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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 **Tuesday, 17th November, 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 1st September 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 93.

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

The total time allowed for questions at short notice is 15 minutes out of the total time of 30 minutes. Any petitions, deputations and questions that have been submitted with prior formal notice will take precedence over questions submitted at short notice. Any questions that are not considered within the

time limit shall receive a written response after the meeting and be the subject of a report to the next meeting.

5) BCT: PRE-CONSULTATION DOCUMENT

To receive a verbal update.

6) YOUNG PEOPLE'S MENTAL HEALTH

To receive Report No. 214/2015 from Jennifer Fenelon, Healthwatch Rutland and Report No. 215/2015 from Leon Charikar, CAMHS Commissioning Manager.
(Pages 5 - 74)

7) AMBULANCE SERVICE

To receive a report from Helen Stubbs, Senior Contracts and Provider Performance Manager, ELRCCG

8) JSNA: UPDATE

To receive Report No. 216/2015 from Karen Kibblewhite
(Pages 75 - 118)

9) ANY URGENT BUSINESS

10) DATE OF NEXT MEETING

The next meeting of the Rutland Health and Wellbeing Board will be on Tuesday, 26th January 2016 at 2.00 p.m. in the Council Chamber, Catmose.

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DISTRIBUTION
MEMBERS OF THE HEALTH AND WELLBEING BOARD:

Mr R Begy (Chairman)	
Mr A Mann	Ms A Callaway
Dr A Ker	Mrs H Briggs
Ms J Clayton Jones	Ms J Fenelon
Inspector L Cordiner	Mr M Sandys
Ms R Dewar	Mr T Sacks
Ms T Thompson	Mr R Clifton
Ms Y Sidyot	

OTHER MEMBERS FOR INFORMATION

Report No. 214/2015

Report to Rutland Health and Wellbeing Board

Subject	**Young People's Mental Health Project**
Meeting Date	**17th November 2015**
Report Author	**Jennifer Fenelon**
Presented by	**Ann Williams & Anya Loomes**
Paper for:	**Note/Approval**

Context, including links to Health & Wellbeing Priorities : Links to Better Care Together Transformational Plan

This report, prepared by Healthwatch Rutland describes progress since the July meeting of the Health and Well Being Board in addressing the wish of young people across Rutland for early intervention and support with mental health issues.

The report asks the Health and Wellbeing Board to note the extensive progress made since the last report in July 2015

Financial Implications

See report for gap in pilot funding and financial implications of the Transformational Plan

Recommendations

That the Board

1. Notes the considerable progress being made to implement a trial early intervention model in Rutland and the intention of extending the pilot to primary & secondary settings if successful.
2. If successful ,it is planned that the evaluation be made available across Leicester ,Leicestershire and Rutland
3. It is noted that the LLR Transformational plan has been submitted to DH and that the plan addresses early intervention and awareness as well as secondary and tertiary care (a summary of that plan is attached as an appendix to this report.)

Comments from the Board

Strategic Lead	

Risk Assessment

Time	**L/M/H**	
Viability	**L/M/H**	
Finance	**L/M/H**	
Profile		
Equality & Diversity		
Timeline		
Task	**Target Date**	**Responsibility**

Summary

Report No. 214/2015

In July 2015 Healthwatch Rutland reported to the Health and Wellbeing Board on the Rutland Young People's Mental Health Project.

Our report described national policy initiatives to address young people's mental health issues and the response required from local health economies as well as national funding being made available to improve young people's mental health.

We also described the work carried out by Healthwatch Rutland supported by Leicester University which articulated the clear wish of young people across the County to de stigmatise mental health and create early interventional support .

Our young people wished to see integrated arrangements to both support young people at an early stage and signpost them into mainstream CAMHS services where that proved necessary. Our report also described the positive response from organisations across Health, Educational (State and Private), Youth, and voluntary to work together to find solutions.

In conjunction with the Rutland Young People's Council (and a successful “Dragons Den”) it then was planned to pilot a prototype early intervention and signposting system which, if successful, could be rolled out to primary and secondary schools.

Recognising that there will be financial constraints everywhere, the objective of the pilot was to produce an effective “support system” by harnessing the existing resources of the many organisations involved, conduct a 6 month pilot and then measure the impact.

This report covers:-

- The Rutland Pilot
- The pilot as part of the LLR BCT Transformational Plan
- Monitoring and Next Steps
- Local and National Recognition and support

The Rutland Pilot
We were delighted that in July 2015, Rutland County College volunteered itself as a pilot site to test the development of a co-ordinated early intervention and support system.

Rutland County Council appointed a part time Project Manager, Steph Logue, Healthwatch Rutland contributed the services of Vice Chair of the Rutland Youth Council, Anya Loomes, and the Healthwatch Young People's Team led by Ann Williams. A Project Board (membership below) and Project Team have worked tirelessly and have included representatives of young people, parents, teachers and the many agencies involved.

Membership of Task & Finish Group:

The Task and Finish Group is chaired by Rutland County Council’s (RCC) Early Intervention Health and Wellbeing Development Officer.

Membership includes:

- 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

This group has moved mountains over the summer holiday to ensure the project was launched on 7th October 2015 to coincide with the new academic year. Strands already in place include:

- Awareness training in mental health for teaching staff
- Awareness training in mental health for parents
- A young people's mental health forum within the school
- Development of a resources library
- A " Drop in Centre " as the focal point of the project staffed by a mental health trained school nurse one day a week * as the focus of support but with access to the resources of many agencies and the ability to signpost young people into mainstream services if required.
- Because the project is focussing upon using existing resources well, resilience training which was requested by the young people was not included on the grounds that it would require funding.(See later for developments)
- A survey of young people at the college has been carried out to establish a baseline against which progress will be measured.
- The pilot project will run for 6 months until the end of March 2016

Note * Because Rutland County Council is a sixth form college, it is not eligible for a school nurse and this aspect of the project is consequently not yet funded. We are hopeful that the funding of this aspect of the project will be resolved and the project able to achieve its intended results.

The Pilot as part of the LLR BCT Transformational Plan.
Dr Tim O'Neill and Dr Ann Williams have been invited to join the Leicester, Leicestershire and Rutland (LLR) Young People's Transformational Planning Group. Its task has been to prepare and oversee implementation of plans to secure and spend the considerable national funding coming to LLR to implement “Future in Mind”. The LLR project plan has been submitted and approval is awaited. Awareness raising and early intervention are part of the submission (a summary of the Transformational Plan is attached as an appendix).

Monitoring of progress
Arrangements are being agreed to monitor the progress of the pilot and its evaluation. A monitoring group is being identified and it is planned to include representatives of primary and secondary schools to share in the learning. It is intended that in this way there will be joint ownership of the project as it widens next year. Councillor Richard Foster, portfolio holder for Safeguarding Children and Young People, has agreed to chair this group.

Next Steps
It is clear already that awareness raising and resilience training will remain key issues and the following additional initiatives may help address these gaps.

- *Awareness Raising* .Leicester University has already been hugely supportive of the project and provided academic rigour. It is hoped that the university will be able to provide support to the Transformational plan and to the awareness raising component .Discussions are underway.

- *Resilience Training*. Discussions are advanced with a major charitable organisation to support a resilience programme led by national experts as part of the possible stage two roll out in Rutland

Local and National Recognition and support
Because it is both grounded upon the views of young people and, as a result, developing at great speed, the project is attracting considerable national interest.

Healthwatch England is planning to develop a film of the project work and thus both share the learning across England and reassure DH and politicians that monies can be effectively spent.

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.

It is hoped that the nurse funding for the project will be resolved shortly and the pilot able to carry on as planned.

Report No. 214/2015

LEICESTER, LEICESTERSHIRE AND RUTLAND

TRANSFORMING MENTAL HEALTH AND WELLBEING SERVICES FOR CHILDREN AND YOUNG PEOPLE

Draft: to be published November 2015

A wide range of organisations are involved in commissioning and delivering services that promote and support the mental health and wellbeing of children and young people. They range from universal children's services such as health visitors, schools and colleges, through to early support services for young people facing emotional of developmental difficulties, and specialist psychiatric support for those with significant and enduring mental health problems. Other services such as the police, the justice system and housing may encounter children and young people with mental health difficulties.

These services need to work better together to ensure that the needs of the child or young person are kept paramount. This will involve commissioning new services together, pooling resources and sharing information to work jointly with a young person and their family.

Why we need to change

Children, young people and carers have told us that that they are worried about a range of issues that affect their mental health and wellbeing. These include academic pressure, peer pressure, family breakdown, sexual exploitation and cyber-bullying. They would like more support in school or through confidential help-lines and websites. Parents have told us of the "battle" to access specialist support and young people being told that they are "not ill enough" to get help. They also report having to repeat their story many times to different practitioners and that organisations do not always know what each other are doing.

We have commissioned an independent review into the specialist CAMHS (Child and Adolescent Mental Health Services) and mapped the community based services which currently provide emotional help and support to children young people and carers. We have also looked at the Joint Strategic Needs Assessments for Leicester, Leicestershire and Rutland which tells us about our local population and prevalence rates for different conditions. We have commissioned a report into a number of serious incidents where as partner agencies, we struggled to provide the right care at the right time for children and young people experiencing acute behavioural or mental health problems. We have also analysed the number and type of hospital beds we need for children with a severe mental health problem such as an eating disorder or psychosis.

This analysis tells us that there is an increasing prevalence of mental health and developmental difficulties such as autism spectrum disorder, ADHD, self-harm and eating disorders. The referrals to the special CAMHS service have gone up 9% per year over the past four years, and it can take a long time to get support from this service. Average waiting time for an assessment from CAMHS is now over 13 weeks. There are some really exciting and innovative community based early support projects such as parental training, self – esteem workshops, school anti-bullying projects and parent led support groups. However these are inequitably spread across the region. These services are all commissioned separately and the standard and quality of therapeutic care can vary.

The reports recommend that we commission two new services: a specialist community based service for children with an eating disorder, and a crisis and home treatment team that will support families experiencing acute difficulties and when the child may need to be admitted to hospital. We should also aim to have more hospital beds available closer to home.

The reports also show that whilst 24% of people in our area are under the age of 20, only 6% of health spending on mental health services is for this age group. We probably spend less on specialist mental health services for children than other comparable areas. There is significant pressure on local authority budgets.

The Department of Health and NHS England have issued a new strategic plan called Future in Mind. This calls for a transformation of services to meet the mental health needs of children and young people. Key elements of Future in Mind include:

- 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 plan is to give additional funding to Clinical Commissioning Groups (CCGs) who can demonstrate through a Transformational Plan that they will take action to address these issues. In total, the three CCGs in our region will receive £1.87 million. This will be used alongside existing funds from local commissioners to implement the plan.

How we plan to improve mental health and wellbeing services for children and young people through Better Care Together

We have decided to use the Better Care Together framework to prepare, develop and implement our transformational plan for children and young people's mental health. This is because the essence of our approach required organisations to work strongly together to meet the needs of the child or young person. We therefore need to make joint decisions about our priorities, the outcomes we aim to achieve and how we will use our funding and other resources.

There will be one transformational plan covering Leicester, Leicestershire and Rutland. Key partners will be the three CCGs, the three Health and Wellbeing Boards, the three local authorities, the Office for the Police and Crime Commissioner, the voluntary sector, schools colleges and GPs. Children and young people will be central to our plans. The key strands of the plan will be as follows:

Health promotion	A campaign to promote mental health and resilience for children and families. This will be led and commissioned by Public Health Departments and involve close work with education providers, GPs and other universal settings. It will utilise social media and other innovative methods to engage with young people. It will also provide accessible information about how to find extra support.
Early Help	To establish a multi-agency first response and early help service that would respond to concerns about the emotional health and development of children and young people. The service would accept referrals from a range of sources including self-referrals from parents, carers and young people. It would offer a first assessment, guidance and advice, and choice of early help offers. To commission a range of low–intensity early help offers that build resilience and prevent escalation to more serious or longer term mental health problems. This will be a collaborative commissioning arrangement between CCGs and local authorities, utilising a range of providers including third sector and community groups.

Access to specialist help	To establish a single gateway to additional help for those with enduring difficulties or at risk of significant harm to self or others. There would be a dedicated multi-agency access team which would accept and assess referrals to specialist CAMHS and other specialist services, maintaining communication with the referring agency and the young person / carer. The Specialist CAMHS service would offer clear evidence based therapies, and report on the outcomes for children in their care. It would support young people moving on to adult services.
Specialist community interventions for children with eating disorders	Establish a specialist community eating disorder service with the capacity to receive 100 new referrals a year and meet the national access standards that all assessments are completed within 4 weeks of referral. This will provide NICE concordant interventions for children and young people with eating disorders, a serious and potentially life-threatening condition.
Intensive / crisis support	Commission an intensive multi-agency "out of hours" and home treatment services for those experiencing acute behavioural or mental health difficulties and at risk of serious harm to self or others. Ensure there is a designated "Place of Safety" for a person under the age of 18.
Workforce Development	Recruit and develop a specialist CAMHS workforce that is skilled and experienced in delivering evidence based therapies (such as CBT, Family Therapy and Interpersonal therapy) and in using clinical outcomes. Develop all practitioners working with children, young people and their carers to have an understanding and skills in supporting children with mental health issues. This will be achieved through face to face and on-line training, case work support and opportunities for secondment and joint working.

The plan will be developed and implemented with core values and standards.

- Listening to the voice of children young people and carers, and designing services to meet their requirements.

- Ensuring equality of access to information, advice and services for all. Commissioning and establishing services which are welcoming and accessible to all, particularly those with "protected characteristics" or specific vulnerabilities.

- Using evidence based interventions, setting quality standards and using outcome measures for all services.

- Collaborative commissioning and partnership working. This will include pooling of budgets and secondment of staff across organisations.

- Sharing of information and learning between organisations.

- Open governance and transparency in decision making. This plan and regular reports will be available for public scrutiny.

What will be benefits be for children, young people and their carers?

Our vision is that by 2020, every child and young person in Leicester, Leicester and Rutland will be able to affirm the following:

Self- care and prevention	Early help and primary care	Specialist care	Urgent care and crisis response
My family and I are able to look after my emotional and mental wellbeing and development day to day. I learn about mental health and how to protect myself at school or college. We can access trusted self-care advice when and where we like including websites, education settings, GPs and children's centres My parents / carers have access to support and guidance I am confident in talking about issues which affect my mental health	I can get high quality support to help me overcome emotional and mental health challenges quickly and locally, without being stigmatised. I will be able to make informed choices about the kind of help I would like. I and those who care for me will be listened to. I will be supported to become resilient and independent. I and my carers will be helped to navigate the system and services. I am involved in peer support groups and community networks in my area.	I will be helped by a specialist team quickly if my mental health problems are serious I will receive support which is safe, reliable and tested. I will be involved in setting my own treatment goals and deciding if I am getter better. With my consent, services will work together to support me and my carers. I will be involved in decisions to transfer or reduce my care. My views and experience will help to improve care for others	I can access intensive support from a range of organisations working together. I will be seen promptly if I attend the Emergency Department I will not be judged by staff for my mental health problems. I will be kept as safe as possible during a crisis. I will be able to access a bed within a reasonable distance from home I will be supported to return home safely as soon as possible.

Baseline data and key performance indicators

There are 250,000 children and young people up to the age of 19 in Leicester, Leicestershire and Rutland

It is estimated that 1 in 10 school children will have a diagnosable mental health or neurodevelopmental condition. This equates to approximately 19,000 school children in Leicester, Leicestershire and Rutland.

The Specialist CAMH Service supports about 3,500 children and young people per year.

The average waiting time for an assessment by the specialist CAMH Service is 13 weeks from referral.

Through this transformational plan we will monitor the following performance indicators:

- A survey of what children and young people understand about mental health and how they feel about their own health.
- The number of educational settings that are part of this plan, and are working to improve understanding on mental health and support their students.
- The number of children, young people, parents and carers who access early support and interventions.
- How children, young people parents and carers rate this support.
- The number of children and young people assessed by the specialist CAMH service.
- How long it takes from a referral to CAMHs to seeing a practitioner.
- How long it takes to see a specialist if you have an eating disorder or psychosis.

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Report No. 215/2015

Report to Rutland Health and Wellbeing Board

Subject:	**Transformational plan for children and young people's mental health services**
Meeting Date:	**17th November 2015**
Report Author:	**Leon Charikar**
Presented by:	
Paper for:	**Note and Discussion**

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

The report presents a partnership plan for organisations across Leicester, Leicestershire and Rutland to transform mental health and wellbeing services for children and young people.

The plan has been developed in response to Future in Mind, the Government's strategy to transform these services by 2020. The Government has committed additional funding of £250,000 per annum to implement Future in Mind. The Transformational Plan has to be accepted by NHS England in order for the local CCGs to receive a proportion of these funds. The plan was submitted on 16th October.

The transformational plan links with priorities within the Rutland Joint Health and Wellbeing Strategy 2013-16 to support the emotional health and wellbeing of children, young people and their families, and to support vulnerable teenagers make a smooth transition into adulthood.

The plan sets out a vision of five years and includes a detailed implementation plan up to 2017/18. The plan will continue to be enhanced and developed and contributions and suggestions from the Rutland Health and Wellbeing Board are welcome.

Financial implications:

If the plan is accepted by NHS England then the three CCGs for Leicester, Leicestershire and Rutland will receive a total of £1,870.000 of recurrent funding per annum. Funding will be made available from November 2015.

This should be used alongside existing funds from CCGs, local authorities and other partners to improve all aspects of children's mental health and wellbeing: from health promotion and preventative work, through to specialist acute mental health services.

The funding should not be used as a replacement for existing budgets.

The governance of the implementation of the transformational plan will be through Better Care Together.

Recommendations:

That the board:

Note and discuss the transformational plan for children and young people's mental health services		
Comments from the board: (delete as necessary)		
Strategic Lead:		
Risk assessment:		
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

LEICESTER, LEICESTERSHIRE AND RUTLAND

BETTER CARE TOGETHER

Transformational plan for mental health and wellbeing services for children and young people

2015 - 2020

October 2015

Contents

1. Introduction & Vision for 2020

This document sets out Leicester, Leicestershire and Rutland's multi-agency transformational plan to improve the mental health and wellbeing of children and young people up to the age of 25. It is a five year plan, based on the principles set out in Department of Health's Task Force Report, *Future in Mind: Promoting and improving our children and young people's mental health and wellbeing.* Future in Mind offers a framework and resources to improve the mental health wellbeing of all children. This report sets out our joint plan to achieve this.

