care users in Rutland self-reported that they have as much social contact as they would like, compared to 43.1% for East Midlands and 44.5% for England as a whole.

In 2012/13, Rutland's rates of those older adults who were supported throughout the year community and residential care was 9,340.1 per 100,000 population, significantly higher than the England average of 7,858.8 per 100,000 population. However, the rates of those permanently admitted to nursing and residential care homes was 691.4 per 100,000 population, similar to the England average, suggesting more older people remain accessing care in the community rather than through residential means. [20]

The rate of delayed transfers of care for 2012/13 was 13.1 per 100,000 population (4 delays). This is similar to the England average value of 9.4 per 100,000 population. Of these, those attributable to social care was 4.6 per 100,000 population (1 delay), again similar to the England average value of 3.2 per 100,000 population.[20]

The rate of permanent admissions to care homes for adults aged 18 and over, during 2012/13 significantly worse than the England average at 171.1 per 100,000 population (50 admissions) compared to 109.8 per 100,000 population.[20] The rate of permanent admissions into nursing care for adults aged 18 and over for the same period was - at 34.2 per 100,000 population (10 admissions) - similar to the England average of 52.1 per 100,000 population.[20] Given the rates of older people permanently admitted are lower than England averages, we may assume that there were greater numbers of younger adults permanently admitted.

However, the rate of adults aged 18 and over in permanent residential care on 31st March 2013 was similar to the England average: 359.3 per 100,000 population (105 admissions) compared to 376.0 per 100,000 population [20]; and the rate of adults aged 18 and over in residential care during the year was significantly better at 359.3 per 100,000 population (105 admissions) compared to 497.2 per 100,000 population.[20]

The same rates for permanent nursing care were also both significantly better:

- in permanent nursing care on 31st March 2013: 68.4 per 100,000 population (20 admissions) compared to 134.0 per 100,000 population.[20]
- in permanent nursing care during the year: 68.4 per 100,000 population (20 admissions) compared to 206.1 per 100,000 population.[20]

Given the seemingly contradictory nature of this data, further detailed analysis, and of local data, would be helpful.

In 2010/11, the proportion of emergency readmissions within 28 days for people aged 16 and over was 9.1%. This is significantly better than the England average value of 11.4%.[20]

The rate of those aged 65 years and over who were discharged from hospital and were offered reablement services was 2.4% in 2012/13, similar to the England average value of 3.2%.[20]

In addition, the rates for the same period of emergency hospital admissions due to falls for adults aged 65 and over, and emergency hospital admissions due to fractured neck of femur for adults aged 65 and over were similar to the England average values, at 2,099.6 per 100,000 population (n = 182) compared to 1,794.4 per 100,000 population, and 695.4 per 100,000 population (n = 60) compared to 568.1 per 100,000 population respectively.[6]

8.3   Ensuring a positive experience of care and support

The overall satisfaction of people aged 18 and over who used services with their care and support was 71.5% in 2012/13. This is significantly better than the England average value of 64.1%. For the same year, 80.3% of people aged 18 and over who used services and carers found it easy to find information about services [20].

In 2012/13, the rate of referrals of new clients (aged 18 years and over) that were dealt with at point of contact and that resulted in further assessment of need was significantly higher than the England averages at 3,422.3 per 100,000 population (1,000 people) and 2,772.1 per 100,000 population (810 people), compared to 64.1 per 100,000 population for both measures [20].

For the same period, rate of adult carers (aged 18 years and over) receiving assessments was also significantly higher: 667.4 per 100,000 population (195 people), compared to the England average value of 64.1 per 100,000 population.[20]

8.4   Carers

According to the 2011 Census, 2,709 people (all ages) reported that they provided between 1 and 19 hours of unpaid care per week; 346 people reported that they provided between 20 and 49 hours of unpaid care per week; and 661 people reported that they provide over 50 hours of unpaid care per week. This is a total of 3,716 people providing unpaid care, 10.8% of Rutland's population. For young people aged 25 years and under, 164 provided unpaid care of at least 1 hour per week. Of those aged 64 years and over, 928 people reported they provided unpaid care, equating to 14.7% of older people in Rutland. The majority of these (337 people) provided over 50 hours per week.

8.5   Safeguarding vulnerable adults

In 2012/13, the proportion of people aged 18 and over who use services who feel safe was 64.3%, similar to the England average value of 64.1%.[20]. The proportion of people aged 18 and over who use services who say those services have made them feel safe and secure was 78.7%, significantly better than the England average value of 64.1%.[20]

In 2011/12, the rate of injuries due to falls in people aged 65 years and over was 1,834.9 per 100,000 population (161 injuries). This is significantly worse than the England average value of 64.1 per 100,000 population.[20]

9.   Mental Health

In 2013/14, the number of people in Rutland registered with dementia was 266 (0.7%). This is significantly higher than the England average value of 0.6%.[15]

The data in the following sections is from the former Primary Care Trust and therefore covers East Leicestershire and Rutland, unless specifically indicated.

9.1   Prevalence

In 2013, the number of Rutland children aged 5-16 estimated to have a mental health disorder was 440 (8.3%). [10]

Prevalence data from 2012/13 indicates:
- the proportion of people aged 18 and over reporting a long-term mental health problem was 3.6%, significantly lower than the England average value of 4.5%.[21]
- the proportion of people who were diagnosed with a mental health problem was 0.7%, significantly lower than the England average value of 0.8%.[21]
- the proportion of people who were diagnosed with a depression or anxiety was 10.3%, significantly lower than the England average value of 12.0%.[21]

An estimated 145 children in Rutland needed specialist mental health interventions (Child and Adolescent Mental Health Service, CAMHS) in 2013.

9.2   Indicators of need

For 2013/14 Q1, the rate of detentions under the Mental Health Act was 8.3 per 100,000 population, significantly lower than the England average value of 15.5 per 100,000 population [21].

Data for 2012/13 indicates that assessment and support was significantly worse than the England average rates:

-    the rate of carers of mental health clients receiving assessments was 43.2 per 100,000 population compared to 68.5 per 100,000 population.[21]
-    the rate of adults supported throughout the year was 71.5 per 100,000 population compared to 377.6 per 100,000 population.[20]
-    the rate of new social care assessments per year for mental health clients aged 18-64 was 23.8 per 100,000 population compared to 257.4 per 100,000 population.[23]

In 2013/14 Q1, the proportion of patients assigned to a mental health cluster was 78.0%. This is significantly higher than the England average value of 69.0%.[21]

9.3   Mortality and suicide

The latest available suicide data is for 2010-12, this indicates a rate of 9.1 per 100,000 for East Leicestershire & Rutland, which is similar to the England average value of 8.5 per 100,000 population.[21]

In the mortality ratio for excess under 75 mortality in adults with serious mental illness was 373.2 in 2011/12. Again, this is similar to the England average value of 347.2.[23]

9.4   Use of services

In 2013/14 Q1, the rate of people in contact with mental health services was 2,187.7 per 100,000 population. This is similar to the England average value of 2,175.7 per 100,000 population.[21]

For Rutland, in 2012/13, the rate of emergency hospital admissions for intentional self-harm was 133.8 per 100,000 population. This is significantly better than the England average value of 188.0 per 100,000 population.[23]

During 2009/10 - 11/12, the rate of hospital admissions for unipolar depressive disorders was 11.6 per 100,000 population, significantly better than the England average of 32.1 per 100,000 population.[22]

During 2010/11 - 2012/13, there were 45 young people admitted to hospital for self-harm. This equates to a rate of 229.9 per 100,000 population. This is significantly better than the England average value of 352.3 per 100,000 population.[10]

During 2012/13, there were 121 attendances at A&E for a psychiatric disorder. This equates to a rate of 37.9 per 100,000 population. This is significantly lower than the England average value of 243.5 per 100,000 population.[21]

During Q1 2013/14, there were 8,105 bed days for mental health disorders. This equates to a rate of 3,205.3 per 100,000 population. This is significantly lower than the England average value of 4,685.9 per 100,000 population.[21]

As the majority of data for which there is national comparators, is for East Leicestershire & Rutland, further work to explore local data and build a more detailed picture of need would be helpful.

10.   Learning Disabilities

10.1   Children

In 2014, the number of school pupils with a learning disability was 209 (2.8%). This is similar to the England average value of 2.9%.[10]

Data for January 2012, provides a more detailed split:

- the rate of learning disabilities known to schools was 16.0 per 1,000 pupils, significantly lower than the England average of 24.5 per 1,000 pupils.[24]
- 103 children had a moderate learning difficulty (14.4 per 1,000 pupils), significantly lower than the England average of 19.7 per 1,000 pupils.[24]
- 12 children had a severe learning difficulty (1.7 per 1,000 pupils), significantly lower than the England average of 3.7 per 1,000 pupils.[24]
- No children a profound or multiple learning difficulty, significantly lower than the England average of 1.2 per 1,000 pupils.[24]

10.2   Adults

For 2012/13, the number of people aged 18 and over registered with a learning disability was 122 (0.4%), similar to the England average of 0.5%.[20]

The rate of adults (aged 18-64 years) with learning disabilities known to the local authority in 2011/12 was 3.0 per 1,000 population, significantly lower than the England average of 4.3 per 1,000 population.[24]

The number of eligible adults with a learning disability who had a GP health check in 2011/12 was 74 (68.2%). This is significantly better than the England average value of 52.7%.[24]

In 2012/13, the proportion of adults with a learning disability who were in paid employment was at 23.1%, significantly better than the England average of 7.2% and the proportion of adults with a learning disability who lived in settled accommodation was 72.3%, similar to the England average of 73.5%.[20]

The rate of adults with learning disabilities supported throughout the year was 214.5 per 100,000 population for 2012/13, significantly lower than the England average value of 317.6 per 100,000 population.[20]

Rates of adults with learning disabilities using day care services supported by the local authority and receiving community services supported by the local authority were 76.9 per 1,000 population and 615.4 per 1,000 population in 2011/12. This is compares to the England average values of 347.2 per 1,000 population and 749.7 per 1,000 population respectively.[24]

11. Autism

Rutland has much lower rates of autism compared to nationally: with a rate of 3.8 per 1000 children with autism known to schools, compared to an England rate of 9.1 and an East Midlands rate of 8.9 for 2013/14; the equivalent of 0.38% of pupils with an autism spectrum disorder.

Further local data on autism is available and will be included within the relevant detailed chapters.

12. Physical Disabilities

In 2010/11, the rate of people aged 18-64 who were registered blind or partially sighted was 139.5 per 100,000 population (30 adults). This is significantly lower than the England average value of 206.9 per 100,000 population. Of people aged 65-74, the rate was 347.4 per 100,000 population (15 adults), again significantly lower than the England average of 653.5 per 100,000 population. The rate of people aged 75 and over was 3444.5 per 100,000 population (125 adults), again significantly lower than the England average value of 4,774.0 per 100,000 population.[20]

The rate of rate of adults aged 18-64 with physical disabilities supported through the year in 2012/13 was 595.9 per 100,000 population (125 adults). This is significantly higher than the England average value of 451.7 per 100,000 population.[20]

13. Military Population

To be inserted when data is available.

14.   Prison Population

To be inserted when data is available.

15. Caveats re Data

15.1 Indicators with no data

Several indicators for Rutland have no data presented in the Public Health Outcomes Framework. In some cases, where the values for Rutland are estimates based on the Leicestershire and Rutland CCGs (for example, low birth weight of term babies), the Rutland estimate would be swamped by the Leicestershire proportion, therefore, the estimates for Leicestershire are combined data for Leicestershire and Rutland respectively - this ensures that all valid CCG data are included in the England total.

