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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, 26th January, 2016** 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

PLEASE NOTE:
The meeting must finish by 4.00 p.m. as the meeting room will be required from 4.00 p.m. promptly.

1) APOLOGIES

PLEASE NOTE:

Apologies have been received from the Chair, Councillor Roger Begy.

This meeting will therefore be chaired by Councillor Richard Clifton, Vice-Chair of the Rutland Health and Wellbeing Board and Rutland County Council's Portfolio Holder for Health and Adult Social Care.

2) RECORD OF MEETING

To confirm the record of the meeting of the Rutland Health and Wellbeing Board held on Thursday, 17th November 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) BCF 2016-17 PROGRAMME - FIRST VERSION

To receive Report No. 26/2016 from Mark Andrews and Sandra Taylor

Input from the Health and Wellbeing Board is invited on the draft BCF plan 2016-17 prior to the initial plan submission on the 8th February 2016.
(Pages 5 - 70)

6) LOCAL SAFEGUARDING CHILDREN BOARD AND SAFEGUARDING ADULTS BOARD: BUSINESS PLANS

To receive Report No. 23/2016 and Report No. 24/2016 from Paul Burnett, Chair of the Leicestershire and Rutland Safeguarding Children and Adults Boards regarding the consultation and input required for the proposed safeguarding business plans.
(Pages 71 - 114)

7) PUBLIC HEALTH: SEXUAL HEALTH STRATEGY

To receive Report No. 25/2016 from Mike Sandys, Director of Public Health and Vivienne Robbins, Consultant in Public Health.
(Pages 115 - 162)

8) CHILDREN'S PUBLIC HEALTH: TRANSFER OF RESPONSIBILITY

To receive a 10 minute verbal update from Mike Sandys, Director of Public Health, regarding the plans and strategy for the new service.

9) ANY URGENT BUSINESS

10) DATE OF NEXT MEETING

The next meeting of the Rutland Health and Wellbeing Board will be on Tuesday, 22nd March 2016 at 2.00 p.m. in the Council Chamber, Catmose.

PROPOSED AGENDA ITEMS:

1. **Better Care Fund 2016-17 – final submission**
   Final Better Care Fund 2016-17 plan for the Health and Wellbeing Board to sign off, following regional review and assurance.

2. **Learning Disability Self-Assessment: ANNUAL REPORT**
   Results of the Rutland LA & CCG annual self-assessment submitted to Public Health England
   Report from Emma Jane Perkins

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

4. **Personal Health Budgets Strategy**
   CCG Strategy on the implementation and extension of Personal Health Budgets 2016-2020
   Report from Yasmin Sidyot

5. **Rutland Health and Wellbeing Board: Future Priorities and Planning for the Development Session**
   Item requested for discussion at the HWB meeting held on the 17th November 2015
   Report from Karen Kibblewhite

6. **EMAS: Quality Accounts**
   Report from Annie Palmer, External Relations and Engagement Manager, East Midlands Ambulance Service NHS Trust

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DISTRIBUTION
MEMBERS OF THE HEALTH AND WELLBEING BOARD:

Mr R Begy (Chairman)	
Mr R Clifton (Vice-Chair)	
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	Ms Y Sidyot

OTHER MEMBERS FOR INFORMATION

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Report No: 26/2016
PUBLIC REPORT

HEALTH AND WELLBEING BOARD

26 January 2016

PLANNING FOR THE BETTER CARE FUND 2016-17

Report of the People Directorate

Strategic Aim: Meeting the health and wellbeing needs of the community

Exempt Information No

Cabinet Member(s) Responsible: Mr R B Begy , Leader and Portfolio Holder for Culture

Contact Officer(s): Mark Andrews, Deputy Director for People | 01572 758339 mandrews@rutland.gov.uk

Ward Councillors Not Applicable -

DECISION RECOMMENDATIONS

That the Health and Wellbeing Board (HWB):

1. Notes the process for drawing up the 2016-17 Better Care Fund plan, the associated national timetable and the HWB role in approving the plan.

2. **Notes that the current draft Better Care Fund plan is provisional and may be subject to change, as national technical guidance and funding allocations are still awaited.** The Rutland Integration Executive is also due to review the proposals on 21 January.

3. Endorses the current draft Better Care Fund plan and budget for 2016-17 for initial submission, as set out in Appendix B, potentially conditional on adjustments following HWB input.

4. Agrees the final approval process for the plan which may require the HWB to approve the plan outside its normal meeting timetable.

1 PURPOSE OF THE REPORT

1.1 The 2015-16 Rutland Better Care Fund (BCF) plan is currently three quarters of the way through implementation, and planning is underway for the 2016-17 period.

1.2 The purpose of this report is:

a) to set out the process and timetable for drawing up the 2016-17 Better Care Fund plan and to confirm its approval timetable and approach;

b) to present the draft Better Care Fund plan and budget for 2016-17 (Appendix B) for HWB feedback and initial endorsement prior to the first plan submission on 8 February 2015; and

c) to agree the final approval process for the plan, which may require the HWB to approve the plan outside its normal meeting timetable.

2 PROCESS AND TIMETABLE

2.1 The current Rutland Better Care Fund programme, which is a joint Local Authority/CCG transformation programme for health and social care, runs until the end of March 2016.

2.2 The high level timetable for agreeing the 2016-17 plan is as follows:

		National milestones	Local milestones
Evaluation and initial preparation	October 2015	National evaluation tools issued.	
	Nov-Dec 2015		Interim evaluation of 2015-16 BCF programme, including new projects workshops
	Dec 2015-early Jan 2016		First draft of 2016-17 programme
Submission round 1	? January 2016	Issue national guidance on BCF 2016-17 and confirmation of minimum budget.	
	21 January 2016		Rutland Integration Executive feed back on draft outline BCF programme 2016-17.
	26 January 2016		Rutland Health and Wellbeing Board feed back on draft outline BCF programme 2016-17.
	8 February 2016	First draft of plan submitted for assurance/moderation – high level plan.	
Submission round 2	18 February 2016		S75 Partnership Board –further refinement - budget and performance metrics. Approval in principle of the joint proposals.
	End Feb/Early March 2016		Moderation feedback received and plan updated.
	Mid March 2016	Refresh due, based on moderation feedback	NB: Date tbc, but **locally, submission after 24 March would be preferable.**
	22 March 2016		**If moderation timetable allows, sign off by Health and Wellbeing Board

	24 March 2016		S75 Partnership Board – final refinements.
Submission of signed off plans	Mid-late April 2016		**Otherwise, sign off by Health and Wellbeing Board by correspondence.
	Mid-late April 2016	Final submission, signed off by Health and Wellbeing Board	

2.3 The Health and Wellbeing Board's approval is required for the new programme.

2.4 To be able to meet the development timetable, provisional work on the 2016-17 Better Care Fund plan has been in progress since November 2015, although full technical guidance on the new BCF programmes and confirmation of budgets are still awaited. **This means that the programme as presented must be seen as provisional at this time and that any aspect may be subject to change before the next version is circulated.**

2.5 The new draft programme is presented as Appendix B. This is to enable the Health and Wellbeing Board to feed its initial views into the programme at the 26 January meeting, before the first high level submission deadline of 8 February 2015.

2.6 Following local assurance and updating, a revised programme will be presented again to the Health and Wellbeing Board for their approval. This is anticipated to be at the 22 March 2016 meeting. However, the assurance timetable at this point is not fully confirmed, and may depend on local factors which mean that this deadline cannot be met. **Therefore, if required, the Health and Wellbeing Board is asked to indicate their preference for a means to agree the programme outside the normal sequence of HWB meetings (eg. by correspondence or delegation to a subset of the Board).**

2.7 The 2016-17 Better Care Fund Policy Framework (see Background Paper) released on 8 January confirms a number of things:

a) **Funding:** The BCF in 2016/17 will comprise £3.9bn nationally, and an additional £1.5bn will be placed in the fund (via LAs) by 2019/20.

b) **Pay for Performance:** The pay for performance instrument (worth £1bn nationally) that was linked to emergency admissions in 2015-16 is being discontinued in 2016-17.

c) **DTOC and admissions avoidance:** In place of this, BCF plans will be required to have locally agreed targets and action plans for improving delayed transfers of care, and will need to demonstrate how the local allocation of the £1bn is being spent on out of hospital NHS commissioned care. This can include a wide range of community services including social care. Finalisation of the detail around this has been the cause of the delays to the issuing of national technical guidance.

d) **National conditions:** BCF plans will be subject to the same national conditions as in 2015/16 (e.g. local agreement of plans, data sharing, use of NHS number, protection of adult social care, 7 day service delivery, joint

approach to care planning, confirmation of impact on providers) plus the new DTOC and out of hospital care conditions noted above. The requirements are described in more detail in Annex A of the policy guidance background paper.

e) **Emphasis:** The twin aims of avoiding emergency admissions and accelerating transfers of care out of acute settings remain key priorities.

f) **For the DTOC condition** – a stretching local target should be set for DTOC improvement using the existing metric of delayed days per 100,000 population. Local areas are advised to consider using a DTOC risk sharing agreement especially where DTOC rates are high/rising. Local areas are to set an action plan which incorporates national guidance such as the 8 high impact changes for DTOC, and demonstrate how capacity is being maximised across the system and how provider markets are being developed in support of hospital discharge. There is also a requirement to show engagement with independent and voluntary sectors in delivery of this national condition.

g) **The planning process:** Brief narrative plans along with a finance and metrics excel template (to be published imminently) are expected to be required. Plans are to be agreed locally by Councils and CCGs and signed off by Health and Wellbeing Boards and will be subject to regional assurance. Assurance will focus on plan quality and risks to delivery. Plans may be approved, approved with support or not approved.

h) **Assurance:** Quality Assurance of plans will then take place nationally via the Integration Partnership Board which comprises DH, DCLG, NHSE, LGA and ADASS (diagram at Annex B of the guidance).

i) **Wider context:** By 2017, each BCF area must also agree a medium term plan for integration of health and social care by 2020. These will run in parallel with and need to be coherent with the NHS Sustainability and Transformation Plans (STP) 2016-2020 (the footprint of the local STP is likely to be Leicester, Leicestershire and Rutland, mapping to Better Care Together).

j) **NHS planning:** Plans need to be coherent with the wider NHS planning guidance issued in December 2015. (The plan has been developed relative to this).