Our plan reflects what we know about our current services and what children, young people and carers in our area tell us they want.

- We know that we have a strong track record of joint commissioning, partnership and innovation. We also have many examples of excellent and innovative services and many further improvements are underway. However, we also know that the current system is fragmented, lacks transparency and requires a new approach to the use of resource.

- Children and young people have made it clear to us that they want education, information and advice about mental health, access to early, non-stigmatising help, and to be treated with respect by friendly staff, using approaches that we know work.

Our vision is that children will have access to the right help at the right time through all stages of their emotional and mental health development. For this to happen, services such as education, social care, health, police, housing and justice will need to align. We will be required to develop shared priorities, joint commissioning, and improve the interfaces between our agencies so that organisational boundaries are not barriers to care.
In Leicester, Leicestershire and Rutland we are committed to achieving this as part of the programme of work called Better Care Together (BCT). Through BCT we will strengthen the co-commissioning and partnership working across our agencies. We will also determine collectively and transparently how to use our resources effectively and efficiently to deliver the care that is valued by children, young people and their carers.

Mental health has been defined by the World Health Organisation as "*a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community*." [1] It is more that the absence of mental illness or disabilities. In this plan we use the term "mental health and wellbeing" to address all children and young people: those who are healthy and resilient, as well as those with emerging or serious mental health difficulties.

The agencies and stakeholders that have been involved in shaping this transformation plan include the local and regional commissioners and providers of health services (CCGs, NHS England East Midlands Specialised Commissioning and Health and Justice Commissioning, Leicestershire Partnership Trust), our three local authorities and the Police and Crime Commissioner. There has been strong engagement with Voluntary Action Leicestershire and Healthwatch. There is further work to do to broaden the engagement with schools, colleges and other educational settings. There has been extensive engagement with children, young people and their families and we are particularly grateful to them for sharing their experiences, which have been central to shaping this plan. An "Easy Read" summary of this plan will be published on our local websites in November 2015. We will launch the Transformational Plan in January to March 2016 through a series of engagement events. This plan marks the start of our journey.

"Only by working in partnership, sharing expertise and making best of finite resources can we achieve the improvements in mental health outcomes that we all want to see, and make a reality of the vision"

Sam Gyimah, Department for Education "Future in mind" (2015)

"If you do one thing, just get people who know what they are doing to work together better".

Young person, Leicester 2015.

[1] Mental health: strengthening our response. World Health Organisation August 2014

Our vision is that by 2020, every child and young person in Leicester, Leicester and Rutland will be able to affirm the following:

Self- care and prevention	*Early help and primary care*	*Specialist care*	*Urgent care and crisis response*
My family and I are able to look after my emotional and mental wellbeing and development day to day. *I learn about mental health and how to protect myself at school or college.* *We can access trusted self-care advice when and where we like including websites, education settings, GPs and children's centres* *My parents / carers have access to support and guidance* *I am confident in talking about issues which affect my mental health*	*We can get high quality support to help me overcome emotional and mental health challenges quickly and locally, without being stigmatised.* *I will be able to make informed choices about the kind of help I would like.* *I and those who care for me will be listened to.* *I will be supported to become resilient and independent.* *I and my carers will be helped to navigate the system and services.* *I am involved in peer support groups and community networks in my area.*	*I will be helped by a specialist team quickly if my mental health problems are serious* *I will receive support which is safe, reliable and tested.* *I will be involved in setting my own treatment goals and deciding if I am getter better.* *With my consent, services will work together with me and my family to give us the best support.* *I will be involved in decisions to transfer or reduce my care.* *My views and experience will help to improve care for others*	*I can access intensive support from a range of organisations working together.* *I will be seen promptly if I attend the Emergency Department* *I will not be judged by staff for my mental health problems.* *I will be kept as safe as possible during a crisis.* *I will be able to access a bed within a reasonable distance from home* *I will be supported to return home safely as soon as possible.*

Our vision is that by 2020 our services will be shaped as follows:

Self- care and prevention	*Early help and primary care*	*Specialist care*	*Urgent care and crisis response*
All schools and colleges educate about mental health, tackling stigma and building resilience. *Information about children and young people's mental health is provided through a range of formats including websites, social media, and publications.* *Front line staff have access to training and support on mental health issues amongst children and young people* *All services provide equality of access and support to all children and young people.*	*Early joint assessment for children and young people who might need extra support* *High quality low intervention services delivered locally across LLR by range of organisations.* *Care navigators who can support children, young people and cares make informed choices to find the right service for them.* *Outcome measures are used to assess individual improvements and to plan the development of services*	*High quality therapeutic and medical support provided by experienced and qualified staff.* *Organisations share information and work together to support the child, young person and their family* *Specialist services for children and young people with eating disorders* *Specialist services for vulnerable children and young people such as young offenders, Looked After Children and those with learning disabilities* *Young people's views inform the improvement of services*	*Services work together to provide intensive out of hours support for children, young people and families at risk of crisis.* *Services work swiftly together to support anyone admitted to the Emergency department* *Specialist hospital beds are available for those that need them.*

HEADLINES

There are 250,000 children and young people up to the age of 19 in Leicester, Leicestershire and Rutland. It is a uniquely diverse community with significant variations in economic prosperity, quality of life and health outcomes. 68% of children and young people in Leicester City are from an ethnic minority background. 1100 children and young people in LLR are looked after by a local authority, 32,000 have special educational needs, and 3466 were recorded as victims of crime in 2014/15.

It is estimated that 1 in 10 school children will have a diagnosable mental health or neurodevelopmental condition. This equates to approximately 19,000 school children in our region. Difficulties include Autism Spectrum Disorder, ADHD, anxiety, depression, self-harm, psychosis, obsessive compulsive disorders and eating disorders.

The specialist Child and Adolescent Mental Health Service (CAMHS) supports about 3,500 children and young people per year. The average waiting time for an assessment by the specialist CAMH Service is 13 weeks from referral. About 80 children and young people a year will require specialist treatment in hospital. Often this hospital will be a long way from their home.

Through this transformational plan we will do the following:

- Promote mental health and resilience through campaigns in schools and to the general public
- Provide quick access to a multi-agency assessment and support service for children and young people with emerging or low level mental health needs
- Improve the access to the specialist CAMHS service to reduce waiting times and improve communication with children, young people and carers
- Establish a specialist community team to support young people with an eating disorder

- Establish a multi-agency team that will support families at risk of a crisis due to the mental health or disturbed behaviour of a child or young people.
- Improve the capacity and capabilities of practitioners to work with children and young people with mental health issues.

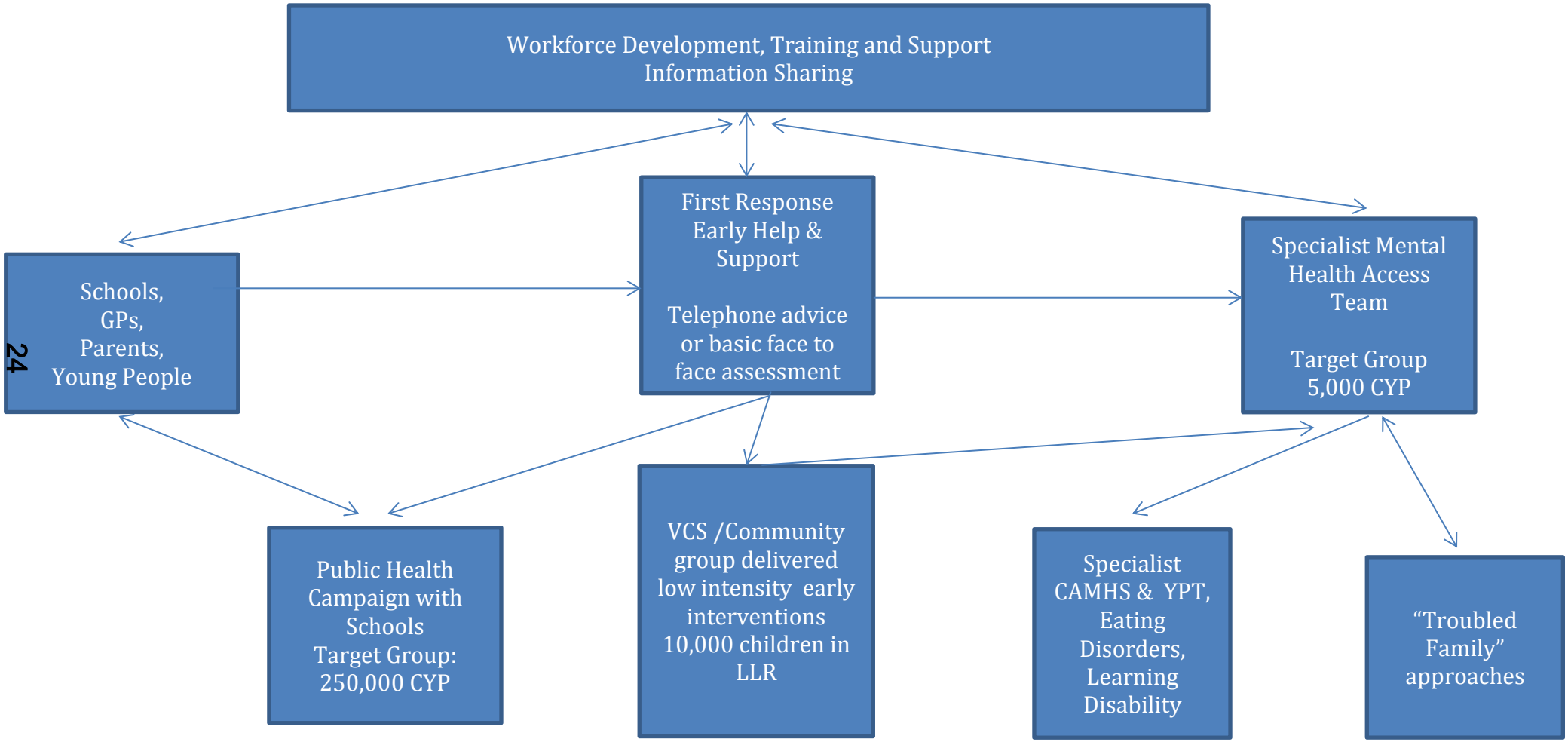
We will measure the success of this plan in the following ways:

- A survey of what children and young people understand about mental health and how they feel about their own health.
- The number of educational settings that are part of this plan, and are working to improve understanding on mental health and support their students.
- The number of children, young people, parents and carers who access early support and interventions.
- How children, young people parents and carers rate this support.
- The number of children and young people assessed by the specialist CAMH service.
- How long it takes from a referral to CAMHs to seeing a practitioner.
- How long it takes to see a specialist if you have an eating disorder or psychosis.
- Hospital admission rates for self-harm and attempted suicide
- The number of young people who attend the Emergency Department due to an acute mental health problem who have to wait more than four hours to be seen by a specialist.
- The number of children and young people who are held in a police cell as a “place of safety”.

PLAN ON A PAGE

ENABLERS	TRANSFORMATION	VALUES
Collaborative Commissioning between health, education, social care and youth justice	A schools-based campaign to promote mental wellbeing and resilience that will reach every child young person and family.	Direct engagement and co-design with young people, parents and carers
A consortium of voluntary, community and public sector providers	Quick access to multi-agency first response, early support and help. A range of high quality early help offers for children young people and families.	Develop the workforce through training, career progression & joint working
Strong open governance and transparency in resource allocation	A single gateway to a community mental health and wellbeing service. Specialist clinical support for vulnerable children and young people.	Ensure equality of access and service for all
Use of evidence based therapeutic help and quality standards	Specialist clinical support for children and young people with eating disorders	Practitioners support each through information sharing, advice and guidance.
Measuring outcomes and impact and using this to shape service developments	Intensive package of support for young people and families at risk of acute mental health problems	Information and choice for children young people and families

CARE PATHWAY FOR CHILDREN AND YOUNG PEOPLE WITH MENTAL HEALTH PROBLEMS



2 Principles and Values

2.1 Engagement with children, young people and families

Children, young people and their families are central to the development of this plan and to the task of transforming services and approaches to mental health. There have been specific engagement events to discuss experiences of mental health problems, and ideas for improving services. This has included engagement with youth parliament representatives, young people's council, youth police commissioners, looked after children and parents and carers. Young people have led a seminar on their experience of self-harm. The CAMHS service recently formed a panel of ex-CAMHS service users to advise the practitioners on how to improve CAMHS. As the transformational plan is developed and implemented, children, young people and families will be part of the governance arrangements and be involved in the delivery of specific initiatives. This will be through involvement in commissioning panels, staff recruitment panels and service user panels. An 'Easy Read' version of the plan will be published on websites.

Young people have told us they want to be taught about mental health issues within schools and for schools to promote an open culture where they are encouraged to talk about mental health issues. They want their teachers to be skilled in supporting pupils with mental health issues. They want their parents to also have advice and support. Young people want help to build resilience and to be part of peer support groups. This can include support through social media and the internet. They would like to be able to access support such as counselling and workshops, with choice about when and where they meet.

They would particularly like easier access to advice and support at evening or weekends, perhaps through a phone line or website. They have spoken about their experience of self-harm and eating disorders. Many young people report a positive experience of the care they received. This is often down to forming a strong trusting therapeutic relationship with their worker. Finally they want to be involved in shaping their own care and support plans.

Best Practice **Rutland Health Watch and Rutland Youth Council. Survey of 965 students on mental health concerns.**

HealthWatch Rutland and Rutland Youth Council carried out a series of engagement events with pupils in local schools to talk about concerns and issues facing young people. The most striking findings came about through a session held with Rutland's Youth Council. A series of concerns (life out of school; drugs and alcohol; transport; sexual health; mental health) were identified and then classified in order of urgency. It was discovered that the overwhelming problem was that of mental health (stress, depression, eating disorders, self-harm)

The Youth Team then prepared a questionnaire concerning the problems of mental health, advised by a team from the University of Leicester. Three schools were selected for the survey and meetings were conducted in assemblies and tutorials to explain the aims.

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 findings were shared at number of workshops with partner agencies and with the school children themselves. The workshops were led and facilitated by young people from the Youth Council. The recommendations included:

- Create a culture where mental health is not taboo. End the stigma.
- Focus on prevention and coping strategies. Include mental health on the educational curriculum
- 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 with peer mentoring .
- 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.

2.2 Partnership commissioning and collaborative working

There is a strong commitment from all organisations to work in partnership to secure the transformation in care that young people want. This requires systems co-ordination: to ensure that services work better together, and to jointly plan the development of new services. Future in Mind is the catalyst which presents the opportunity to tackle the issues of fragmented and disjointed planning, and to work collectively towards a shared vision. There are already excellent examples of collaborative commissioning across Leicester, Leicestershire and Rutland. We plan to build on these projects and extend the model of partnership commissioning to the whole pathway. There are fundamental opportunities now for joint commissioning including pooled budgets. We will build on current work, set out below and learn from examples from other services.

- The Young Person's Team which provides mental health assessments and interventions for Looked After Children, young offenders and those who are homeless. We know that these young people are particularly vulnerable to mental health problems. The team is jointly commissioned by CCGs and local authorities. It provides training and guidance for social care staff and foster parents, as well as direct work with young people.

- The Leicester City Early Intervention in Psychology service which provides individual and group work support for children and young people aged up to 19 with issues around anger, anxiety, self-esteem or low mood which do not meet the threshold for a specialist CAMHS intervention. This work is commissioned in partnership between the City CCG and City Council. The service receives clinical supervision from the CAMHS service.

- The Healthy Schools Programme. This is a partnership between the Leicestershire County Public Health and local schools, academies and colleges which takes a whole school approach to improving the health and wellbeing of pupils and students. The programme promotes the link between good health, behaviour and achievement through four key areas: healthy eating; physical activity; personal, social and health education (PSHE); and emotional health and well-being. The programme has recently appointed two healthy school

advisers to support schools to improve pupils' mental/emotional health and wellbeing, delivery of mental health promotion training in schools including positive psychology coaching skills (Youth Mental Health 1st Aid training), suicide & self- harm awareness training.

- The school nursing service has developed specific expertise to support children and young people who self-harm. It has successfully piloted the use of joint posts with the CAMHS service to ensure that all school nurses have skills and confidence in supporting children with mental health issues. The service has also developed an innovative CHATHEALTH application for mobile technology which enables all children to contact the school nursing service at any time on an anonymous basis.

- There is a vibrant, diverse and strong voluntary and community group sector which provides a range of holistic services which support children, young people and their families. These services often work in collaboration to support the whole family.

- Health for Teens and Health for Kids websites which have a range of information and advice for children, young people and parents. These websites have been co-designed with young people and will be developed to contain more self-help information and resources. www.healthforkids.co.uk www.healthforteens.co.uk

- Leicestershire and Leicester City Public Health Teams and LLR CCGs have jointly commissioned an on-line counselling service for young people. This commenced in October 2015. A new service which offers advice, support and access to online counselling for children and young people aged 11-18 in Leicester City, Leicestershire and Rutland. The service, Kooth, offers easily accessible professional support to young people who are experiencing a wide range of emotional and mental health issues. The service will link to existing local services to ensure young people receive the help they need easily and quickly.

- Collaboration between Leicestershire Public Health and Voluntary Sector: Teenage Mediation (http://www.thebridge-eastmidlands.org.uk/talk2sort). The talk²sort mediation service works with young people aged 11-19 and families who may be having

problems at home or with their relationships. The service supports people to look at ways of resolving conflict, often working with issues such as arguments, breakdowns in communication and relationships, difficult emotions, mental health problems and concerns around substance misuse.

- CCG and local authority commissioned workshops for young people on protective behaviours and self-esteem. These workshops build resilience and self-worth, and reduce the risk of problems escalating.