Some estimates are based on survey data (for example, utilisation of outdoor space for exercise/health reasons) and are not available due to small sample size. These have been omitted from this summary.

For indicators that are presented as age-standardised rates (for example, under 75 mortality rate from liver disease), where the observed total number of events is less than 25, the rates have been suppressed as the figures are too small to calculate directly standardised rates reliably. Other indicators that are based on small numbers (for example, treatment completion for Tuberculosis) are supressed due to the risk of disclosure of patient identifiable information.

15.2 Indicators based on rate per thousand

As Rutland has a population of 38,000, rates that are calculated as per 100,000 population effectively give numbers three times the size of Rutland's.   At first glance numbers may therefore appear to be much higher than they really are; this effect is particularly noticeable with smaller cohorts, for example the hospital admission rate for asthma for children under 19 years in Rutland was 94.6 per 100,000 population, however this is calculated from 8 admissions for a 8,600 population of children. [9]

15.3 Confidence Intervals

Confidence intervals are used to address imprecisions in data rates - either as a result of sample sizes being used, or as a result of a natural variation – by presenting estimates with a confidence interval which indicates that how certain we can be that the true rate lies somewhere between the lower and upper limits of the confidence interval.   For example, a 95% confidence interval indicates that the true rate is 95% likely to lie between the upper and lower confidence limits. For a given level of confidence, the wider the confidence interval, the greater the uncertainty in the estimate. The confidence interval may be used to compare an estimate against a benchmark value; if the benchmark value is outside the confidence interval it can be inferred that the difference between the estimate and the benchmark is statistically significant. For example: in 2011 Fuel Poverty was reported to be 18.4% with 95% confidence intervals of 17.8% - 19.1%. The England value was 14.6% and this is below the confidence intervals range for Rutland, resulting in Rutland being worse than the England average for Fuel Poverty.

16. What does this mean for Rutland?

Overall, the data for Rutland indicates that our residents experience largely low levels of deprivation, good health, and long lives. Indeed, the Public Health Outcome Framework indicators show Rutland as one of the healthiest places in England to live.

However, this doesn't mean that we don't have issues within the county nor that there aren't areas in which our performance could be improved. It is important that as we move forward, we clearly identify where our areas of need are and target our resources accordingly to address them – in particular our local data and service user voices will help us to identify these.

16.1 Proposed Chapters

The nationally comparable data has some time lags and consequently local data may give us a better picture of the 'here and now'. The more detailed chapters focusing on specific areas will enable both nationally comparable data and local data to be drawn together.

In addition, a number of areas have already been identified for further work, some of which has started:

- Sexual health needs and service provision
- Children's health provision 0-19
- Children and young people's mental health
- Children's oral health
- Learning disabilities
- Residential care for older people
- Substance misuse
- Frequent attendees to Primary Care

Appendix 1 – Summary of Indicators

To be inserted – Table indicating overarching indicators.

Appendix 2 – Detailed Datasets

The detailed data can be found at the following hyperlinks. Please note that this data covers Leicestershire and Rutland and in some cases, Rutland specific information will need to be selected from the drop-down boxes.

Overarching:
https://public.tableau.com/views/CoredatasetMASTER_Overarching/OverviewandMetadata?:embed=y&:showTabs=y&:display_count=yes&:showVizHome=no

Best Start in Life:
https://public.tableau.com/views/CoredatasetMASTER_Beststartinlife/MetadataandOverview?:embed=y&:showTabs=y&:display_count=yes&:showVizHome=no

Health and Wellbeing of Adults:
https://public.tableau.com/views/CoredatasetMASTER_Earlyintervention/MetadataandOverview?:embed=y&:showTabs=y&:display_count=yes&:showVizHome=no

Ageing:
https://public.tableau.com/views/CoredatasetMASTER_OlderPeople/MetadataandOverview?:embed=y&:showTabs=y&:display_count=yes&:showVizHome=no

Learning Disabilities:
https://public.tableau.com/views/CoredatasetMASTER_Learningdisabilities/MetadataandOverview?:embed=y&:showTabs=y&:display_count=yes&:showVizHome=no

Physical and Sensory Disabilities:
https://public.tableau.com/views/CoredatasetMASTER_Disabilities/MetadataandOverview?:embed=y&:showTabs=y&:display_count=yes&:showVizHome=no

Mental Health:
https://public.tableau.com/views/CoredatasetMASTER_Mentalhealth/MetadataandOverview?:embed=y&:showTabs=y&:display_count=yes&:showVizHome=no

Appendix 3 - References

To be included with final document

Appendix 4 – Statistical Neighbours

The following are the statistical neighbours used to compare Rutland with other authorities. The list is the statistical neighbours which are used by PHE for public health performance reporting:

North Yorkshire

West Berkshire

Wiltshire

Cheshire East

Worcestershire

Cambridgeshire

East Riding of Yorkshire

Oxfordshire

Central Bedfordshire

Buckinghamshire

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Report No. 140/2015

Report to Rutland Health and Wellbeing Board

Subject:	Report of East Leicestershire & Rutland CCG NHS Quality Premium 2015/16
Meeting Date:	23rd July 2015
Report Author:	Yasmin Sidyot & Kate Allardyce
Presented by:	Samantha Brown Performance Manager Arden & GEM CSU
Paper for:	Note / Approval

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:
The purpose of this report is to provide H&WBB with information on specific indicators that relate to the Quality Premium 2015/16 and request support on those indicators where choices need to be made. The options chosen have been linked to the HWBB priorities and Better Care Fund priorities.

Financial implications:
No financial implications

Recommendations:
That the board: 1. **Approves the options recommended by ELRCCG in Section 5.**

Comments from the board:

Strategic Lead:	ELRCCG

Risk assessment: N/A

Time	L/M/H	
Viability	L/M/H	
Finance	L/M/H	
Profile	L/M/H	
Equality & Diversity	L/M/H	

Timeline:

Task	Target Date	Responsibility

Purpose of report

1. The purpose of this report is to provide Rutland H&WBB with information on specific indicators that relate to the NHS Quality Premium 2015/16 and request support on those indicators where choices need to be made by East Leicestershire & Rutland CCG (ELR CCG).

Background

2. The NHS Quality Premium for 2015/16 has been published by NHS England, and is intended to reward CCGs for improvements in the quality of the services that they commission for associated improvement in health outcomes. This premium will be paid to CCGs in 2016/17, and covers a number of national and local priorities. Monies will be awarded for the achievement of the following:
   - Reducing potential years of lives lost through causes considered amenable to healthcare (PYLL) 10%
   - Urgent and emergency care 30%
   - Mental health 30%
   - Improving antibiotic prescribing in primary and secondary care 10%
   - Two local measures 20%

3. There are also a number of NHS Constitution indicators that will also impact on the Quality Premium for which monies will be deducted for non-achievement. These are:

   - RTT; 90% completed admitted; 95% completed non-admitted and 92% incomplete standard
   - Maximum four hour waits for A&E departments – 95% standard
   - Maximum 14 day wait from an urgent GP referral for suspected cancer – 93% standard
   - Maximum 8 minutes responses for Category A (Red 1) ambulance calls – 75% standard

4. There are choices and decisions that require the formal agreement of Health & Wellbeing Boards. NHS England's Area Team has advised that the choice of these indicators will need to be submitted by 14th

May 2015. Given the timeframe of information being supplied by NHS England this is the first opportunity the CCGs have had to submit to Rutland H&WBB.

Proposals/Options

5. There are a number of indicators that CCGs were able to choose as part of their Quality Premium. Full list in Appendix A. The H&WBB members are asked to approve and support the following:

- PYLL: ELRCCG have opted to choose a reduction in the potential years of life lost from amenable mortality for the CCG population to be achieved over the period between the 2012 and 2015 calendar years of 1.2%. This is the minimum requirement to meet this element of the Quality Premium.

- Urgent & emergency care: ELRCCG have opted to choose 'The total number of delayed days caused by delayed transfers of care (DTOC), attributable to the NHS, in 2015/16 should be less than the number in 2014/15'. This is a joint priority within the Better Care Fund hence the rationale for choosing this indicator.

- Mental health: ELR CCG have opted to choose 'Reduction in the number of patients attending an A&E department for a mental health-related needs who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E'.

- 2 Local Priorities:

 (1) Number of primary care completed care plans in Care Homes to reach 97% by April 2016, based on current levels of 2310 (95%) completed care plans - The rationale for having this as a local priority is that ELRCCG want to ensure proactive co-ordinated care management of care home residents who are often vulnerable with complex frailty.

(2) Deaths in Usual Place of Residence + hospice to achieve 50% by April 2016. (14/15 target: 49%) - we want to continue to ensure that patients in ELRCCG are supported to die in their usual place of residence/choice. We achieved our ambition for last year and plan to stretch this during 15/16.

Conclusions/Recommendations

H&WBB are asked to support the options made by ELR in Section 5.

Background papers

http://www.england.nhs.uk/wp-content/uploads/2015/04/qual-prem-guid-1516.pdf
http://www.england.nhs.uk/ccg-ois/qual-prem/

Officer to Contact

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List of Appendices

A) Full list of Quality Premium options

Appendix A

Full list of Quality Premium 15/16 options

Indicator	% of QP
Reducing potential years of lives lost through causes considered amenable to healthcare	10%

Urgent & emergency care: There is a menu of measures for CCGs to choose. One, several or all measures can be selected
    (1) Avoidable emergency admissions – composite measure of:
      • Unplanned hospitalisation for chronic ambulatory care sensitive conditions
      • Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
      • Emergency admissions for acute conditions that should not usually require hospital admission
      • Emergency admissions for children with lower respiratory tract infections (LRTIs)
    (2) Delayed transfers of care
    (3) Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays
 	
The choice must be done in conjunction with the Health & Well Being Board & NHS England local team.
	30%

Mental health: There is a menu of measures for CCGs to choose. One, several or all measures can be selected.
    (1) Reduction in the no. of patients attending A&E for mental health-related needs who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E
    (2) Reduction in the no. of people with severe mental illness who are currently smokers
    (3) Increase in the proportion of adults in contact with secondary mental health services who are in paid employment
    (4) Improvement in the health related quality of life for people with long term mental health condition
The choice must be done in conjunction with the Health & Well Being Board & NHS England local team
	30%

Improving antibiotic prescribing in primary and secondary care. This is a composite measure consisting of:
    (a) reduction in the number of antibiotics prescribed in primary care
    (b) reduction in the proportion of broad spectrum anti-biotic prescribed in primary care
    (c) secondary care providers validating their total antibiotic prescription data
	10%

Two local measures; These should reflect local priorities identified in joint health and wellbeing strategies. Local measures should not duplicate the national measures	10% 10%

Report No. 138/2015

Rutland Health and Wellbeing Board

Subject:	Step Up Step Down – Integrated Prevention, Discharge and Reablement Model and IUR 2 Business Case
Meeting Date:	23rd July 2015
Report Author:	Yasmin Sidyot
Presented by:	Yasmin Sidyot
Paper for:	Comment

Context, including links to strategic objectives and/or strategic plans:

Introduction

The Step up Step Down business case was approved by the Health and Wellbeing Board on 05.02.15. The business plan combines the 3 Better Care Fund Schemes: - Hospital Discharge (HDR1), Reablement (HDR2) and Crisis Response (IUR1). It links closely with the business plan for Integrated Health and Social Care Pathways and Service Delivery (IUR2).

The business case for IUR 2 is attached to this report for consideration and approval. This business case outlines the work to develop a whole system response to ensure a fully coordinated and integrated service offer is available for individuals with health and social care needs in Rutland.