2.8 The initial draft 2016-17 BCF plan is presented at Appendix B. The document sets out how the new programme was developed and what factors have been taken into account in shaping it, including:

k) regular programme monitoring and performance reports,

l) the moderated interim evaluation of the 2015-16 programme (summarised in the plan on p3-5 and in Plan Appendix 1 and informed by a national framework addressing six domains of integrated care (see Appendix A).)

m) the November/December new projects workshops (summarised in the plan on p6 and in Plan Appendix 2),

n) iterative dialogue with partners (including via the 21 January Integration Executive discussion)

o) relevant plans and strategies locally, including (notably the Health and Wellbeing Strategy, the LLR Better Care Together (BCT) programme and Urgent Care Vanguard, the Rutland Adult Social Care Strategy and the ELRCCG Community Services Strategy),

p) regional networking and relevant national health and care research.

2.9 Strong continuity is proposed with the current BCF programme, but with changes built in to build on the progress and learning secured during the current programming period.

2.10 The proposed aim of the 2016-17 programme is that: **"By 2018 there will be an integrated social and health care service that is well understood by users, providers and communities and used appropriately, has significantly reduced the demand for hospital services and puts prevention and self management at its heart, including by building on community assets."**

2.11 Four priorities are proposed, summarised in the table below, and set out in fuller detail in Appendix B (including diagrams showing the connection between current and future schemes and scheme level descriptions):

a) **Unified Prevention** - broadened and made more coherent rather than scheme based, with opportunities for more coordinated responses through a new commissioning model;

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

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

d) **Enablers** - including IT, information sharing and joint commissioning.

2016-17 BCF Priorities	Proposal	Impact on service users
Unified prevention services	• Make it easier to find out what services are on offer locally to support health and wellbeing, by further developing the Rutland Information Service as a joint platform for the public, professionals and advocates. • Bring prevention services in Rutland communities into a more coherent, consistent offer, including housing expertise and support to carers, including by using a new commissioning model. Build community capacity so communities are more self sufficient. • Provide better coordination and communication of the offer in communities and via trusted primary care settings so that local people have easy access to information, help and advice.	• People keep themselves well and know where to go to get information and advice if needed about what is available in their communities. • People feel supported to live independently at home. • Delaying the need for invasive and costly care packages. • Equipment provides peace of mind for users. • Patients can manage their own care. • More self sufficient, self sustaining communities, tackling social isolation.
Long term conditions	This priority addresses the support offered by primary and community health and social care for patients with long term conditions and the frail elderly, including through: • Enhanced approaches to care management and support planning (building on the care coordinator approach), including anticipating and reducing needs. • A review of care pathways. • An integrated system spanning primary care and community based health and care services in and out of hours. • Consolidating, integrating and extending a number of Rutland's community health based services into one 24/7 service operating across health and social care – to focus on maintaining independence in the community for as long as possible.	• Care services are effectively coordinated around the patient, reducing duplication and increasing effectiveness. • Service users feel in control of their care. • Service users feel supported and that their needs are understood. • Service users are better able to manage their condition(s). • Service users are able to stay as well as possible for as long as possible.
Crisis response, transfer and reablement	• Rapid response services avoid unnecessary hospital admissions and residential care for those needing urgent assistance. • Significant improvements in the timeliness and effectiveness of discharge pathways from hospital, especially for frail older people by consolidating new approaches to transfers of care. • Optimised independence and recovery when returning home.	• Reassurance for the service user and their family that there is effective support closer to home reducing likelihood of being admitted to hospital. • If they must be hospitalised, patients return sooner to a community setting, rather than deconditioning in hospital. • People can more easily resume their normal lives on their return home, maintaining independence. • Choice for end of life patients who may want to remain at home.

		• Acute beds are freed up for acute needs.
Enablers	IT and Information Governance facilitate integrated care rather than being a barrier to it. Integrated commissioning is progressed as an important transformational enabler.	• Health and social care systems will be aligned/joined up with a common dataset so patients are asked less often to tell their story and can receive improved service. • Joint commissioning drives integration and reduces duplication, reducing overall costs of care.

3 DISCUSSION TO SUPPORT THE EVALUATION AND REPLANNING PROCESS

3.1 To support the replanning process, the views of the Health and Wellbeing Board are invited on the 2016-17 draft BCF plan.

3.2 Observations

e) We will need to work up an action plan for DTOC prevention 2016-17, building on national guidance about how to strengthen DTOC responses around both planned and unplanned hospital stays. Recent East Midlands events have prepared the ground for this work. The high use of out of area acute services is a particular aspect to address locally. In 2015-16, DTOC performance overall has been fairly good, but is not yet robust and has tended to be vulnerable to staff change or absence.

f) Further planning is needed around out of hospital services.

g) Non elective admissions remain an important focus, even though related pay for performance will cease. The increased focus on case management and long term condition management aims to increase the plan's ability to drive down emergency admissions.

h) In addition, we need to plan for more public, user and patient engagement around the new BCF plan.

3.3 Questions

a) Does the revised Better Care Fund vision reflect Rutland's health and social care needs and aims?

b) Are the proposed priorities clear, coherent, relevant, ambitious and realistic? Is anything missing from the programme?

c) Is the Better Care plan brave enough (pace, scope, innovation)?

d) Are we clear on the key success factors and are they in place? Eg. Does programme governance need to change to drive the programme more effectively and to connect into wider programmes of change (eg. BCT and the Vanguard)? Does the partnership want to consider a risk sharing agreement for DTOC?

e) How can we best engage with the public and users around the BCF plan?

4 CONSULTATION

4.1 This agenda item forms part of the consultation on the 2016-17 Better Care Fund approach.

5 ALTERNATIVE OPTIONS

5.1 The proposed new Better Care Fund plan has been informed by 2015-16 progress monitoring to date, a moderated interim evaluation of the programme, new projects workshops, wider local strategies including Better Care Together and the ELR CCG Community Services Strategy, regional learning through networking and national health and care research activities. It was also refined through iterative dialogue with partners (leading to an Integration Executive discussion on 21 January).

5.2 The current proposal offers a 'middle ground' approach where there is considerable continuity with the 2015-16 programme, but with evolution in terms of the scope, arrangement and/or funding allocation of schemes where this allows change to be progressed further in the desired direction.

5.3 In terms of the extent of change, two more extreme approaches were possible, neither of which could be recommended:

a) to continue on with the 2015-16 programme as-is, without changing its priorities and schemes, or

b) to develop a new programme from a 'blank page'.

5.4 Continuing the programme without change would mean that opportunities were missed to increase the impact of the programme and deepen local integration, whether by building on foundations created by the 2015-16 plan (eg. consolidating discharge and reablement arrangements), addressing important areas not fully addressed in earlier programmes (eg. broadening and increasing the focus on long term conditions) or adjusting the focus away from less effective measures (reducing the funding available to crisis response to better match the level of real need).

5.5 In turn, developing a new programme from scratch risked a significant negative impact on the momentum of the programme – especially given the time needed in 2015-16 for BCF schemes to get up to full speed due to the time needed, variously, to plan direction, procure services and/or to recruit and induct new personnel. It would also not be warranted in that the policy context is not changing dramatically and the programme to date has shown an overall positive performance.

5.6 Views are sought from the Health and Wellbeing Board on whether the proposed programme strikes the right balance between the two extremes.

6 FINANCIAL IMPLICATIONS

6.1 The current and next Better Care Fund programmes are an important aspect of ensuring the longer term financial sustainability of social care by aiming to reduce and better manage demand for both health and social are services, including by developing community capacity and the ability of individuals to be proactive in

managing their own health journey.

6.2 Financial allocations for the 2016-17 programme have not yet been confirmed. The 2016-17 draft budget is based on the 2015-16 programme and will be updated in due course. Any changes to the programme could create an additional pressure on the Council's General Fund and officers will be seeking to avoid any impact.

6.3 Some underspend is anticipated from the 2015-16 programme and it is proposed that some of this would be converted into a contingency fund for the BCF programme (most BCF programmes nationally have a contingency fund but the small size of Rutland's programme meant this was not set up initially). There is also the option to dedicate some underspend to increasing the budget for some 2016-17 measures where they have the potential to contribute to accelerating transformation or integration (details to be confirmed when budget allocations are known).

7 LEGAL AND GOVERNANCE CONSIDERATIONS

7.1 The Council must agree and implement a Better Care Fund Programme for 2016-17 with ELRCCG.

7.2 The Better Care Fund has been and is likely to continue to be an enabler for changes that have been necessary for the Council to meet its obligations under the Care Act 2014. However, at this stage, most of the new Care Act obligations have been met. In some areas, eg. universal information and advice, further investment will help to ensure that relevant obligations can be met ongoing.

7.3 Where commissioning activities are required, these will be undertaken in line with procurement regulations.

8 EQUALITY IMPACT ASSESSMENT

8.1 This agenda item invites views to feed into the Better Care Fund programme. The new programme may then need to be subject to an Equality Impact Assessment if it is sufficiently different to the previous programme and presents a changed balance of impact.

9 COMMUNITY SAFETY IMPLICATIONS

9.1 No implications.

10 HEALTH AND WELLBEING IMPLICATIONS

10.1 The Better Care Fund programme is a key instrument coordinating the work of the Council and its partners, including in the health and Voluntary, Community and Faith sectors, to impact positively and sustainably on health and wellbeing in Rutland, particularly as it relates to older people and people suffering one or more long term conditions.

11 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

11.1 The Health and Wellbeing Board are invited to feed back on and endorse the

provisional draft 2015-16 Better Care Fund proposal set out in Appendix B.

