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Rutland County Council

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

Ladies and Gentlemen,

A meeting of the **HEALTH AND WELLBEING BOARD** will be held in the Council Chamber, Catmose, Oakham, Rutland, LE15 6HP on **Tuesday, 1st September, 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 23rd July 2015 (previously circulated).
(Pages 5 - 10)

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) FUTURE URGENT CARE (60 MIN)

To receive a presentation from Caron Williams, Director Strategy & Planning, West Leicestershire Clinical Commissioning Group
(Pages 11 - 28)

6) AUTISM SELF-ASSESSMENT (15 MIN)

To receive report no. 156/2015 from John Morley on the results of the Rutland Local Authority and CCG annual self-assessment submitted to Public Health England in March 2015.
(Pages 29 - 32)

7) COMMUNITY AGENTS (15 MIN)

To receive report no.160/2015 from Karen Kibblewhite
(Pages 33 - 50)

8) BOARD ASPIRATIONS (15 MIN)

Item added for discussion at the request of the Integration Executive Group.

9) ANY URGENT BUSINESS

10) DATE OF NEXT MEETING

The next meeting of the Rutland Health and Wellbeing Board will be on Tuesday, 17th November at 2.00 p.m. in the Council Chamber, Catmose.

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DISTRIBUTION
MEMBERS OF THE HEALTH AND WELLBEING BOARD:

1.	Cllr Roger Begy	Rutland County Council
2.	Cllr Alastair Mann	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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Rutland County Council

Catmose Oakham Rutland LE15 6HP.
Telephone 01572 722577 Facsimile 01572 75307 DX28340 Oakham

Minutes of the **MEETING of the HEALTH AND WELLBEING BOARD** held in the Council Chamber, Catmose, Oakham, Rutland, LE15 6HP on Thursday, 23rd July, 2015 at 2.00 pm

PRESENT:

1.	Councillor Roger Begy (Chair)	Leader of Rutland County Council
2.	Dr Andy Ker	Vice Chair, East Leicestershire and Rutland Clinical Commissioning Group
3.	Helen Briggs	Chief Executive, RCC
4.	Jane Clayton-Jones	CEO of Rutland Citizen Advise Bureau
6.	Mike Sandys	Director of Public Health, Leicestershire and Rutland
7.	Tim Sacks	Chief Operating Officer, East Leicestershire and Rutland Clinical Commissioning Group
8.	Jennifer Fenelon	Healthwatch Rutland

IN ATTENDANCE:

9.	Kevin Pulley (representing Lou Cordiner)	Leicestershire Constabulary
10.	Councillor Alastair Mann	Representing the Portfolio Holder for Health and Adult Social Care
11.	Sarah Smith	Better Care Together, ELRCCG
12.	Kaye Burnett	Better Care Together, ELRCCG

OFFICERS PRESENT:

13.	Dr Tim O'Neill	Deputy Chief Executive and Director for People, RCC
14.	Mark Andrews	Deputy Director for People, RCC
15.	Julia Eames	Team Manager Health and Social Care Integration, RCC
16.	Karen Kibblewhite	Head of Commissioning, RCC
17.	Jane Narey	Corporate Support Officer (minutes), RCC

143 APOLOGIES

18.	Katy Sagoe	Housing Rep
19.	Lou Cordiner	Leicestershire Constabulary
20.	Trish Thompson	NHS England Local Area Team
21.	Councillor Richard Clifton	Portfolio Holder for Health and Adult Social Care

144 RECORD OF MEETING

The minutes of the meeting of the Rutland Health and Wellbeing Board held on the 24 March 2015, copies of which had been previously circulated, were confirmed and signed by the Chair.

---oOo---

Tim Sacks joined the meeting at 2.04 p.m.

---oOo---

145 DECLARATIONS OF INTEREST

No declarations of interest were received

146 PETITIONS, DEPUTATIONS AND QUESTIONS

No petitions, deputations or questions were received from members of the public.

147 TERMS OF REFERENCE

The Terms of Reference were presented by Mr Begy. During discussion the following points were noted:

a) The attendance of 'minimum membership' was not always possible especially the attendance of the Portfolio Holder for Health and Wellbeing and the Leader of Rutland County Council.

AGREED:

1. Each member of the Board would have a named representative to attend in their place if they were unable to attend a meeting of the Board.
2. Mr Alastair Mann would be the named representative for the Leader of Rutland County Council and the Portfolio Holder for Health and Wellbeing.
3. Dr Hilary Fox would be the named representative for Dr Andy Ker.

148 BETTER CARE TOGETHER: UPDATE

A presentation on Better Care Together was received from Sarah Smith and Kaye Burnett from Better Care Together at the East Leicestershire and Rutland Clinical Commissioning Group.

During discussion the following points were noted:

a) The Better Care Together plan required greater detail even though it was a 5 year plan.
b) Change has already happened and has shown tangible results.
c) Partners must work together towards common goals using limited resources.

---oOo---

Sarah Smith and Kaye Burnett left the meeting at 2.32 p.m.

---oOo---

149 YOUNG PEOPLE'S MENTAL HEALTH

Report No. 139/2015 was received from Jennifer Fenelon, Chair of Healthwatch Rutland.

During discussion the following points were noted:

a) The pilot project at Rutland County College has been established and has already met three times.
b) More schools are now involved.
c) Teachers require specialist training as part of the programme.
d) Rutland County Council would offer strong support to identify current and future provision.

AGREED:
1. The Board noted the considerable progress made to date and endorsed the next steps identified within the report.
2. Jennifer Fenelon to present a progress report the Health and Wellbeing Board on the 17 November 2015.
3. Leicestershire Partnership Trust to be invited to the meeting on the 17 November to join discussion regarding Young People's Mental Health.

150 JOINT STRATEGIC NEEDS ASSESSMENT: DRAFT OVERVIEW

Report No. 133/2015 was received from the Director for People and was presented by Karen Kibblewhite, Head of Commissioning.

During discussion the following points were noted:

a) The report has been updated since its distribution to the Health and Wellbeing Board.
b) Data in the report had been quality assured and was correct.
c) The HMP Stocken Health Needs Assessment had been received and would be incorporated into the JSNA.
d) Section 8.4 – Carers (page 55) would be extended as more data was received.
e) The previous JSNA had not changed since its publication in 2012. The new JSNA would be updated on an on-going basis so that the data within the document was up-to-date.
f) Need must be identified before re-commissioning and data must drive the identified needs.

---oOo---
Julia Eames joined the meeting at 3.00 p.m.
---oOo---

<u>Proposed JSNA Chapters (page 36)</u>

g) Frequent Attendees to Primary Care: has increased by 75%. Better communication was needed regarding the availability of other services and the utilisation of these services.
h) Children's Oral Health: data shows that the county has a large number of children under the age of 5 who have tooth decay. The numbers involved are small but show a large percentage in comparable numbers. Officers need to identify if this was the true picture or an anomaly in the data.

i) The proposed JSNA chapters would be reviewed as data was received to ensure they met emerging issues.

AGREED:

1. Tim O'Neill would send Karen Kibblewhite the recent health assessment report on the armed forces, which included data regarding local barracks.
2. Proposed JSNA Chapters should include 'Dementia' and 'Obesity'.
3. The Board agreed the detailed chapter subjects and timescales to complete them.

---oOo---

Karen Kibblewhite left the meeting at 3.20 p.m.

---oOo---

151 ELRCCG QUALITY PREMIUM 2015/16

Report No. 140/2015 was received from Dr Samantha Brown, NHS Arden & Greater East Midlands Commissioning Support Unit and Jane Chapman, Chief Strategy and Planning Officer, East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG).

During discussion the following points were noted:

a) Five options were chosen by the CCG to be part of the Quality Premium including two local priorities (iv & v):

(i) Potential Years of Lives Lost
(ii) Urgent and Emergency Care
(iii) Mental Health
(iv) Primary Care Plans
(v) Deaths in Usual Place of Residence

AGREED:

1. The Board approved the five options recommended by the ELRCCG

---oOo---

Helen Briggs and Dr Samantha Brown left the meeting at 3.32 p.m.

---oOo---

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

Report No. 138/2015 was received from Tim Sacks, Chief Operating Officer, on behalf of Yasmin Sidyot, with support from Julia Eames, Team Manager, Health & Social Care Integration.