The Project will develop pathways, protocols and possibly co-location of health and social care teams to allow the health and social care economy to fully realise its vision of integrated care.

By bringing our resources together we aim to have an integrated pathway of home based support which can enable people to live more independently within their own homes.

One of the milestones in the business plan is to make recommendations for the future delivery model for these services.

The purpose of this report is to provide an update on the progress of the plan to date and share the 'Integrated Prevention, Discharge and Reablement Model' as developed through the Integration Executive over recent months.

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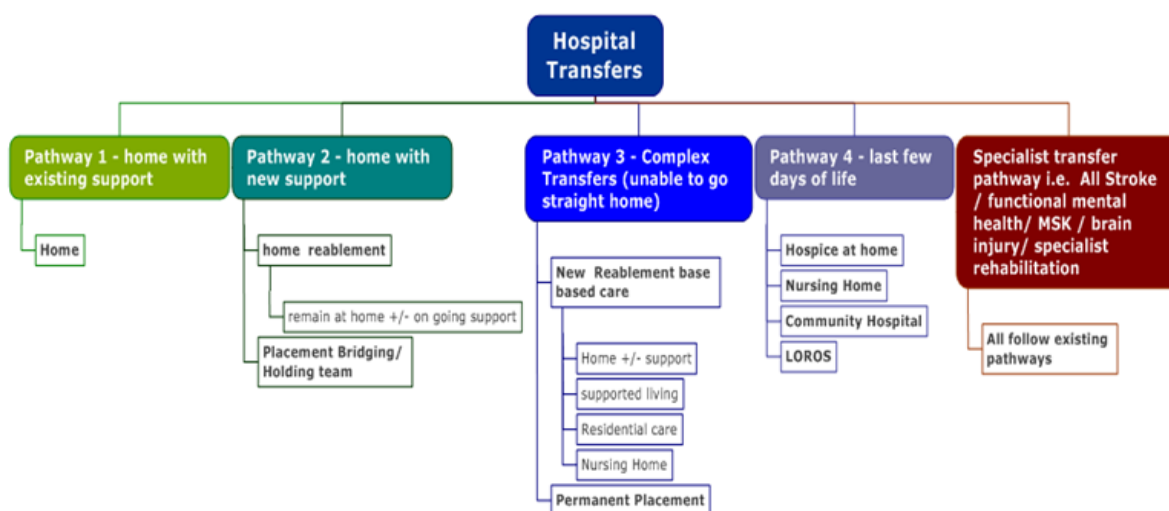
Detailed above is the transfer pathway diagram to simplify transfer routes from our local NHS acute and community providers to enable the shift from the acute sector to the community and home environment as part of the redesign of our local health and care system.

This paper outlines the Rutland model to deliver the above pathways 1-3. Key objective is to provide capacity to develop an integrated team and 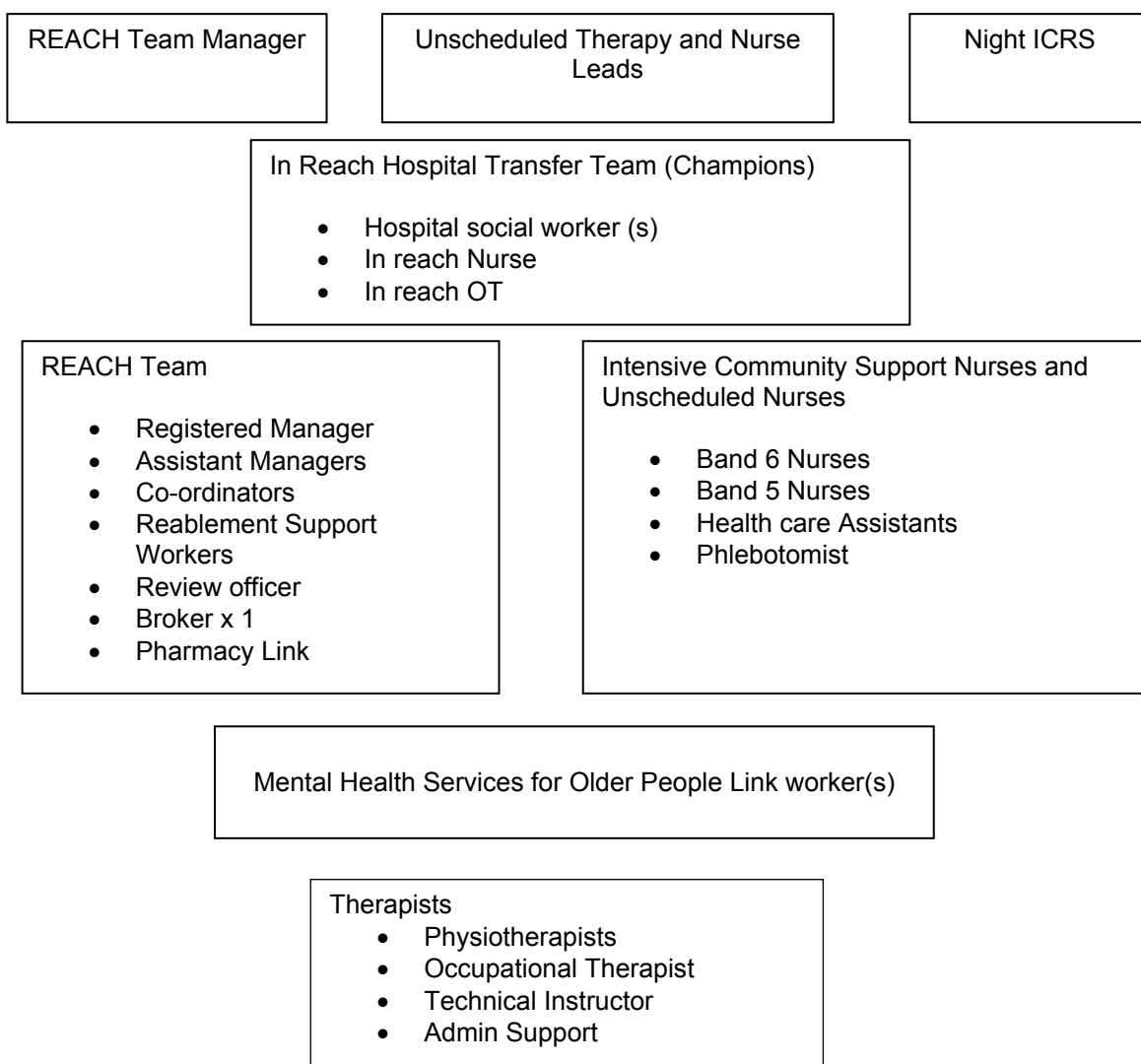way of working to facilitate the implementation of the transfer pathways from all hospitals. The emphasis will be on delivering 7 day services

Reablement can also help patients to stay in their own home for longer, reduce the need for home care and improve outcomes for service users.

Proposed Integrated Prevention, Transfer and Reablement model

REACH Team Manager	Unscheduled Therapy and Nurse Leads	Night ICRS

In Reach Hospital Transfer Team (Champions)

- Hospital social worker (s)
- In reach Nurse
- In reach OT

REACH Team

- Registered Manager
- Assistant Managers
- Co-ordinators
- Reablement Support Workers
- Review officer
- Broker x 1
- Pharmacy Link

Intensive Community Support Nurses and Unscheduled Nurses

- Band 6 Nurses
- Band 5 Nurses
- Health care Assistants
- Phlebotomist

Mental Health Services for Older People Link worker(s)

Therapists
- Physiotherapists
- Occupational Therapist
- Technical Instructor
- Admin Support

Who is Involved?

ICRS Night Nursing Service, Leicestershire Partnership NHS Trust (an element of the LPT Community Health Services (CHS) Unscheduled Care Team provision). The service offers a roving night team to provide home visits and overnight support incorporating nursing assessment and interventions and management of low level social care needs to ensure the person is safe at home over night.

Unscheduled Care, Nursing and Therapy Service, Leicestershire Partnership NHS Trust CHS Unscheduled Care Teams. A multidisciplinary team which provide a range of responsive nursing and therapy interventions.

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REACH, Rutland County Council. Registered domiciliary care service providing re-ablement and social care interventions provided by Reablement Support Workers, who are supported by a management team and therapists.

Hospital Transfers
(In reach Nurse, In reach Occupational Therapist(OT), Hospitals Social Workers)
These posts will be proactive in the identification and transfer of patients to the appropriate pathways from Peterborough Hospital and the community hospitals. This builds on the discharge link nurse role that previously existed. It is proposed to make the temporary dedicated Social Worker post for Peterborough Hospital permanent. Other existing Hospital Social Workers would work closely with this Integrated team.

As reablement develops and pathways 2 and 3 progress, it is important to ensure that an experienced therapy team is commissioned on a recurrent basis to provide continuity of care and expertise that in turn will aid planning and delivery.

The focus of the reablement programme for pathways 2 and 3 is as follows:

- To provide a reabling environment and approach, where the emphasis will be on maximising independence and the primary transfer destination would always be home
- The Reablement programme will be delivered in the main by Reablement Support Workers (RSW's), under the direction of the therapists. The RSW's will be managed on a day to day basis by the REACH Registered Domiciliary Care manager and Assistant Managers and the team will work to the principles of the Health and Social Care Protocol.
- Specific Physiotherapy and Occupational Therapy and Nursing interventions will be provided to the patient in an integrated way.
- Patients/service users will have clear goals set with them within one working day of transfer which will be reviewed constantly
- Twice weekly multi-disciplinary team (MDT) meetings will occur to review progress against goals and transfer assessments/plans
- The Stepping Stones Flat will be extended for 3 months, an alternative pathway 3 option, to allow for a thorough evaluation by the 'enhanced integrated team' to establish if it could have any added value or should be discontinued.
- All assessments both health and social care required for formal discharge will be completed in the care facility rather than in the hospital setting once the person is medically stable and fit for discharge.
- Following transfer home, the patient/service user or family member/carer will be contacted:

    o At 24 hours)
    o At 7 days   )   review progress and determine whether packages of care are in place, suitable, timely and appropriate
    o At 4 weeks   )

- The maximum reablement period is for no longer than 6 weeks. It is anticipated that patients will transfer from residential Reablement to home based Reablement during the 6 week period. In most instances, patients will not require the maximum period of Reablement.
- Therefore, it is important from the outset that goals are set and patients and their family/carers are given clear guidance as to aims and objectives for the patient and perceived timescales.

At the end of the reablement period the patient/service user would go home with any of the following:

- No formal support
- No formal care but may have assistive technology, equipment, universal services
- Self-funded package of care
- Social care package of care/ongoing planned health care.
- Joint funded package of care
- Continuing health care (CHC) funded package of care

The intention is for these groups of staff to have a co-located base and work as an Integrated Hub.

Workforce development to create a culture where roles within the teams are re-designed to make the

optimum use of team skills and knowledge and everyone is working in an integrated and person centred way is critical.

This local model needs to work closely with the Crisis Response Integrated Night Nursing Service that forms part of this BCF Step Up step down Business Plan.