11.2 The proposal sets out a coherent next step for health and social care integration in Rutland which builds on progress to date but still continues to challenge the partnership to progress further on its integration journey. The proposal has been developed iteratively via dialogue with key BCF partners and informed by available contextual inputs, notably the ongoing monitoring and recent evaluation of the current BCF programme, related strategic frameworks and strategies and available guidance.

11.3 The HWB is also asked to note the provisional nature of the attached proposals and the tight timetable for new programme development and approval, and to confirm the preferred sign off process as this may need the HWB to approve the final version of the plan outside the normal pattern of quarterly HWB meetings.

12 BACKGROUND PAPERS

12.1 2016-17 Better Care Fund Policy Framework, published 8 January 2016: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf

13 APPENDICES

13.1 Appendix A: BCF self assessment framework - six domains of integrated care

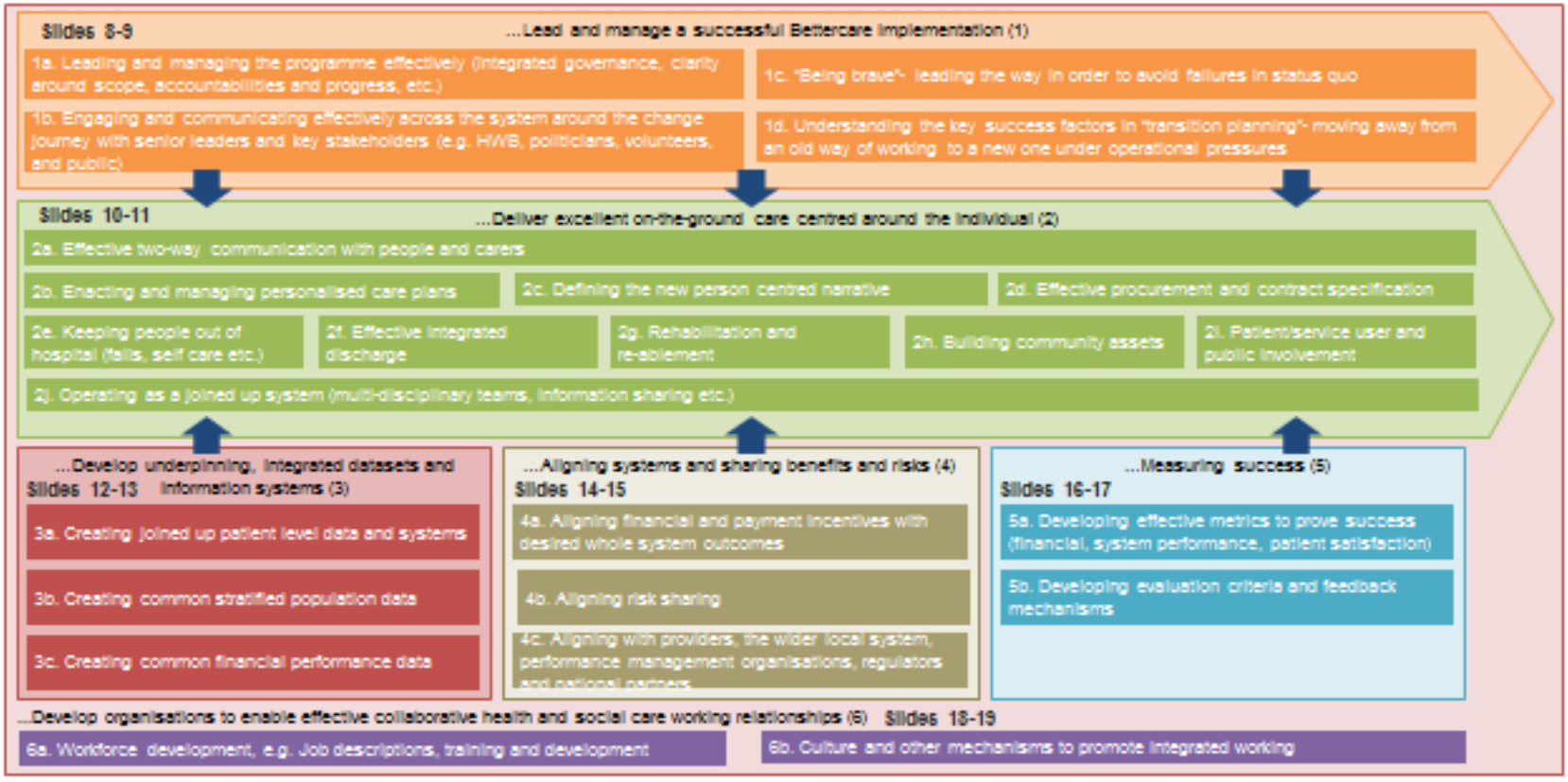
13.2 Appendix B: Rutland Better Care Fund 2016-17 - Provisional draft Plan

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

14 APPENDIX A: BCF SELF ASSESSMENT FRAMEWORK - SIX DOMAINS OF INTEGRATED CARE

Self-assessment and evaluative framework

Six Domains of Integrated Care. Please refer to this for part one of this self-assessment.



APPENDIX B: RUTLAND BETTER CARE FUND 2016-17 - PROVISIONAL DRAFT PLAN

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

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

Contents

Introduction

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

The proposals have been informed by:

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

Interim Evaluation of the 2015-16 programme

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

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

Progress against indicators

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

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

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

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

Scheme level evaluations

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

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

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

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

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

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

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

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

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

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

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

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

New projects workshops

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

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

Key areas where ideas were generated were:

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

Revisiting the original Rutland BCF aim and priorities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The BCF priorities and schemes

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

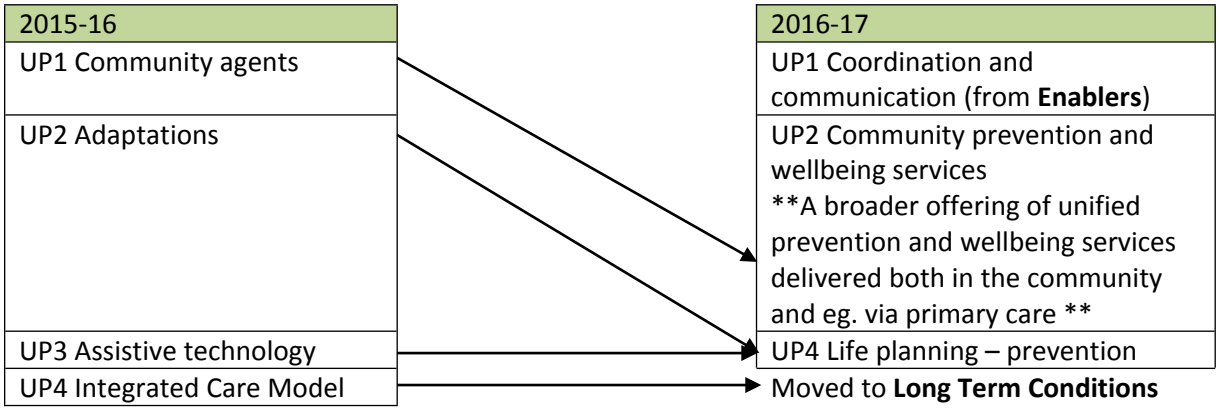
The priorities are described in more detail below. Each section summarises the rationale for the proposed changes, sets out how the 2016-17 proposals relate to 2015-16 schemes, and summarises each scheme and its potential to contribute to the programme's key metrics (assuming these remain the same as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

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

1. Unified prevention

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

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



Unified prevention - schemes

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

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

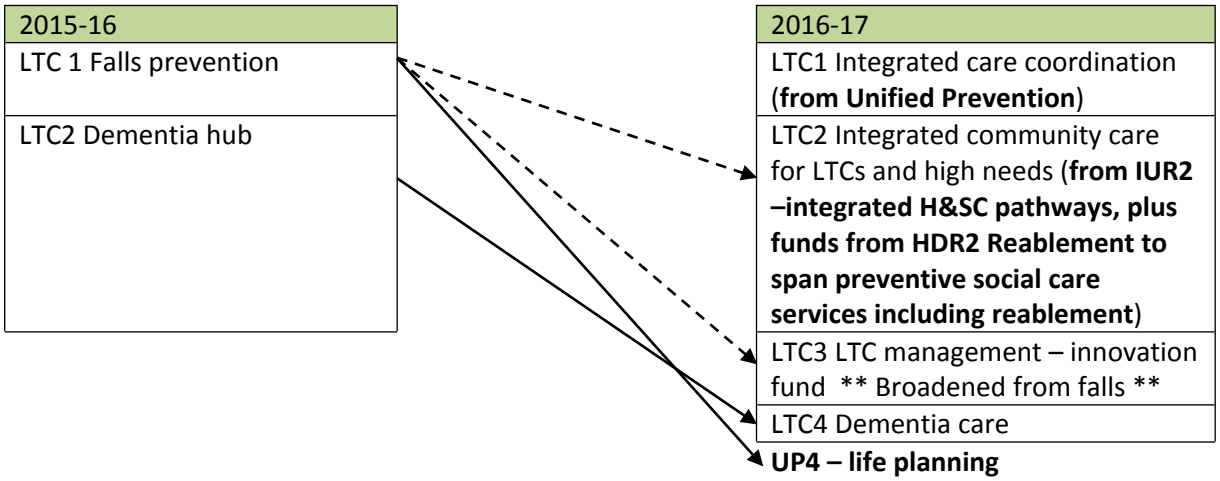
Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
		areas (cf. the Speakset pilot that allows video calling to/by service users). A number of other potential changes in approach were identified during the evaluation eg. new DFG purchasing choices where they offer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