During discussion the following points were noted:

a) There would be underspends within the IRI scheme, as not all posts in the new structure had been recruited to but some posts were being covered by locums.
b) Recruitment was difficult if posts weren't substantive as it was not known if the funding would continue after March 2016.

AGREED:

1. The Board noted the contents of the report.
2. The Board supported the recruitment of the proposed new posts.
3. The Board approved the business case for Integrated Health and Social Care Pathways (IRU2).
4. Mr Roger Begy to speak with the LGA Chair to ask the Government if BCF funding would continue after March 2016.

---oOo---

Sergeant Kevin Pulley left the meeting at 3.44 p.m.

---oOo---

153 BETTER CARE FUND: QUARTER 4 - NATIONAL RETURN

Report No. 141/2015 was received from the Deputy Director for People.

During discussion the following points were noted:

a) The new reporting template would be used to provide quarterly updates to the Health and Wellbeing Board.
b) Not all of the Better Care Together performance targets had been met but were consistent regionally and nationally.
c) Awaiting decision regarding BCF validation but if successful we would receive funding of £23k.
d) Performance was on track for the next quarter but we were still waiting for June's data and the performance data could change due to the small numbers dealt with by Rutland.

AGREED:

1. The Board noted the contents of the report.

154 ANY URGENT BUSINESS

A) FORMAT OF THE HEALTH AND WELLBEING BOARD

Mr Roger Begy queried if the meetings of the Health and Wellbeing Board were in the correct format. Was the Board dealing with the correct agenda items? Should the Board invite outside organisations to attend meetings? Or would this be a duplication of what other committees, boards, panels etc. were already doing?

AGREED:

1. Mr Begy would discuss the format of the Health and Wellbeing Board with Dr Tim O'Neill and Mark Andrews.

---oOo---

The Chairman declared the meeting closed at 3.55 pm.

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'It's about our life, our health, our care, our family and our community'

Better care together

Leicester, Leicestershire & Rutland health and social care

Urgent Care

Rutland Health and Wellbeing Board Brief

Sept 2015

Agenda Item 5

Rutland County Council healthwatch Leicester City Council Leicestershire County Council NHS

Summary Plan

To improve the public offer for Urgent and Emergency Care. Ensuring that a clearly understood easily navigated offer is available in each care setting.

To reduce inappropriate admission by offering a viable community alternative when it is appropriate and improve smooth flow through the acute trust to take people ‘home first’ after they have had an episode of ill health.

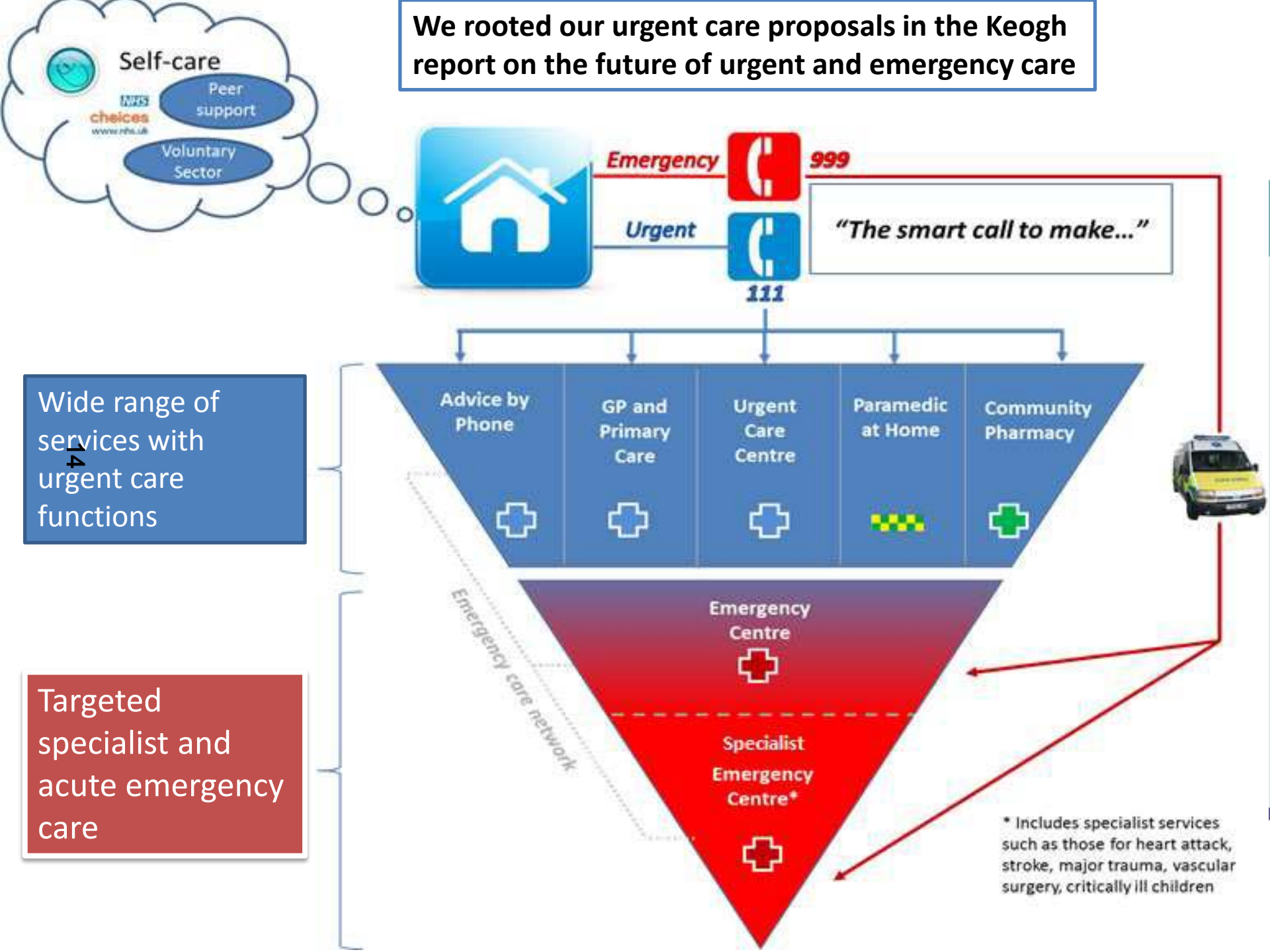
Better care together
Leicester, Leicestershire & Rutland health and social care

Introduction

- Strong system Governance – System Resilience over sight and Urgent Care Group
- Strong programme structure- Inflow, flow, outflow and Futures work
- Strong Plan:- SRG and CCG board approved
- Vanguard Site
- Improved performance
- But still a lack of embedded resilience

Rutland County Council healthwatch Leicester City Council Leicestershire County Council NHS