Financial implications:

Costs already identified

Spend area	Value £
Reablement Team in BCF HDR2	£536,000
ICS Team in BCF IUR2	£405,000
0.5 Hospital Social Worker HDR1	£25,000
0.5 In Reach Nurse HDR1	£25,000

Cost for Proposed New posts

Spend area pay and non-pay	Value £ (FYE costs)
0.4 REACH Physiotherapy cost centre 4494a	£25,000
0.5 Hospital Social Worker	£25,000
0.5 In Reach Nurse	£25,000
0.5 In Reach OT	£25,000
Additional Band 6 Nurse	£50,000
Phlebotomist/Health Care assistant Band 2	£25,000
Additional Physio 1.3wte	£65,000 (£50,000 RCC £15,000 CCG)
0.2 wte OT – deliver ICS & REACH	£10,000
0.25 wte Technical Instructor	£10,000
1 wte reablement support worker	£30,000
1 wte admin	£20,000
1 wte Broker	£40,000
1 wte MHSOP Link worker	£50,000
ICRS/SPA contribution	£50,000
Total	**£450,00**

Funding Available

Funding Source	Value £
BCF Crisis Response IUR1	£450,000
Total	**£450,000**

Revised Template 2011-12-13

Recommendations:		
(a) Notes the contents of this report (b) Support the recruitment of the proposed new posts. (c) To approve the business case for Integrated Health and Social Care Pathways (IUR2)		

Strategic Lead:	Yasmin Sidyot CCG and Mark Andrews RCC	
Time	High	Recruitment may take some time and until posts are filled the additional capacity required will delay progress. Delayed discharges continue to be a difficulty.
Viability	Medium	Recruitment may be difficult for some posts. Will need time and commitment to establish new ways of working. Having some difficulty identify a care home that is willing and able to provide the bed based options required.
Finance	Medium	Funding available within the scheme for 2015/16 but not yet clear about recurrent BCF funding but indications are that it will continue in some form.
Profile	High	Delays in hospital discharges are high profile, impact on individuals' recovery and damaging to our reputation.
Equality & Diversity	Low	No groups will be disadvantaged.

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Project Business Case

Integrated Health and Social Care Pathways and service delivery

1 12 2014

Distribution of this product is (UN)RESTRICTED

Lead organisation: East Leicestershire and Rutland Clinical Commissioning Group

Local Authority Lead: Sandra

Health Lead: Yasmin Sidyot

DOCUMENT CONTROL   Change Control History

Version	Change Summary	Change author	Date
0.1	Initial document production	Yasmin Sidyot	1.12.14
0.2	Additional milestones added	Julia Eames	26.5.15
0.3	Alterations made following Integration Executive feedback to clarify delivery times and dependency on organisational developments	Julia Eames	15.6.15

Reporting Schedule:

This draft went to the Integration Executive of the Health and Wellbeing Board on 4th December 2014

Next draft due to go to the Health and Wellbeing Board on 23rd July 2015

How would this scheme be described to the service user?

Individuals will be supported to live more independently in their own homes through the provision of joined up, co-ordinated health and social care services, designed to meet individual need and delivered at local level.

1   Description of Project

Business need:

Evidence from cross-cultural examples indicates that:

- integration is most effective when it is targeted towards people with severe, complex and long-term needs

- it is best suited to frail older people, those with long-term chronic conditions and mental health illnesses and those requiring urgent care

- it is most effective when it is population based and approaches the holistic needs of a patient, rather than being based on the patient's condition

- Condition-based approaches to integration can create silos and thus lead to different types of fragmentation. [1]

Locally, as nationally, there is an ageing, frail population and an increasing prevalence of chronic disease.[2]

The result of engagement in across Leicester, Leicestershire and Rutland tells us that people want joined up care closer to home and a wellness service, not just an illness service. This will only be possible if sustainable community solutions are in place.[3]

The Project is in line with ELRCCG's Two Year Operational Plan and Integrated Community Services Strategy and the LLR wide Better Care together; Five Year Strategic Plan, all of which recognise the need to move towards integrated services provided by multi-disciplinary teams of primary, community and social care services which can be wrapped around the individual; promoting and sustaining independence in a home based setting.

The Better Care Together; Five Year Strategy Plan summarises the delivery of care under eight service pathways delivered across six settings of care (see below). This Project will contribute to service pathways for '*frail older people*' and '*long term conditions*' delivered in the settings of care '*self-care, education and prevention*', '*community and social care services*' and '*crisis response, Reablement and discharge*'.

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[1] The King Fund – case for Integrated care 2011; Nuffield Trust – preventing hospital readmissions; The King Fund – making our health and care systems fit for the ageing population 2014; Safe and Compassionate care for frail older people – using an integrated pathway practical guidance for commissioners, providers and nursing, medical and allied health professional leaders NHS England

[2] Rutland JSNA

[3] East Leicestershire and Rutland CCG Integrated Community Services Strategy 2014
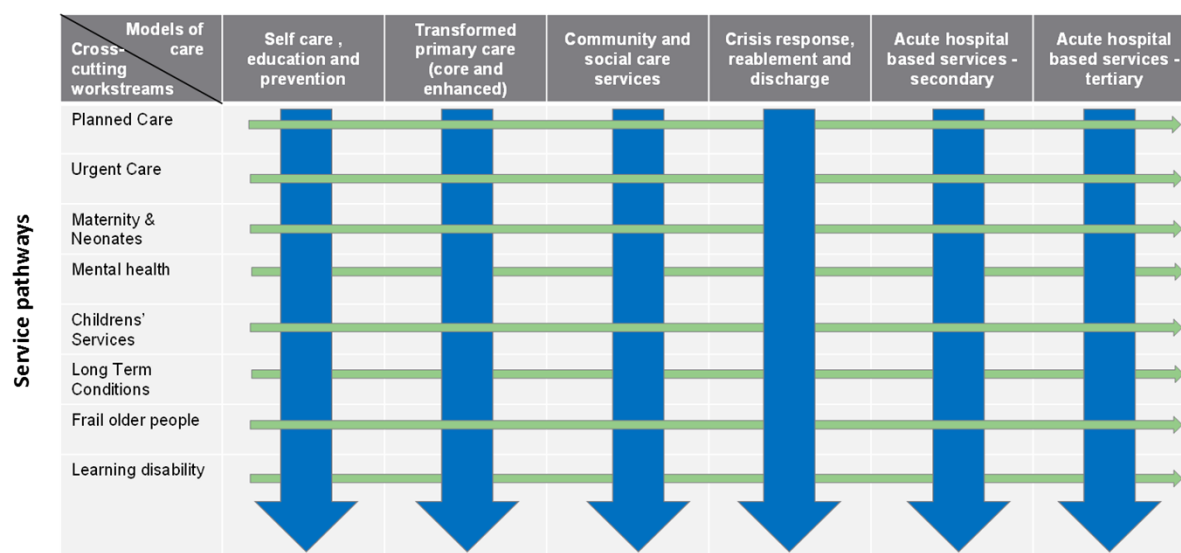
NHS Planning Guidance 2014 – 2019 identifies that any high quality, sustainable health and care system in England will have the following six characteristics in five years' time:

- A completely new approach to ensuring citizens are fully included in all aspects of service design and change and that individuals are fully empowered in their own care

- Wider primary care, provided at scale

- A modern model of integrated care

- Access to the highest quality urgent and emergency care

- A step change in the productivity of elective care

The Kings Fund document *'Transforming our Health Care System' (April 2013)* states that:

'the ageing population and increased prevalence of chronic diseases require a strong re-orientation away from the current emphasis on acute and episodic care towards prevention, self-care, more consistent standards of primary care and care that is well co-ordinated and integrated'.

The Kings Fund document *'Community Services: How they can Transform Care' (February 2014)* identifies an approach required to develop community services in a way that will deliver transformation. This approach requires locality based teams that are grouped around primary care and natural geographies, with multi-disciplinary teams offering 24/7 services as standard and complemented by highly flexible and responsive community and social care services. These teams need to work in new ways; offering individuals a much more complete and less fragmented service.

1.1 Project Objectives

The overall aim of the project is to develop a whole system response to ensure a fully coordinated and integrated service offer is available for individuals with health and social care needs in Rutland.

The Project will develop pathways, protocols and possibly co-location of health and social care teams to allow the health and social care economy to fully realise its vision of integrated care.

By bringing our resources together we aim to have an integrated pathway of home based support which can enable people to live more independently within their own homes.

1.2 Key Deliverables

	Project Deliverable	Delivery targets	How?
1	Localities will have arrangements in place for aligned clinical leadership of nursing (clinical case managers) and allied health professionals (OT and physiotherapy), with Social Workers and Social Care workers, delivered through multi agency teams, including MHSOP	March 2016	Through workforce and organisational development
2	Localities will include operational management and administrative support	October 2015	Development of existing teams, resources and provider services
3	Multi agency teams will be in place for delivery of planned care, each serving a cluster of GP practices with a registered list of c30-35,000 individuals to: • Deliver planned pathways of health and social care for people with long term conditions, people with Continuing Health Care needs and people at the end of their life; through integrated care plans and case management • Support GPs in delivering care plans for patients aged 75 and over • Work with GPs and Integrated Care Co-ordinators to support risk stratification and care planning • Support self-care and provision of patient and carer information, including patient held records which include a care plan detailing an individual's nursing and therapy needs • Proactively identify and prevent falls for 'at risk' individuals, including advice and training in falls prevention and management for care homes and health and social care teams so that falls awareness and assessment are part of every contact • Rehabilitation and Reablement provision • Explore the use of combined personal health budgets and social care budgets.	March 2016	Development of existing teams, resources and provider services
4	There will be in place a multi-disciplinary and integrated unscheduled care service comprising: • An unscheduled care team containing nursing staff, allied health professionals, social care workers and generic health and social care support workers	November 2015	Development of existing teams, resources and provider services

Project Deliverable	Delivery targets	How?
• Intensive Community Support (ICS) • Integrated Crisis Response Service (ICRS) • Reablement		

1.3 Project Milestones

Identify the significant milestones (phases, stages, Attach the work stream Plan. This should outline the main stages of the work stream, milestones and any interdependencies

Activity	Milestone	Dependency	Responsible	Start Date	End Date
Map and review existing structures and pathways	Existing services and pathways in and out of services are understood	Partner organisations own readiness for change	Project leads	Nov 14	Jan 15
Explore future delivery model for community based health services in line with Integrated Community Services Strategy	Opportunities for integration, alignment and co-location are identified	Wider engagement across ELRCCG	CCG Adult Social Care	Nov 14	July 15
Agree an information governance protocol which covers all partners linked in to Rutland's health and care system	There will be one Information Sharing protocol which is understood and implemented by all partners from board level to operational staff.	Commitment from partners	CCG to lead	June 2015	Sept 2015
Revised pathways are mapped out, including: • new multi-agency team structures that will support new pathways • role and contribution of community and voluntary sector • role and	Identify opportunities for Social Care Staff to integrate with GP practices. Review the NHS and Social Care Occupational	Partner organisations own readiness for change	Project leads Service Managers	July15	Sept 15

Activity	Milestone	Dependency	Responsible	Start Date	End Date
contribution of other council services	therapy provision to identify plans for joint or aligned posts.				
Develop Integrated Clinical Leadership through a joint programme of workforce development	Leadership style across partners will promote the values of integration and support the right culture and processes.	Funding – proposal to link with workforce development in IUR1	CCG Lead, LPT, Julia Eames	July 2015	Dec 2015
New model for integrated delivery of health and social care services is agreed by key partners	Proposals to be developed and presented to H&WBB	Clear and robust proposal being established	H&WBB CCG Board	17 Nov 2015	26 Jan 2016
New arrangements, pathways and service delivery arrangements established	Timed and resourced plan in place to move to new arrangements	Approval from H&WBB	Service Managers	Dec 15	Mar 16
Review of Continuing Health Care protocols and pathways to deliver a partnership approach to assessment and integrated care plans.	Assessments will be completed at the right time and place with support from relevant professionals. Joint care plans will be managed in an integrated way, facilitating the use of personal health budgets and direct payments where appropriate.		CCG		Mar 16
Develop Multi-agency meeting to jointly review 'high users of services' and people with complex needs	There will be a partnership approach to assessing and	Agreed Information sharing protocol	CCG – GP Practices (one already established at OMP)	July 2015	Dec 2015