2. Long term condition management

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

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

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



Long term condition - schemes

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

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

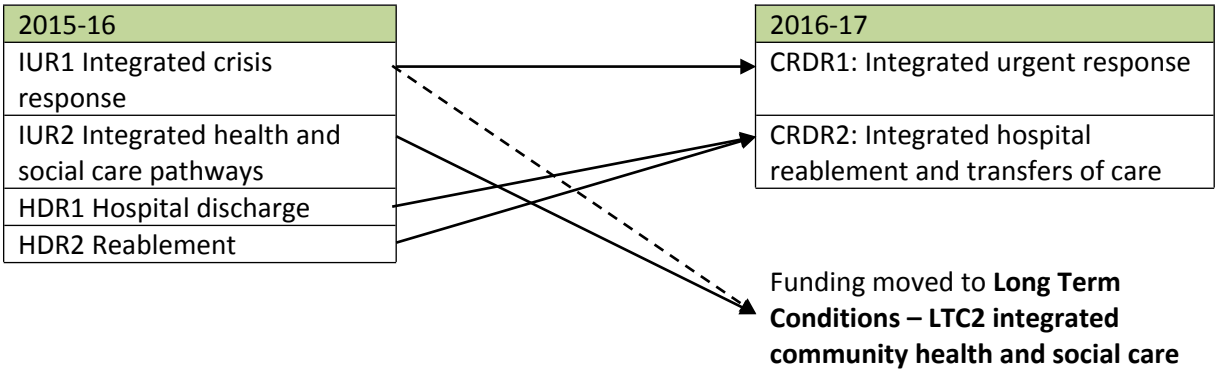
Ref	Scheme Name	Plans	Res Admissions	Still at home	DTOCs	NELs	Satisfaction	Preventing falls
	management – innovation fund	conditions are managed, including through patient activation and self care. This would allow scope for the case managers anticipated in LTC1 to progress pilot projects trialling approaches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

3. Crisis response, discharge and reablement.

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

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

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



Crisis response, transfer of care and reablement schemes

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

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

4. Enablers.

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

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

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

Enablers schemes

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

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

Draft budget allocations

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

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

Priorities and schemes	**%**	**In BCF programme (£k)**	**From/Lead**	**Comment**
1. Unified Prevention Services	19%	429		
UP1 Coordination and communicating the offer	1%	30	RCC	
UP2 Community prevention and wellbeing services	8%	190	RCC	Alongside parallel public health spend and some existing VCF contracts.
UP3 Life planning – preventative services	5% 5%	104 105	DFG Capital RCC	DFGs will be higher. Sum not known. Alongside relevant existing VCF spend and eg. subset of Active Rutland budget.
2. Long Term Condition Management	35%	795		
LTC1 Integrated case management for LTCs	2% 4%	40 100	RCC CCG	Care coordinator CCG 2015-16 underspend for case managers – accelerating change
LTC2 Integrated community health and care services for LTCs and high needs	18% 4%	405 100*	CCG RCC	Is community nursing, end of life, ICS. Alongside RCC long term team spend. Creates a shared integration priority.
LTC3 LTC management – innovation fund	2%	50	RCC	
LTC4 Dementia care	4%	100	RCC	
3. Crisis response, transfer of care and reablement	42%	936		
CRDR1: Integrated urgent response	4% 5%	100* 115**	RCC CCG	Used to be £450k - 20% of the programme – too much relative to level of need.
CRDR2: Integrated hospital reablement and transfer of care	24% 2% 6%	536 50* 135**	RCC RCC CCG	* Former £250k for RCC crisis & discharge, redistributed. **Former £250k CCG crisis & discharge redistributed
4. Enablers	4%	90		
E1 Enablers	2%	39	RCC	
E2 Integrated commissioning				No funding allocated.
E3 Programme support and communications	2%	50	RCC	
Total	100%	2249		This consists of: £104k DFG capital

				£2045k BCF revenue (of which £655k CCG) £100k CCG 2015-16 underspend from crisis response

Appendix 1: Internal interim evaluation of the 2015-16 BCF programme – summary of priority and scheme level evaluations

Overall, there have been many positive changes delivered as part of Rutland's BCF programme to date. The Rutland health and social care economy would now benefit from a stage of consolidation in which progress to date is more fully embedded to avoid eg. those situations where progress is lost simply through staff turnover. This need for consolidation is a strong argument to sustain the overall aim of the programme and its main priorities, whilst being open to adjusting and retuning them to build on the progress made to date.

Priority 1: Unified prevention services – learning from the 2015-16 evaluation

Under the 2015-16 programme, four prevention schemes have been supported:

- two signposting and enrichment schemes - the **Rutland Community Agents** and the GP-based **Integrated Care Coordinator**, both of which work to ensure that individuals in need can identify routes for assistance or involvement that will help them to better manage their health and wellbeing; and
- two schemes helping individuals to retain their independence and remain living in their homes through the supply of equipment and devices (the more traditional home **Adaptations/Disabled Facilities Grants** and **Assistive Technology**).

Highlight reports to date and the scheme level evaluations indicate that, following an early phase of design, recruitment and procurement (where relevant), the schemes have each been operating successfully relative to their initial objectives, gaining good buy-in and momentum. However, the dynamic so far has been very much one of separate schemes strands rather than a unified prevention offer.

- There is arguably scope to improve the reach, coordination, coherence, visibility and accessibility of Rutland's prevention activities.
- As part of this, it may be time to build on successes to date by reducing the fragmentation and overlap across services. It is possible that the support offer has become more complex for users rather than less, with more services operating in the same finite space.
- Anecdotal feedback also indicates that, without an advisor to navigate the services available, it remains difficult for people to identify what services and support might be right for them. A number of cataloguing initiatives have been undertaken (notably the online Rutland Information Service collects online service listings, and service catalogues by the Citizens Advice and the Rutland Community Agents). There appears to be potential to improve how services are presented online (for people searching online and for those advising or representing them).
- We should consider whether the balance is right between signposting activities and the provision of tangible hands-on services, and whether the reach of services is sufficient.

UP1 Community Agents

The Community Agents scheme needed to be restructured after its initial launch, with Lottery funded activities becoming a separate activity. This caused some early confusion. It took some time to recruit to short-term posts, but the scheme has been fully staffed since September, focussing first on delivering face to face services and online information, then moving on to work to develop community capacity. There are several aspects to the service:

- the assistance to individuals has good momentum and the Health Agent has been a positive addition. The duration of support per household has needed to be longer in many cases than anticipated (6-8 weeks rather than 2-3 weeks), with the agent taking a more active role on behalf of the user in many cases, brokering support. 227 individuals have received advice and everyone who has moved on from the service has demonstrated progression in their aims as a result of the support.
- Community capacity building activities building on local community assets were just getting going when the evaluation was done. The aim here is to encourage more community based activity with the potential for wellbeing outcomes (eg. social groups, good neighbour schemes). Nine new groups have been set up so far.
- The service is exploring how it can progress eg. by strengthening the relationship with GP surgeries and with health more generally (flagged as something needing work) and playing a greater role post-discharge from hospital. The scope for greater coordination and a more holistic approach to access has also been highlighted.
- The negative impact of short term procurement rounds on recruitment and stability of service was also highlighted.

Reviewing the self-evaluation the Integration Executive agreed that the Community Agents scheme was a valued part of the BCF programme that could evolve further – coordinating with Public Health and other universal services, progressing community development further and flagging observed gaps or issues back to the Integration Executive to inform BCF decision-making.

UP4 Integrated care coordination

The integrated care coordinator is a member of Rutland County Council staff who works at the 4 Rutland GP practices, following up on patients over 60 with long term conditions who may not be accessing all the support available to them – including social care. The aim is to keep people well and, in the process, to reduce health crises and admissions to care or hospital. The post has similarities with the community agents, but is more targeted. There was a delay in recruitment but, since then, the appointed person has made good progress. Activities have spanned both providing advice to individuals and raising awareness among GPs of the wide range of services that are available.

There is potential to further develop the mechanisms that are bringing key services from different disciplines together to support patients, broadening this scheme out from its focus on the coordinator post to a wider picture of integrated service provision. It will be important to continue work on enablers that help to support this – eg. datasets and information systems are developing but there are still challenges in terms of using health and social care platforms to coordinate care.

UP2 Adaptations/Disabled Facilities Grants

The delivery of DFGs is a statutory obligation on the Council that has been brought into the scope of the Better Care Fund Programme. Positive work has continued on this scheme, which is required by law to deliver only necessary adaptations at the point of need. Speed of processing of DFG requests was affected temporarily by a social care staffing reorganisation, but this ground has since been made up. Nine major adaptations have been completed (cost £38k), a further 11 approved (£56k) and 8 more recommended and subject to means testing and tendering (£57k). These projects are effective in helping individuals to stay in their own homes and avoid moving to residential care. A

recent review of DFG impacts in England confirms the benefits of DFGs more broadly, finding that they can postpone admissions to residential care by an average of four years.

The DFG scheme, which contributes directly to BCF programme aims (ability to remain at home, falls prevention, avoided admissions), is set to continue. It is recognised that there is also scope to evolve - for example:

- First, to provide different adaptations within the scheme where this offers an equivalent service but reduces overall costs. For example, switching to single rather than dual operator equipment in appropriate cases. This can have a higher up front costs but lower 'on costs', reducing the overall cost of operation. Such equipment can also be more compatible with the wishes of users and with the constraints of their home.
- Second, DFGs only address one extreme of housing adaptations – major adaptations at the point of urgent need. There is a much broader range of adaptations activity, with existing processes to deliver more minor and less urgent adaptations, including to people who are self-funding and, at the other extreme, scope for people who do not yet have health or social care needs to make more accessible choices when they invest in their homes. All of this has preventative potential. There may be scope for greater coherence and coordination in this space and to encourage more preventative investments at an earlier stage.
- There is also scope for closer working across health and social care OTs when delivering urgent adaptations for health care needs (often associated with life limiting illness).

UP3 Assistive Technology

Assistive Technology is a broad term for enabling technologies that help people to continue to manage their day to day activities and maintain their independence. Following procurement of a provider, Spire Homes, the scheme got off to a very good start, with strong demand for this type of support (at or above the target level of 15-17 referrals a month), that has been answered to the timescales set out in the contract.