- Police, mental health and probation services have worked collaborative to commission and provide the "Mental Health Triage Car" which provides an out-of- hours mobile mental health assessment service for adults and young people. This has led to a 40 % reduction in the Police use of S136 powers, where people are detained by the police for a mental health assessment. [2]

- The local authorities and CCGs are actively involved in regional work across the East Midlands. This includes participation in the East Midland Strategic Clinical Network and CAMHS Working Group. We also participated in a regional mapping of readiness to implement the Future in Mind recommendations. We will establish specific links with neighbouring health and social care communities to consider best practice on issues such as eating disorders and crisis and home treatment services

[2] http://www.theguardian.com/healthcare-network/2013/nov/13/triage-scheme-police-mental-health

2.3 Equality and Health Inequalities

All partners affirm their commitment to meet the requirements of the Equality Act 2010, the Human Rights Act 1998 and the Health and Social Care Act 2015. We will ensure that our plans promote services which are accessible to all, free from discrimination or harassment, tackle stigma and promote positive relationships and community cohesion. In particular we will consider the impact for those young children known to be vulnerable to mental disorders. This includes children and young people;

- "looked after" by the local authority,
- living in families with difficulties around mental health or substance misuse,
- involved in anti-social or criminal behavior,
- with physical, sensory or learning disabilities or special educational needs,
- with housing needs,
- victims of neglect or sexual exploitation,
- who are carers for others,
- who are a refugee or asylum seeker
- who are gay or bi-sexual,

Leicester, Leicestershire and Rutland is a particularly diverse area. Leicester City has one of the highest percentage ethic minority populations in the country, and there are significant levels of poverty. Rutland is one of the most rural counties in England and is relatively affluent. A key aspect of our approach will be to tackle stigma within communities and promote awareness and openness about mental health and developmental difficulties. As this plan is developed it will undergo a full equality impact assessment to ensure that the needs of all children and young people with "protected characteristics", as well as those who are vulnerable are addressed.

2.4 Workforce Development

A skilled, confident workforce is key to the successful delivery of all services. Presently, there are 80 full- time equivalent clinical posts within the specialist CAMH service. This is less than the guidelines recommended by the Royal College of Psychiatrists. The CAMH service has established a workforce development plan. This covers issues such as recruitment, leadership development, and training in specific therapeutic approaches such as cognitive behavioural therapy and Interpersonal Psychotherapy.

Other practitioners, in public, voluntary, community and independent sectors, working with children, young people and their families also need understanding and confidence in working with mental health issues. We will provide a programme of training and support for all practitioners, drawing on the expertise of our experienced clinicians. This will include multi-agency face-to-face and online training in child and adolescent mental health case management support, and an advice line.

2.5 Children & Young People's Improving Access to Psychological Therapies Programme (CYP-IAPT)

The three CCGs have applied twice, as part of larger consortia, to join the national CYP-IAPT programme. Unfortunately the consortium bid was unsuccessful on both occasions. Our partnership is therefore not currently part of the programme. There is no local CYP-IAPT training provider within the Midlands and East Region. We are keen to support the Leicestershire Education and Training Board to develop a course.

In the meantime, the workforce development plan for the specialist CAMHS service recognises the need to develop leadership skills, and therapeutic skills in approaches such as CBT, IPT and family therapy. The service is also extending the regular use of clinical outcome measures in line with the CYP-IAPT guidelines. We will invest in IT infrastructure to ensure that our services are well placed to make clinical and planning use of systematic outcome monitoring.

2. National Context

In the past few years there has been a plethora of national reviews and reports with regard to the mental health and wellbeing of children and young people. They have all concluded that the current system of care requires significant improvement. This chapter provides an overview of the most relevant reports and identifies the key findings that we have taken into consideration when creating this Leicester, Leicestershire and Rutland transformational plan.

3.1 Future in Mind (Department of Health 2015)

The Department of Health and NHS England Task Force on CAMHS reported on March 2015. The recommendations from this report will form the basis for government policy through this Parliament. The report, Future in Mind[3], found that there was a clear economic, health and moral case for early intervention to promote resilience and prevent escalation to serious mental health concerns. Many health conditions show first signs in childhood, and if left untreated, can develop into conditions that need regular care. 75% of mental health problems in adult life (excluding dementia) start by the age of 18. Early intervention can avoid expensive and longer-term interventions into adulthood.

The report sets out 10 aspirations for the development of services, with an emphasis on promoting resilience, prevention and early intervention. It states that organisations need to dismantle the artificial barriers between services, and plan and commission services together. The objective is easy access to the right support at the right time. This requires a clear joined-up approach with intelligent use of information, accountability and transparency to drive improvements in delivery of care and standards of performance. Care will be provided for the most vulnerable children and young people. Along with this the workforce, both universal and specialist, needs development to enhance capacity and capabilities.

[3] Future in Mind: promoting and improving our children and young people's mental health and wellbeing. Dept of Health and NHS England 2015

3.2 Right here, right now CQC report on crisis care for people with mental health problems 2015 & Mental Health Concordat[4]

The recent CQC report found variation in the experience of care for people during a mental health crisis. People raised concerns about delays in receiving support, co-ordination of help from different agencies and attitudes of some staff which were not compassionate or understanding.
The report found that 31% of those under 18 who were detained by the Police under section 126 were taken to a police cell as a Place of Safety. The national target is that no person aged under 18 will be taken to a police cell in future as a place of safety. The Mental Health Concordat requires local agencies to develop co-ordinated support for people of all ages who experience a mental health acute episode or crisis.

3.4 Mental Health and Behaviour in Schools: Advice for School Staff (DfE 2015)[5]

This guide sets out the evidence that in order for pupils to succeed, schools must have a role in supporting them to be resilient and mentally healthy. It advises that schools can promote mental health by having a healthy school approach, committed leadership, access to specialist support, enabling peer support and mentoring, continuous staff development, and work in partnership with children young people and parents. The guide is supported by advice for schools on commissioning emotional support services such as counselling. Schools could do this independently or with other schools, or in partnership with the local authority and CCG.

3.5 Achieving Better Access to Mental Health Services by 2020 (DH 2014)[6]

Achieving Better Access to Mental Health Services by 2020 outlines the first waiting time standards for mental health. This is part of the drive for parity of esteem, where people with mental health conditions can expect the same level of service as those with physical ailments. For 2016 there will

[4] Right Here, Right Now: help, care and support during a mental health crisis. Care Quality Commission 2015
[5] Mental Health and behaviour in schools: advice for school staff. Department for Education 2015
[6] Achieving Better Access to Mental Health Services by 2020. Department of Health / NHS England 2014

be a national standard that at least 50% of people of all ages referred for early intervention in psychosis will start treatment within two weeks. There will also be requirement for all CCGs to commission specialist community services for children with eating disorders. These children are at high risk of serious illness and mortality. A waiting time standard for access to this specialist service will be set for 2016/17.

3.6 Eating Disorders

There is a specific requirement set out in Achieving Better Access for all CCGs to commission specialist community services for children with eating disorders. Eating disorders such as anorexia nervosa and bulimia nervosa are debilitating mental disorders with high mortality rates[7]. If untreated within the community, it is likely that a young person with an eating disorder will require a long period of hospitalisation to stabilise the medical condition and then treat the underlying psychological condition. NICE clinical guidance recommends family interventions for those with anorexia and cognitive behavioural therapy for children and adolescents with bulimia.[8] The Department of Health will expect all CCGs to have commissioned such services for their region to be operational from 2016/17. They will be multi-disciplinary teams, providing a range of evidence based interventions. There will be a specific access waiting time target of 4 weeks from referral to commencement of treatment for routine cases, 1 week for urgent cases.

3.7 National review of CAMHS Tier 4 (DH 2014)[9]

This report identified a national shortage of hospital beds for children. It recommended an investment in extra capacity and strong joint working between specialist commissioners and local clinicians to improve the access to hospital and facilitate earlier discharge. The report also found that intensive community support services for children and their families can prevent the need for admission. It is still the case that many young people have to be placed in a hospital far away from their home.

[7] Guidance for commissioners of eating disorder services: Joint Commissioning Panel for Mental Health
[8] Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders: National Institute for Clinical Excellence 2004
[9] Child and adolescent mental health services (CAMHS) Tier 4 report 2014

3.8 Children and Family Act 2014 and Children with Special Educational Need or Disability

This Act sets out clear responsibilities for education, health and social care organisations to work together to meet the needs of children and young people up to the age of 25 with Special Educational Needs or Disability (SEND). Each local authority must publish a "local offer" of health social care, education and training services that are available. There must be a single education, health and care health plan for every child which can run up to the age of 25. The young person or their parent can ask for a "personal budget" to choose how elements of their care plan will be met.

Many organisations manage services differently for children and for young adults. There is often a "cut-off" at an age between 16 and 19.
The Act will require services to re-examine these structures and ensure at the very least that there is planned and co-ordinated transition between services. The Act also requires authorities to provide support for young carers and for families post–adoption.

The Winterbourne Review has highlighted specific problems in the long term health and social care residential services for people with learning disabilities. All CCGs have been tasked to develop Transformational Care plans. This plan must also consider the needs of adolescents and young people with learning disabilities and mental health problems, and their transition into adult services.

3.9 Equality Act 2010 & Humans Right Act

The Equality Act requires all public bodies to

- give due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic and those who do not share it;

- give regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities

The National Joint Commissioning Panel for CAMHS[10] has identified some children as having higher risk factors for emotional distress and mental disorders. It is also accepted that there is stigma attached to mental health problems and illnesses within numerous communities. We will ensure that our plans promote services which are accessible to all, free from discrimination or harassment, tackle stigma and promote positive relationships and community cohesion. In particular we will consider the impact for those young children known to vulnerable to mental disorders.

The Human Rights Act 1998 sets out a number of fundamental rights of all citizens including children and young people. These include:

- freedom from torture and inhumane and degrading treatment
- respect for private and family life
- no punishment without law
- freedom of expression

We will ensure that all services supporting children, young people and their carers adhere to these rights. It will also be important to tackle inequalities in access to health services and in health outcomes.

[10] Guidance for commissioners of CAMHS: Joint Commissioning Panel for Mental Health 2013

3.10 Key findings from the national agenda for the Transformational Plan

The national agenda has highlighted the following key issues that will be addressed within our local transformational plan

- There should be access standards for all services. There will be a national requirement from 2016/17 that at least 50% of children and young people referred for early intervention in psychosis will start treatment within two weeks;
- Local services for children and young people with eating disorders should be commissioned. There will be a national access time standard for this service of 4 weeks for a routine referral and 1 week for an urgent referral from 2017/18.
- Schools should adopt a healthy schools approach and offer emotional support services such as counselling, group work and peer support.
- Intensive community support services should be established that can prevent the need for admission and keep children and young people close to home
- Services for young people with special educational needs and disabilities should be clearly planned with adult services to ensure planned and co-ordinated transition;
- Targeted support should be available to young carers;
- Target support post-adoption;
- A place of safety for children and young people should be available for times of mental health crisis;
- Access to hospital beds should be improved and earlier discharge facilitated
- Some children and young people have higher risk factors and preventative and specialist services should be able to respond to their needs.
- All services should be free from discrimination, harassment and victimization, tackle stigma, and address health inequalities
- All services should promote or protect the rights of the child. In particular, they must adhere to the Humans Rights Act.

4. Level of Need and Local Context

4.1 Children and Young People in Leicester, Leicestershire & Rutland

There are approximately 250,000 children aged up to 18 in Leicester, Leicestershire and Rutland (Census 2011). Leicester City has one of the highest percentage ethnic minority populations of any area in England[11]. 68% of school children are from a Black or Ethnic Minority background, predominately South Asian. Leicester City Council estimates that the local Somali community comprises about 10,000 people. There are between 6,000 and 8,000 migrants of working age from Poland, Portugal, Slovakia, Latvia and Lithuania, including 1,000 – 2,000 people from the Slovak Roma community. Other new communities include asylum seekers and refugees. There are as many as 150 languages and dialects spoken in Leicester. Approximately 35% of children live in poverty and 64% in total live in families on low income. Poverty and low income levels correlate with poorer child health outcomes. The significant young ethnic minority population requires services to have a strong understanding of cultural norms and experience of discrimination that can impact on emotional health, as well as access to good language support services. The staffing population should reflect the diversity of the communities we serve. The CHIMAT Report[12] on child mental health reported that Leicester had higher levels of childhood obesity, tooth decay and a higher infant mortality rate than the national average. Admission rates to hospital for self-harm for those aged 10-24 have decreased in recent years and are lower than the national average.

Leicester City's Health and Wellbeing strategy 2013-16, "Closing the Gap"[13] has strategic priorities to improve outcomes for children and young people and to improve mental health and emotional resilience. The focus is on prevention and early intervention. This can help prevent emotional and behavioural difficulties, under-attainment at school, truancy and exclusion, criminal behaviour, drug and alcohol misuse, teenage pregnancy and

[11] Leicester Joint Strategic Needs Assessment 2012/ Leicester City Council
[12] Child Health Profile Leicester June 2015: Public Health England
[13] Closing the Gap: Leicester's Joint Health and Wellbeing Strategy 2013-16. Leicester City Council 2013

the subsequent need for high cost statutory social care in later life. The strategy also calls for intensive support for families with multiple problems and to tackle discrimination and stigma.

Leicestershire and Rutland are rural and relatively affluent counties. The health of children is generally better than the national average. There are however issues around rural isolation and social or academic pressure that influence mental health. Leicestershire's Health and Wellbeing Strategy 2013-16[14] sets out priorities to "get it right from childhood" and "improving mental health and wellbeing". It states that one of the most significant challenges to the health of the population is caused by the intergenerational cycle of health inequalities. Targeting families with the greatest overall needs (as per the "Supporting Leicestershire Families" initiative that has been developed in locally) is key to ensuring that the most vulnerable children have the best opportunity for good health and wellbeing throughout their lives. Rutland hosts two military bases with 700 children living there. The Rutland Joint Health and Wellbeing Strategy 2013-1615 has priorities to support the emotional health and wellbeing of children, young people and their families, and to support vulnerable teenagers make a smooth transition into adulthood.

4.2 Prevalence rates for mental health and developmental conditions

The last national survey of prevalence of mental health conditions in children was conducted in 2003[16]. This indicated that, at the time, in an average class of 30 schoolchildren, 3 will have a diagnosable mental health disorder[17]. The survey, extrapolated to Leicester, Leicestershire and Rutland indicates that

[14] Leicestershire's Health and Wellbeing Strategy 2013-16. Leicestershire County Council 2012
[15] Rutland Joint Health and Wellbeing Strategy 2013-16. Rutland County Council and East Leicestershire CCG
[16] Green H, McGinnity A, Meltzer H, Ford T, Goodman R (2005). Mental health of children and young people in Great Britain, 2004
[17] YoungMinds Mental Health Statistics.

11,000 children will have a conduct disorder: 6,250 will have anxiety: 1,700 will have diagnosable depression: 2,850 will have severe ADHD.

The specialist CAMH service provides therapeutic and medical interventions to assess and support children with mental health or neurodevelopmental needs. The current case load indicates the spread of conditions that the service supports.

Condition	Number of open cases
Anxiety	360
Conduct	50
Depression	139
Eating Disorder	100
Psychosis	11
Obsessive Compulsive Disorder	23
Self-Harm	78
Stress	70
Neurodevelopmental (ASD and ADHS)	562
Other	261
	1092

40

Often a child or young person will present with two or more related mental health conditions. Other service such as pediatrics, health visitors, school nurses and educational psychology also provide significant support for children with neurodevelopmental and mental health conditions. Nevertheless the data would suggest that if there are 21,000 children and young people with potential mental health or neurodevelopmental concerns, only one in twenty is receiving specialist assessment and therapeutic support from CAMHS.

4.3 Baseline Workforce Data

The charts below set out workforce data for the specialist CAMHS service including primary mental health, community CAMHS, specialist CAMHS teams and local Tier 4 hospital services.

Role	Grade	WTE
Medical	Consultant	13
	Specialty Doctor	1
Nursing	Qualified	46
	Unqualified	11
OT	Qualified	8
	Apprentice	1
Psychology		22
Therapy		7
Overall Total		109

24% of staff have an ethnic minority background. They range in age from 21-65 with 20% aged over 50. 4/5 of staff are female. There are a wide range of other services, in health, social care, education, youth offending amongst others, which work with children with mental health problems and their families.

4.4 Baseline financial data

The three CCGs fund the specialist CAMHS service to the value of £6.5 million in 2015/16. They also fund under children's services such as Paediatrics, disabled children's services and speech and language therapy which also work with many children and young people who will have

associated neurodevelopmental or mental health conditions. Adult mental health services (which receive CCG funding of £80million per year) also support young people aged 16-25.

Local Authority Children's and Early Help services are funded at around £25million per annum. This includes a range of specialist services (such as Educational Psychology) and generic child and family services.

NHS England (East Midlands) estimates an annual cost of £3.5 million per year on hospital and specialist services for children and young people from Leicester, Leicestershire and Rutland.

The Office for the Police Commissioner has committed £140,000 per annum to commission emotional support services for child victims of crime as a contribution to a partnership approach.

There is a commitment from the partners to this plan to deploy existing budgets alongside the Transformational Plan funding to jointly address the issues facing our local communities.

4.5 Vulnerable Children and Young People

There are approximately 1110 Looked after children in Leicester, Leicestershire and Rutland. The numbers have steadily risen over the past five years from 837 in 2010. Most are placed within foster placements. National research, Meltzer et al (2003)[18], showed that 46% of looked after children had a least one psychiatric diagnosis. There are approximately 9,000 children in need. A local health needs assessment has highlighted mental health as a key issue, with access to early support vital.

[18] The mental health of young people looked after by local authorities in England. Meltzer el al (2003)

For 2014, the proportion of school pupils with Special Educational Needs was 19.6% for Leicester City and 15.6% for Leicestershire County and Rutland. The England average was 17.9%. Children with a learning disability can often present with challenging and difficult behavior, which may also be associated with emotional distress. There is a specialist LD CAMHS service which provides and urgent, seven day a week service to reduce the risk of hospital admission or loss of residential care. This is linked to Transforming Care plans for all people with learning disabiliites.