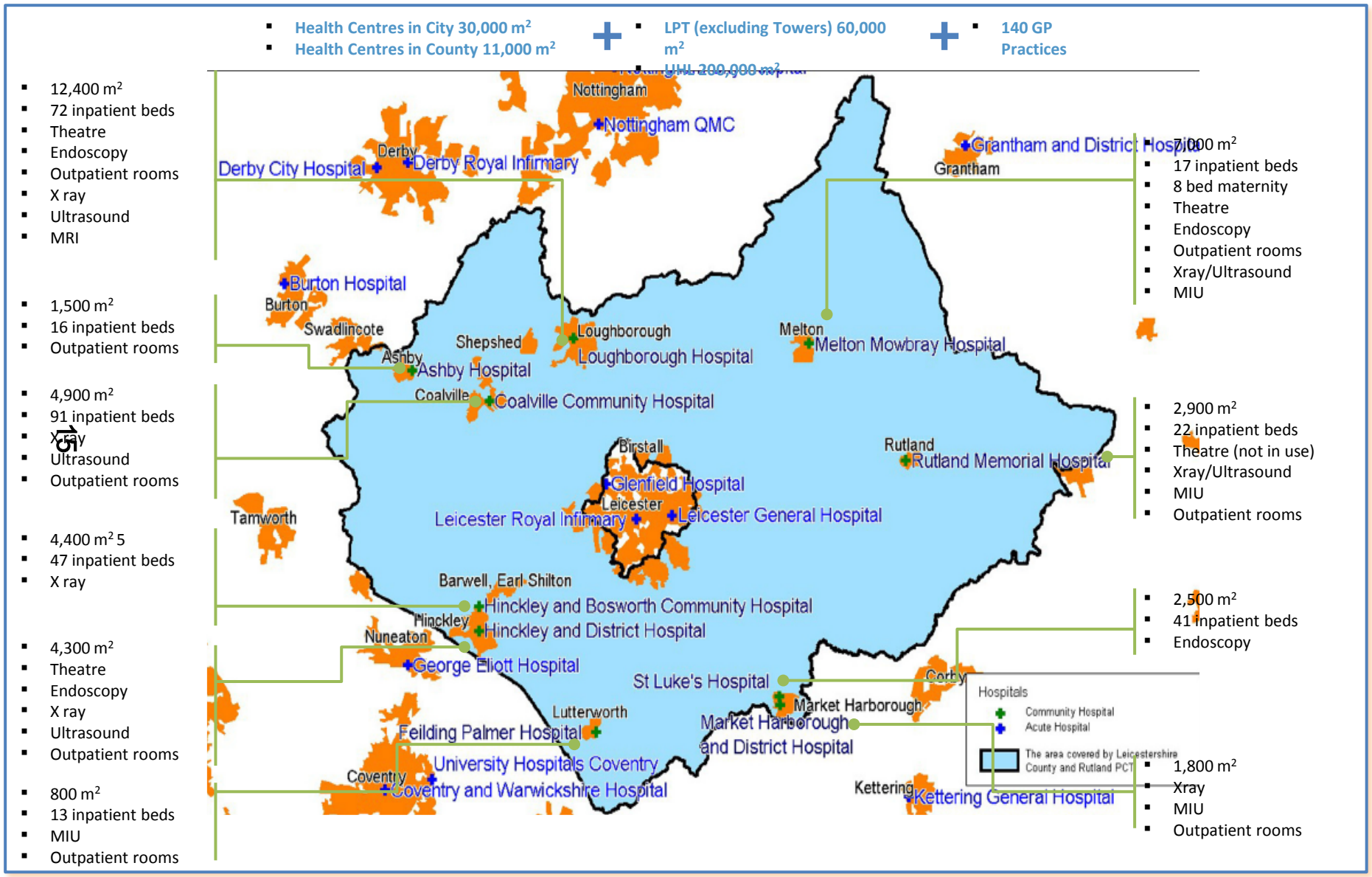
We rooted our urgent care proposals in the Keogh report on the future of urgent and emergency care



Wide range of services with urgent care functions

Targeted specialist and acute emergency care

Settings of care are distributed across LLR, catering to different population needs



Source: March 2013BCT plan; LLR Community Hospitals Operational briefing paper; Capita data
All data is as accurate as presented at that time, services availability has not been updated pending **2014 consultations**

System Principles

0: Self care & prevention	1. Primary Care	2: Enhanced routine care	3: Urgent care & Crisis response	4: Emergency acute care

Keogh 1: Provide better support for people to self care

- Patients will be supported to look after themselves when appropriate without needing to access urgent care services. Physical and mental health will have parity of esteem.

Keogh 2: Help people with urgent care needs get the right advice in the right place, 1ST time.

- Patients will be signposted to the most appropriate service through a locally focussed and responsive single point of access which incorporates clinical triage. They will be able to Choose Well and the urgent and emergency care system will be simple for people to navigate.

Keogh 3: Provide highly responsive urgent care services outside of hospital so people no longer choose to queue in A&E

- Patients will have equitable and prompt access to services wherever they are in LLR and in whichever care setting they enter the system at. More patients will be treated and cared for closer to home.

Keogh 4: Ensure people with serious or life threatening needs receive treatment in centres with the right facilities & expertise in order to maximise chances of survival & good recovery

- Urgent care services across LLR will be consistent and geographic variation will not disadvantage patients.

Keogh 5: Connect urgent & emergency care services so the system becomes more than the sum of its parts

- Urgent and emergency services will be integrated around community footprints.





System Outcomes

0: Self care & prevention	1. Primary Care	2: Enhanced routine care	3: Urgent care & Crisis response	4: Emergency acute care

As providers and commissioners in the local health and social care economy we will work to achieve the following outcomes:

- Improved patient outcomes and patient experience from more joined up working and information sharing between organisations.
- A reduction in avoidable admissions to hospital in a sustainable way so our patients are supported close to home where possible.
- Consistent achievement of national emergency care targets for the NHS including the 4 hour A&E target which we commit to owning as a system.
- A reduction in avoidable A&E attendances as we help our population to Choose Well and access alternative urgent care services when appropriate.
- An increase in the number of patients we support to return home in a timely manner.






Care Setting Principles

0: Self care & prevention	1. Primary Care	2: Enhanced routine care	3: Urgent care & Crisis response	4: Emergency acute care
Patients will easily engage with advice, support and information services. Patients will be able to access these services without a referral. Patients will have the ability to Choose Well.	Patients will access Primary health care as the first active point of contact in the health and social care system. Patients will have access to primary health care when needed on the same day, tomorrow or planned in advance.	Patients will receive proactive and targeted care delivered routinely and as part of a package of care; long or short term. Patients will be cared for in a consistent and planned way. Access will be same day, tomorrow and planned.	Patients can access urgent advice, care, treatment or diagnosis 24/7. Patients will receive consistent and rigorous assessment of the urgency of care need. Patients can expect a response within 2 hours and completed care within 48/72 hours.	Patients are guaranteed immediate response to time critical, serious and life threatening need. Patients can rely on a mobile response through 999 and have a care decision made in under 4 hours. Patients will access intensive input to treat & care for episodes of crisis.






Care Setting Patient Outcomes

0: Self care & prevention	1. Primary Care	2: Enhanced routine care	3: Urgent care & Crisis response	4: Emergency acute care
I am able to look after my physical and mental well being day to day. I am able to access self-care advice when needed. I know where to get guidance on the resources I can use from the health and social care system. I will be able to access patient education courses. I am linked in to the wider voluntary and community support networks in my area. I know who to call if I want more information	I can get a Primary Care appointment on the same day. My GP knows what care I have been receiving elsewhere. I am referred promptly to other services when needed. I feel supported to manage my own condition. My mental health needs are given equal priority.	I am involved in my care and understand my condition. I have a named care worker and a care plan shared across partner agencies. I am supported at home and in the community. I am helped to navigate the system. I can talk with my GP about my care plan. I know who to call if I am worried. I can access short or long term care depending on my needs. I am assessed once and have regular check ups.	I can access the same level of treatment at any UCC within LLR. I can access crisis response services within 2 hours day or night. I can speak to a clinician about my urgent care needs within 2 hours. I have rapid access to community services when needed. I understand alternative options to the Emergency Department. I am seen by trained and competent staff.	I will be seen promptly if I need to attend A&E. I will have access to senior clinical advice when needed. My onward care decisions will be made quickly. If admission is necessary, I will be transferred to a ward in a timely fashion. I will have comprehensive discharge planning in place upon admission. I will not be in hospital for longer than is necessary. I will be discharged before 12pm on day of discharge and have no delays. I will be returned home as the first and preferred option.

Urgent Care door

Front A&E door

Admission door

Discharge door

Future service offer

See Excel printouts!