- The Assistive Technology scheme merits being sustained and the contract could begin to be managed as part of 'business as usual' provision.
- It could be linked more closely with the Adaptations scheme – the schemes together offer a menu of options that can help people to maintain independence and quality of life.
- There is still a need to promote the service among professionals and raise awareness of the role AT has to play alongside more traditional measures. The action learning group has been a successful part of this process.
- Demand is anticipated to grow further for AT as community health, social care and other community advisors start to consistently call on this as part of their 'toolkit'. Some aspects of AT delivery have become routine. Where the devices are simple to set up and only have only a capital cost, delivery could be undertaken as part of social care or health to reserve specialist capacity for those cases needing more expert involvement. A further option is the active prioritisation of requests.
- There is further scope to innovate eg. in terms of remote interactions with service users supplementing face to face contact.

Priority 2: Integrated Crisis Response and Integrated pathways

IUR1 Integrated crisis response

The aim of this scheme is to reduce the number of avoidable admissions to acute hospitals and residential care by providing alternative forms of care to manage crisis where this is more appropriate eg. a nursing watch service. The plan and funding were initially for a night nursing service and developing a social care crisis response service. However, the scale of the scheme was found to not be well matched to the scale of demand in Rutland, so the management of this service and scheme was merged with the reablement and hospital discharge schemes under a 'Step up step down' banner. BCF has provided new posts in the Prevention, Discharge and Reablement model that may be responding to issues or deterioration before a crisis point is reached.

Since the scheme's launch in September 2014, there have been 25 cases that we are confident were prevented from being admitted to hospital or residential care as a result of the service. This has included helping patients at end of life to stay at home, an important outcome for them and their families. Overall, involved patients have seen tangible outcomes, but the overall volume of use feels low relative to an average local rate of over 100 non elective admissions per month.

It is proposed that work should continue on this scheme, also coordinating with the LLR Vanguard work on Urgent and Emergency Care, particularly the workstrand addressing integrated community urgent care. There is a need for more detailed work to ascertain whether there is potential (and capacity) for more admissions at crisis to be avoided. Are alternatives systematically considered? If so, and options are still underused, is this rooted eg. in workforce development or more fundamental issues that might benefit from changes to the service scope or design?

Night and day services are also operated differently, and while ICS and Reach are starting to feel more joined up in the day but less connected with the night service. There is a reliance on ICS to make the scheme work but they are pressured. The scheme could usefully evolve to address this eg. through improved use of trusted assessments to reduce the ICS load, secondment of reablement support workers to ICS. Not all posts in the health establishment have as yet been filled, giving an opportunity to revisit the resourcing model.

IUR2 Integrated health and social care pathways

This is a broad and varied scheme whose aim has been to develop a whole system response ensuring coordinated and integrated health and social care in Rutland. It is useful to differentiate between two aspects of change: first, shaping the strategic framework and commissioning as routes to change and, second, operational change and reshaping as part of ongoing delivery. This latter area includes use of risk stratification to support care planning; linking public health to health services more effectively; and, new pathways, integrated care plans and case management for key groups eg. patients over 75, with long term conditions, at end of life or with continuing health care needs.

From a strategy and commissioning perspective, an important goal has been progressing the wider ELR CCG Community Strategy which has recently been out for public engagement (October 2015 to January 2016). This sets out a model for three tiers of integrated local, community and sub-acute health services and will guide commissioning decisions and the overall configuration of local services going forward.

In terms of change work on the ground, some of this work is captured more fully in other workstrands reported on and evaluated here (eg. under care coordination, discharge and reablement). However, the broader work to evolve community health services and integrate them with social care services in more fundamental ways (changed pathways and care planning approaches, integrated teams, etc) does not feel as strongly connected as it could be into the Rutland BCF programme and its governance framework. For these aspects of the scheme to achieve their full potential, it is suggested that leadership for change, focussed at the Rutland scale, could usefully be allocated more clearly to relevant providers, so that there was direct proximity, ownership and accountability, linking back to the BCF programme. This could better enable progress to be driven proactively, working closely with local stakeholders, including social care, as part of the delivery of the Rutland BCF programme.

In the next programming period, it is proposed that the operational dimension of the scheme could be reshaped into a joint health and social care scheme, led locally, to deliver integrated community health and care services (particularly focussed around long term conditions, frail elderly, end of life). This could be positioned under the Long Term Conditions priority. The transition to leadership by providers for this work could usefully begin, however, during the current programme.

Priority 3: Hospital discharge and reablement

This is the heart of the Better Care programme. Good progress has been made in reducing delays to hospital discharges and to reabling people following discharge so that they are not readmitted to hospital or admitted to permanent residential care. There is further potential for improvement in both areas, as detailed below.

HDR 1 Hospital discharge

This scheme aims to reduce delayed bed days from acute hospitals, freeing up beds for those with a priority need and reducing the clinical risks for people of being in hospital, also reducing the overall cost of acute care and preventing reimbursement charges to the local authority. The scheme aims to make pathways between services simple, effective and consistent, and to ensure that home first options are considered wherever possible.

Particular attention has been given to out of area discharges. An in-reach nurse role has been created to provide a home first approach. This nurse and a designated social worker work with Peterborough Hospital to ensure smooth discharge.

Performance has fluctuated, mainly due to staffing changes or absences, but it is clear that, when consistent staff are in place, performance improves markedly. We also have a better understanding of the reasons for delayed discharges. We are now looking for more consistent DTOC patterns, including by identifying alternative mechanisms to ensure that there is always somewhere for patients to be discharged to who cannot return straight home.

This scheme needs to be continued and consolidated, developing use of the minimum dataset, becoming more resilient to staff change and absence (eg. by capturing, publishing and refining processes), embedding the trusted assessment processes, and developing shared outcome measures and evaluation tools to learn from the customer experience.

HDR2 Reablement

The aim of this scheme is to deliver successful reablement that reduce the need for health and social care services, reducing avoidable admissions, preventing readmissions and reducing delayed transfers of care. Activities have included: delivering more integrated working, streamlining pathways, reducing duplication and ensuring that services are timely, safe, effective and person centred.

There was already a reablement service at RCC, REACH, and this has evolved to work in more integrated ways. Some new approaches have been trialled: a 'stepping stone' flat was tried, evaluated and discontinued due to limited use; offering reablement via a care home setting prior to returning fully home has been more successful. These initiatives have also generated lessons for the programme where new approaches are being taken eg. in the building blocks to help with take-up. ICS have built up more of a relationship with the reablement team, with a member of the REACH team attending Board rounds and RMH ward rounds. Relationships are building well and the integration is broadening out beyond REACH to involve the whole Discharge and Reablement Team. There has been reduced duplication, improved use of the Health and Social Care Protocol and the skills of reablement workers have been extended. The changes are believed to be having a positive impact on patients. Over 60% of service users do not have ongoing eligible needs at the end of the reablement period and the readmission rate is low.

Building on the closer working that has been established, there is more scope for integration across health and social care in the next programme eg. with the alignment of outcome measures, job descriptions and recruitment processes and scope for joint generic and skilled posts. The required skills mix could also be reviewed. Seven day services are not in place currently and this is something that will need to be worked towards. Alongside post-hospital recovery, there is also potential for more reablement work targeting admissions avoidance, and to call more consistently on a wider range of interventions that can complement reablement to keep people at home eg. assistive technology. This set of work will need to continue to be proactively driven forward and would benefit from strong leadership to sustain the momentum and integrate related health and social care services more fully.

Priority 4: Long term conditions

Two schemes have been progressed to improve the management of long term conditions, one focussed on dementia and the other on falls prevention. Both schemes have had a slow start, but are now gaining momentum. The aim here is to keep individuals in the best health possible for as long as possible, and, as a result, both improve their quality of life and reduce the demands placed on health services and, in particular, the need for emergency admissions to hospital when conditions are exacerbated.

A key question for the next programme is whether the programme has the right balance of long term condition interventions. In particular, long term conditions are a significant cause of non elective hospital admissions. Most of the longest duration non elective hospital stays are by older people and, if these could be reduced in number or duration, including through improved management of LTCs, this would both be better for those patients and reduce the acute NHS burden. This is an active area of innovation and research. Alongside this possibility, there is also potential for closer integration between community health services and social care providing ongoing support to people with from long term and age-related conditions.

LTC1 Falls prevention

The Falls Prevention scheme was only approved in March 2015, replacing a Learning Disability scheme at an early stage of the programme (the rationale being that falls was a significant issue locally and that learning disability interventions would be more effective if mainstreamed across the other parts of the programme. A falls summit was held in June 2015 to better understand existing provision in this area and work with partners to identify gaps. The scheme then followed through to address a number of gaps via: a call for projects to raise awareness of falls prevention in the wider community; falls prevention training for practitioners including in care homes; a research based exercise referral project for people who have already fallen (FaME); and, a lifelong design project accrediting local suppliers able to help householders make their homes more accessible.

Although it took time, the falls summit is recognised to have been a strength in terms of stakeholder engagement and joint priority setting informed by the Rutland context and expert input. The resulting projects have a strong rationale and are developing well, but are all at too early a stage to have had tangible impacts. It is important that the projects have the opportunity to be seen through to completion (many will extend into the 2016-17 programming period) and that lessons are drawn from them that can help to inform future approaches and practice. This does not necessarily have to be done in the next programme via a stand-alone falls scheme.

In the interim, a number of other schemes across the programme have continued to help to prevent falls by working directly with individuals eg. via post discharge reablement, assistive technology, DFGs and other services, some accessed directly and others signposted via the community agents and care coordinator.

LTC2 Integrated dementia pathway

The aim of this scheme has been to improve the quality of life and experience of care and support for people living with dementia, their families and carers in Rutland. The scheme has included helping to map out and coordinate support, encouraging awareness and early diagnosis and providing tangible support services throughout the journey of an individual and their carer(s). In parallel, there has been continuing work to develop dementia friendly communities (including proposals involving the business community). These activities are being delivered through a dementia contract, RCC dementia specialist staff and active work with local stakeholders including Healthwatch. Some progress was delayed due to recruitment issues, so the scheme is at a fairly early stage in terms of some of its impacts. It is proposed that the scheme be continued as there is potential for more to be achieved building on recent foundations.