Activity	Milestone	Dependency	Responsible	Start Date	End Date
and long term conditions, including GP Practice Nurses.	delivering care with a focus on supporting self directed care and the use of personal budgets.				
Strengthen links with Mental health Services for Older People.	managers and operational staff will participate in relevant strategic and operational meetings	Availability of staff	LPT	July 2015	Sept 2015
Improving care for people at the end of their life by working in an integrated way	Will be delivering National End of Life best practice.	Training for relevant staff groups.	CCG	July 2015	Mar 2016
Establish shared outcome measures to be used across relevant health and social care settings.	Identify a task and finish group	People able to contribute and agree an approach	Julia Eames	Sept 2015	Dec 2015
Review the implementation of the new Health and Social Care Protocol locally, including utilisation by Independent Care providers.	The principles of the protocol will be embedded to reduce duplication	LLR protocol	John Morley	July 2015	Dec 2015
Progress opportunities for joint commissioning and performance managing of domiciliary care and nursing care and joint brokerage.	Appropriate contracts will be joint. The market will be well managed and responsive to demands in a way that provides best value for money	Availability of sufficient providers	Karen Kibblewhite	June 2015	Mar 2016
Strengthen links with Public Health outcomes and activities.	All services will contribute to primary and secondary	Closer working between all partners.	Mike Sandys	July 2015	Dec 2015

Activity	Milestone	Dependency	Responsible	Start Date	End Date
	prevention. Utilisation of the Third Sector to provide early preventative interventions				

1.4 Exclusions

Clearly state any areas that are out of scope and whether these are to be delivered by another area/at a later date/not at all, etc.

Integrated Crisis Response, Hospital Discharge and Reablement services are separate BCF Projects in their own right.

2 Approach

Indicate what impact the proposed work will have on business as usual. E.g. will it fit naturally with an existing service? Will an existing service need to change in order to accommodate the maintenance or on-going delivery of the products or services? Does this work stream fall within the Better Care Together work stream?
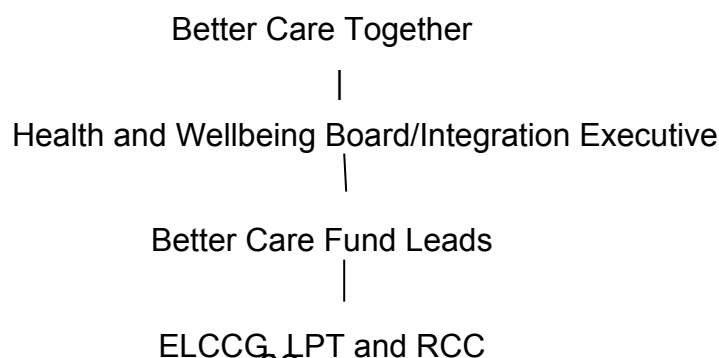
2.1 Operational Readiness

Existing health and social care services are in place but this Project will better co-ordinate, align and locate service delivery to reduce duplication and provide more seamless service provision.

2.2 Work stream structure

Consider key Business areas such as procurement, IT, workforce and delivery into Service.

Provide a diagram of the proposed Project structure and brief details of the governance approach

- Accountable to Health and Wellbeing Board
- Formal performance reporting against work stream progress and metrics as in 3.2 below
- Project leads identified

Better Care Together
|
Health and Wellbeing Board/Integration Executive
|
Better Care Fund Leads
|
ELCCG, LPT and RCC

2.3 Work stream metrics

BCF Metric	Description of Impact as set out in BCF Significant/moderate/other
Metric 3 – Reducing Delayed Transfers of Care	Significant impact – contribute towards the 8.4% reduction in DTOC
Metric 4 – Reducing Avoidable Emergency Admissions	Moderate impact contribution towards the 2.4%
Other metrics: Outcomes	
Contribution to achieving 7 day working	Moderate impact
Improve the patient/service users experience	significant impact
Reduce the number of injuries due to falls	Moderate impact
Other desired outcomes include: a) Improved partnership working between health and social care partners b) Reduction in avoidable hospital admissions through the provision of accessible, targeted community based health and social care services which support independence c) Reduction in admissions to residential care through the provision of support to enable individuals to remain independent in their own home for as long as possible d) Reduction in delayed transfers of care through improved information sharing, a co-ordinated approach that is able to maximise step down options and resources to support hospital discharge e) Reduced length of stay through facilitated early secondary care discharge f) Reduced impairments attributable to long term conditions g) To rehabilitate individuals to their optimum level of functioning h) To promote social inclusion and utilise community capacity where appropriate i) To enable the development of individual capability in self directing their care and self-manage their conditions j) To enable and support individuals at end of life to be cared for in the place of their choice k) Through enhanced co-ordination and community facilities to assist and support informal carers	

2.4 Work stream metrics recording

Information being collected	At what stage in the patient pathway is the information being collected?	Information collected by whom	Database on which information is collected / captured/ stored
ASCOF service user feedback	Annually	Adult Social Care	

2.5 Work stream performance reporting against metrics

Type of report being prepared (e.g. SITREPS/ RAISE)	By whom	Reporting dates	Reporting timeframes
SITREPS and Dashboard Reporting on Metrics to Integration Executive	SITREPS – CCG Contract Management Dashboard – GEM	TBC	Monthly

3   Communication and Engagement

3.1 Stakeholder Analysis

Stakeholder Name	How they will impact on the project	How they will be impacted by the project	Communication requirements/methods
Individuals who may require or use the service	Able to contribute to service design	Will require the service to respond in a timely and effective way	Promotion of the service to reassure people that they will get a safe and effective service, that is a better option for them than being admitted to hospital or residential care
Partners (including staff) who will want to refer to services	Need to understand pathways to be able to make use of them appropriately	Will provide an option for them rather than admitting/conveying people to hospital or residential care	Relevant/targeted material to explain pathways, services, referral routes etc.
Existing service staff	Support values and behaviours required to facilitate successful service changes	May affect job roles and responsibilities, work location	Need to keep involved through staff meetings and newsletters and individual supervisions and PDR's
Hospitals	Providing appropriate referrals and information using agreed minimum data sets and trusted assessments	Will help with speedier and smooth discharges and free up capacity in acute sector	Need to ensure are aware of referral pathways. Need to ensure they are confident about community services being able to deliver high quality services, so are not anxious/risk averse to discharging people.

3.2 Project Reporting and Communication

Type of communication	Communication Schedule	Communication Mechanism	Initiator	Recipient
Status report	Monthly	Highlight Report to Integration Executive	Work stream Lead	Integration Executive
Exception report	Quarterly	Report to Integration Executive	Work Stream Lead	Integration Executive

4 Risks

4.1 Key Risks

Risk No.	Date Opened	Risk Owner	Risk Description	Probability (High, Med, Low)	Impact (High, Med, Low)
1	1.12.14	Yasmin Sidyot/Julia Eames	Key partners are not engaged or willing to make the necessary transformation	Low	High
2	1.12.14	Yasmin Sidyot/Julia Eames	Tools and IT support systems are not able to support transformation	Med	Med
3	1.12.14	Yasmin Sidyot/Julia Eames	Staff are not equipped to embrace and deliver change	Med	Med

5 Costs

5.1 Project Costs

Include all direct and indirect costs

Description	2014/5(£)	2015/6(£)	Total (£)
Core expenditure for nursing and therapy services.		405	405
Workforce development costs		50	50
Total			**455**

5.2 Funding

Include detail of any potential, or definite, sources of funding. Indicate whether this is likely to come from inside or outside of the BCF approved allocation for this work stream. If external, identify the proposed source.

Funding Source (External - name/Internal)	Confidence rating of funding being provided (H/M/L)	2014/15 (£000)	2015/16 (£000)	2016/17+ (£000)	Totals (£000)
ELRCCG – Existing funding for Intermediate care – Unscheduled care team for Rutland and Intensive Community Support - 48 virtual beds (8 Rutland)	H	405	405		810
Transfer of funds from IUR1 towards workforce development costs.					
Total Funding			**405**		

6   Exit Strategy

Describe how this work stream will be sustained e.g. post 31st March 2016[4]

This workstream is already part of core service provision and is recurrently funded by ELRCCG. The purpose of bringing into the BCF is so that the greater integration can be achieved between health and social care provision enabling a fully integrated service offer. It is line with the CCG's Community Services Strategy.

Will some existing services be replaced by the introduction of this service?

No

What will be the impact (both to the council, health service and to residents) if this service was to cease?

As identified above this is core service provision and therefore the intention is not to cease but to deliver this provision in a different way that enables greater integration

The aim of this this Project is to transform existing pathways, services and resources into new business as usual activity.

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[4] As at September 2014 the government has only indicated funding for 2014/15 and 2015/16

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Report No. 141/2015

Report to Rutland Health and Wellbeing Board

Subject:	Quarter 4 National Return
Meeting Date:	23.7.15
Report Author:	Julia Eames
Presented by:	Mark Andrews
Paper for:	Note / Discussion

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:
The First Better Care Fund quarterly report (incl. pay for performance metric) was submitted at the end of May relating to the period from January to March 2015, see copy attached (Appendix A). Due to the tight deadline after receipt of the template and the fact that the Health and Well Being Report was not sitting due to the elections the report was agreed outside of the meeting.   However it is anticipated that future returns will be presented to the Board before submission. The return required no performance data to be submitted on the wider metrics and only key health indicators have been collated by the BCF National team independently of the return.   Details have not yet been received regarding the requirements for submission for quarter 1, which will cover the period April to June 2015. The Midlands and East of England reporting returns and key metrics report is also attached for comparison (Appendix B). This shows that developments in Rutland are in line with the majority of the Midlands and East of England. The Board should note that Rutland is one of the 23 of the 35 areas in the region that has achieved a performance payment from Q4 against non-elective admissions. However like the rest of the East Midlands, Rutland was significantly above plan for Q4 for Delayed Transfers of Care with an outturn of 570 days against a target of 275 days. Action has been taken to address rising delays in Peterborough and to tackle reasons for significant delays in March delays across LPT sites. Improved performance in April and May of 135 days looks likely to bring us back on plan against a Q1 target of 194 days.

Financial implications:
The pay for performance amount will provide some additional resource to support the ambitions of the Better Care Fund Plan. Proposals will be put to the Health and Well Being Board when developed by the Integration executive.

Recommendations:
That the board: 1. Note the contents of this report.

Comments from the board:		
Strategic Lead:	Mark Andrews	
Risk assessment:		
Time	M	Most plans are on track, with some delays in staffing and adjustments made
Viability	M	Risks have been identified for individual schemes and actions to mitigate.
Finance	M	Partnership agreement in place
Profile	H	National and local significance
Equality & Diversity	L	No specific group of individuals subject to any discrimination.

Revised Template 2011-12-13

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics from the Health & Wellbeing Board plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 29th May 2015

This initial Q4 Excel data collection template focuses on the allocation, budget arrangments and national conditions. Details on future data collection requirements and mechanisms (including possible use of Unify 2) will be announced ahead of the Q1 2015/16 data collection.

To accompany the quarterly data collection we will require the Health & Wellbeing Board to submit a written narrative that contains any additional information you feel is appropriate including explanation of any material variances against the plan and associated performance trajectory that was approved.