0- Self Care	1- Primary Care	2- Enhanced/Routine Care	3- Urgent Care and Crisis Response	4- Emergency and Acute care
Right Care: patient decision aids	General Practice	**Enhanced care planning:**	**24/7 SPA: 999/111/OOH SPA all interoperable with one single assessment**	Acute medical / surgical care
Health Coaching	Comprehensive disease registers	Risk stratified population: Managing the high risk 10-20%	**Clinical triage at single point of access**	Emergency Department: Majors and Minors
First Contact- multi agency support	Primary care nursing and ANP support	Integrated and proactive care planning using standard shared care plans and records	Direct booking to local services	Cardiac arrests
Lifestyle Hub-city	ECG/Spirometry/INR NPT in federated hubs.	EOLC pathways and plans	**Rapid Response services:**	Stroke
Public health schemes you can access yourself	2% at risk patients profiled and managed	Supported residents reviews	-Leicester care alarm & falls response	Trauma
Weight management	7 day access and working between practices	**Enhanced management:**	-Fast Response Vehicle + see & treat ambulance	Neuro
Alcohol and drug misuse	Expert patient programmes	Community health and mental health wraparound services	Acute Visiting Service (West)	Paeds
Smoking Cessation	Dementia care advisors	Case management through virtual ward schemes	Integrated crisis response Service	Major Trauma Unit- out of county
Sexual Health	Optometry services	'Locality' health and social care teams targeting at risk and case managed patients (HSCCs)	MH Assertive Outreach	Maternity
Wider community & vol. sector support	Dental surgeries	Key workers	Psychosis Intervention and Early Recovery (PIER)	Neonates
Local Area Coordination/ Local Support Groups	Community Pharmacies	Case workers	**At increased risk group:**	Discharge date and pathway agreed at point of admission
Healthy Cities Programme		Direct booking in to primary care	Pharmacist lead medication reviews	Mental health acute admissions
Customer portal; self assessment and signposting		Falls response team- trusted responders	Palliative care and night nursing	
Carers and Young carers support and training		**Remote monitoring:**	**Urgent care centres**	
Dementia cafes		Tele care	Standard offer across Urgent care centres	
Integrated housing support service		Tele health	Comprehensive assessment (including CGA)	
Falls prevention information			Ambulatory care sensitive conditions pathways with access to MDT: asthma, COPD, Heart Failure, DVT, Cellulitis	
		Step up/down services:	**Frailty hubs/ Older people's unit**	
		Domiciliary care		
		Intensive primary care/ social care interventions immediately following discharge	Observation "beds"	
		Intermediate care beds: social care	Community diagnostics (digital links/ near patient testing)	
		Residential and non-residential reablement services	ECG/X Ray/Ultrasound	
		Intensive Community Support	Pathology/Phlebotomy	
		Community hospital inpatient care (length of stay 0-5 days- increased acuity and throughput)	Intravenous procedures: Diuretics, antibiotics	

IMT: 1 shared primary care system. Standardised and accessible care plans and risk stratified approach to promote continuous care planning. One SPA with clinical assessment at point of contact and local alternatives available for direct booking: eDOS. Customer portal and single point of information. **Workforce**: skill-mix mapping and redesign across sectors. Understand impact of shift in services "to the left" and increase in acuity of patients managed in the community **Premises**: understanding virtual and physical hubs/ footprints. link to City premises review **Other**: Demand/ capacity whole system modelling. Capacity management & early warning system/ emergency planning system.

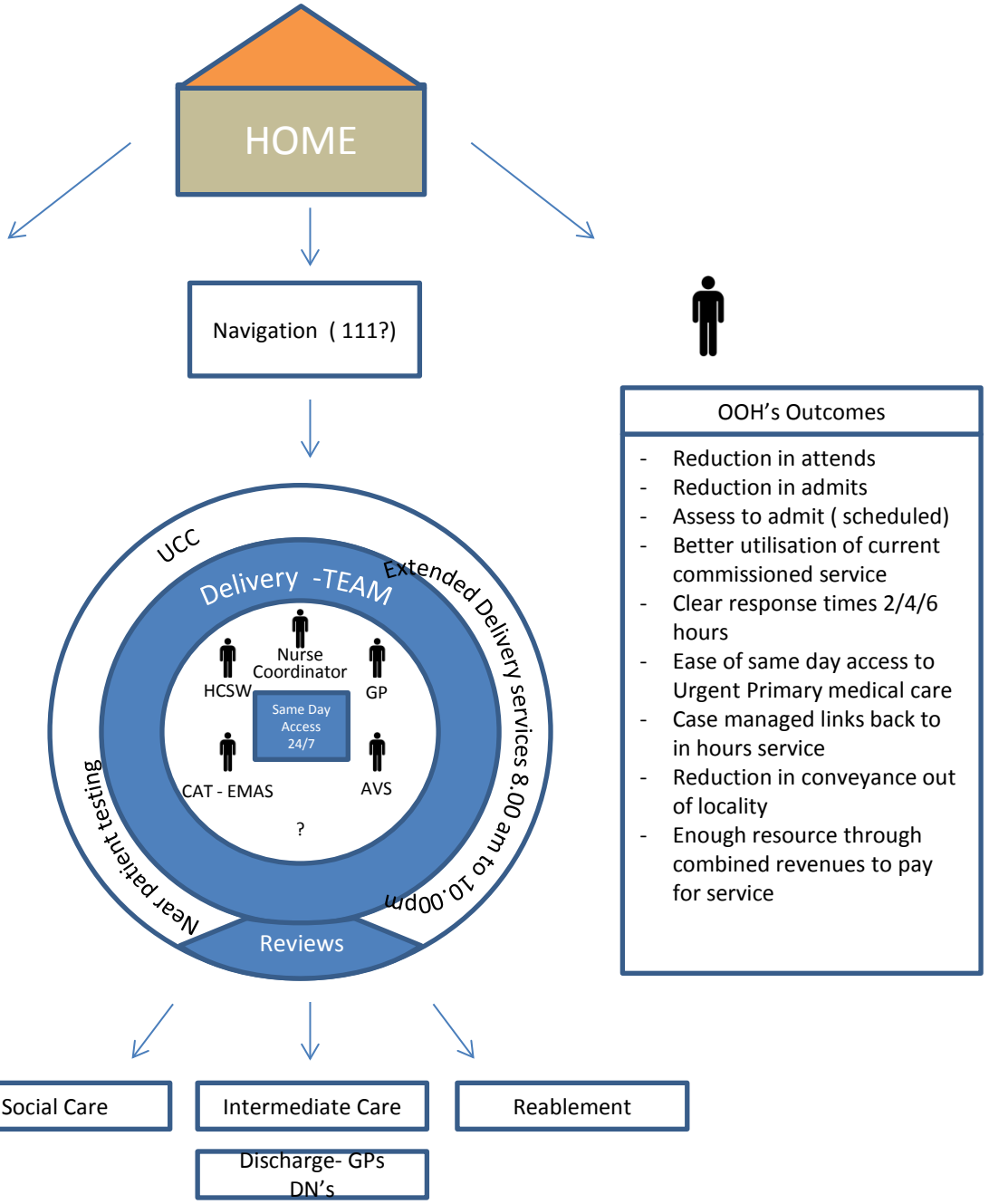
Current Status - 2015

- Improving performance position but not as resilient as we need it to be
- Increasing footfall onto the LRI site- this diminishes resilience
- Year of change contract deployed – there is still significant financial/ change challenge based on activity growth
- Procurements due to be completed April 2016 for NHS 111/ OOH's Loughborough and LRI UCC
- NHSE Gateway publication halting current procurements on NHS 111/OOH's
- Good relationships leading to a Vanguard bid

This Years Actions - that impact on Demand and Delivery

- Front Door Work
- NHS 111 procurement
- Integrated OOH's procurement
  - 7 day Primary Care
  - UC centres
  - AVS / CRT
  - Older Persons Unit Loughborough…. Assess to Admit
- SPA – start of integration (LA – CHS County)

OOH's integrated response



Front Door Work 2015-17

Current Status:

- Heavy footfall
- Single front door through the UCC

Next Steps:

- Separate out the triage/assessment function- head up with GP's and trained UC nurses
- UCC becomes a disposition, alongside minors and majors 2017
- New ED Floor
- Train and retain specialist UC GP's and skill mixed workforce

NHS111

Current Status:

- Provided as protocol based telephony
- Light on elements of clinical triage
- Too many dispositions to A+E, 999 and OOH's services

Next Steps:

- Work with NHSE through Agree future model of provision
- Link to OOH's
- Consider Social care SPA implications

Governance

Clinical:

- Clinical lead – Avi Prasad/ Dick Hurwood/ Nick Wilmot
- Work Stream Steering Group
- Urgent care Board

PPI:

- Lead – Philip Parkinson
- Cross checks with PPI reps for Frail Older People and Long Term Conditions
- Ongoing interface with established forums

Board to note:

- SRG accepted draft Urgent Care Improvement Plan
- Workstream has funds built into contracts and transitional resource of 2 million revue allocated
- SPA programme has capital allocation-1.3 million and 230K business planning fund in the county BCF- 700K capital established for mobile working
- Vanguard Bid part of the national 8 urgent and emergency care systems
- Strong system infrastructure, multi stakeholder engagement embedded.
- Need to strengthen comms and broader programme understanding of transformational rather than transactional change
- Need to engage broader stakeholders and out of county acute trusts

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Report No. 156/2015

Report to Rutland Health and Wellbeing Board

Subject:	**Autism Joint Self-Assessment Framework 2014/15**
Meeting Date:	**1st Sept 2015**
Report Author:	**E Perkins**
Presented by:	**J Morley**
Paper for:	**Note**

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

This report links to the following strategic aims of Rutland County Council:

- Creating a brighter future for all
- Meeting the health and wellbeing needs of the community

This report provides members of the Health and Wellbeing Board (HWB) with information about the National Autism Strategy Self-Assessment Framework (SAF) which was submitted to Public Health England in March 2015.