Priority 5: Enabling services

There were three schemes under the enablers heading: Care Act 2014 compliance; ICT and data sharing; and programme management/support.

Care Act compliance projects have largely been completed meaning that enabling element is no longer required. Programme support needs to continue to sustain momentum and serve the programme's governance, coordination and reporting requirements.

IT and data sharing is the core of the enabling services strand and has contributed the following, either directly, or via wider Better Care Together projects: a universal online information and advice platform was established, the **Rutland Information Service**; f**oundations were laid for information sharing** by obtaining verified NHS numbers for social care users and implementing the same social

care case management system used by Leicestershire and Leicester City; i**mproved insights into real patient pathways and local health and care trends were obtained via the Health and CareTrak system**, making it possible to shape and steer change projects with more confidence; and reciprocal network access at partner sites meant workers could access their own information systems and resources without using remote access. This went online in Rutland in October and is already facilitating side-by-side working between health and social care colleagues.

In future:

- **How we are working:** The connection could be strengthened between the enablers workstrands and the frontline workers/managers who are the intended beneficiaries for this work, whether in terms of IT systems, sharing agreements, analysis, etc. As a small authority that is part of a bigger health and care economy, Rutland also needs to remain an active participant in LLR-wide IT and IG initiatives. This includes the LLR Information Governance forum.
- **Information:** There is considerable scope to develop programme communications – to keep staff in the loop, to let the public know what is changing locally and to encourage feedback and input.
- **Information governance:** NHS numbers will start to be used as the common identifier between health and social care in the next programme. This may need some awareness raising/refresher training for staff so common standards are used to protect information across health and social care. There is also still a need to confirm what data sharing agreements need to be set up or revised to support new ways of working, including between community health services and social care. National work is progressing which will make this easier to achieve. As part of its compliance activities, RCC is working on securing NHS Information Governance Toolkit compliance as a common Information Governance benchmark or assurance mechanism.
- **ICT:** The BCT project to implement a data sharing system called the MIG is still ongoing. By participating, social workers should be able to gain direct access via LiquidLogic to summary health data, supporting their decision making. Adapting LiquidLogic collectively at the LLR level may reduce the cost to the three Councils. At a practical level, some staff are having to do more double and triple recording on IT systems as a result of closer working. There is a need to streamline this wherever possible. The MIG may help address this, but there is a need to understand the issues in more detail to be sure.

Appendix 2: Outcomes of the new projects workshops

Communications driving change

Issues/opportunities

- Multiple info systems and lots of mapping and pathways, but the 'offer' isn't fully captured or clear
  - duplication, missed opportunities,
  - organised to the logic of providers not users – not person centred
  - Even the providers can't keep track
- More/different comms needed
  - For staff and stakeholders
  - For the public
  - Joint comms
- How to reach the hard to reach – esp those who will only seek help when in crisis?
- Life changes trigger the need for new info/support eg. retirement, bereavement, having a fall.
  - How well do we respond to this?
  - Opportunity to be person centred

Ideas

- Understanding the links between different info systems and offerings – reduce duplication, drive up clarity
- Further development of the Rutland Info Service community content – positive offer
- Consider how to present the offer in a more person-centric and less fragmented way
- BCF comms plan. Possible newsletter
- Front line staff are the direct route to understanding user needs and views – encourage this conversation
- Reach the hard to reach…via the easier to reach
  - friends, neighbours, practitioners who want to change and will tell/influence others

Innovation for established services

Issues

- **Disabled facilities grants (DFGs)** – statutory = 'business as usual' – missing out on innovation?
- **Assistive Technology (AT)** –Good uptake and parts becoming business as usual. Can we go further, mindful of local conditions eg. rural?

Ideas

- DFGs – continue and build in change, eg.
  - to deliver adaptations faster or
  - that have lower on-costs (for a higher initial cost).
  - DFGs as a form of support to carers.
  - Independent advice to self funders on most useful purchases?
- AT – alongside 'Speakset' video calling pilot, explore scope for:
  - video calling to augment advice giving/follow up care during change/ crisis (proven in prisons and for mental health)
    - With care homes – eg. established for mental health backup in some LLR areas
    - For individuals/families at home with access challenges
    - A way to deliver some Integrated Care Coordinator & Community Agent support?
    - 'Buddying' contact from volunteers
  - Evidence from contact with service users that some are confident online with tablets, smartphones etc – we could improve their services using this - often at no extra cost to them.
  - Telehealth – eg. condition monitoring undertaken at home – logged via technology? Useful to avoid admissions? Appetite for this & viable here?

Rutland County Council — Continue building partnership

Issues/opportunities

- Relationship with users is unequal – little scope to shape services. Could offer more…
  - Listening
  - Focussed involvement of end users rather than consultation/awareness – coproduction
  - Low on the 'ladder of involvement' – doing to and for, not yet 'doing with'
- Joint commissioning with health underdeveloped
- Co-design
- Relationship with providers can be unequal
- What does the wider business community have to offer?

Ideas

- Engaging users
  - Regular multi-agency listening
  - Front line staff hear views on the ground – encourage the conversation & structure to capture and learn from it
  - Small grants for bottom up ideas, community capacity? Local ownership
- Joint commissioning, RCC and health
  - map the overlaps and gaps
  - identify and progress concrete opportunities
- Providers – look at ways to engage with them more positively
  - Build on market shaping
  - Joint look at workforce issues?
- Business community
  - Continue to look for scope to involve them

Rutland County Council — Making it easier to keep well

Issues/opportunities

- People's 'health' needs are broad as so many things have an impact eg. health plus housing, money, relationships, stress, lifestyle, work
  - Hard work now for an individual to deal with their own 'whole person' set of issues
  - Dispersed and disjointed agencies & services
  - Coherent front door?
- GPs don't have time to deal with everything discussed with them. 19% of time on non health issues. Less time for health.
- Social prescribing is growing – can we take this further?

Ideas

- Potential to pilot a more rounded set of wellbeing support closer to primary care?
  - Successful precedents elsewhere – various designs and mixes
  - More than signposting – substantive support, often there and then
    - Public health prevention eg. stop smoking, weight management
    - Management of non health matters – debt, relationships, housing…
  - Potential for side by side presence – allowing GP+ appointments there and then?
  - Integrated Care Coordinator would still focus on the subset with greatest need for condition management

Admissions avoidance – Long Term Conditions

Issues/Opportunities

- Is our LTC view broad enough – just falls & dementia?
  - Need to do more to avoid admissions
  - Half of GP appointments are for long term conditions.
  - Admissions stats reflect heart & respiratory issues, cancer, what else?
  - Mental health is the main LTC for 30-50s.
  - Also the impact of combinations of conditions.
- Care coordinator is valued BUT does the toolkit need to be enriched?

Ideas

- Enrich risk stratification
- Understand local patterns of admission and adjust to respond
  - analytics followed through into response design
- Identify condition management opportunities Join up local insights and wider innovation.
  - eg. telehealth monitoring
  - UTI detection
  - …?

Other issues

Issues/Opportunities

- Short term projects = workforce instability
- Right balance of signposting vs substantive services?
- IT remains a barrier – different systems, lack of a shared view onto patient data.
  - Must respect patient data and rights, but standing in the way of better service

Ideas

- Short-termism – no easy answers, but needs consideration in planning and commissioning
- IT
  - Engage more with the BCT IM&T technology workstream.
  - Build understanding of the real front line issues locally to ensure the right solutions.
  - Look at the scope to change who has access to what system instead of changing the systems.
- Need to better understand and broaden out the LTC work locally
  - Continue to support via Integrated Care Coordinator & risk stratification – but don't stop innovating
  - Analysis to understand patterns
  - Scope for targeted condition management projects like the falls projects to contribute to hospital avoidance?

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Department of Health

Department for Communities and Local Government

2016/17 Better Care Fund

Policy Framework

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2016/17 Better Care Fund

Policy Framework

Prepared by the Department of Health and the Department for Communities and Local Government

Contents

Background

The Better Care Fund 2016/17 Policy Framework

The Better Care Fund is the biggest ever financial incentive for the integration of health and social care. It requires Clinical Commissioning Groups and local authorities in every single area to pool budgets and to agree an integrated spending plan for how they will use their Better Care Fund allocation. In 2015-16, the Government committed £3.8 billion to the Better Care Fund with many local areas contributing an additional £1.5 billion, taking the total spending power of the Better Care Fund to £5.3 billion.

Current health and care approaches have evolved to respond reactively to changes in an individual's health or ability to look after themselves, and they often do not meet people's expectations for person-centred co-ordinated care. Greater integration is seen as a potential way to use resources more efficiently, in particular by reducing avoidable hospital admissions and facilitating early discharge.

We recognise that local areas are at different points in their integration journey and in supporting them to achieve their ambitions for integrated care, we will need to prioritise progress on known barriers to change to ensure the key factors associated with successful integration are embedded and shared across the system. The Better Care Fund and other drivers of integrated care such as New Care Models pave the way for greater integration of health and social care services.

In 2016-17, the Better Care Fund will be increased to a mandated minimum of £3.9 billion to be deployed locally on health and social care through pooled budget arrangements between local authorities and Clinical Commissioning Groups. The local flexibility to pool more than the mandatory amount will remain. From 2017-18, the government will make funding available to local authorities, worth £1.5 billion by 2019-20, to be included in the Better Care Fund. In looking ahead to 2016-17, it is important that Better Care Fund plans are aligned to other programmes of work including the new models of care as set out in the NHS Five Year Forward View and delivery of 7-day services.

This document sets out the policy framework for the implementation of the fund in 2016-17, as agreed across the Department of Health, Department for Communities and Local Government, Local Government Association, Association of Directors of Adult Social Services, and NHS England. In developing this policy framework, the strong feedback from local areas of the need to reduce the burden and bureaucracy in the operation of the Better Care Fund has been taken on board, and we have streamlined and simplified the planning and assurance of the Better Care Fund in 2016-17, including removing the £1 billion payment for performance framework.