The total number of Children and Young People who were a victim of a crime in 2014/15 across LLR was 3466. Of these the most prevalent crime types were assault, harassment, indecency and theft. It is well documented that young people are at a greater risk of becoming a victim of crime than the general population and that very few young victims go on to report their crime. The Office of the Leicestershire Police and Crime Commissioner has conducted qualitative research with young people and identified a need for therapeutic support for children and young people who are victims of crime and witnesses to crime[19].

Leicestershire County Council's Public Health Department[20] carried out a mapping review of mental health and wellbeing support services for children in 2014. This report found high levels of anxiety, more anger, more challenging behavior including violence and more self-harming. Children raise issues of bullying, family separation, domestic abuse and academic pressure as causes of emotional and mental distress. There has also been a rise in issues relating to social media, including cyber-bullying, and internet sites or groups which promote self-harm or eating disorders.

The report found examples of good early intervention and low level support services. These included counselling, self-esteem group work parental support, family mediation. However these are not universally available leading to a patchwork of provision. Such services may not always have links into statutory services such as educational psychology or CAMHS.

[19] Children and young people victim service review. Office of the Leicestershire Police and Crime Commissioner / Baker Tilly (2015)
[20] Mapping of children and young people's mental health and wellbeing support and services. Leicestershire County Council 2014

There has been significant pressure on local authority budgets which has led to a reduction of some early help services, either provided directly by the Councils or commissioned by them.

4.6 Role of Schools

Schools have greater responsibility and autonomy for developing pastoral and educational support services. They can utilise pupil premium funding to provide additional emotional health and well-being support to enable those eligible for funding to access learning and improve outcomes. Young people in Rutland have recently stated that they want greater education and discussion about mental health issues at school, to help overcome stigma and discrimination. School teachers want opportunities to develop their skills and expertise in supporting their students, and in accessing specialist help at the right time. Schools have a very important role to play in supporting children and young people to be resilient and mentally healthy.

A recent Chief Medical Officer's report[21] highlighted '*Promoting physical and mental health in schools creates a virtuous cycle reinforcing children's attainment and achievement that in turn improves their wellbeing, enabling children to thrive and achieve their full potential*.' In Leicestershire the Leicestershire Healthy Schools Programme provides a framework for a coordinated and effective approach to the planning and delivery of health and wellbeing improvement in schools. The programme operates a whole school approach to education and health improvement in schools ensuring that the whole community is involved in the process.

[21] Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence

4.7 Role of the Voluntary and Community Sector

Voluntary Action Leicestershire (VAL) holds a database and public directory of voluntary and community sector (VCS) organisations for Leicester, Leicestershire & Rutland (LLR). These groups cover a range of services, and just over 450 groups help with emotional health and wellbeing with the main beneficiaries as children, young people and families (CYPF). These groups deliver a range of local community based activities, from, street based art, sport, drama and music, to more specialist support for conditions, such as Attention Deficit Hyperactivity Disorder (ADHD), for the whole family. VCS groups have a strong track record in building strong relationships with families, breaking down barriers, have direct access into families at a community level and have built trust with communities over a number of years. The VCS will have a pivotal role in delivering interventions and preventative projects and services working in consortia and/or in collaboration with statutory partners. There is currently a patchwork provision of commissioned VCS early help and support services that needs coordination and integration as part of a whole system wide local offer for families. This has the potential to reduce pressure on specialist CAMHS and waiting times for access to these services.

4.8 Redesign of Specialist CAHMS

The specialist CAMHS Community Outpatient service has seen an increase in referrals of about 9% per year over the past four years. The main reasons for referral include conduct disorders, family problems, requests for assessment for neurodevelopmental conditions, low self-esteem, self-harm and eating disorders. This has led to significant pressure on the CAMHS teams with increased waiting times for assessment and treatment. Average waiting times for assessment are rising and are currently around 13 weeks. Some children and young people have to wait much longer. Around 30% of referrals are not accepted or redirected as they do not meet the thresholds for a CAMHS intervention. This indicates that work can be done to improve the understanding of the role of the specialist CAMHS service and promote other services that can provide appropriate support.

The service provides a range of therapeutic interventions including Cognitive Behavioural Therapy (CBT), Systemic Family Therapy (SFT) and Interpersonal Psychotherapy amongst others.

In 2014 the CCGs commissioned an independent review of the CAMHS community outpatient services to examine and address these issues[22]. The review also considered concerns about joint working with other organisations such as GPs, schools and social care services. The key recommendations from this review centred on the referral and assessment process, clinical leadership , caseload management and advice, information and support for other practitioners and service users.

These recommendations have been adopted into a Service Development Improvement Plan and a redesign of the specialist CAMHS[23] . Key elements of the plan are to manage the current waiting lists to ensure that all children are safe, improve access, tackle low discharge rates, work to agreed quality standards as set by the Royal College of Psychiatrists, and improve engagement with stakeholders.

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CAMHS uses the following clinical and patient-centred outcome measures:

- Health of the Nation Outcome Scales for Children and Adolescents (HONOSCA)
- Friends and Family Test (FFT)
- Paediatric Index of Emotional Distress (PI-ED)
- Strengths and Difficulties Questionnaire (SDQ)

[22] Review of NHS CAMHS Tier 3 services in Leicester, Leicestershire and Rutland. Tim Jones 2014

[23] CAMHS Service Development and Improvement Plan 2015/16. Children and Families Commissioning Team, West Leics CCG

There has also been a recent Care Quality Commission inspection of children and families services provided by Leicestershire Partnership Trust (July 2015)[24] [25]. This has recommended a number of areas of CAMHS community and in-patient services which require improvement. These include ensuring staff have regular supervision, training and appraisals; assessing and treating young people in a timely manner; the development of crisis response services; learning from serious incidents; and ensuring service users give consent to treatment and are informed of their rights.

4.9 Crisis and In-patient Care

There have been seven serious incidents involving children known to the CAMHS service over the past two years who have been admitted to an adult in-patient ward or had an extended wait within the Emergency Department at the Royal Infirmary hospital. The CCGs commissioned an independent review into these cases which was conducted by Verita[26] and reported in July 2015. The key themes that were highlighted within this review were:

- Develop multi-agency care plans, risk assessments and crisis response plans for children and young people at risk of acute mental health or conduct difficulties
- There should be a clear place of safety for young people under the age of 18
- Commission a crisis response service
- Ensure that there is a clear protocol and procedure for accessing in-patient services which is communicated to all relevant practitioners

Leicester, Leicestershire and Rutland has been selected as one of only eight urgent and emergency care vanguard sites The Vanguard will create a new alliance-based urgent and emergency care system where all providers work as one network. This will bring together ambulance, NHS111, OOH

[24] Leicestershire Partnership Trust: specialist community mental health services for children and young people. Care Quality Commission July 2015

[25] Leicestershire Partnership Trust: child and adolescent mental health wards. Care Quality Commission July 2015

[26] A thematic review of seven incidents involving Child and Adolescent Mental Health Services. Verita 2015

and Single Point of Access services to ensure that patients get the right care, first time. The Vanguard will also progress work to ensure that there is an all ages crisis response service including children and young people experiencing acute mental distress.

Children in Leicester, Leicestershire and Rutland who require a period of time in a mental health hospital can access beds commissioned from NHS England. There is a 10-bedded unit within Leicestershire. Young people from LLR may be placed there or at another unit across the Midlands and East region. There are no specialist units in the region for young people with eating disorders or requiring a Psychiatric Intensive Care Unit (PICU). These young people may be placed anywhere in the country. This presents problems in continuity of care and education, difficulties for families and carers in visiting, and can damage the young person's links with friends and peers. We are keen to see a greater provision of general and specialist beds within the Midlands region. The data for June 2015 shows that 48 young people from LLR were placed in a hospital, 5 of these in eating disorder unit, 8 within a PICU and 4 in Low Secure setting. All 17 requiring a specialist unit are placed outside the East Midlands region.

4.10 Eating Disorders

The CAMHS service is presently not specified to provide a specialist eating disorder service. There has been a significant increase in referrals for this condition from around 40 to 100 per year. These children and young people are supported by the generic community CAMHS team. An eating disorder such as anorexia nervosa can be a particularly serious mental health condition with a risk of severe damage to physical health or mortality. There is a growing evidence base that early access to specialist community based eating disorder service operating to NICE guidelines can improve outcomes and be financially cost-effective by reducing reliance on long-term hospital placements. The CCGs have agreed to commission a specialist community based eating disorder service with the capacity to provide NICE concordat therapeutic interventions for 100 children and young people per year. This will serve an overall population of 1 million. The service will meet the national access standards by 2017/18. These are four weeks from referral to assessment and commencement of treatment for routine cases, and one week from referral to assessment and commencement of treatment for urgent cases. This development will potentially reduce pressure on generic CAMHs. It should also prevent the escalation of eating disorder conditions to critical levels where emergency admission to specialist or paediatric hospital wards is required.

4.11 Key findings impacting on the transformational plan

- Our region has a significant child ethnic minority population and all services will need to accessible and culturally appropriate. Peer and parental support groups for these communities may be particularly beneficial.

- There has been an increase in young people experiencing anxiety, anger and challenging behaviour and referrals to specialist CAMHS.

- Education services are very important in promoting resilience and good mental health and in commissioning specific pastoral support services

- There are some excellent and innovative voluntary and community sector providers. There is a patchwork provision of early help and support services. These services need to be integrated within a care pathway and commissioned in a strategic way to ensure that there is consistent and equitable offer to children across the region.

- The CAMHS service must transform the assessment and treatment process so that help can be offered quicker. It can offer more advice, training and support to other organisations and practitioners. It can make better use of routine outcome measures.

- Specific community services for children and young people with eating disorders are required.

- A co-ordinated multi-agency response to children and young people experiencing a mental health crisis is required.

- There is a need for more generic and specialist hospital beds commissioned in the East Midlands.

5 Transformational Plan for 2020

5.1 Promote good emotional health and resilience for all children, young people and their families

Young people have said that they want to have the confidence to talk about emotional problems openly and without stigma. They want to be able to find information and support from the school, college or youth service, and also from websites and social media. Education services want to offer education and guidance for their pupils, provide pastoral support and know when to ask for specialist assistance. Parents, young people and schools are all concerned about the impact of cyber-bullying.

Our partnership will commission and deliver a public health campaign on mental health and resilience. A key element of this will be to form partnership with education settings to develop and deliver age appropriate education on mental health problems. We will also review the current approaches and resources that are being used to address the misuse of social media, including cyber-bullying and sexual exploitation. The best practice approaches will then be shared across educational settings.

Our partnership will develop a range of ways for children, young people and carers to find out about mental health and the range of services that can help this. This will be through utilising social media and more traditional communication methods. It will involve building on current best practice and innovation.

The financial investment in this work will come initially from the transformational plan and from public health departments. The partnership will also engage with schools to release direct funding contribution. Indicative funding would be £200,000 from the transformation plan and £230,000 from Public Health.

5.2 Development and delivery of co-ordinated, accessible and non-stigmatising early and targeted support for those experiencing emotional distress and the first signs of mental disorders

Young people and carers have said that they want access to help and support quickly and locally, without being stigmatised. They want to have a choice about the kind of help they receive and be encouraged to become resilience and maintain their independence. They also want potentially serious problems to be recognised quickly, and no longer be told that "they are not ill enough" to get help. Organisations such as health, education, youth justice and social care want to work together to understand the needs of a young person and decide together with the young person and / or parent what support to offer. We know that a range of public, private and community organisations can provide effective support. They want their services to be part of a commissioned pathway of support, meeting high quality standards and linked to more specialist services.

Our partnership will commission a multi-agency "First Response" service which will assess the level of distress and risk facing a child, young person or family, and co-ordinate the right intervention and support. It is important that there is quick local access to this first response, and that it benefits from the expertise and knowledge of practitioners from various agencies. The services will signpost the young person or family, escalate the case if required, or offer low intensity support and help. This will include offers such as counselling, group work and parental support. But it will also include direct access to specialist mental health services if required.

There will be financial contributions from local authorities, CCGs and the OPCC to supplement and support transformational plan investment in this approach. Indicative funding would be £460,000 from the transformational fund with matched funding (or work in kind) from local commissioning partners.

5.3 Single gateway to specialist CAMHS services with clear access standards

Young people value the quality of care and support they receive from the specialist CAMHS service. They have said that they appreciate the therapeutic relationship they can develop with their practitioners and the support offered to their family and carers. However, it remains difficult to access the service quickly and there is a perception that a young person will be told that they are “not ill enough” to receive CAMHS help.
The CAMHS service is experiencing a rising number of referrals (up about 9% per year) and increasing these are for complex or urgent situations.

The CAMHS service will pilot establishing a single access team. This team will receive all referrals to the service and will make direct contact with the referrer, the young person and the carers (if appropriate) to understand the presenting issues. It will offer short term interventions or ensure that the young person can access the specialist CAMHS services if required. The pilot service will run during 2015/16 with the aim of commissioning a full service to operate from 2016/17 onwards. There will be locally agreed access waiting time standards There will be strong engagement with local authority social care access teams to share information (with consent) and to plan joint interventions.

The service will also provide a set range of evidence based NICE concordat therapies. This will include Systemic Family Therapy, Cognitive Behavioural Therapy, Parenting Support and Interpersonal Psychotherapy. These will be specified clearly within contract documentation.

The indicative financial commitment would be £50,000 from the transformational fund with £100,000 CCGs.

5.4 Specialist support for vulnerable children and young people with mental health problems

The CCGs and local authorities will review and consider expanding the specialist therapeutic support that is available for children and young people who are particularly vulnerable. This includes looked after children, those at risk of offending, those with learning disabilities, those with a family of mental health problems, those who have been exposed to sexual exploitation and children who are refugees or asylum seekers. It is known that these children and young people are more likely to require psychological support and would benefit from swift access to services which are skilled and experienced in responding to their needs.

The indicative financial commitment would be £50,000 from the transformational fund and £200,000 from CCGs and local authorities.

5.5 Systematic use of outcome measurement to drive clinical and service improvement

Our partnership will strengthen the use of outcome measures. These will be used both to inform clinical practice for individuals, and also to improve the overall design of services. Measures will include HONOSCA, PI_ED, Friend and Family Tests, Outcome Star, Strengths and Difficulties Questionnaire, and Signs of Safety. A range of measures are set out in the guidance for the Children and Young People's Improving Access to Psychological Therapies programme (CYP-IAPT) and the Child Outcomes Research Consortium (CORC). We will prepare for the Mental Health Service Minimum Data Set (MHSMDS). This work will involve ensuring that data systems are in place to record, analyse and report on the outcome measures. It will also involve developing information sharing protocols between organisations.

The LLR CAMHS services are presently not part of the National CYP-IAPT programme. There is not a training provider for the Midlands region. However, the partnership is keen to support the Local Education and Training Board to develop provision locally. Non-recurrent transformational funding will be used to support this.

5.6 Specialist community services for children and young people with eating disorders

Eating disorders such as anorexia nervosa and bulimia nervosa are debilitating mental disorders with high mortality rates[27]. Nationally and within LLR there has been an increasing prevalence of eating disorders amongst children and young people. The number of referrals to CAMHS has substantially increased from an average of 40 a year in 2011 to over 100 in 2014/15. If untreated within the community, it is likely that a young person with an eating disorder will require a long period of hospitalisation to stabilise the medical condition and then treat the underlying psychological condition. NICE clinical guidance recommends family interventions for those with anorexia and cognitive behavioural therapy for children and adolescents with bulimia.[28] The Clinical Commissioning Groups have therefore decided to invest in the commissioning of a specialist multi-disciplinary community based eating disorders service for children and young people up to the age of 18. The service will deliver NICE concordant treatments for up to 100 new referrals per year. It will operate to the national access and waiting time standards so that all routine cases will be assessed within 4 weeks and urgent cases within 1 week of referral. Over the period of this transformational plan there will be the opportunity to further enhance the service to meet all aspects of the national guidance (2015)[29] and respond to new NICE guidelines which are due in 2017. The potential benefits of this investment include reductions in admissions and length of stay in specialist hospital settings. It also have the potential to reduce the number of crisis and acute cases.

Indicative financial contribution: £440,000 from the transformational fund.

[27] Guidance for commissioners of eating disorder services: Joint Commissioning Panel for Mental Health
[28] Eating disorders: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders: National Institute for Clinical Excellence 2004
[29] Access and Waiting time standards for child and young people's eating disorder services, NHS England 2015

5.7 Co-ordinated support to prevent crisis and at time of crisis

There is also a need to develop specific support for children and young people, and their carers experiencing a crisis situation due to significant behavioural or mental health disorders. This may include a young person being violent, using threatening behaviour towards themselves or others, or facing a life-threatening condition. In these situations, an urgent assessment or intervention may be required and the young person may need to be taken to a safe and calming environment where, in time, a full assessment can be undertaken. There is also a requirement to establish a designated "Place of Safety" as required under Section 136 of the Mental Health Act 1983. This Place of Safety should never be a police cell. The CCGs, in partnership with the local authorities, will commission a crisis resolution and home intervention service which will operate beyond normal office hours and offer home or community based assessments and interventions. The team will also liaise with NHS England and Tier 4 providers to facilitated planned admission and discharge. This is set out in the action plan for Leicester, Leicestershire and Rutland to deliver the Mental Health Crisis Care Concordat[30].

Indicative funding would be £500,000 from the transformational plan.

5.8 Workforce Development

We have established a workforce development plan for the specialist CAMHS service. This focusses on succession plan and recruitment and the development of leadership and specific therapeutic skills. The plan recognised the need to develop skills and experience in therapies such as cognitive behavioural therapy, interpersonal psychotherapy and family therapy. It is also important to have a workforce that is balanced in terms of age and gender and is ethnically diverse to reflect the profile of the children and families we work with.

[30] Crisis Care Concordat for Mental Health: Leicester, Leicestershire and Rutland action plan

We will recommission a child mental health training and development programme. This will build on our successful approach of ensuring that local specialist practitioners deliver the training to other practitioners such as children's centre staff, social workers, police officers and school teachers. Indicative funding would be £70,000 from Future in Mind and £70,000 from local authorities.