Background

The Autism Act 2009 required that local authorities and local health bodies work together to improve on supporting the needs of adults with autism. The Act was followed by a national strategy (*Fulfilling and Rewarding Lives)* and statutory guidance for local authorities and NHS organisations. The self-assessment includes the priorities set out in *'Think Autism'*, the update to the national strategy published in 2014.

The purpose of the self-assessment is to enable local areas to review their progress against the strategy and support future planning with partners including people with autism and their families. The self-assessment is also a key means of identifying progress across the country which the Government has a duty to monitor. The information provided will be analysed by the Public Health England Learning Disabilities Observatory and will help in this process.

The Self-Assessment (SAF)

The SAF is divided into 10 main sections under the following headings:

1. Introduction
2. Planning
3. Training
4. Diagnosis
5. Care & Support
6. Accommodation
7. Employment
8. Criminal Justice System

9. Local good practice
10. Self-Advocate experiences

There are a mixture of RAG rated questions, data responses and narrative required to complete the SAF.

Whilst the Local Authority is tasked with the consolidation of the return as the lead body locally, delivery against the framework is a multi-agency responsibility.

2014 Rutland SAF

Rutland County Council worked closely with the Leicester, Leicestershire and Rutland (LLR) CCG's and Local Authorities in completing the SAF. The SAF analysis shows that Rutland is doing very well in 12 areas such as:

- Working together across CCG's, police LPT and Local Authorities – a new LLR Autism Partnership board has been established. This board will provide a multi-agency oversight to the implementation of the Statutory Guidance and the 2015 LLR Adult Autism Strategy. The LLR Adult Autism Strategy was developed from information provided in the SAF reports of all 3 LLR LAs
- Planning together with people who have autism and their families. Carers of people who have autism are offered an assessment
- Rutland have a JSNA
- In LLR there is an agreed diagnostic pathway
- Young people with autism are supported into adulthood
- There is an independent Advocacy service available

In the following areas Rutland needs to do more:

- Improve the information on people who have autism and the quality of data received from education, children and adults social care, CCGs
- More reasonable adjustments made to Council, health and public services for people with autism, including awareness training, training in communication skills and how to assess people with autism
- Identify older people and women with autism in Rutland
- Support people with autism into employment and provide local housing options

The following areas need a lot more work:

- Information sharing and awareness raising in courts, prison and probation services for people with autism
- Support for people with autism to access Psychology, Speech and Language and Occupational Therapy services

Next Steps

The LLR Autism Partnership board members will work together to identify, agree and monitor the priority areas for action going forward.

Financial implications:

There are no financial implications to the council with regards to completion of the

SAF. The data submission may highlight areas for development across Health and Social Care which may require resources.		
Recommendations:		
It is recommended that the Health and Wellbeing Board: (a) Notes the content of the Self-Assessment		
Strategic Lead:	E Perkins	
Risk assessment:		
Time	L	The Self-Assessment has been completed and returned
Viability	L	The Self-Assessment has been completed and returned
Finance	L	No implications anticipated
Profile	M	The profile of quality Learning Disability and Autism service provision has increased recently as a result of the abuse sustained at Winterbourne View
Equality & Diversity	L	No adverse impact anticipated

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Report No. 160/2015

Report to Rutland Health and Wellbeing Board

Subject:	**Rutland Community Agents**
Meeting Date:	**1st September 2015**
Report Author:	**Amy Callaway, Spire Homes & Sam Howlett, Rural Community Council**
Presented by:	**Amy Callaway, Spire Homes & Sam Howlett, Rural Community Council**
Paper for:	**Note**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:

This paper is to provide an update on progress on the implementation and delivery of the Better Care Fund element of the Community Agents Scheme for Rutland from 1st April – 31st July 2015. The service is delivered in partnership with the Rural Community Council through funding received from The Big Lottery.

The Scheme links to the following Strategic Objectives:

- Creating a safer community for all
- Meeting the health & wellbeing needs of the community

Progress to date:

a) The staffing structure for the scheme has been updated following a review of the service to ensure effective management of the staff team and service. The service structure now comprises a Partnership Management Group to ensure robust monitoring and management of the operational management team, and a joint operational management team in replacement of the two tier model **(Appendix A).**

b) Following four unsuccessful recruitment rounds the service has now recruited to the two vacant P/T positions. One of these vacancies was filled in July and the other is due to be filled from the beginning of September. One of the existing F/T agents resigned from their post in July, interviews for this vacancy are scheduled for the 18th August, following successful recruitment the service will be at full capacity. As an interim measure we are using some bank hours to support the service whilst recruitment is being undertaken.

c) As of 1/08/15 The Bridge will cease to provide services as a funded partner of the RCA. Due to internal staffing changes they are no longer able to provide a designated worker to manage the EET cases. A meeting has taken place with RALs and the Spire Homes Floating Support service to ensure that individuals with an EET need are able to access support accordingly. This will be monitored and revised depending on demand and outcomes achieved.

d) The first Advisory Committee meeting took place in May, the group discussed and confirmed the Terms of Reference and were provided with a service update. Following review of the service structure and the implementation of the Management Group it is proposed that the Advisory Committee is reshaped and renamed as

'Partner Engagement Panel' to better reflect the role of the group. The panel will provide feedback and support to ensure the scheme maintains a focus on its objectives and makes links across as many services as possible. This will be in addition to the formal contract and performance monitoring RCC will undertake with Spire as the lead agency for the duration of the contract.

e) The service continues to work in partnership with local voluntary, community and statutory organisations to ensure a holistic approach to service delivery, to date the service has made143 outward referrals (primarily through First Contact Rutland). The service has established links with 24 new groups/activities/services across the county as well as continuing to work with known partners. A full Partner Engagement and Networking list can be made available on request.

Future partnership working includes holding pop-up clinics out in the villages in partnership with CAR, developing Rutland information packs in partnership with the Integrated Care Co-ordinator for use in hospitals and GPs, Community Agents assisting with providing Assistive Technologies and the development and provision of E Learning training modules for clients to build their skills for employment.

f) The Community Health Link Agent (HLA) is now working closely with the senior OT at RCC to improve hospital discharge and prevent unnecessary admissions. Strong links have been made with the Hospital Discharge Teams at both Peterborough and Rutland Memorial Hospital. The HLA is now based on the ward at the RMH twice weekly and attends Board Rounds which has had a positive impact on the level of referrals received. A meeting has been arranged with the Admissions Avoidance Team at Peterborough Hospital to develop future partnership working. The HLA met with and gave a presentation at Melton Hospital in early August; as a result the HLA will partake in Board Rounds every Thursday. To date the HLA has received and processed 11 hospital referrals, supporting individuals with their return home.

The HLA gave a presentation at the GPs Federation Meeting on the 2nd July 15. It was agreed at the meeting that the GPs preferred method of referral to the Rutland Community Agents is to provide applicable patients with a RCA card and encourage them to make contact with the service. Consequently information packs have been compiled containing the agreed cards and service leaflet; these were mailed out to GP practices in Oakham, Empingham and Uppingham at the end of July. The HLA is now working on establishing links with the practice in Market Overton.

To date the HLA has offered advice, assistance and signposting to 36 individuals to support them to sustain their independence.

g) Formal Outcome Star training was undertaken in July, Agents are now able to use the electronic tool to capture outcomes achieved and distance travelled. From August the service will be able to produce more comprehensive reports relating to impact achieved for service users.

h) Promotion and marketing of the service is on-going to further raise the profile and imbed the service within the county. Actions set out in section 4 of the Communication Plan continue to be completed against set timescales **(Appendix B).** A review of the Plan is due to take place in September with the Spire Homes Marketing & Communications team. The launch event took place in June and was well attended. The service has been promoted in the local press, through targeted mail outs, drop-in sessions, face to face networking, social media including Twitter and Facebook and by providing presentation and talks at local events and agency team meetings. Once the service is at full capacity our marketing material will include

detail on each Agents designated area, a full marketing campaign will be launched to promote this. Currently the Agents use calling cards across the areas they oversee.

i) The services website is now fully established with a reported 3,237 visits since April which is exceptionally high for a brand new service. The site now hosts its own RCA information centre which provides self-help toolkits and information on a wide range of topics under the following headings; Health, Education, Social Activities, Support ,Employment and Lifestyle. The site promotes and links in to the Councils Rutland Information System which the Agents update regularly.

j) As at 31st July 15 the RCC funded element of the service has supported 132 individuals across Rutland, with an additional 36 individuals supported through the Big Lottery funded element of the partnership delivered by the Rural Community Council. Of the total amount of closed cases where an Outcome Star has been completed 100% of individuals have demonstrated progression in the areas in which they had an identified support need.