Content

The data collection template consists of 4 sheets:

1) Cover Sheet - this includes basic details and question completion
2) A&B - this tracks through the funding and spend for the Health & Wellbeing Board and the expected level of benefits
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Narrative - please provide a written narrative
To note - Yellow cells require input, blue cells do not.

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 4 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) A&B

This requires 4 questions to be answered. Please answer as at the time of completion.
Has the Local Authority recived their share of the Disabled Facilites Grant (DFG)?
If the answer to the above is 'No' please indicate when this will happen.
Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track for delivery (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.
Full details of the conditions are detailed at the bottom of the page.

Cover and Basic Details

Q4 2014/15

Health and Well Being Board	Rutland

completed by:	Yasmin Sidyot
e-mail:	Yasmin.Sidyot@EastLeicestershireandRutlandCCG.nhs.net
contact number:	0116 295 5177
Who has signed off the report on behalf of the Health and Well Being Board:	Helen Briggs, CEO RCC and Tim Sacks, Chief Operating Officer

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB.xls' for example 'County Durham HWB.xls'

	No. of questions answered
1. Cover	5
2. A&B	4
3. National Conditions	16
4. Narrative	1

Selected Health and Well Being Board:

Rutland

Data Submission Period:

Q4 2014/15

Allocation and budget arrangements

Has the housing authority received its DFG allocation?	Yes

If the answer to the above is 'No' please indicate when this will happen	dd/mm/yy

Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?	Yes

If the answer to the above is 'No' please indicate when this will happen	dd/mm/yy

Selected Health and Well Being Board:

Rutland

Data Submission Period:

Q4 2014/15

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	Comment
1) Are the plans still jointly agreed?	Yes	Plans signed off by CCG Governing Body and RCC Cabinet. Health and Wellbeing Board is working well in terms of providing assurance, with buy-in from all partners.
2) Are Social Care Services (not spending) being protected?	Yes	The majority of our schemes have a substantial social care element e.g. Reablement, DfG, Assistive Technology, Care Act enablers
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	No - In Progress	We have some provider services working across 7 days as a result of the BCF e.g. Community Services, Reach, Intensive Community Services and Integrated Crisis Response (ICRS). Work is ongoing with Care Homes to facilitate 7 day discharges and to prevent admissions, we are also promoting the use of proactive care plans
4) In respect of data sharing - confirm that:		
i) Is the NHS Number being used as the primary identifier for health and care services?	Yes	The NHS number is matched to over 90% of social care records however operational use of the NHS number is work in progress due to the limitations of the current case management system. We are currently going through procurement for a new system, 2016 will see vast improvements and enable better information sharing,
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	We are moving to Liquid Logic as our case management system, this system is an open API platform.
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	Yes	There is an information sharing protocol between our reablement service and ICRS as a new integrated scheme. An outstanding action for Rutland is to pursue an overall information governance protocol which covers all partners linked in to Rutland's health and care system (e.g. Peterborough, Leicester, Community Services),
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	No - In Progress	There have been a number of issues recruiting to the Health and Social Care Coordinator post which has been vacant since October 2014; this post specifically works with local GPs to risk stratify patients with 3 or more long term conditions, the post has now been recruited to with new starter beginning on 1st June (further update will be available at Q1). We are making progress in other areas to contribute to our joint approach to assessments and care planning; we have developed operational
6) Is an agreement on the consequential impact of changes in the acute sector in place?	Yes	Leicester, Leicestershire and Rutland Better Care Together Delivery Board have undertaken mapping and developed an action plan for implementation, locally this will fit with our plans for developing integrated Intensive Community Support and Reablement colocated team. As a HWB we have reviewed our NEL admission

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed
The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Selected Health and Well Being Board:

Rutland

Data Submission Period:

Q4 2014/15

Narrative		remaining characters	31,314

Please provide any additional information you feel is appropriate to support the return including explanation of any material variances against the plan and associated performance trajectory that was approved by NHS England.

Since the original submission of the Rutland BCF plan we have made the following material variances: 1) revised our NEL admissions baseline to ensure our original targets are realistic, the HWB in March 2015 agreed to keep the target as per the original plan. 2) LTC 1 Learning Disability scheme has been replaced with a falls prevention and falls management scheme; this is because the original scheme had minimal impact locally on the acute sector, the falls scheme will support originally identified schemes in reducing admissions due to falls and improving patient experience. An amended annex was submitted to NHS England on 14.5.2015 following approval at HWB on 17.3.2015 3) We have combined 3 schemes into one operational plan, these are: hospital discharge, reablement and ICRS; this is due to their integrated nature and similar contributions to the BCF metrics, this will allow us to be creative and flexible in trying out new models of delivery 4) Dementia and Integrated Care Coordination schemes have experienced some delays in getting going due to staffing changes at a management level as well as recruitment issues, both schemes now have a plan and will be reporting initial outcomes to the HWB in September 2015 5) the delivery of Assistive Technology service is closely linked to the community agent service which are both up and running, this is due to successful procurement of 1 provider who will deliver both services in 2015/16.

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Progress in delivering local BCF plans

Summary of BCF quarterly reporting returns and key metrics for Q4 2014-15

The Midlands and the East of England

02 July 2015
Version 2

The Better Care Fund

Key Findings

- 83% of HWBs have secured a signed Section 75 agreement.

- 94% of housing authorities have received their DFG allowance.

- 91% of HWBs reported that Social Care Services (not spending) are being protected. There were three exceptions; Norfolk, Staffordshire and Suffolk.

- 57% of HWBs reported that the NHS number being used as the primary identifier for health and care services.

- 83% of HWBs reported that they are pursuing open APIs (i.e. systems which speak to one another).

- A total of 23 HWBs in the Midlands and East achieved a performance payment from Q4 of 2014-15.

- The total value of P4P payments in the Midlands and East for this period is **£8,140,047**

Pooled budgets

Have funds been pooled via a Section 75 pooled budget arrangement in line with the agreed plan?

- 29/35 HWBs responded 'Yes' (83%)
- 6/35 HWBs responded 'No' (17%)

All but 2 HWBs (Bedford & Central Bedfordshire) in the Midlands and East of England expect to have this in place by mid June 2015.

Analysis of the narrative provided by the 6 HWBs who answered 'No' suggests there are some areas where further information may be helpful:

- 3 HWBs – Bedford, Central Bedfordshire, and Norfolk - have indicated that the delay is due to financial difficulties of the CCG, and

- The remaining 3 HWBs have provided no explanation for not having yet signed their Section 75 agreement.

- All these may warrant further investigation to understand if support is needed.

■ No explanation   ■ Financial pressure

Pooled budgets

The below table details information provided on why HWBs have not yet signed their section 75 agreement, and the date they plan to have this in place.

HWBs that responded 'No'	Expect to Complete By	What they said within their narrative about S.75
Bedford	31/07/2015	The Bedfordshire CCG is now in 'special measures' due to its financial position, this has impacted on the ability to agree and sign off the s75 agreement. Work is ongoing to develop an agreement that is acceptable to both BCCG and BBC. Progress was made at a meeting held on Tuesday 2nd June and a further meeting to work towards final agreement is being scheduled for the week beginning 8th June.
Central Bedfordshire	31/07/2015	Prevailing and challenging issues of leadership, finance pressures, capacity and engagement within our local health and care system. Key partner in the BCF plan, Bedfordshire Clinical Commissioning Group, is facing important financial and organisational challenges. This includes a change in leadership and rapid turnover of personnel who have been involved in the BCF. The CCG's current focus is on its financial recovery which naturally has implications for wider joint investments in transformation….Due to the limitations outlined, capacity to fully deliver the BCF plan may be at risk, however joint working to explore all options available to us is underway.
Norfolk	12/06/2015	Better Care Fund programme delivery is progressing as agreed. The local integration boards are established and are managing programme delivery… the health system in Norfolk has been under considerable pressure over recent months, CCG's are experiencing financial challenge and working closely with NHS England to ensure plans to address this are robust and assured, one of the acute hospitals and the mental health trust in special measures. An impact on the BCF has been a delay in signing two of the s75 agreements but there is assurance these will be signed by 12th June on the basis of testing the impact of urgent care initiatives on the modelling of metrics.
Solihull	10/06/2015	No explanation provided within the narrative section.
Thurrock	01/04/2015	No explanation provided within the narrative section.
Warwickshire	15/06/2015	No explanation provided within the narrative section.

Disabled Facilities Grant
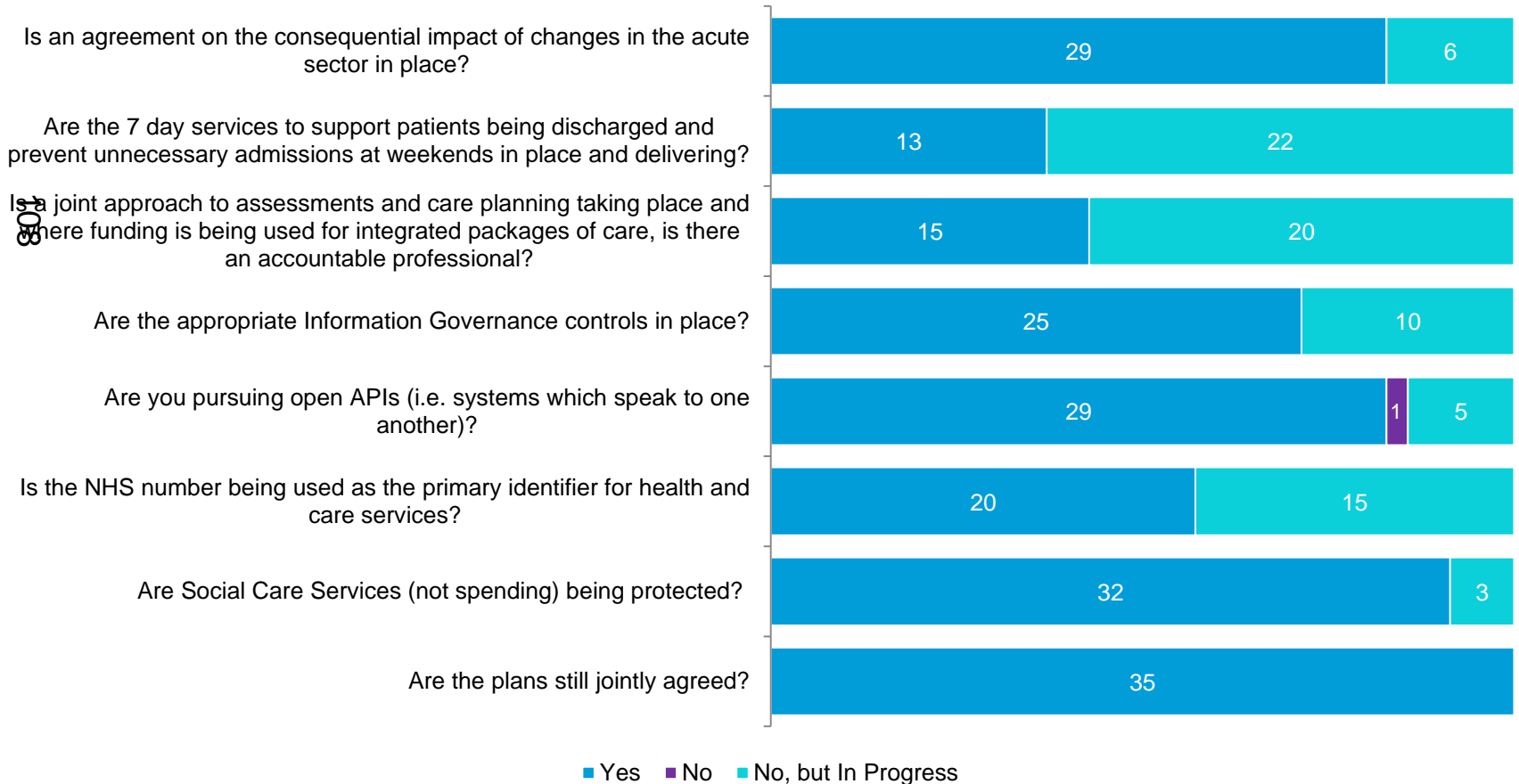
Has the housing authority received its DFG allowance?