6 Governance and Transparency

This transformational plan presents a significant challenge to all partner organisations. But the vision is clear and the determination to make these changes now is set. The programme will require strong governance and management to ensure that it delivers against the objectives, and remains transparent and open to scrutiny and review. This is why we have decided to embed the Future in Mind Transformational Plan within the Better Care Together (BCT) Programme Framework. This approach offers the benefit of greater engagement with a wide range of stakeholders as well the potential to make links with other workstreams such as adult mental health and urgent care.

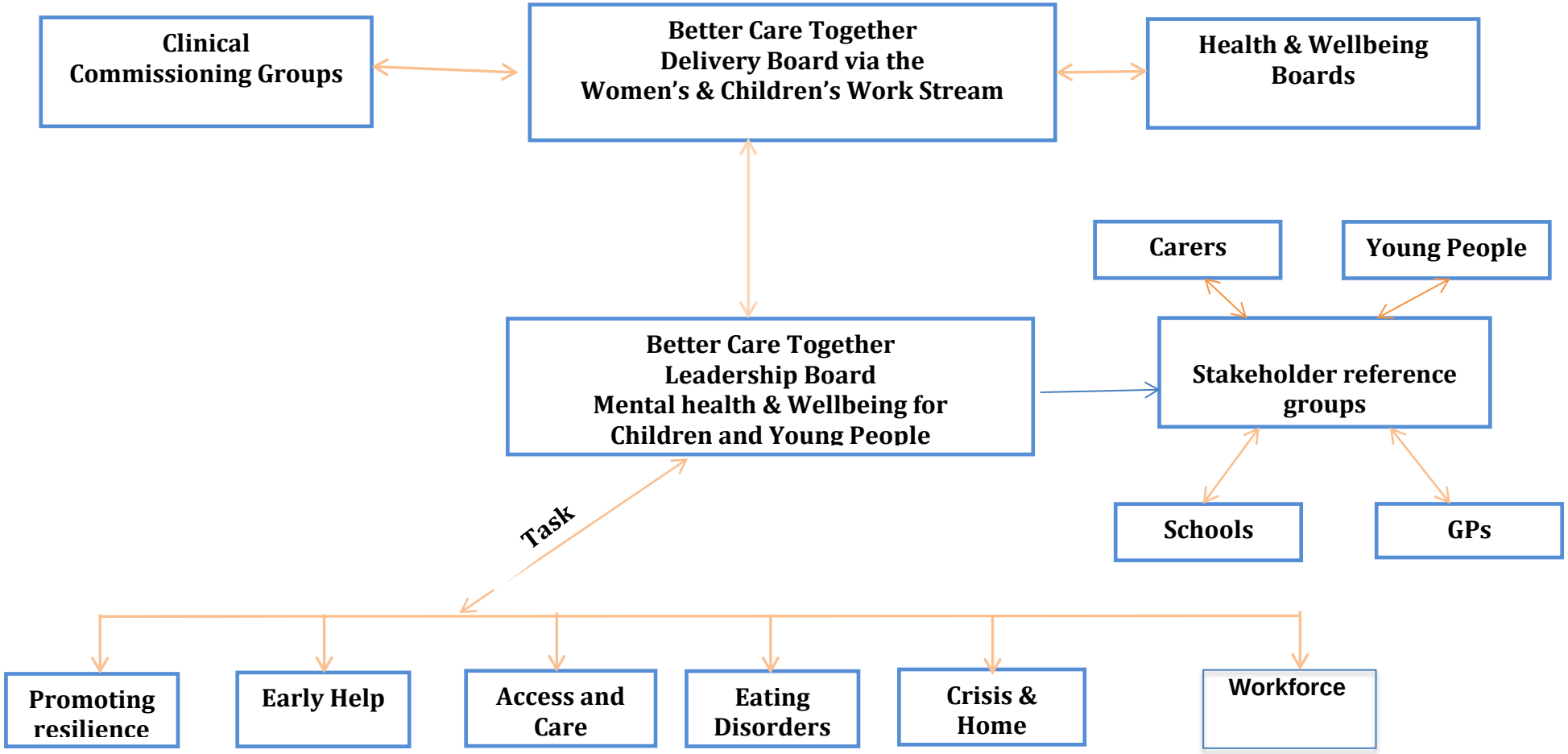
The programme will be led by the BCT Delivery Board which is accountable to the Boards of the three CCGs and three Health and Wellbeing Boards for the area. It will be part of the Women and Children's Workstream, and be jointly led by the Director of Children's Services at Leicestershire County Council and the Director of Nursing at Leicester City CCG. A Steering Group[31] has already been established with representation from local authorities, voluntary sector, Healthwatch, the OPCC and health commissioners and providers.

There is a programme lead officer, who will be supported by additional project officers responsible for delivering key aspects of the programme. Task groups are being established to manage each element of the programme. There will also be specific stakeholder reference groups for schools, GPs, parent/ carers, and young people. These groups will hold the overall programme to account, and ensure that it remains focussed on what local children, young people and carers have said that they want. The structure is set out in the diagram below.

An "easy read" summary of the plan will be published on the websites for each CCG and Health and Wellbeing Board in November 2015.

[31] Better Care Together Mental health and wellbeing of children and young people steering group 2015: terms of reference

Governance Framework
Mental Health & Wellbeing for Children and Young People



7 Indicative Financial Allocations

The three CCGs for Leicester, Leicestershire and Rutland will receive a total of £1,870,000 recurrent funding on assurance of the transformational plan. This will be set alongside other funding contribution from the CCGs and partner organisations to implement all aspects of the plan.

The detailed financial commitments and costing will be subject to further analysis. However the outline indicative commitment to each priority area is set out below. For the remainder of 2015/16 funding will be used for a range of investments linked to the plan. This includes engagement events, IT infrastructure, programme management, and pilot schemes.

Priority	Funding	Contributions	
		Future in Mind	**Other**
Programme Management	£ 130,000	£ 100,000	LAs £30,000
Eating Disorders	£ 440,000	£ 440,000	
Crisis and Home treatment	£ 500,000	£ 500,000	
CAMHS Access Team and specialist teams	£ 300,000	£ 100,000	LAs £200,000
Early Help	£ 700,000	£ 460,000	OPCC approximately £140,000 CCGs £100,000
Public Health and engagement with schools	£ 430,000	£ 200,000	Public Health £230,000
Workforce development	£ 140,000	£ 70,000	LAs £70,000
Total	**£2,640,000**	**£1,870,000**	**£770,000**

8 Implementation Plan 2015-17

The Implementation Plan for 2015-17 set out below is based on the aspirations set out in Future in Mind. It is the first stage of our journey to transform the mental health and wellbeing of children and young people by 2020. Each objective aims to be SMART: to be clear, measurable, to a deadline and with a clear accountable officer. There are identified leads for each objective, although all will require strong partnership working.

The implementation plan will form the work programme of the BCT Steering Group for children and young people's mental health and wellbeing. It will be closely managed and reviewed to ensure that there is progress in all areas.

IMPLEMENTATION PLAN 2015-2017

Future in Mind Aspiration 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			
Where we want to get to: *My family and I are able to look after my emotional and mental wellbeing and development day to day. I learn about mental health and how to protect myself at school or college. I am confident in talking about issues which affect my mental health. I know how to access information and advice when I need it.*			
Action	**Lead**	**Outcomes**	**Timescale**
1a) Commission implement and evaluate a public health campaign on mental health and resilience for children and young people	Directors of Public Health	An annual programme of public health campaigns that raise awareness and promote resilience	Commission Dec 2015 Launch April 2016 Review Dec 2016 Re-commission April 2017
1b) Commission programmes of work within schools and colleges to raise awareness of mental health issues	Directors of Public Health	Programmes of work within schools to raise awareness on mental health issues	Commission Dec 2015 Launch April 2016 Review Dec 2016 Re-commission April 2017
1c) Review current approaches and resources to social media bullying and sexual exploitation	Directors of Public Health in partnership with schools and police	Identify current best practice and share across schools and colleges	Review March 2016 Disseminate May 2017

Future in Mind Aspiration 2. Meet the national and local waiting time standards for access to community mental health services for children and young people			
Where we want to get to: *I will be helped by a specialist team quickly if my mental health problems are serious*			
Actions	**Lead**	**Outcomes**	**Timescales**
2a) Commission, implement and deliver a new "Access team" for CAMHS.	CAMHS Commissioner	No child or young person will have to wait more than 13 weeks from referral to access CAMHS	Pilot August 2015 Review Jan 2016 Commission Feb 2016 Implement April 2016
2b) Implement the enhancement of the specialist service for people with first episode psychosis	Director of FYPC Services, LPT	All children and young people with a first episode of psychosis will receive specialist therapeutic support within two weeks of referral.	Enhance service 2015/16 Achieve standard April 2016
2c) Commission, implement and deliver a community based eating disorder service for children and young people	CAMHS Commissioner	All children and young people with an eating disorder will receive NICE Concordat specialist support within 4 weeks of referral	Commission Sept 2015 Service commences April 2016. Standard met 2017/18

Future in Mind Aspiration 3 A step change in how care is delivered moving away from a system defined by organisations, "a tiered model" to one based around needs of children and their families			
Where we want to get to *I can get support to help me overcome emotional and mental health challenges quickly and locally, without being stigmatised. I will have choice about the kind of help I would like. I and those who care for me will be listened to. I will be supported to become resilient and independent. With my consent, services will work together with me and my family to give me the best support. I will be involved in decisions to reduce or transfer my care*			
Actions	**Lead**	**Outcomes**	**Timescales**
3a) Develop and implement a multi-agency "first response" service young people and families with mental health needs	Director of Children's Services, Local Authorities	All children and young people with mental health needs can access help quickly and easily.	Develop model Dec 2015 Implementation from April 2016 onwards Review and develop 2017/18 onwards
3b) Commission and implement a collaboration of early help mental health support services.	Director of Children Services, Local Authorities	There are a range of quality assured low intensity interventions available to children, young people and families	Develop commissioning model by January 2016 Implement June 2016
3c) improve the support for young people transferring from child to adult services	CAMHS Commissioner	Every young person has a care plan covering age 16-19	Audit February 2016 Include in specs for April 2016

Future in Mind Aspiration 4 Increased use of evidence based treatments with services focusing on outcomes			
Where we want to get to: *I will receive support which is safe, reliable and tested. I will be involved in setting my own treatment goals and deciding if I am getter better*			
Actions	**Lead**	**Outcomes**	**Timescales**
4a) Review the range of therapeutic interventions against best practice guidelines evidence base and specifications.	CAMHS Commissioner	A clear offer of accurate assessment and therapeutic interventions is set out in specifications and information to other agencies, children, young people and carers	A programme of reviews is conducted during 2016/17 Specifications revised April 2017
4b) Commission, implement and monitor the use of routine outcome measures to inform clinical decisions and service developments	CAMHS Commissioner	All commissioned services use clinical and service user outcome measures.	April 2017
4c) Support the development of a regional CYP-IAPT training programme	CAMHS Commissioner	The CAMHS service will be part of the national programme, using CYP_IAPT outcome measures	Through 2016/17

Future in Mind Aspiration 5 Making mental health support more visible and easily accessible for children and young people and their families			
Where we want to get to: *I can access trusted self-care advice when and where we like including websites, education settings, GPs and children's centres. I can get support to help me overcome emotional and mental health challenges quickly and locally, without being stigmatised. I will be able to make informed choices about the kind of help I would like.*			
Actions	**Lead**	**Outcomes**	**Timescales**
5a) Develop and make available information and advice services including social media, mobile communication and face-to-face.	Directors of Public Health	A range of ways for all children, young people and carers (including those with protected characteristics) to find information and advice about mental health issues.	Map needs March 2016 Develop service April 2016 Fully implement April 2017
5b) Provide and publicise a clear local offer of services for children their families including mental health and wellbeing services	Directors of Children's Services.	"Local offer" and Directory of services prepared and publicised annually	March 2016 and annually
5c) Ensure first response mental health services are easily accessible for all young people and carers.	Director of Children's services.	Young people and carers can access help and support quickly and locally ,	Develop model Dec 2015 Implementation from April 2016 onwards

Future In Mind Aspiration 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			
Where we want to get to: *I will be helped by a specialist team quickly if my mental health or behavioural problems are serious. Organisations will work together to support me. I will be seen promptly if I attend the Emergency Department. I will not be judged by staff for my mental health problems. I will be able to access a bed within a reasonable distance from home. I will be supported to return home safely as soon as possible.*			
Actions	**Lead**	**Outcomes**	**Timescales**
6a) Commission and implement a multi-agency home treatment and crisis response service	CAMHS Commissioner	Children and their carers are supported during times of crisis. Less inappropriate use of the emergency services and ED	Develop model Nov 2015 Commission December 2015 Commence April 2016
6b) Create a designated place of safety for children and young people detained by the Police under sections 135 and 136 of the Mental Health Act 1983. This is a shared action with the Crisis Care Concordat.	CCG Mental health Commissioning Lead	There will be a designated place where the police can take a child or young person with possible mental health problems	Report on options Oct 2015 Agree and set up place of Safety. July 2016
6c) Implement clear multi-agency protocols to co-ordinate services to support children and their families in a mental health crisis	CAMHS Commissioner	Organisations work swiftly together to support child and family during mental health crisis	Autumn 2015 and then reviewed on three monthly basis.
6d) Support the case for more hospital beds in the East Midlands	CAMHS Commissioner	Commission more generic and specialist beds locally	Commission beds for 2017/18

Aspiration 7 Improved access for parents and carers to evidence based programmes of intervention and support to strengthen attachment between carer and child, avoid early trauma, build resilience, and improve behaviour			
Where we want to get to: *All parents and carers, particularly those vulnerable to mental health problems, have access to effective programmes of intervention and support.* *Perinatal support and advice is available for all parents*			
Actions	**Lead**	**Outcomes**	**Timescales**
7a) Ensure that the health visitor service deliver perinatal mental health advice and support.	Directors of Public Health	All new parents receive advice and support around their mental health	Review spec Jan 2016 Implement April 2016
7b) Commission and implement range of parental support programmes across all regions and ages	Directors of Children's Services	Parents will receive appropriate support.	Review current services by Dec 2015 for commissioning for April 2016
7c) Commission and implement attachment training and trauma recognition training for schools and children's centres	Directors of Children's Services	School and children's centre staff understand attachment and trauma	Commission March 2016 Commence training October 2016

Future in Mind Aspiration 8 A better offer for the most vulnerable children, making it easier for them to access support they need when and where they need it

Where we want to get to:

I can get high quality support to help me overcome emotional and mental health challenges quickly and locally, without being stigmatised.
I will be able to make informed choices about the kind of help I would like. I and those who care for me will be listened to.
I will be supported to become resilient and independent. I and my carers will be helped to navigate the system and services.
I am involved in peer support groups and community networks in my area.

Actions	Lead	Outcomes	Timescales
8a) Review and if necessary enhance capacity of specialist services (YPT and LDT) support looked after children, young offenders and children with learning disabilities	CAMHS Commissioner	Identify where additional capacity is needed to support vulnerable children	Review in Nov 2016 Commission enhanced capacity for April 2017
8b) Commission and establish peer support networks for vulnerable children (e.g. young carers, gay and lesbian young people, young refugees and asylum seekers)	Director of Children's services	Vulnerable children and young people have access to facilitated peer support networks.	Commission services to commence April 2016
8c) Ensure that issues of equality and diversity and human rights are addressed within all commissioned services.	CCG and Local Authority Commissioners	Ensure that all services are accessible, do not discriminate on irrelevant considerations and promote diversity and respect	June 2016

Aspiration 9 Improved transparency and accountability across the whole system, to drive further improvements in outcomes			
Where we want to get to: *I am confident in talking about issues which affect my mental health. My views and experience will help to improve care for others*			
Actions	**Lead**	**Outcomes**	**Timescales**
9a) Establish a unified approach to capture and respond to the views and experiences of children, young people, and carers. Use this to shape commissioning plans	CAMHS Commissioner	Strategic plans have been directly influenced by the views and experience of children young people and carers	June 2017
9b) Establish a specific stakeholder group including children, young people and carers to develop and evaluate the transformational plan	CAMHS Commissioner	Stakeholder Group influences and informs the transformational plan.	First meeting December 2015
9c) Publish the Transformational Plan on websites and report on progress at regular intervals.	MD for each CCG	Plan is available for public scrutiny	Publish November 2015

Aspiration 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 those who need it			
Where we want to get to: *I can get high quality support to help me overcome emotional and mental health challenges quickly and locally, without being stigmatised. I and those who care for me will be listened to. With my consent, services will work together with me and my family to give us the best support. There will be a skilled, experienced and knowledgeable workforce across all organisations who have access to training and advice on child mental health and how to access specialist support*			
Actions	**Lead**	**Outcomes**	**Timescales**
10a) Develop a child mental health training strategy and commission a partnership training programme . This will include the MINDEd online programme.	Chair of Workforce task group	A child mental health training strategy and programme is in place which all practitioners can access	Review Autumn 2015 re-commission to start in April 2016
10b) increase capacity of front-line practitioners by offering specialist support	Director of FYPC	Front-line practitioners have greater confidence and skills to support children and young people with mental	Ongoing

Thank you for reading our plan

END

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Report No. 216/2015

Report to Rutland Health and Wellbeing Board

Subject:	**Joint Strategic Needs Assessment and Health & Wellbeing Priorities**
Meeting Date:	**17th November 2015**
Report Author:	**Karen Kibblewhite**
Presented by:	**Karen Kibblewhite**
Paper for:	**Discussion**

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

Strategic Objectives

- Meeting the health and wellbeing needs of the community

Background

Rutland's draft Joint Strategic Needs Assessment (JSNA) was presented to the Health & Wellbeing Board in July and was approved pending some minor amendments. The existing Joint Strategy for Health & Wellbeing runs to 2016 will need to be refreshed in light of the data and information contained within the JSNA.

Whilst the detailed chapters of the JSNA which will support the Strategy refresh are being completed, the Health and Wellbeing Board still need to drive forward the Health & Wellbeing agenda for Rutland and as such need to identify current priorities for focus.