Further operational and statistical detail is included in the service report for July in **Appendix C**.

Financial implications:

The service is jointly funded through the Better Care Fund with further funding provided to the Rural Community Council through The Big Lottery Fund.

Recommendations:

That the board:

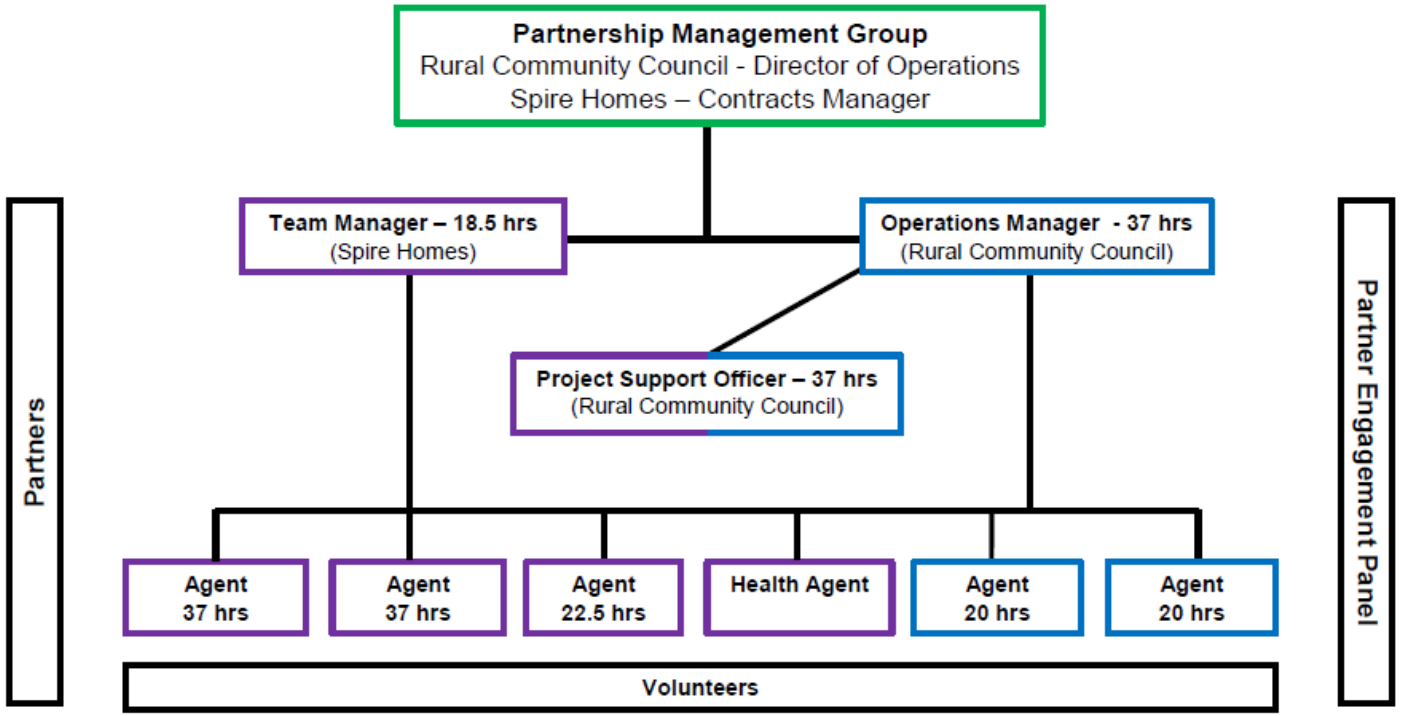
1. Note the contents of the report.
2. Provide any suggestions or comments to support further service development.

Strategic Lead:	Karen Kibblewhite	
Risk assessment:		
Time	Low	The Community Agents scheme became operational from 1st April 2015. The Scheme will start to impact on the BCF targets within the year.
Viability	Low	The Scheme is operational.
Finance	Medium	Funding for the financial year 2015/16 is secured through the BCF funding allocation. In order to allow the scheme to be implemented, evaluated and modified (if appropriate) then funding needs to be in place for a three year period. It is anticipated that BCF funding will remain in place. If this is not the case then a realignment of funding within the People Directorate will be required. The addition of the Lottery funding in the Rural Community Council will secure the scheme further. The proposals are within the resources available.
Profile	Medium	This scheme is central to our early intervention and preventative response in communities as part of the Better Care Fund.
Equality & Diversity	Low	A full impact assessment will be undertaken against the service specification.

Appendix A

Rutland Community Agents

Delivery Structure



PURPLE = Better Care Funded Post
BLUE = Big Lottery Funded Post

Funded by: Rutland County Council; LOTTERY FUNDED

Delivered by: spire HOMES; RCC

Appendix B

4 Key Communications

These are the key actions to take us from launch to the first 6 months of the service.

Key: CA (Community Agents), RCC (Rutland County Council), SHO (Spire Homes Operations) – includes the marketing team, and head of service from Spire Homes, SR (Sue Renton, Operations Manager employed by the Rural Community Council), AM (Andy Maguire).

When	What	Who	Status
w/c 31st March	All general collateral prepared: letterhead, compliment slips, auto-signatures, etc. prepared and in use.	SHO	Complete
w/c 6th April	Uniforms and Lanyards ordered – these will provide a consistent image for all of our agents and will help them become more and more recognisable as the service develops.	SHO SR	Complete
w/c 6th April	Promotional Letter and Initial Leaflet sent to key stakeholder list	SHO, AM, SR	Complete
w/c 13th April	Press promotion in local media	SHO & RCC	Complete
16th April	New R C Agents – website launched and this will also be communicated via an e-newsletter	SHO	Complete
April & May	More collateral prepared – specific service literature.	SHO	Complete
13 the April – On-going	Identify and draw up a list of local businesses, groups, services to target – to share information and sign-post users to the service	CA	209 contacts identified and on mailing list to promote service to and generate referrals. 24 new agencies / services identified and added to the RIS.

1st May	Contact local agencies, services and groups identified to promote the service and establish community links	AM, SR CA	Complete & on-going Local services have attended team meetings to give briefs / presentations also provided by team members at meetings. Mail outs completed to all including all service information. Newsletter uploaded and circulated periodically.
18th June	Launch Event for key stakeholders and also local residents (two events held at the Victoria Hall – morning and afternoon)	SHO, CA & RCC	Complete
Quarterly e-newsletter	First one delivered in: June & then every following quarter	SHO	Complete
April – On-Going	Coffee meetings/mornings will be held throughout the county to promote the service and what's available.	CA	Complete 7 x weekly meetings / coffee mornings set up over county.
April and Continuously as the service develops	Providing leaflets to venues within wards	CA	Complete Extensive leaflets drops completed by agents.
April Onwards	Arranging network meetings with key agencies and invite to RCA Team Meetings	SR/AM	Complete. Key agencies are attending meetings to give brief of their services i.e. Police, Fire Service, Alzheimer's Society, Red Cross, VAR.
April onwards – as relevant	Press releases about the service	SHO	Complete
April - onwards	Building up the mailing list digitally and in print – so that the service can be fully promoted.	SHO	Currently 209 contacts identified. On-going

May & On-going	Set up and provide presentations to key partners and referrers	AM, SR & CA	Complete / on-going. Presentations have been provided i.e. Parish Council Meeting, Adult Social Care & all RCC employees, GP's Federation Meeting, Learning Disability Forum, Rutland Tenant & Leaseholders Partnership etc.
May onwards	Promote integration across services and referring people across a variety of sites	CA	Complete Referrals have been made to 23 different agencies.
May and on-going	Establish pop up surgeries in the wards to take place quarterly	SR/AM/CA	Complete, 4 x pop up surgeries have been organised.
May and on-going	Promoting service across the county through activities, event, forums, meetings etc.	CA	Complete – Networking & Partner Engagement List provides further detail.
May and on-going	Set dates to promote the service through the First Contact bus	SR/AM	Complete Agents have been out on Contact Bus and will continue to do so.
May and on-going	Feeding back into Rutland Information Service	CA	Complete Monthly uploads are being undertaken.
May and on-going	Promoting and confirming position as first port of call for people seeking advice	AM, SR & CA	Complete and on-going To date 132 individuals have accessed the service, 3,237 hits on website, 143 external referrals to partner agencies.
May and on-going	Identifying the most vulnerable within the county and targeting services to these people	CA	Complete & on-going Active use of lifeline activations /falls reports. Contact made at hospitals, GPs,