- 33/35 HWBs responded 'Yes' (94%)
- 2/35 HWBs responded 'No' (6%)

The 2 HWBs who responded know plan to have this completed by the end of June 2015, but have provided no explanation for the delay.

HWBs that responded 'No'	Expect to Complete By
Norfolk	30/06/2015
Warwickshire	15/06/2015

The national conditions

There is a mixed picture of performance against the national conditions in the Midlands and East of England, with 7 day services, joint assessments and using the NHS number being the conditions that appear to be taking longer to deliver.

Question	Yes	No	No, but In Progress
Is an agreement on the consequential impact of changes in the acute sector in place?	29		6
Are the 7 day services to support patients being discharged and prevent unnecessary admissions at weekends in place and delivering?	13		22
Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	15		20
Are the appropriate Information Governance controls in place?	25		10
Are you pursuing open APIs (i.e. systems which speak to one another)?	29	1	5
Is the NHS number being used as the primary identifier for health and care services?	20		15
Are Social Care Services (not spending) being protected?	32		3
Are the plans still jointly agreed?	35		

■ Yes ■ No ■ No, but In Progress

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The national conditions – by GOR

There is some interesting variation between areas across the Midlands and East when looking at the % of HWBs who said 'Yes' to questions on the national conditions…

Only 21% of HWBs in the West Midlands are currently meeting the 7 days service condition, compared to 44% in East Midlands and 45% in East of England

Only 27% of HWBs in the East of England are currently meeting the national condition for assessments, compared to 67% in the East Midlands and 43% in West Midlands

Only 64% HWBs in East of England feel there is agreement about the impact of BCF plans on the acute sector compared to 100% in the East Midlands and 86% in West Midlands

■ East Midlands ■ West Midlands ■ East of England

6
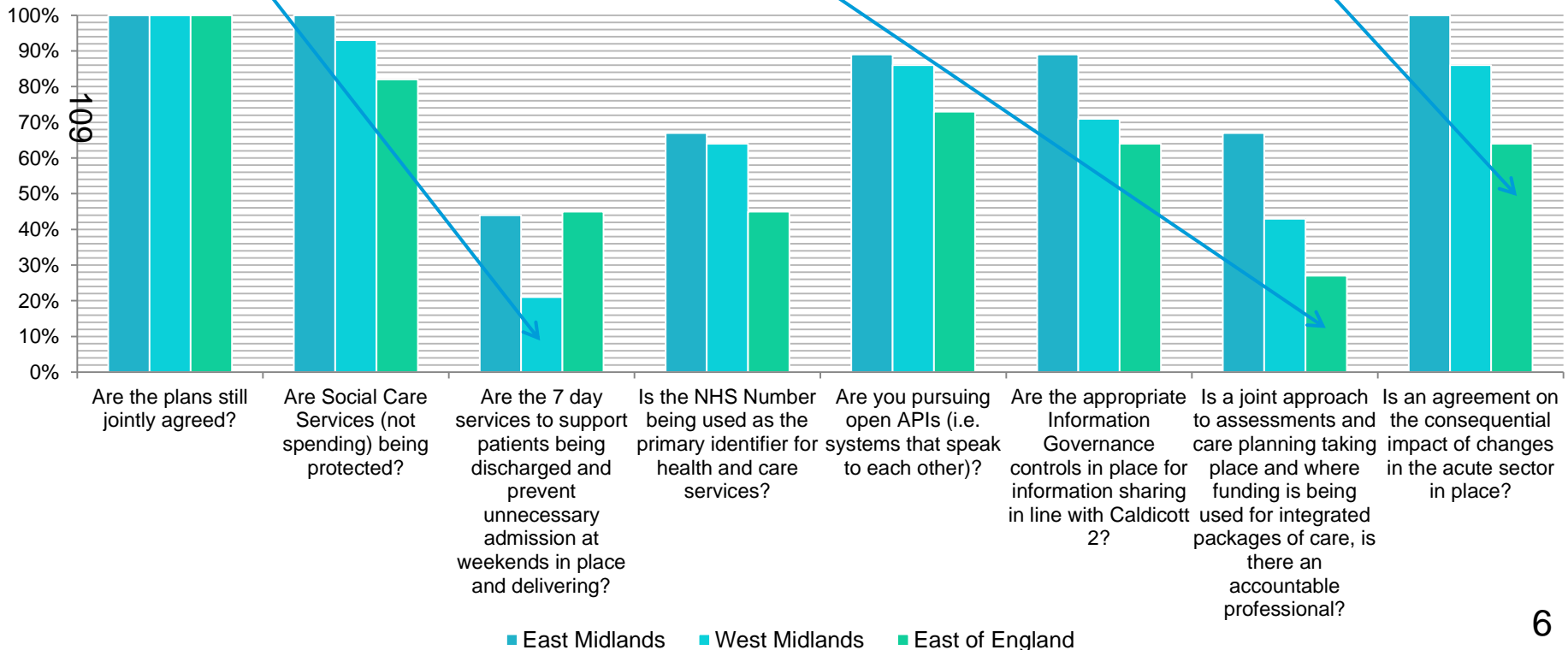
The national conditions – further analysis

Is social care protected?

3 HWBs suggested they were still in the process of protecting social care. Responses suggest there is still on-going commitment to meeting the condition but that the scale of challenge requires further work

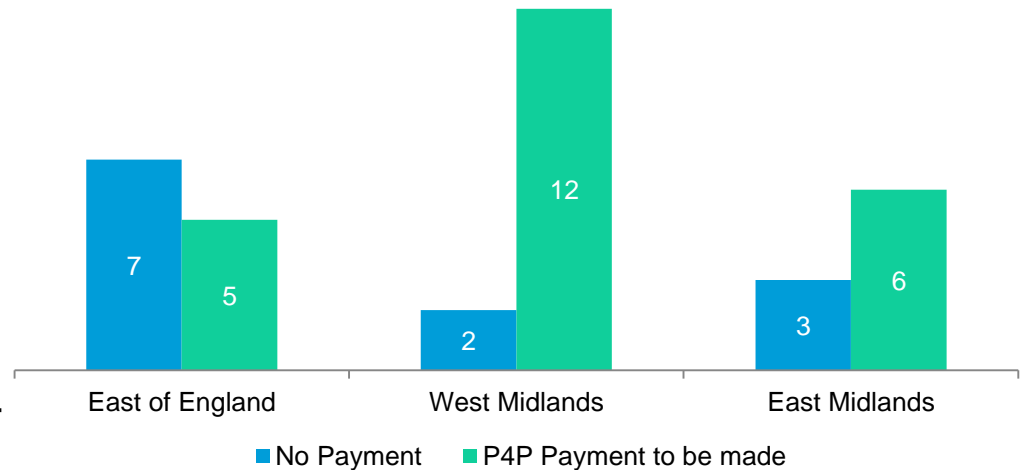| HWBs that responded 'No'	Comments provided
Norfolk	S75 agreements in place with WN, GY&W and Norwich CCGs. North & South Norfolk CCGs have committed to the HWB to sign S75 agreements. (mid June).
Staffordshire	The Staffordshire BCF Plan submission outlined an approach for the Protection of Adult Social Care. All partners will be working together to further develop and deliver detailed plans for this National Condition, with the Partnership Board and Health and Wellbeing Board holding partners to account on delivering these plans.
Suffolk	There are agreed plans which will protect services, although progress in achieving the amounts identified has lagged behind original anticipated timelines.

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Other responses of note

One Health and Wellbeing Board – Leicester - indicated they are not meeting the requirement to pursue open APIs, and have no plan to do so. From their comments they are planning to pursue this as part of the next stage of their integration plans and are already talking to potential providers:
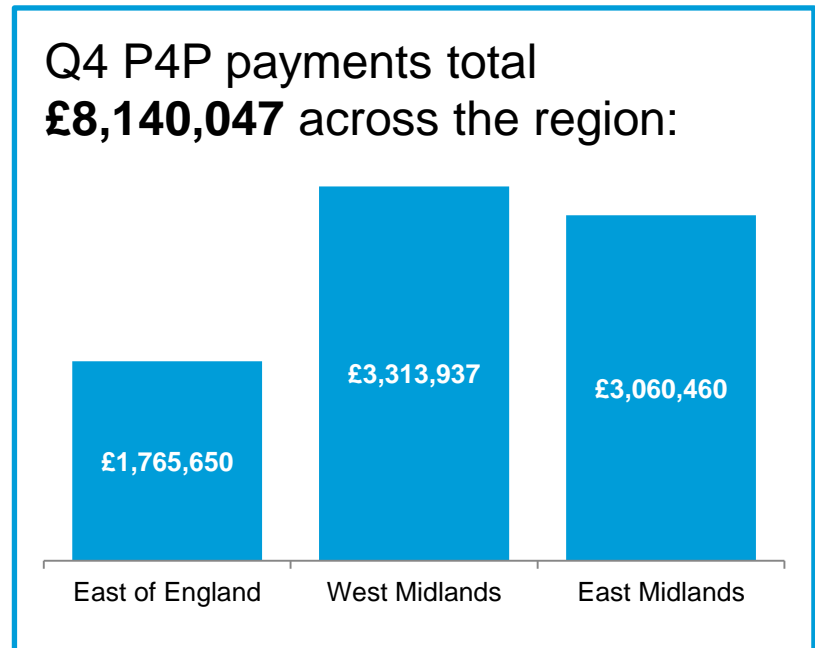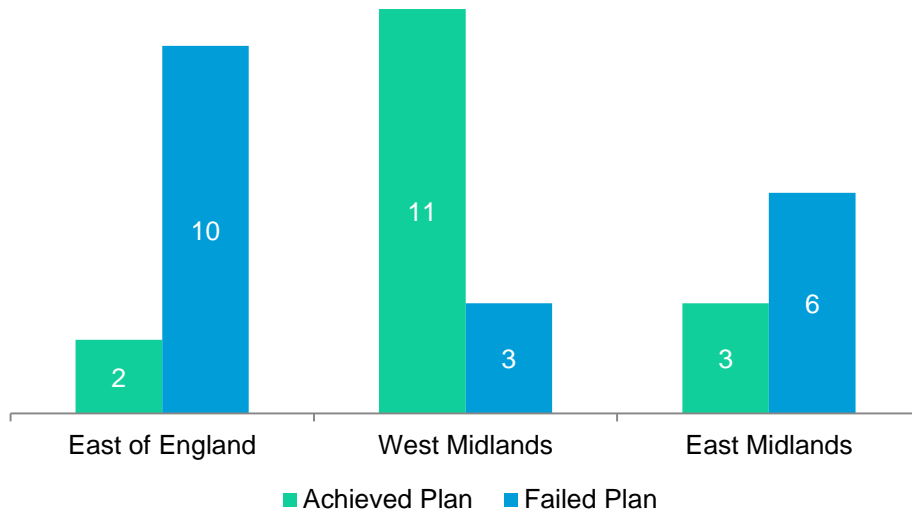
"The partnership is open to and supportive of the use of open APIs and, when procuring software, favours systems with this capability. LCC has no actual direct integration project underway between the Council's main Social Care case management system with health systems or feeds. This is only anticipated at the next stage of maturity of health and social care integration. Currently focussed on bringing copies of verified NHS numbers into the LCC system and accessing NHS systems and data via secure N3 connections. In preparation for phase two the CCG and LA have had a number of joint presentations from providers of middleware solutions which would offer the potential to allow data to be viewed across systems - e,g. ""EPR Core"" from SystmOne."