Existing Priorities within the Joint Health & Wellbeing Strategy

The existing Strategy identified 3 themes, within which there were a number of priorities:

Theme 1: Giving children & young people the best possible start
Priorities: i) Vulnerable Families;
ii) Vulnerable Teenagers;
iii) Emotional health and wellbeing of children, young people and their families.

Theme 2: Enable people to take responsibility for their own health
Priorities: i) Obesity;
ii) Smoking;
iii) Alcohol.

Theme 3: Help people live the longest healthiest life they can
Priorities: i) Frail elderly;
ii) Dementia
iii) Cancer
iv) Depression and anxiety
v) Wider determinants of health

Potential Priorities

There are three key drivers for health and wellbeing work in Rutland currently:
- Health and social care integration
- Better Care Together (BCT)
- Better Care Fund (BCF)

As well as these and the workstreams contained within BCT and BCF, the JSNA Overview identified several additional areas for focus:
1) Planning care for an ageing population
2) Dementia
3) Carers
4) Obesity
5) Children's oral health
6) Factors affecting access to information and advice, including access to preventative services.

The Board may wish therefore to concentrate on a thematic priority, for example ensuring that the considerations of integration run through all the work undertaken; or the Board may wish to identify a particular area of interest on which to focus some dedicated work over the next three to six months, for example alcohol or obesity.

Financial implications:

There are no specific implications of identifying priorities themselves, although there may be financial implications attached to specific pieces of work.

Recommendations:

That the Board:

Discuss the potential priorities and identify where they wish to focus over the next three to six months.

Strategic Lead:	Karen Kibblewhite

Risk assessment:

Time	L	The intention to identify an initial priority (or priorities) for the next three to six months is viable and is in line with good practice recommendations for high performing Health & Wellbeing Boards.
Viability	L	Once priorities have been identified, they will be woven through existing work and plans.
Finance	L	There are no additional financial implications of identifying the priorities themselves.
Profile	M	The priorities identified will drive the Health and Wellbeing Board's work and will be public-facing..
Equality & Diversity	L	Full Equality Impact Assessments will be completed for individual pieces of work.

Rutland County Council

Joint Strategic Needs Assessment

Overview 2015

Version Control	Version 1.1
Document Owner / Authorising Officer	Head of Commissioning
Target Audience	Health & Wellbeing Board; RCC Staff; Providers
Publication Date	November 2015
Review Date	November 2016
Links to other policies/processes	Better Care Fund Programme; Better Care Together.

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 reviewed 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 2. 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 be updated as new data becomes available.

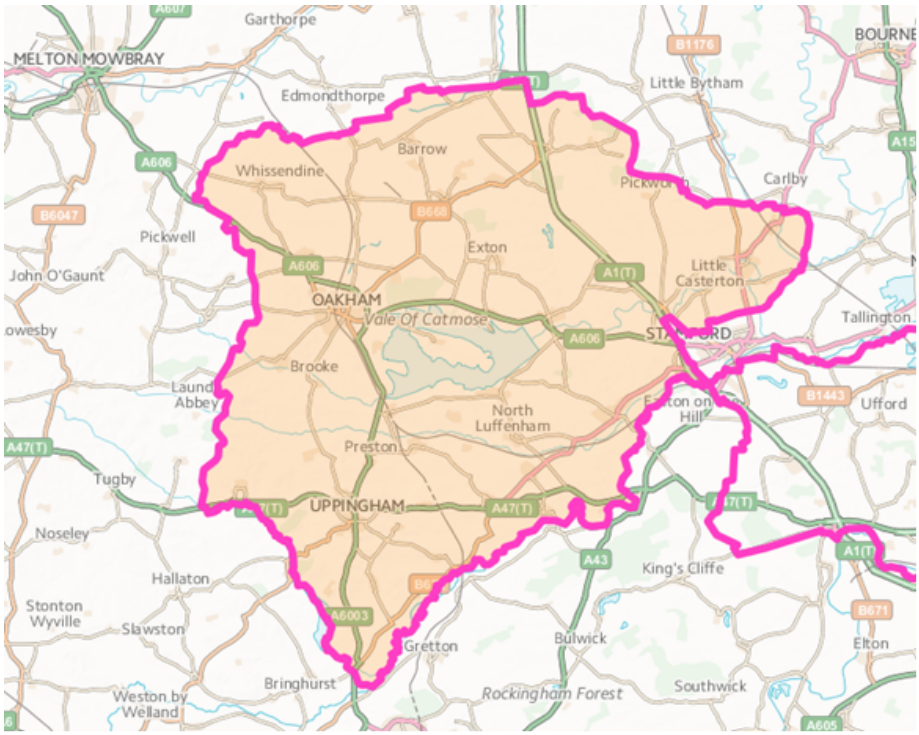
This summary document will inform both the areas chosen for detailed chapters, and the Health & Wellbeing Board's refreshed Strategy.

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



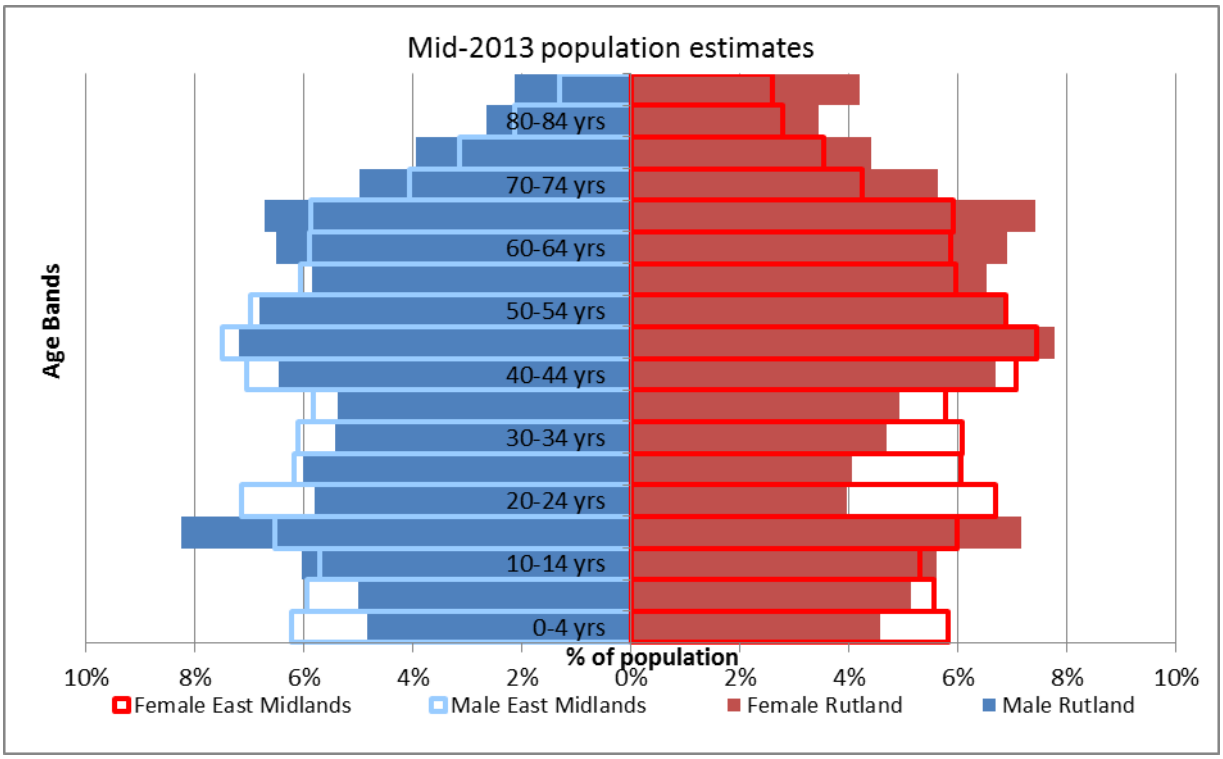
There are 16 wards in Rutland.

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, and may well be as a result of the local independent boarding schools in Oakham and Uppingham. 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 post school. 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 longer life expectancy of females.

4.1.1 Ethnicity

As at the 2011 Census, the majority of Rutland residents were White British (94%) with the remaining 6% of the population made up of: 3% White Other; 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% for the East Midlands region and 14.6% for England. The ward with the highest proportion of BME residents is Greetham at 9.0%.

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

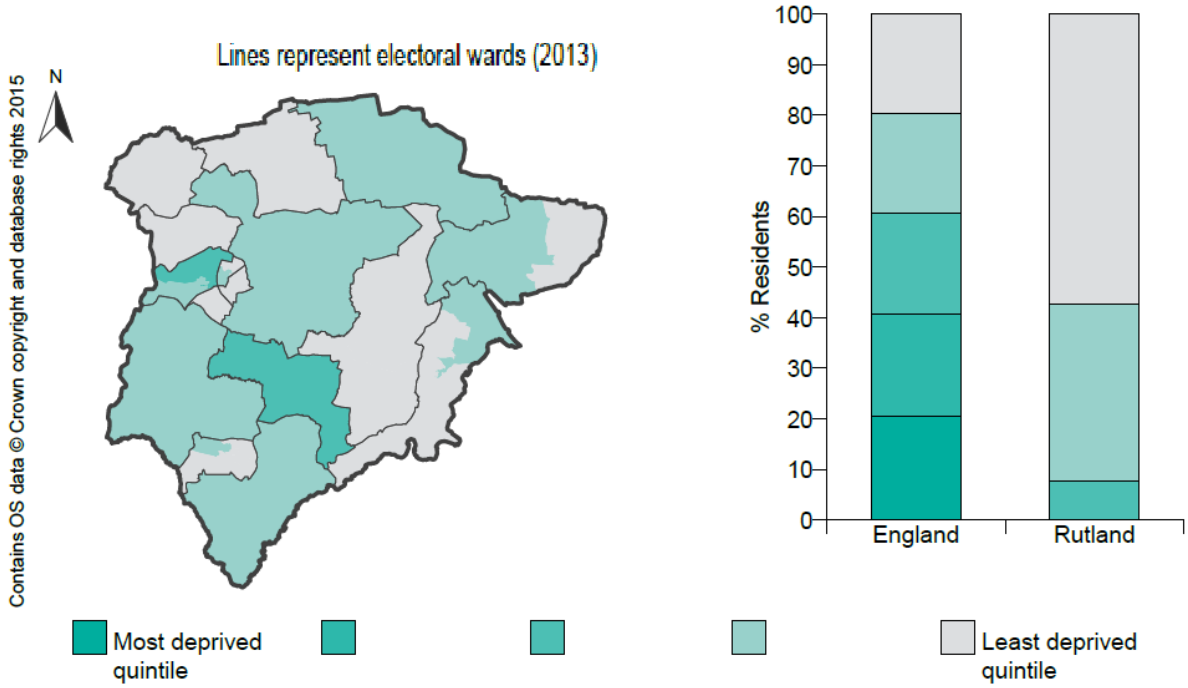
main language is Oakham North East, with 0.20%. This compares with 3.60% for the East Midlands, and 4.40% for England.

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. 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 on the high side, as the rate for the region as a whole for 2013 was 0.2% lower than the national figure, at 1.4%.

4.2 Deprivation

Rutland is one of the most affluent counties in England; 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 levels of deprivation. At a more granular level, there is variation across Rutland in levels of income deprivation. In 2010, when placed in a national context, while there were no wards that ranked in the two most deprived quintiles nationally, two wards were in the middle quintile – Uppingham and Oakham North West (see below).



Source: Rutland Health Profile - 2 June 2015, Public Health England

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 homeless, a rate of 1.8 per 1000 compared to the England average of 2.32 per 1000.

Radon
Radon is a natural radioactive gas which is present in all parts of the UK. In some parts of Rutland, some buildings contain a higher than average amount of radon due to local geological conditions. Sometimes, owners of mainly older properties need to carry out works in order to reduce radon to a safe level. This can help to prevent health problems such as an increased risk of lung cancer with prolonged exposure, particularly for those who also 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%.

4.3 Births

In 2013 there were 339 live births in Rutland. This is a general fertility rate of 58.6 births per 1,000 women aged 15-44 years. This is lower than the England average (62.4 per 1,000 women).

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, at 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.

Premature deaths from cardiovascular disease in Rutland were - at 65.7 per 100,000 population – lower than the England average of 78.2 per 100,000 population for 2011-13. Cardiovascular disease includes heart disease and stroke. 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.

In 2011, 2.3% of all babies in Rutland had a low birth weight. This was similar to the England average value of 2.8%. In 2012, the number of low birth babies was small and therefore the figure is not available.

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

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 Leicestershire and Rutland combined. 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.

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 1,000 in 2001-03 (similar to the England rate of 5.3 per 1,000), and at a peak in 2005-07 of 5.5 per 1,000 and a low of 1.9 per 1,000 in 2008-10; 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 2013/4. This is significantly better than the England average value of 12.0%.

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

Only combined immunisation data is available for Rutland and Leicestershire. In 2013/14, the percentage of children vaccinated in Leicestershire and Rutland was generally higher than the national average (see Table), meaning in some cases that World Health Organisation targets are met locally that are not met nationally (eg. take-up of Diphtheria, Tetanus, Pertussis, Polio and *Haemophilus influenzae* type b vaccine in the first year of life, where the local rate of 97.7% exceeds the WHO target of at least 95%).

Although take-up of the MMR vaccine has been increasing nationally since heath scares reduced take-up, the World Health Organisation target of at least 95% having received a first and second MMR dose by 5 years is not quite met locally (with a rate of 94.2% in Leicestershire and Rutland). This is a national issue: the target is met in none of the English regions and, at a more granular level, is only met in 8 Local Authority areas.

2013/14 Child Vaccination Figures

Cohort	Vaccination	Take-up England	Take-up Leicestershire and Rutland
Children by their first birthday	Diphtheria, Tetanus, Pertussis, Polio and *Haemophilus influenzae* type b	93.4%	97.9%
Children by their first birthday	Pneumococcal conjugate vaccine (PCV)	96.1%	97.7%
Children by their second birthday	Pneumococcal conjugate vaccine (PCV)	92.4%	96.9%
Children by their second birthday	MMR first dose	92.7%	96.7%
Children by their fifth birthday	MMR first dose	94.1%	96.1%
Children by their fifth birthday	MMR first and second dose	88.3%	94.2%

Source: NHS Immunisation Statistics, England, 2013-14 Excel tables, www.hscic .gov.uk.

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%, 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%.

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. 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.

5.8 Unintentional and Deliberate Injuries

The rate of hospital admissions for unintentional and deliberate injuries in 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

below 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 51.7%. 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 69.1%. 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%.

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%.

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.

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%.

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

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%.

Nineteen applicant households with dependent children or pregnant women 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.

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.

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 lower than the England average value of 440.9 per 100,000 population.

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

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 (47 admissions), lower than the England average value of 103.4 per 10,000 population;
- 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;
- 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 10,000 population.

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 lower than the East Midlands average of 20.5 per 100,000 and the England average value of 20.7 per 100,000 population.

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.

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 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. Of the children in need, the proportion 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. 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 slightly higher than 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.

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

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. The spend on safeguarding children and young people's services was a rate of £1,364,978 per 10,000 population.

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 reported that they were in bad health (2.7%); and 283 reported that they were in very bad health (0.8%).

- 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%).

6.1 Tobacco

The overall smoking prevalence for adults in 2013 was 22.3%, slightly higher than the England average of 18.4%. However, the prevalence for adults in the 'routine and manual' cohort (ie. those in manual occupations) 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.

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.

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. 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. 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.

6.2 Obesity

In Rutland, in 2012, the rate of adults over the age of 16 who were overweight or obese was 65.6%, this is similar to the England average value of 63.8%. 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. 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%.

6.3 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%. 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%.

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

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

In 2013/14, Rutland had the second 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 -2.2.

6.4 Substance Misuse

In 2012/13 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. 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.

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 14.6 per 100,000 population.

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.

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.

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.

Between 2010 and 2012, the rate of mortality from causes considered amenable to healthcare was 110.5 per 100,000 population, similar to the England average of 116.4 per 100,000 population.

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.

6.7 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 higher than the England average value of 52.7 per 1,000 population.

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. Of those, 76.0% of abortions were performed under 10 weeks gestation, similar to the England average value of 79.4%.

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 lower than the England average value of 2.1 per 1,000 population.

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. 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.

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 1387.5 per 100,000 population. 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%).

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%. 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 96.7%.

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 Leicestershire and Rutland combined. This is 0.7% worse than the England average value of 73.4%. In 2013-14, combined Rutland and Leicestershire figures showed a rate of immunisation of 73.6%, similar to the English figure of 73.2%.

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 lower than the England average value of 22.9.

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.

In 2013/14, the proportion of people aged over 18 years who used services who have control over their daily life was 75.5%. This similar to the England average value of 76.8%.

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%.

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%.

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%. 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%.

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% 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.

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.

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.

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.
- adults who received direct payments: 462.0 per 100,000 population. (135 people) compared to 352.0 per 100,000 population.
- adults who received equipment and adaptations: 1,505.8 per 100,000 population (440 people) compared to 887.1 per 100,000 population.
- adults who received home care: 1,368.9 per 100,000 population (400 people) compared to 1,152.7 per 100,000 population.
- 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.

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.

8.2 Delaying and Reducing the Need for Care and Support

In 2013/14, only 36.5% 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.

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.

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. 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. 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; 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.

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.
- in permanent nursing care during the year: 68.4 per 100,000 population (20 admissions) compared to 206.1 per 100,000 population.

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%.

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%.

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 hip fractures 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 2,011 per 100,000 population, and 695.4 population (n = 60) compared to 568.1 per 100,000 population respectively.

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.

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 2,636 and 2,229 per 100,000 population respectively.

For the same period, rate of adult carers (aged 18 years and over) receiving assessments was also significantly lower: 667.4 per 100,000 population (195 people), compared to the England average value of 977 per 100,000 population.

8.4 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 65.1%. 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%, similar to the England average value of 78.1%.

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 similar to the England average value of 2,035.2 per 100,000 population.

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%.

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%).