			Adult Social Care, Sheltered Housing Services, Mother & Toddler Groups etc. Further work being undertaken in villages establishing contact with local businesses.
May and on-going	Targeting patients at risk of isolation or breakdown in their health condition	CA	HLA linked in with 3/4 GPs and 3/4 Hospitals. Contact made with AAT, OTs, Integrated Care Coordinator and more.
May and on-going	Identify and work proactively with key individuals and links in the community, Parish and Town Councils	CA	Complete Contact made with Parish councillors, clerks. Combination of phone contact, mail outs. This work will be on-going.
May and on-going	Undertake home visits to provide access to information and services	CA	Complete Agents completing advice / assessments at client's homes.
May and on-going	Community Agents shall promote themselves widely within their communities and actively carry out publicity activities to reinforce their role	CA	Completed and on-going. See Networking & Partner Engagement list for more details.
Aug and on-going	Provision of case studies to sign-posted stakeholders so they are fully aware of the role of the CA	CA	Case studies with Marketing to be uploaded to website. Case study to be included in next edition of service newsletter and circulated to stakeholders.
Sept and on-going	Mapping existing resources/services across service types	CA	
Sept and on-going	Identify gaps in provision	SR/AM/CA	

Appendix C

Rutland Community Agents
Monthly Service Report
July 2015

1. Service Counts

Service	Number throughout the month	YTD total
Number of existing clients accessing the service carried forward from last month	22	
Number of new individuals accessing a Community Agent (C.A.)	23	96
Number of new individuals accessing the Health Agent (H.A.)	5	36
Number of individuals accessing the RCA service (Lottery funded element)	10	36
Total number of individuals supported by the service	**60**	**168**
Number of C.A. appointments undertaken	46	141
Number of H.A. appointments undertaken	11	45
Number of C.A. support contacts via the telephone	69	79
Number of H.A. support contacts via the telephone	10	15
Number of individuals who have completed the full Outcome Star Assessment	10	49
Number of individuals receiving 'One off' information & advice	18	95
Number of clients contacted through group events	46	380
Number of professionals/local business owners contacted through networking events	100	292

Note: During July the service operated 37 hours per week under capacity due to a combination of A/L and vacancies. Interviews for the remaining vacant position are taking place on the 18th August, vacant hours are being part back filled with bank staff in the interim. Once at full capacity the number of clients accessing the service will continue to grow.

2. Incoming Referrals / Contacts

Number of C.A. cases carried forward from last month	10
Number of H.A. cases carried forward from last month	12
Number of referrals from outside agencies	11

Number of self-referrals/contacts/ Family & Friends	7
Number of referrals generated by RCA's	10

Breakdown of external agency referrals

GP	0		Alzheimer's Society	0
CAB	0		The Bridge EET	0
Age UK	0		Rutland Memorial Hospital	2
Adult Social Care	1		Peterborough Hospital	1
RCC Front Desk	0		LRI and Leicester General	0
Housing Provider	3		Glenfield Hospital	0
Lifeline	1		Police	0
Fire	1		Homestraight	1
St John & Anne Service	1			

Breakdown of referrals by wards

Braunston & Belton	1		Normanton	1
Cottesmore	0		Oakham North East	0
Exton	1		Oakham North West	0
Greetham	0		Oakham South East	3
Ketton	1		Oakham South West	2
Langham	2		Ryhall & Casterton	6
Lyddington	0		Uppingham	10
Martinsthorpe	1		Whissendine	0
Homeless	0			

Note:

Leaflet drops have commenced in areas direct to homes where no referrals have been received from. Drop-in clinics have been arranged for Oakham and Cottesmore and widely advertised. Further events will be arranged in areas with low contact/referral rates.

3. Equal Opportunity Monitoring

The information below relates to new starters during the reporting period, not all clients choose to share this information.

Age Group	**No**
16-25	0
25-40	1
40-60	8
Over 60	19

Gender	**No**
Female	13
Male	15

Sexual Orientation	**No**
Heterosexual	10
Gay	0
Lesbian	0
Bisexual	0
Transgender	0

Ethnicity	Tick
White British	9
White Other	
Black British /Caribbean/ African/ other	1
Asian British / Pakistani / Bangladeshi / Indian / Other	
Chinese	
Other	

Disability/Carer Responsibility	No
Has a disability	2
Has a caring responsibility	2

Needs Analysis

Individuals receiving 'One Off' information/advice:

The ratings show the combined top 3 support needs across the county.

Support Need	No	Support Need	No
Living Environment	2nd	Managing Symptoms	3rd
Family & Friends		Work, Volunteering & Activities	
Lifestyle		Managing Money	
Looking after yourself	1st	Feeling Positive	

Individuals receiving Outcomes Star Assessment:

The ratings show the combined top 3 support needs across the county.

Support Need	No	Support Need	No
Living Environment		Managing Symptoms	
Family & Friends		Work, Volunteering & Activities	1st
Lifestyle	2nd	Managing Money	3rd
Looking after yourself		Feeling Positive	

Description of Support Area
The following descriptions provide an overview of the type of advice/guidance/signposting that the agents support with in relation to the top three areas of need:

Work, volunteering & activities:

- Conditions individuals have that affect their ability to do the work, volunteer, study or partake in other activities.
- Access to EET
- Preparing for EET
- Changes in employment
- Information on activities of interest
- Support to develop own/community activities

Lifestyle:

- Advice on lifestyle changes recommended for specific conditions or changes in need
- Healthy eating, exercise, nutrition, balanced diet, being active

- Mental Health, Stress Management,
- Getting connected, socialising

Managing Money:

- Changes in financial circumstances
- Budgeting
- Debt Assistance
- Rent Arrears
- Utilities
- Setting up a bank account
- Benefit entitlements

Progress made against Outcome Star Areas:

(Based on the 15 individuals exiting the service)

Outcome Star Area	**Average score at initial assessment**	**Average score at exit assessment**	**Progress made (+ or -)**
Living Environment	7.86	8	**+0.14**
Family & Friends	6.53	6.8	**+0.27**
Lifestyle	5.33	5.66	**+0.33**
Looking after yourself	5.13	5.46	**+0.33**
Managing Symptoms	5.06	5.4	**+0.34**
Work, Volunteering & Activities	4	4.46	**+0.46**
Managing Money	5.73	6.13	**+0.4**
Feeling Positive	4.86	6.06	**+1.2**

Note: The online Outcome Star tool is based on a scale.

Stage 1 “Not thinking about it”, client not ready to about this need yet.

Stage 2 “Finding out”; client is ready on finding out how you can improve things.

Stage 3 “Making changes”, this step is to use the information and tips to decide what to improve this area of their life.

Stage 4 “Getting there”, at this point the client is managing this area of their life pretty well but there is more they could do.

Stage 5 “As good as it can be”, client is doing everything they can to manage this aspect of their life well.

Therefore the higher the score the more in control the client is within this area of their life. 100% clients receiving support in July and to date have progressed in areas where a support need was identified.

4. Exits (Closed Cases)

Number of exits this month	34

Reason for Move-on / Departure

Reason	No	Reason	No
Support no longer needed as outcomes achieved	33	Support ended due to risk	
Non - engagement	1	Client Deceased	
Relocation			

Note: One client refused to complete the second assessment however advice and signposting was completed.

5. Outgoing Referrals

Referrals to sub-contracted partners

CAB	1
The Bridge EET	1
Age UK	2
Home Straight	2

Referrals to outside agencies

Agency name	No	Agency name	No
Spire Home Improvements	0	Healthcall Eyecare	0
Floating Support	2	Falls Clinic	1
VAR Car Scheme	2	Adult Social Services	1
Red Cross	3	Assistive Technology	
Carers Support	0	Trading standards	
Fire Service	0	Housing	

6. Refusals

No refusals in to service to report for July 2015.