In place of the performance fund are two new national conditions, requiring local areas to fund NHS commissioned out-of-hospital services and to develop a clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets. The conditions are designed to tackle the high levels of DTOC across the health and care system, and to

ensure continued investment in NHS commissioned out-of-hospital services, which may include a wide range of services including social care.

Further detailed guidance will be issued by NHS England, working with the partners above, on developing Better Care Fund plans for 2016-17. The guidance will form the Better Care Fund section of the NHS technical planning guidance, which will be available on NHS England's website. Local areas are asked to refer to and follow this guidance.

Beyond the 2016-17 Better Care Fund

The Spending Review sets out an ambitious plan so that by 2020 health and social care are integrated across the country. Every part of the country must have a plan for this in 2017, implemented by 2020. Areas will be able to graduate from the existing Better Care Fund programme management once they can demonstrate that they have moved beyond its requirements. Further details will be set out shortly in guidance.

1. The Statutory and Financial Basis of the Better Care Fund

The Care Act 2014 amended the NHS Act 2006 to provide the legislative basis for the Better Care Fund. It allows for the mandate to NHS England to include specific requirements relating to the establishment and use of an integration fund.

Under the mandate to NHS England for 2016-17, NHS England is required to ring-fence £3.519 billion within its overall allocation to Clinical Commissioning Groups to establish the Better Care Fund. The remainder of the £3.9 billion fund will be made up of the £394 million Disabled Facilities Grant, which is paid directly from the Government to local authorities.

Of the £3.519 billion Better Care Fund allocation to Clinical Commissioning Groups, £2.519 billion of that allocation will be available upfront to Health and Wellbeing Boards to be spent in accordance with the local Better Care Fund plan. The remaining £1 billion of Clinical Commissioning Group Better Care Fund allocation will be subject to a new national condition.

NHS England and the Government will allocate the Better Care Fund to local areas based on a framework agreed with Ministers. For 2016-17, the allocation will be based on a mixture of the existing Clinical Commissioning Group allocations formula, the social care formula, and a specific distribution formula for the Disabled Facilities Grant element of the Better Care Fund.

Within the Better Care Fund allocation to Clinical Commissioning Groups is £138m to support the implementation of the Care Act 2014 and other policies (£135m in 2015-16). Funding previously earmarked for reablement (over £300m) and for the provision of carers' breaks (over £130m) also remains in the allocation. Further information on this can be found in the Better Care Fund Planning Requirements.

Individual allocations of the Better Care Fund for 2016-17 to local areas and the detailed formulae used will be published on NHS England's website in early January.

2. Conditions of Access to the Better Care Fund

The amended NHS Act 2006 gives NHS England the powers to attach conditions to the payment of the Better Care Fund. In 2016-17, NHS England will set the following conditions, which local areas will need to meet to access the funding:

- A requirement that the Better Care Fund is transferred into one or more pooled funds established under section 75 of the NHS Act 2006
- A requirement that Health and Wellbeing Boards jointly agree plans for how the money will be spent, with plans signed-off by the relevant local authority and Clinical Commissioning Group(s)
- A requirement that plans are approved by NHS England in consultation with DH and DCLG (as set out in section 3 below)
- A requirement that a proportion of the areas allocation will be subject to a new condition around NHS commissioned out of hospital services, which may include a wide range of services including social care.

NHS England will also require that Better Care Fund plans demonstrate how the area will meet the following national conditions:

- Plans to be jointly agreed;
- Maintain provision of social care services;
- Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate;
- Better data sharing between health and social care, based on the NHS number;
- Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional;
- Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans;
- Agreement to invest in NHS commissioned out-of-hospital services, which may include a wide range of services including social care;
- Agreement on local action plan to reduce delayed transfers of care.

Detailed definitions of these national conditions are set out at Annex A.

Conditions of Access to the Better Care Fund

Under the amended NHS Act 2006, NHS England has the ability to withhold, recover or direct the use of funding where conditions attached to the Better Care Fund are not met. The Act makes provision at section 223GA(7) for the mandate to NHS England to include a requirement that NHS England consult Ministers before exercising these powers. The 2016-17 mandate to NHS England confirms that NHS England will be required to consult Ministers before using these powers.

NHS England's power to set conditions on the Better Care Fund applies to the £3.519bn that is part of Clinical Commissioning Group allocations. For the £394m paid directly to local government, the Government will attach appropriate conditions to the funding to ensure it is included in the Better Care Fund at local level. As set out in Better Care Fund technical guidance, for 2016-17 authorities in two-tier areas will have to allocate Disabled Facilities Grant funding to their respective housing authorities from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people.

3. The Assurance and Approval of the Local Better Care Fund Plans

Local Better Care Fund plans will be developed in line with the agreed guidance, templates and support materials issued by NHS England and the Local Government Association. For 2016-17, we have set out a more streamlined process that is better integrated into the business-as-usual planning processes for Health and Wellbeing Boards, Clinical Commissioning Groups and local authorities.

The first stage of the overall assurance of plans will be local sign-off by the relevant Health and Wellbeing Board, local authority and Clinical Commissioning Group(s). In line with the NHS operational planning assurance process, plans will then be subject to regional moderation and assurance. The key aspects of the process for the planning, assurance and approval of Better Care Fund plans are:

- Brief narrative plans will be developed locally and submitted to regional teams through a short high level template, setting out the overall aims of the plan and how it will meet the national conditions
- A reduced amount of finance and activity information relating to local Better Care Fund plans will be collected alongside Clinical Commissioning Group operational planning returns to submitted to NHS England, to ensure consistency and alignment
- Better Care Managers will work with NHS England Directors of Commissioning Operations teams to ensure they have the knowledge and capacity required to review and assure Better Care Fund plans. To support this local government regional leads for the Better Care Fund (LGA lead CEOs and ADASS chairs) or their representatives will be part of the moderation process at a regional level (supported with additional resource to contribute to both assurance and moderation)
- There may be flexibility permitted for devolution sites to submit plans over a larger footprint if appropriate
- An assessment will then be made of the risk to delivery of the plan due to local context and challenges, using information from NHS England, the Trust Development Agency, Monitor and local government
- These judgements on ‘plan quality’ and ‘risks to delivery’ will contribute to the placing of plans into three categories – ‘Approved’, ‘Approved with support’, ‘Not approved’.

A diagram of the above assurance and approval process is included in Annex B. The full details will be set out in the Better Care Fund section of the NHS technical planning guidance, which will be available on NHS England’s website.

Assurance and judgements on potential support needs through the planning process will be 'risk-based' (based on a planning readiness self-assessment pooled with other system level intelligence) with the level of assurance of an area's plan being proportionate to the perceived level of risk in a system. Recommendations of approval for Better Care Fund plans for high risk areas will be made by the regional moderation process but those decisions will be quality assured by the Integration Partnership Board (which is a senior programme leadership board comprising DH, DCLG, NHS England, Local Government Association and the Association of Directors of Adult Social Services). Final decisions on approval will be made by NHS England, based on the advice of the moderation and assurance process, in accordance with the legal framework set out in section 223 GA of the NHS Act 2006.

Where plans are not initially approved, or are approved with support, NHS England will implement a programme of support to help areas to achieve approval (and / or meet relevant conditions) ahead of April 2016.

NHS England has the ability to direct use of the fund where an area fails to meet one of the Better Care Fund conditions. This includes the requirement to develop a plan approved by NHS England and Ministers. If a local plan cannot be agreed, any proposal to direct use of the fund will be subject to consultation with DH and DCLG (as required under the 2016-17 mandate to NHS England).

4. National Performance Metrics

Under the 2015-16 Better Care Fund policy framework, local areas were asked to set targets against the following five key metrics:

- Admissions to residential and care homes
- Effectiveness of reablement
- Delayed transfers of care
- Patient / service user experience
- A locally-proposed metric

In the interests of stability and consistency, areas will be expected to maintain the progress made in 2015-16. The detailed definitions of these metrics are set out in the Better Care Fund section of the NHS technical planning guidance.

5. Implementation 2016-17

The implementation of local Better Care Fund plans will formally begin from 1 April 2016. As part of its wider planning process, NHS England will require local areas to produce a multi-year strategic plan, showing how local services will get from where they are now to where the Five Year Forward View requires them to be by 2020. This will set out the actions and specific deliverables that NHS England will take forward to deliver the objectives set out in the multi-year mandate to NHS England – including those relating to the integration of health and social care and the continuation of the Better Care Fund.

In implementing the Better Care Fund in 2016-17, NHS England will continue to:

- Provide support to local areas to ensure effective implementation of agreed plans;
- Work with partners to identify and remove barriers to service integration;
- Promote and communicate the benefits of health and social care integration;
- Monitor the ongoing success of the Better Care Fund – including delivery against key national performance metrics;
- Prepare as necessary for the continuation of the Better Care Fund over the next Parliament.