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%.

- 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%.

- 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%.

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.

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.
- the rate of adults supported throughout the year was 71.5 per 100,000 population compared to 377.6 per 100,000 population.
- 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.

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%.

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.

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

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.

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.

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.

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.

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.

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.

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%.

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.
- 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.
- 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.
- No children had a profound or multiple learning difficulty, significantly lower than the England average of 1.2 per 1,000 pupils.

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%.

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.

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%.

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%.

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.

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 compared to the England average values of 347.2 per 1,000 population and 749.7 per 1,000 population respectively.

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 & Sensory 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.

The 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.

13. 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, 1,117 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.

14. Military Population

There are two military bases within Rutland:

St George's Barracks North Luffenham is situated between the villages of Edith Weston and North Luffenham close to the south shore of Rutland Water. Kendrew Barracks Cottesmore is on the North shore of Rutland Water

St Georges is home to three units:

i) 16 Regiment Royal Artillery, an air defence Regiment. The Regiment are currently rebasing to Thorney Island in West Sussex, although elements of the regiment will remain in North Luffenham until summer 2016. The Regiment undertake rolling deployment in the Falkland Islands.

ii) The 1st Military Working Dog Regiment is currently relocating to North Luffenham from Germany, with a completion date of the latter part of 2017. The Regiment is now a hybrid unit consisting of both regulars and reserve personnel.

iii) 2 Medical Regiment focuses on patient-centred excellence in the pre-hospital environment and delivers deployed medical, dental and nursing support to the force in the pre-hospital care setting; delivering emergency, community and primary care. During 2014, the Regiment became a hybrid Medical Regiment consisting of Regular and Reserve personnel.

Kendrew houses two units:

i) Second Battalion The Royal Anglian Regiment is the Infantry Regiment for the ten counties of East Anglia and the East Midlands. The Battalion has completed operational tours in Sierra Leone, Iraq, Northern Ireland and Afghanistan.

ii) 7 Regiment The Royal Logistics Corps relocated to Cottesmore in 2013. 7 Regiment RLC is part of 102 Logistic Brigade and consists of almost 500 personnel.

There is no recent healthcare assessment available, however an in-depth assessment undertaken in 2012, gives some indication of the types of health needs residents on the barracks may face. It should be noted that there has been a changeover in units based there since the needs assessment was undertaken.

14.1 Healthcare needs

Primary Care
The military population is young and generally in good health as most common health conditions prevent military service. The families are also likely to be young and thus much less likely to suffer with the more common conditions seen in Rutland such as cardiovascular disease, stroke and respiratory disease. The GP is likely to primarily manage infectious disease, sexual health, musculo-skeletal problems and minor injuries.

Anecdotally it has been suggested that some personnel prefer to register with a practice local to their barracks however this is not recommended nor supported by the Army and is contrary to the NHS contract for Her Majesty's forces which states that all personnel should deregister with their local practice upon enlistment. Families may choose to register with a local practice if they prefer.

Dental Services
There is some research to show that serving Army personnel have consistently lower levels of dental health than other personnel in the military, and that this reflects dental health at the time of recruitment. It is suggested that this represents the lower socio-economic background of Army recruits compared with their other service colleagues. A defence dental service (DDS) facility is planned for MOD Cottesmore but this will treat serving personnel only, dependants will require treatment within the local system.

Opticians
There is no evidence to suggest that soldiers' or their families' need for opticians will differ from the civilian population.

Pharmacies
The incoming population should have a lower than average need for repeat prescriptions or rare drugs as a consequence of their younger age.

Podiatry
There is little published evidence regarding the use of podiatry services by soldiers however the nature of both training and operational deployment makes injuries to the foot and ankle a likely occurrence. Local NHS community services run podiatry clinics on weekdays at Rutland Memorial Hospital.

Planned Care
As a consequence of their younger age and lower than average chronic health issues service personnel are unlikely to be heavy users of planned care services.

Paediatrics and maternity services will probably be the only areas where an increase is noted, however both UHL and Peterborough have capacity to manage the expected numbers.

Acute Care
Acute care services for Army personnel and their families will be provided by the local hospitals; University Hospitals Leicester and Peterborough and Stamford Hospitals Trust. The number of incoming personnel is likely to be too small to have a noticeable impact on services within the hospitals.

Minor Injuries
Anecdotally it has been suggested that the presence of a military population drives up the use of minor injuries services, although there is no published evidence to support this. The nature of military training puts the population at a higher risk of musculo-skeletal injury; there is also a culture of physicality which increases the risk of sports injuries. Unfortunately this culture, when combined with increased use of alcohol, does lead to physical aggression resulting in minor injuries. Taking risks is also inherent within military culture and may result in injury. There may be an increase in the number of cases seen in the minor injuries unit at Rutland Memorial Hospital.

Mental Health
The military population is not at greater risk of mental health problems than the general population, however the type of disorder is likely to be different from those affecting the Rutland population. Common mental health disorders in the military population include alcohol abuse, depression and anxiety.

Risk factors for the development of mental health problems include deployment to active operations and having a combat role whilst deployed. It is clear that the mental health needs of the service population are going to be different from that of the current population in Rutland.

Obesity
A 2011 study found that risk factors for obesity within the Army included being male, white, and a non-commissioned officer. Commissioned officers of both sexes had the same, lower level of obesity. Obesity levels tended to be higher in those who were not in a frontline fighting role and in those who were aged over 35. One third of those with a raised BMI were not found to have an increased waist circumference so around one in three soldiers classified as obese may simply have a high non-fat mass. However with an overall prevalence of 13% this still leaves a significant proportion of soldiers with a weight problem.

Alcohol Use
In a 2007 study Fear et al found that 67% of men and 49% of women in the UK Armed Forces had an Alcohol Use Disorders Identification Test (AUDIT) score of greater than 8 (classified as hazardous drinking). This is high in comparison with the UK general population.

Drug use
The Army maintains a near-zero tolerance policy on drug use and nearly all service personnel found to be using drugs will be dishonourably discharged. The near-zero tolerance policy combined with compulsory drugs testing (CDT), introduced across the Army in 1995, act as a deterrent.

Smoking
Published studies show a reduction in the rate of smoking within the Army in line with that seen in the population at large. Smoking is associated with similar factors as in the general public (males under 25) but outside this age group smoking rates are lower than in the rest of the UK. This is likely to be related to the levels of physical fitness required to perform the job and attitudes which see smoking as a sign of weakness and lack of self-discipline in much the same way as drug use.

Sexual Health
Anecdotally, soldiers are heavy users of GU medicine services and will tend to access local rather than MOD clinics for issues of privacy. There is a walk-in clinic in Peterborough and another in Leicester. There is no published evidence to suggest that being in the Army nowadays is in itself a risk factor for the development of sexually transmitted infection (STI) however rates of STI are known to be highest amongst young men and women (aged <25) and amongst those from more deprived backgrounds. As a consequence of the influx of young men there may also be an increase in the need for GU medicine services for the civilian population. Similarly, there may be an increase in the number of individuals or establishments offering sexual services in return for payment in Rutland and this could have public health implications.

Disability
Serving soldiers are at increased risk of significant disabling injury, including traumatic amputation. The Armed Forces have an excellent pathway in place from point of wounding through to rehabilitation but eventually a wounded soldier who has been discharged from service will come under the remit of the local healthcare system.

Ante-natal and midwifery services
Army wives tend to have more children and to have them at a younger age than their civilian counterparts (22½ years vs 25 years), though they tend to be in stable relationships and are often married. There is no available UK research into specific midwifery and health visiting needs of Army families, however a US study suggested that the transition to motherhood for women married to soldiers was more challenging because of the additional stresses of military life, and because they were often a long distance from their mothers, traditionally the primary source of support. The same study found that group ante-natal classes provided more benefit to military mothers than one-to-one sessions.

Children's Health and Wellbeing
A report on the health needs of children living at Catterick Garrison found that service children were no more or less likely than their civilian peers to be diagnosed with developmental, medical, or speech and language problems. There are however some areas where service children differ. A report by the Royal Navy and Royal Marines Children's Fund identified ten key areas where service children faced increased challenges:

- Stresses and strains on children when their parent is away
- Impact of living in a temporary one-parent or no-parent family, when parents are deployed
- Influence of the media
- Adjustments to family life when the parent returns
- Impact of moving homes, schools and communities
- Stigma of being viewed as a 'military brat'
- Dealing with bereavement
- Dealing with parental illness or injury
- Dealing with divorce and family breakdown
- Living with special educational needs or a disability

The report also identifies challenges which are not in themselves unique to service life but which are made unique by the circumstances in which the child has to cope with them: for instance studying for an exam whilst a parent is deployed to Afghanistan.

There is evidence of differences in social and emotional development of service children and the reasons for this - alongside those listed above – include family function affected by:

• Mothers who are younger when their first child is born
• Parents who may have had a poor parenting experience themselves
• Frequent mobility
• The loss of extended family and social networks

There are also clear differences in behaviour with relation to lifestyle choices and staying healthy: service children are more likely to smoke, drink alcohol, use illegal drugs and engage in risky sexual behaviour. They are also significantly more likely to be victims of bullying.

Immunisation and Vaccination
Reports of the immunisation of service children in the UK show there is no difference in the numbers who have not completed a course of vaccination by school entry.

Accessibility of health services
MOD Cottesmore is approximately four miles from Oakham. It has been noted that there are only 7 buses per day between Cottesmore the base and the town and that four miles is an unrealistic distance to walk for routine purposes. The people most likely to need to access the town are young mothers with children and many of them are presumed not to have cars, however this will not be confirmed until the families have arrived. It is important to recognise however the community spirit engendered amongst Army wives as a result of a shared experience. This cannot be understated and garrison families have usually developed strong networks of mutual support. It is to be expected that these families will not live in isolation and will provide lifts or share cars more readily than might be seen in the rest of the population.

Promoting Health and Wellbeing
Both barracks have a central information facility known as the HIVE designed as a support centre for both service personnel and their dependants. The HIVEs provide local information

sheets on accommodation; education; employment; health; and other local community information.

Social Inclusion
Although the close-knit nature of garrison life provides mutual support and assistance it can lead to exclusion from the wider community. Soldiers' wives are often in the unique position of being a part-time single parent. This means that they face the challenges shared with other single parents throughout the UK; taking decisions alone, managing children upset at missing their father, coping alone with behavioural problems and compromising on employment options, yet they miss the recognition and support that 'true' single parents are offered by wider society. However, a great deal depends on the nature of the garrison, the number of regiments based there and the speed of turnover and redeployment amongst personnel.

14.2 Kendrew Community Survey

A community survey was undertaken with residents at Kendrew in January 2014. Uptake of the survey was low, although it was noted that the responses received were broadly in line with anecdotal evidence from RCC staff who engage with the community there. The survey indicated that:

- Generally, facilities are thought of as adequate, but people want more activities available at different times
- Evening events were the most popular activity idea offered
- Advertising and promotion of activities needs to be improved.
- Facilities in Oakham are not being visited regularly by Kendrew residents
- There is not a culture of broad community engagement at the present time
- Residents feel passionately about community, yet do not feel that there is a strong sense of it on Kendrew

15. Prison Population

HMP Stocken is an adult all-male prison. It was built in 1985 as a Young Offenders Institution and opened as a category C closed training prison, with an operational capacity of 320. Over the years, it has been expanded on a number of occasions with new accommodation being built. At the time of carrying out the Health and Social Care Needs Assessment (HSCNA) in November 2014, there were a total of 844 prisoners, 98% of the operational capacity.

Primary healthcare and substance misuse services are provided by Nottinghamshire Healthcare NHS Foundation Trust. Mental health services are provided by Northamptonshire Healthcare NHS Foundation Trust. There are a variety of healthcare services provided within HMP Stocken including GP, nursing, psychology, psychiatry, psychosocial interventions, pharmacy, dental, optician, podiatry, physiotherapy and sexual health services.

15.1 Health & Social Care Needs Assessment 2014

A full Health & Social Care Needs Assessment was undertaken and published in November 2014[1] which identified a number of issues, and made recommendations to address these. A summary of the main key issues is below:

1) Demands on GP It was reported that the GP waiting list had been steady increasing. The waiting time was around 4 weeks and there were 70 prisoners on the waiting list. It may be helpful to review the workload and priorities of the GP in order to assess the current demands and to consider how they can be addressed in order to reduce waiting times.

2) Out of Hours GP Provision: The Healthcare staff raise no specific issues of concern about the Out of Hours service, although some staff commented that some of the on-call GPs could be reluctant to come out due to the distance that they had to travel from Leicester, so prison staff have to resort to calling an ambulance. The data for 2014 shows that the Out of Hours GPs were called on 27 occasions but only came out to the prison on 3 occasions, but an ambulance was called out or a prisoner was escorted to hospital on 18 occasions. It is important that access to this service is equitable with access to community-based Out of Hours GP provision.

3) Mental Health and Stigma: In 2011/12, around 39% of assessed prisoners were provided with ongoing support from the Team. In 2012/13, this had reduced to 30% and by 2013/14, only 25% of assessed prisoners were receiving ongoing support from the Team. It is unclear why this should be so, as referrals to other sources do not appear to have increased.

4) Mental Health Team Capacity: While the work of the Mental Health Team is viewed by staff and prisoners as positive, the Team is small and there are concerns about the capacity of the Team to cope with the increasing demands around mental health issues, particularly in providing more flexible and accessible support to help prisoners deal with stress, anxiety, and thoughts around self-harm and suicide.

5) Learning Disabilities Screening: There is a pathway for those prisoners with learning difficulties or autism for staff to use during the Induction process, which will help Healthcare staff identify prisoners and to create a care plan. In spite of the pathway for learning

[1] The full report is available as a separate document on the JSNA section of the RCC website (*link to be added*).

difficulties there were concerns amongst Healthcare staff that some vulnerable prisoners with learning disabilities were *"not always recognised and pick up at reception screening"*

6) Recording of Disability and Mobility Issues

There is a lack of clarity and discrepancies about the number of prisoners with disability and mobility issues. The discrepancies may be the result of under-reporting or variations in recording practices, but it is important that the range and type of mo0bility issues are correctly recorded to ensure the needs of vulnerable prisoners are being met.

16. Caveats re Data

16.1 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.

16.2 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 two and a half 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]

16.3 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 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.

17. 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.

17.2 Detailed 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.

From the data contained herein, a number of key areas of additional focus have been identified:

1) Planning care for an ageing population

2) Dementia

3) Carers

4) Obesity

5) Children's oral health

6) Factors affecting access to information and advice, including access to preventative services.

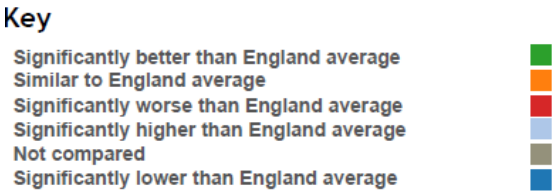
In addition, a number of other areas have already been identified for further work and/or part of other workstreams already underway and will form additional chapters:

- Sexual health needs and service provision
- Children's health provision 0-19
- Children and young people's mental health
- Learning disabilities in children and adults
- Substance misuse
- Frequent attendees to Primary Care
- Physical and sensory disabilities in children and adults

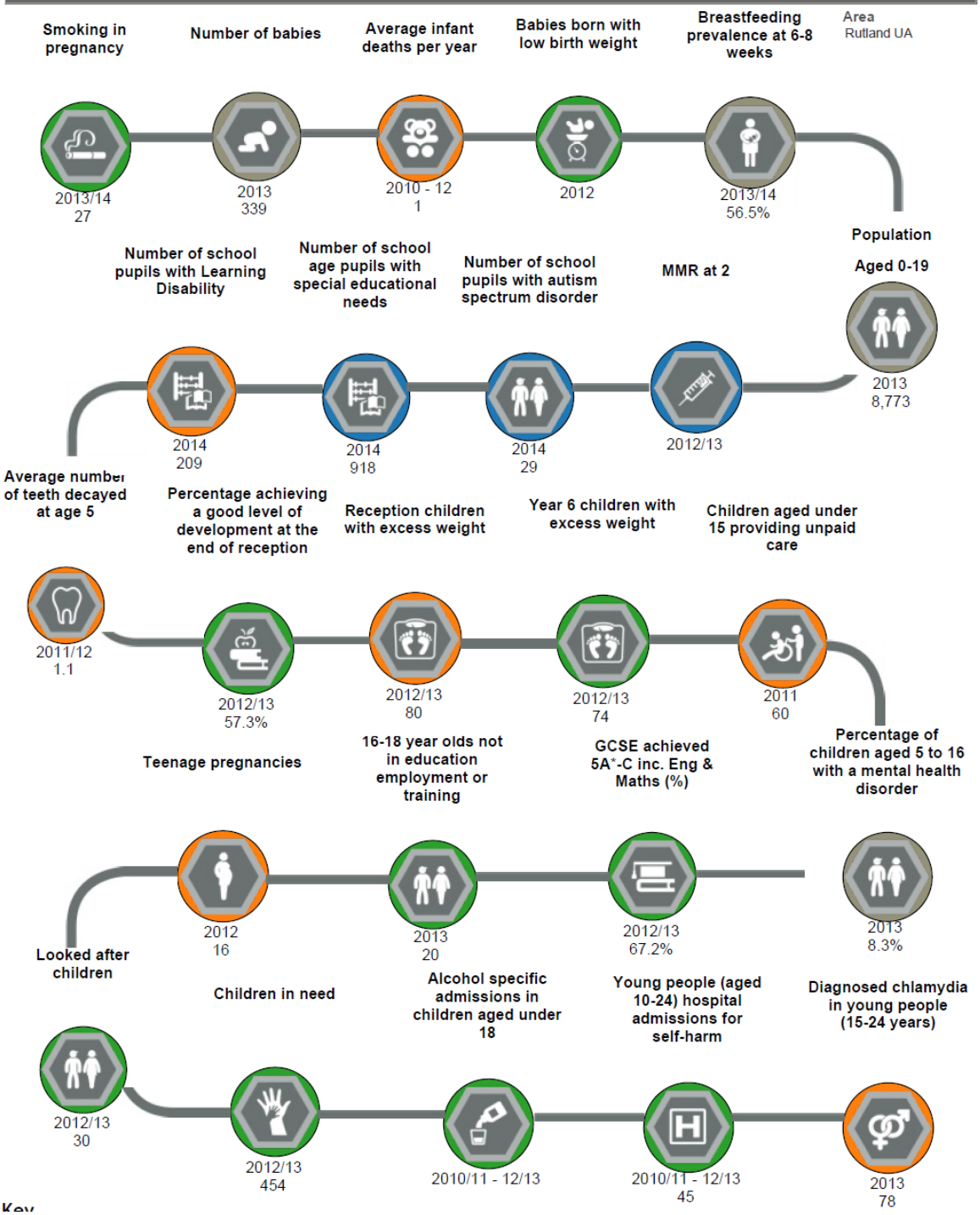
Additional themes may be further developed during the lifetime of the JSNA, depending on the requirements of the Health and Wellbeing Board.