7. Performance against KPI's

KPI	No this month	Monthly Performance %	Year to date	Notes
Contact made within two days of referral	28	100%	132	
Advice completed within 14 days of referral	28	100%	132	
Number of volunteers recruited	0		1	One volunteer in post
Number of new community groups established / one off activities held in the community	2		9	
Number of new groups still in place after a 6 month period	0		N/A	

Number of individuals engaging in volunteering, education or employment	0		0	
Number of individuals demonstrating progression in the Outcome Star areas where they have an identified need	15	100%	3	
Number of individuals supported by a C.A. to leave hospital or prevent a hospital admission	4		18	
Number of new community groups linked to the RIS	9		24	

Partner performance

CAB

Service	Number on last day of month	Number throughout the month
Total number of individuals who have accessed the CAB RCA Service	11	11
Total number of clients receiving telephone support – Face to Face	11	11
Total number of clients receiving a home visit	2	2
Total number of home visits completed	2	2
Total number of cases closed	10	10

KPI	Target	No	Performance %
Contact made within five working days of referral	100%	11	100%
Number of contacts completed (Face to face or over the phone)	16 per month	33	206%
Number of individuals supported	8 per month	11	138%
Number of pop up surgeries completed	1 every 13 weeks	0	0

Age UK

Service	Number on last day of month	Number throughout the month
Number of individuals who have been referred to the Age UK RCA Service this month	3	3
Total number of clients receiving volunteer/befriender support through home visit this month	2	2
Total number of home visits completed this month	5	5
Total number of cases closed this month	2	2

KPI	Target	No	Performance %
Contact made within three working days of referral	100%	3	100
Initial volunteer visits completed within 7 days of referral	100%	3	100
Number of individuals supported this month	2 per month (on average)	5	
Number of individual supported year to date	24 per annum	15	
Number of volunteers who have provided befriender support for RCA clients this month	6 individuals per year	2	
Number of individuals supported who are isolated		2	
Numbers of individuals supported who have returned from hospital/care setting or are at risk of being admitted.		0	
Number of individuals supported to access social/community activities		3	

The Bridge

Service	Number on last day of month	Number throughout the month
Number of individuals who have been referred to The Bridge RCA Service through First Contact this month	1	1
Number of direct referrals (not received through the RCA service) this month	0	0
Total number of clients receiving support this month.	1	1
Total number of support hours provided this month		
Total number of cases closed this month		

Due to an internal restructure at The Bridge the EET service will no longer be provided in relation to the RCA service. Clients with an EET need will now be referred to RALS and/or for Spire Floating Support depending on their needs at nil cost. The Bridge continues to be fully engaged with the RCA service in terms of their homeless support provision in Rutland.

Home Straight

Service	Number on last day of month	Number throughout the month
Number of individuals who have been referred to The Home Straight RCA Service this month	3	3
Total number of clients receiving support this month.	3	3

KPI	Target	Monthly Total	Monthly Performance %
Contact made within 48 hours of referral	100%	3	100%
Urgent works completed within 72 hours of referral	100%		N/A
Non urgent works carried out within 6 working days of referral	100%	3	100%
Number of handyman hours provided	7.5 per week on average	2	
Total cost of works undertaken (Including Handyman hourly rate)		£30	

8. Case Studies

Case study A

Hospital to Home Case Study

An 89year old patient, Xx, was readmitted into hospital after a second fall causing an arm injury. When I met her on the ward she seemed frail and weary. She was concerned about being able to cope when she returned home and was afraid of falling again. Xx lives with her 91year old husband who has been diagnosed with Vascular Dementia. Although he is physically quite strong he is forgetful and also prone to falling.

I discussed the various options available to her, which focused on supporting her and her husband at home. Her priority was to remain at home with her husband; to try and maintain an independent life. I took her contact details and she agreed that a home visit/assessment would be useful.

Xx already had a care package in place, which was partly funded by the local authority. Since her return home it was evident that she needed more care. Her daughter could not get hold of the Social Worker to arrange a care assessment. I was able to contact the SW and alert her re: change in care needs. I also arranged for her to have a commode installed as she not strong enough to walk to the toilet and was in danger of falling. Family members requested that she have a wheel chair as she could no longer go out, and they were keen to take her out. I called Dial- a-Wheelchair and it was delivered the next day.

A referral was also made to Telecare for a falls detector to be installed, which was funded by the local authority (her husband was also fitted with a falls detector through a separate assessment). When a staff member from Telecare arrived at the home, Xx had fallen and she was kneeling on the living room floor. Her daughter had called the ambulance and the paramedics were able to pick her up without injury. Fortunately on this occasion their daughter was visiting and was able to call the emergency services. Now the family and clients can feel reassured that the emergency services will be able to detect a fall automatically and respond accordingly.

Summary of Health Link Agent's Intervention:

- liaised with Social Services for re-assessment of care package;
- contacted OT for equipment to be installed, i.e. commode;
- contacted Red Cross for a wheelchair to be delivered;
- contacted Homestraight for garden to be levelled so Xx can go outside with reduced risk of falling or feeling discomfort;
- made a referral to Telecare via RCC for funding for Fall Detectors to be installed (two now installed).

Case study B

Mrs P and a family friend Mr E who has been living at her home in Ryhall for 43 years contacted me as their local Agent directly asking for help.

Sadly over the last 5 years Mr Es health has declined and he is now showing signs of Dementia.

Mrs P is 84 and in poor health, she has managed to look after and care for Mr E who is 92 with little practical or financial support.

Mrs P is due to go into hospital for a hip replacement .They currently live in a 3 bedroom property with a large garden and have found that suddenly everything is becoming too much for them to deal with.

After lengthy discussion and with their agreement I made referrals to our Partner agencies , Adult Social Services, Alzheimers, Age UK, CAB, VAR car scheme and Care and Repair Rutland.

As their appointed Rutland Community Agent I was able to collect and assist with the completion and submission of a Housing Application to the RCC waiting list, to be considered for a 2 bedroom bungalow in Ryhall.

Since our first meeting all referral agencies have been in contact, giving on-going assistance. I have also maintained contact with all concerned and will be returning to see Mrs P and Mr E in August. They have been overwhelmed by the support and information that has been given so far, and are very appreciative. I will continue to work with them over the coming weeks, to ensure they have received all possible help and financial advice available to them.

I will be following up at a later date with a further case study for Mrs P and Mr E . To report exactly how they have benefited from the CA service etc.

9. Key Activities / Events

The following activities/events have been arranged and/or held in July:

- 2 x day trips organized in partnership with Sheltered Scheme assistants.

    a. Wednesday 15th July 2015, trip on the Nottingham Princess River.

    b. Wednesday 22nd July 2015, trip on Baldwin Trust Canal.

- Presentation on service to Good Neighbours' Scheme (Whissendine)
- Presentation on service given to Rutland Older persons Forum
- Continued presence at pop up clinics / social gatherings at St John & Anne and Spire Sheltered Schemes.

- Contact made with Parish councillors / clerks that cover following areas: Edith Weston / North Luffenham / Whissendine / Uppingham / Langham / Barleythorpe / Normanton / Manton / Morcott / Wing / Martinsthorpe / Ridlington / Braunston / Brooke / Belton / Lyddington / Stoke Dry / Caldecott / Beaumont Chase / Thorpe By Water / Seaton.

10. Engagement with Health & Social Care

Networking & meetings held and/or completed with:

- Practice British Heart Foundation
- Uppingham GP Surgery
- Oakham GP Surgery
- Empingham GP Surgery
- Meeting with Senior OT & Integrated Care Coordinator
- Meeting / presentation at the Integrated Health & Social Care meeting at Rutland Memorial Hospital
- Health Link Agent (HLA) now attending weekly Board Rounds at RMH & Melton Hospital
- RCA Contact/Referral packs distributed to GP practices as requested at the end of July

11. Staff Training & Development

- BS attended an Autism training course.

12. Changes to Staff Team

No changes to report this month.

13. Significant Incidents (involving emergency services)

None to report for July.

14. Safeguarding Alerts

Referral made to Adult Social Services / Safeguarding Team – concerns client was victim of financial abuse, case taken up.

16. Partnership Working & New Partners

- First referral received from the St John & Anne service.
- Presentation received from VAR Car Scheme service.
- Presentation received from CPO.

17. Complaints / Compliments

None to report for July.