P4P Summary

- A total of 23 HWBs in the North achieved a performance payment from Q4 of 2014-15

- The West Midlands had a significantly higher achievement rate than other areas

- Only 16 HWBs achieved their Non-Elective plan in Q4

- Only 2 HWBs in the East of England achieved their plan in Q4

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East of England — No Payment 7, P4P Payment to be made 5
West Midlands — No Payment 2, P4P Payment to be made 12
East Midlands — No Payment 3, P4P Payment to be made 6

■ No Payment ■ P4P Payment to be made

East of England — Achieved Plan 2, Failed Plan 10
West Midlands — Achieved Plan 11, Failed Plan 3
East Midlands — Achieved Plan 3, Failed Plan 6

■ Achieved Plan ■ Failed Plan

Q4 P4P payments total **£8,140,047** across the region:

East of England £1,765,650
West Midlands £3,313,937
East Midlands £3,060,460

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Delayed Transfers of Care

- Performance is significantly above plan across the regions

- DTOC rates are higher than planned across the board but with the greatest variance from plan in the West Midlands with 4,600 more delayed transfers than planned in BCF plans

- The East of England has achieved reduction of 1,800 delayed transfers from Q3 to Q4 of 14-15
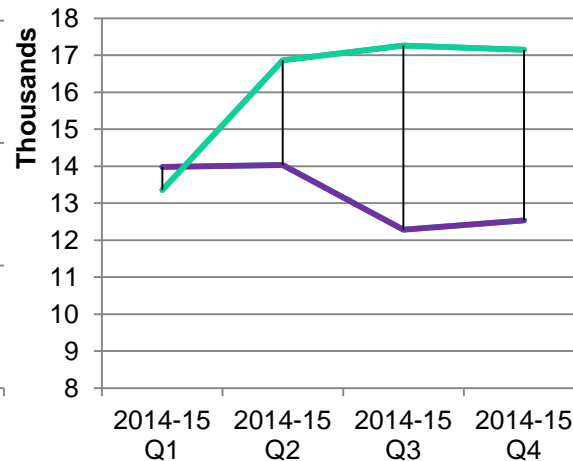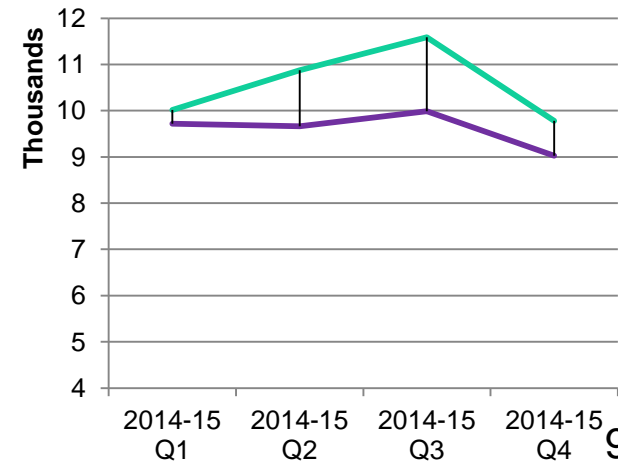
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DTOCs - Midlands and East

Plan — Performance
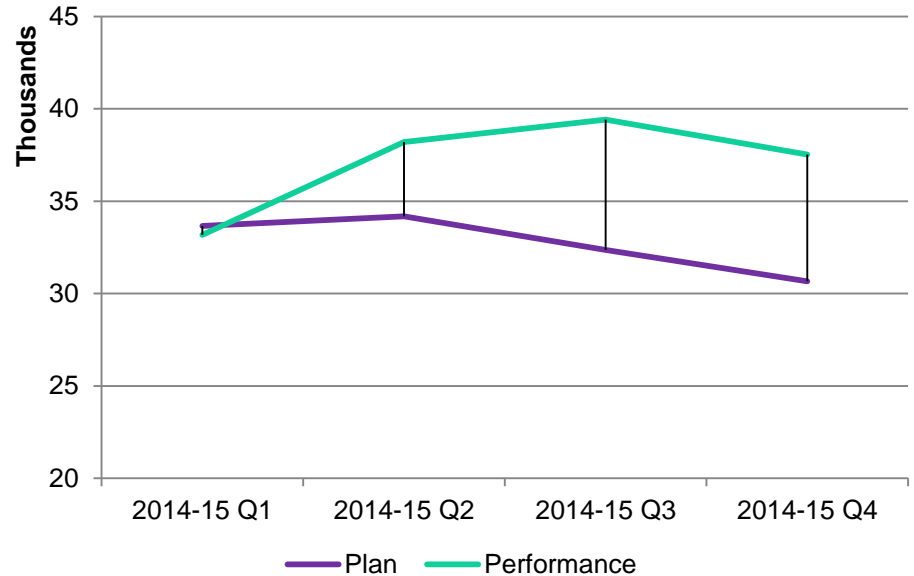
DTOCs - East Midlands
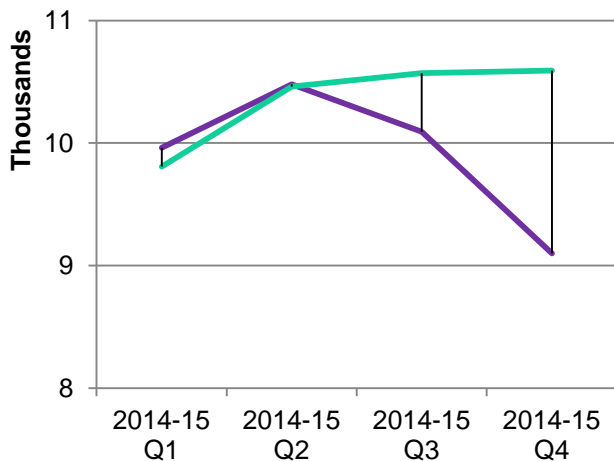
DTOCs - West Midlands

DTOCs - East of England

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Suggested lines of enquiry

The data provided by local areas through the first BCF quarterly return suggests a number of areas that require follow up in order to understand whether they are indicators of material problems with BCF delivery. This information is a snapshot but provides an indication of localities who may require further support. Regional BCF leads are asked to consider the following questions after reviewing this pack.

Overview

- Does the information provided indicate any localities that require significant support - and if so are they getting that support or is this something we can work together to broker?

Signing Section 75s

- Have the 6 areas who had not signed when returns were submitted on 29 May now signed?
- Are the 3 Health and Wellbeing Boards which cited financial pressures as the driver for failing to finalise their Section 75 agreement planning reduce their contributions to the pooled fund?
- What is driving the lack of agreement in the other 3 areas where no information has been provided?

Transferring the Disabled Facilities Grant

- What is preventing the 2 HWBs who have not done this from doing so?

National Conditions

- Are there any wider problems in the 3 localities who do not yet feel that they are meeting the requirement to protect social care services through delivery of their BCF plan?
- What is driving the differences in the % of areas meeting specific conditions, as outlined on slide 6?
- What support might help the high proportion of local areas who are yet to fully meet the conditions for: 7 day services, joint assessments and care planning, and use of the NHS number?

Metrics and P4P

- Are these showing us what we expected to see at this point?

Appendix 1

The national picture

The Better Care Fund

Performance so far against national conditions

National conditions – further analysis

Section 75 issues

- 38 areas saying not currently signed
- All but one area have confirmed will be in place by 31 July (reaming area by end of August).
- Delays seem to be largely caused by ongoing uncertainty over CCG activity plans
- Will be following up through regional teams in order to ensure the revised timescales are adhered to.

Protecting social care

- 8 areas not meeting this condition
- Down to section 75's or risk shares not being in place (Medway, Norfolk, Northumberland) or still finalising details of money/savings needed (Blackburn with Darwen, Staffordshire, Suffolk, Wakefield); North Tyneside saying this is due to CCG financial problems.

What next?

- BCST regional leads to consider qualitative commentary provided across each area to give a feel for areas where issues/complications with delivering conditions is becoming apparent
- Once reviewed data packs will be sent out to regional teams with requests for further information/clarification where needed.

Performance metrics Q4 2014-15

Non elective admissions

- Important to note that the activity reductions increase quarter by quarter; planned Q4 NEL reduction = 38,180 (20% of full year)

- Total P4P pot available for Q4 = c.£56m; **Actual P4P achieved = c.£20m**

- 59 HWBs (39%) receiving P4P, of which 36 achieving maximum available

- 91 HWBs (61%) not receiving any P4P (but 20 systems not planning for reduction in Q4 so did not expect a payment)
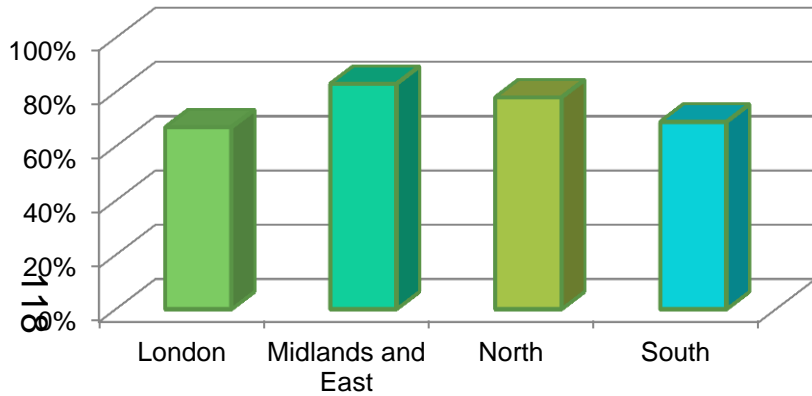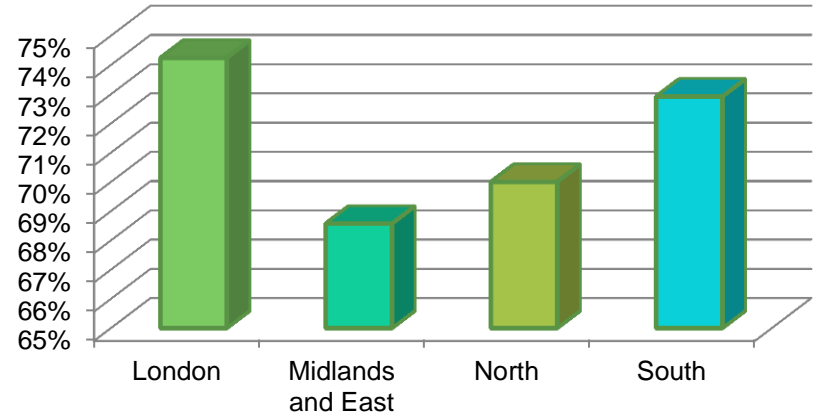
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Delayed transfers of care

- Nationally there has been 18% increase in the number of delayed days between Q4 13/14 and Q4 14/15.

- 54 out of the 150 areas saw some positive movement in reducing delayed transfers of care, and of these 49 performed better than they had planned.

Regional variations?

% Section 75 agreements in place

% compliance with all national conditions

P4P payment as % of pot available