Appendix 1 – Summary of Indicators

The diagrams below provide a pictorial summary of the indicator data for each theme.

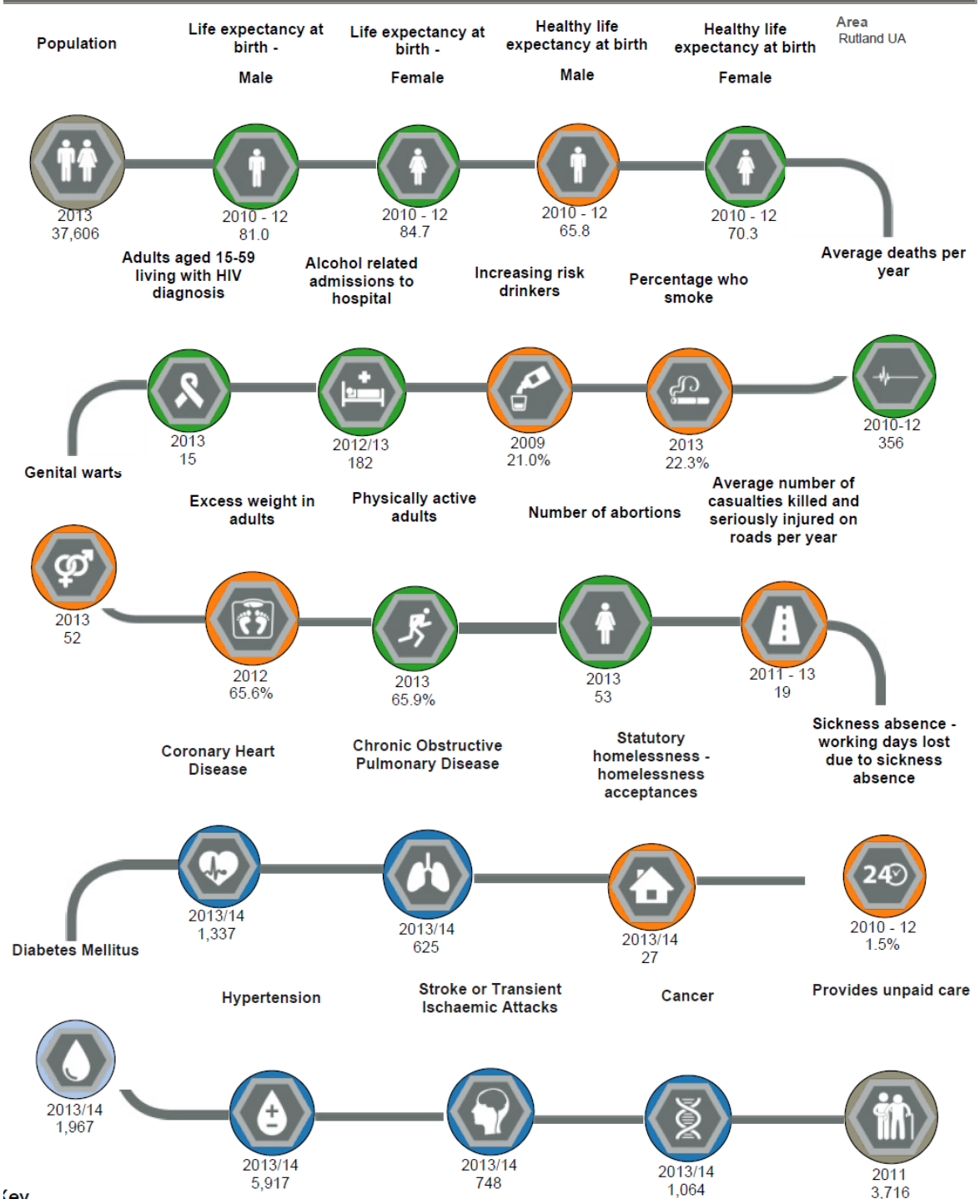


Best start in life: Rutland UA

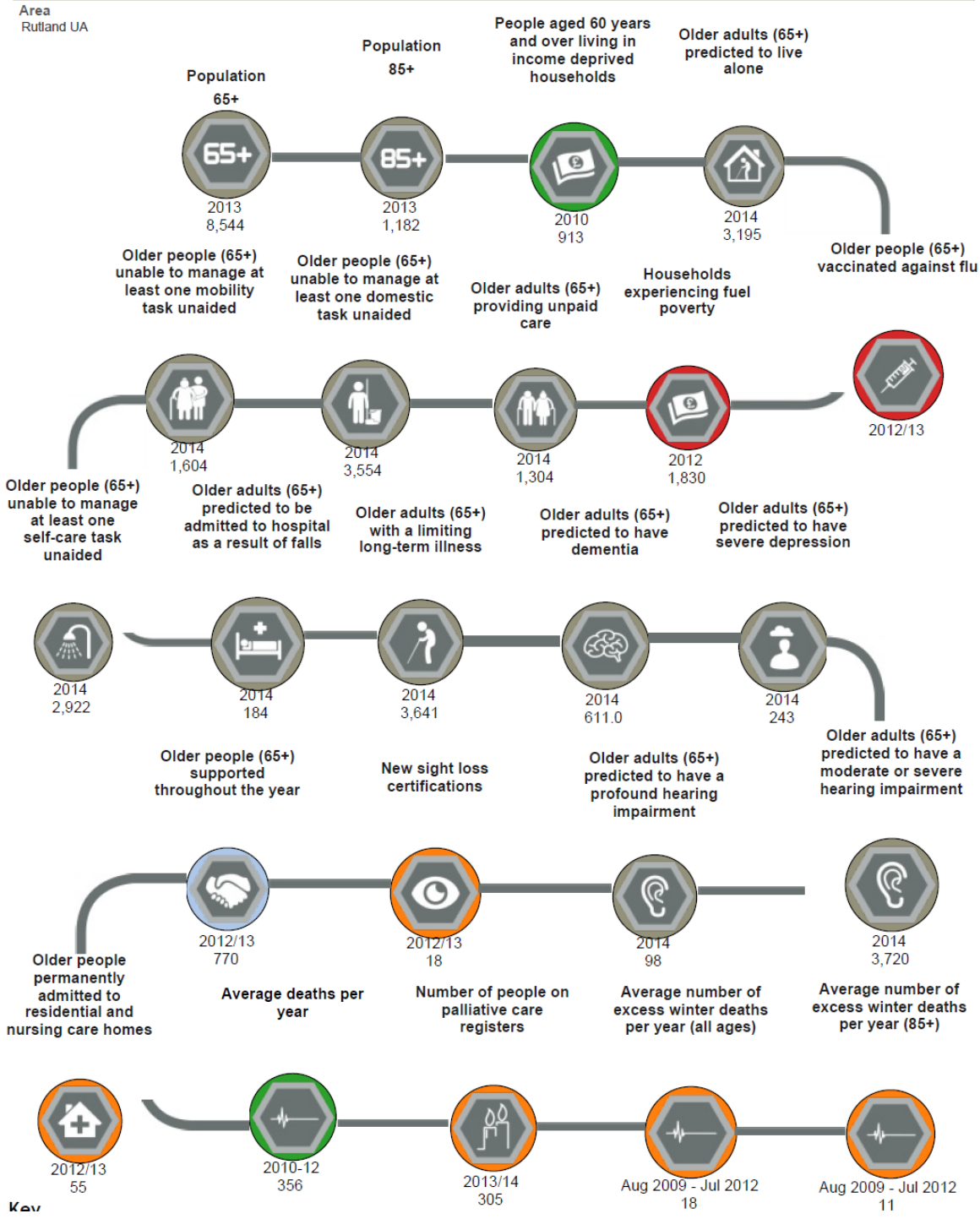


Key

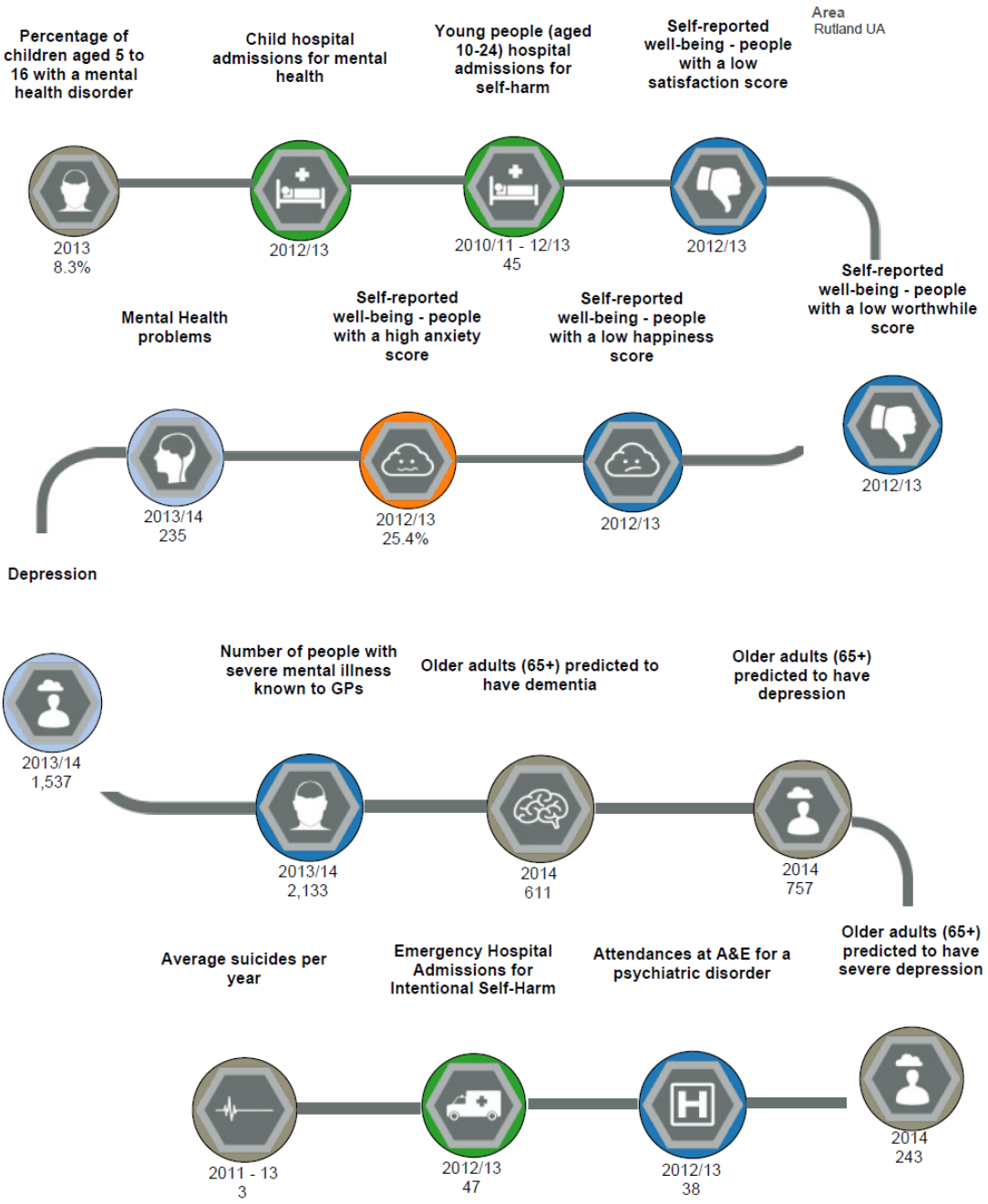
Health and wellbeing of adults: Rutland UA



Issues specific to ageing: Rutland UA

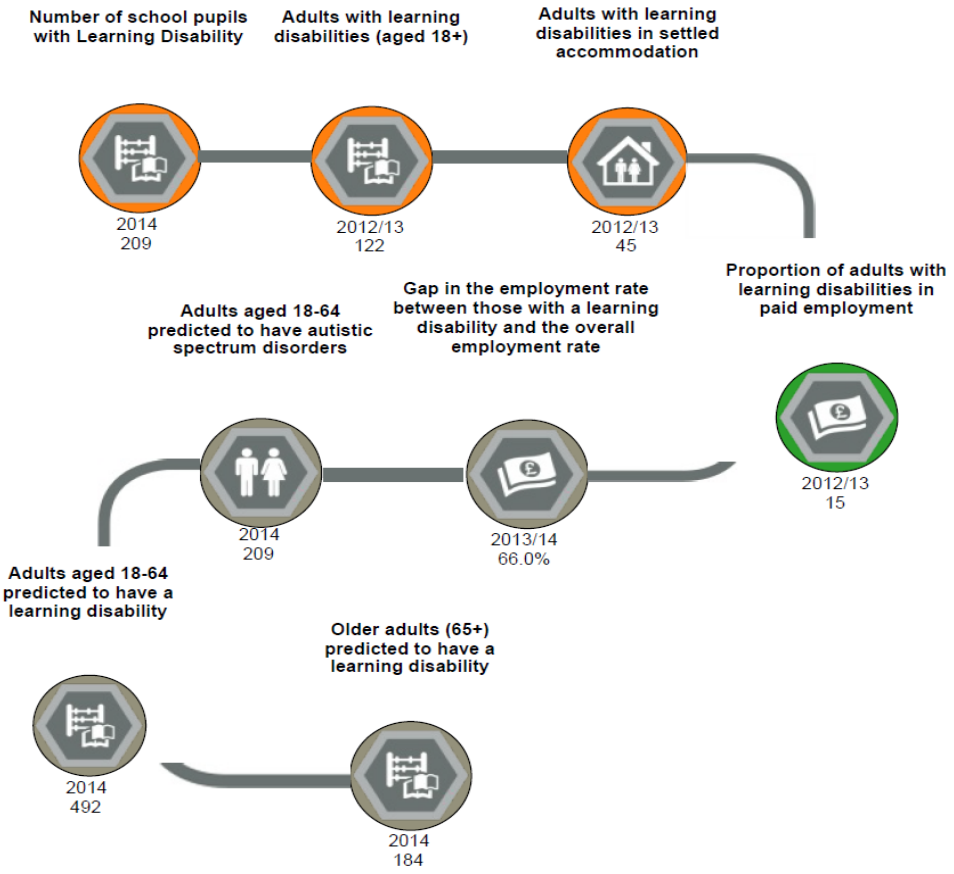


Mental health: Rutland UA



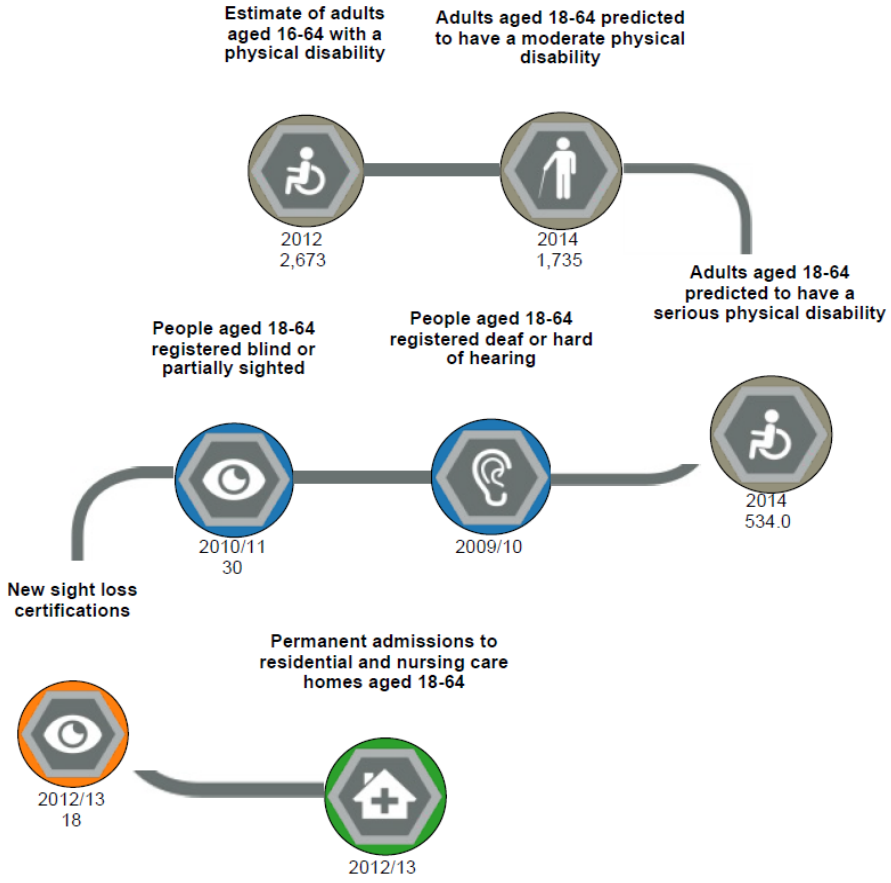
Learning disabilities and autism: Rutland UA

Area
Rutland UA



Physical and sensory disabilities: Rutland UA

Area
Rutland UA



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 – 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 Public Health England for public health performance reporting:

- North Yorkshire
- West Berkshire
- Wiltshire
- Cheshire East
- Worcestershire
- Cambridgeshire
- East Riding of Yorkshire
- Oxfordshire
- Central Bedfordshire
- Buckinghamshire