Annex A: Detailed Definitions of National Conditions

CONDITION	DEFINITION
Plans to be jointly agreed	The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Review, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with health and social care providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. Furthermore, there should be joint agreement across commissioners and providers as to how the Better Care Fund will contribute to a longer term strategic plan. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences. The Disabled Facilities Grant (DFG) will again be allocated through the Better Care Fund. Local housing authority representatives should therefore be involved in developing and agreeing the plan, in order to ensure a joined-up approach to improving outcomes across health, social care and housing.
Maintain provision of social care services	Local areas must include an explanation of how local adult social care services will continue to be supported within their plans in a manner consistent with 2015-16. The definition of support should be agreed locally. As a minimum, it should maintain in real terms the level of protection as provided through the mandated minimum element of local Better Care Fund agreements of 2015-16. This reflects the real terms increase in the Better Care Fund. In setting the level of protection for social care localities should be mindful to ensure that any change does not destabilise the local social and health care system as a whole. This will be assessed compared to 2015-16 figures through the regional assurance process. It should also be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14: https://www.gov.uk/government/uploads/system/uploads/attac

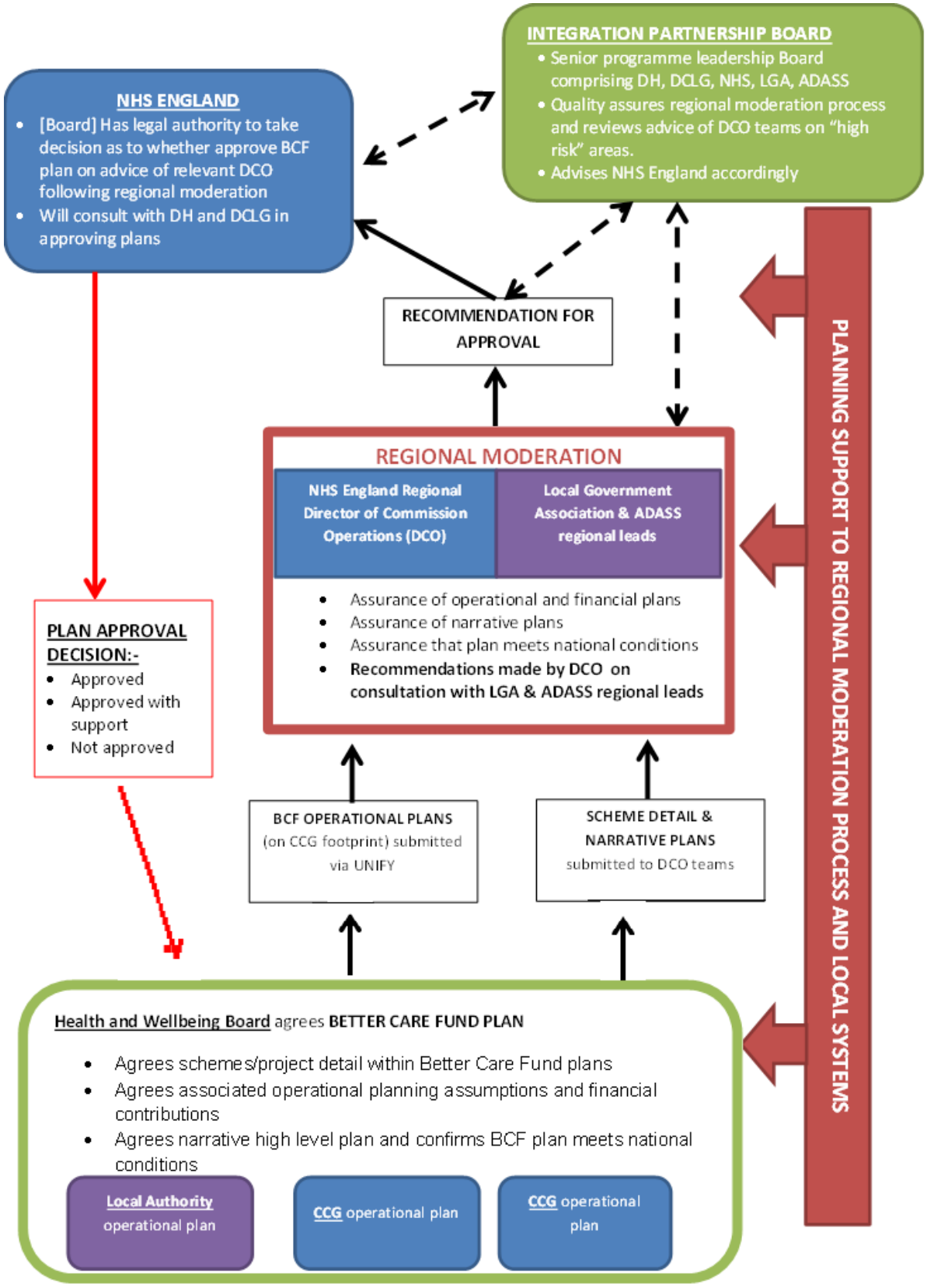
	hment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf"
Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate.	Local areas are asked to confirm how their plans will provide 7-day services (throughout the week, including weekends) across community, primary, mental health, and social care in order: • To prevent unnecessary non-elective admissions (physical and mental health) through provision of an agreed level of infrastructure across out of hospital services 7 days a week; • To support the timely discharge of patients, from acute physical and mental health settings, on every day of the week, where it is clinically appropriate to do so, avoiding unnecessary delayed discharges of care. If they are not able to provide such plans, they must explain why. The 10 clinical standards developed by the NHS Services, Seven Days a Week Forum represent, as a whole, best practice for quality care on every day of the week and provide a useful reference for commissioners (https://www.england.nhs.uk/wp-content/uploads/2013/12/clinical-standards1.pdf). By 2020 all hospital in-patients admitted through urgent and emergency routes in England will have access to services which comply with at least 4 of these standards on every day of the week, namely Standards 2, 5, 6 and 8. For the Better Care Fund, particular consideration should be given to whether progress is being made against Standard 9. This standard highlights the role of support services in the provision of the next steps in a person's care pathway following admission to hospital, as determined by the daily consultant-led review, and the importance of effective relationships between medical and other health and social care teams.
Better data sharing between health and social care, based on the NHS number	The appropriate and lawful sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a consistent identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas should: • confirm that they are using the NHS Number as the consistent identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing interoperable Application Programming Interfaces (APIs) (i.e. systems that speak to each other) with the necessary

	security and controls (https://www.england.nhs.uk/wp-content/uploads/2014/05/open-api-policy.pdf; and • ensure they have the appropriate Information Governance controls in place for information sharing in line with the revised Caldicott principles and guidance made available by the Information Governance Alliance (IGA), and if not, when they plan for it to be in place. • ensure that people have clarity about how data about them is used, who may have access and how they can exercise their legal rights. In line with the recommendations from the National Data Guardian review. The Information Governance Alliance (IGA) is a group of national health and care organisations (including the Department of Health, NHS England, Public Health England and the Health and Social Care Information Centre) working together to provide a joined up and consistent approach to information governance and provide access to a central repository guidance on data access issues for the health and care system. See - http://systems.hscic.gov.uk/infogov/iga
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas should identify which proportion of their population will be receiving case management and named care coordinator, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by care coordinators, for example dementia advisors.
Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans	The impact of local plans should be agreed with relevant health and social care providers. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. This should complement the planning guidance issued to NHS organisations There is agreement that there is much more to be done to ensure mental and physical health are considered equal and better integrated with one another, as well as with other services such as social care. Plans should therefore give due regard to this.
Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care	Local areas should agree how they will use their share of the £1 billion that had previously been used to create the payment for performance fund. This should be achieved in one of the following ways: • To fund NHS commissioned out-of-hospital services, which may include a wide range of services including social care, as part of their agreed Better

	Care Fund plan; or • Local areas can choose to put an appropriate proportion of their share of the £1bn into a local risk-sharing agreement as part of contingency planning in the event of excess activity, with the balance spent on NHS commissioned out-of-hospital services, which may include a wide range of services including social care (local areas should seek, as a minimum, to maintain provision of NHS commissioned out of hospital services in a manner consistent with 15-16); This condition replaces the Payment for Performance scheme included in the 2015-16 Better Care Fund framework.
Agreement on local action plan to reduce delayed transfers of care (DTOC)	Given the unacceptable high levels of DTOC currently, the Government is exploring what further action should be taken to address the issue. As part of this work, under the Better Care Fund, each local area is to develop a local action plan for managing DTOC, including a locally agreed target. All local areas need to establish their own stretching local DTOC target - agreed between the CCG, Local Authority and relevant acute and community trusts. This target should be reflected in CCG operational plans. The metric for the target should be the same as the national performance metric (average delayed transfers of care (delayed days) per 100,000 population (attributable to either NHS, social care or both) per month. As part of this plan, we want local areas to consider the use of local risk sharing agreements with respect to DTOC, with clear reference to existing guidance and flexibilities. This will be particularly relevant in areas where levels of DTOC are high and rising. In agreeing the plan, Clinical Commissioning Groups and local authorities should engage with the relevant acute and community trusts and be able to demonstrate that the plan has been agreed with the providers given the need for close joint working on the DTOC issue. We would expect plans to: • Set out clear lines of responsibility, accountabilities, and measures of assurance and monitoring; • Take account of national guidance, particularly the NHS High Impact Interventions for Urgent and Emergency Care, the NHS England Monthly Delayed Transfers of Care Situation Reports Definition and Guidance, and

	best practice with regards to reducing DTOC from LGA and ADASS; • Demonstrate how activities across the whole patient pathway can support improved patient flow and DTOC performance, specifically around admissions avoidance; • Demonstrate consideration to how all available community capacity within local geographies can be effectively utilised to support safe and effective discharge, with a shared approach to monitoring this capacity; • Demonstrate how CCGs and Local Authorities are working collaboratively to support sustainable local provider markets, build the right capacity for the needs of the local population, and support the health and care workforce - ideally through joint commissioning and workforce strategies; • Demonstrate engagement with the independent and voluntary sector providers.

Annex B: Assurance and Approval of Better Care Fund Plans



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Report No. 23/2016

Report to Rutland Health and Wellbeing Board

Subject:	**LEICESTERSHIRE AND RUTLAND SAFEGUARDING ADULTS BOARD (LRSAB) BUSINESS PLAN 2016/17**
Meeting Date:	**Tuesday 26th January 2016**
Report Author:	**Paul Burnett**
Presented by:	**Paul Burnett**
Paper for:	**Action/Discussion**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy: Themes 2, 3 and 4

Purpose of report

1. The purpose of this report is to bring to the attention of the Rutland Health and Wellbeing Board the Business Plan 2016/17 for the Leicestershire and Rutland Safeguarding Adults Board (LRSAB). This is brought for consultation and comment. It is also intended to trigger consideration of any implications that these business plans may have for the health and well-being strategy and supporting action plans.

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

Policy Framework and Previous Decisions

3. The LRSAB became a statutory body on 1st April 2015 as a result of the Care Act 2014. The Act requires that the SAB must lead adult safeguarding arrangements across its locality and oversee and coordinate the effectiveness of the safeguarding work of its member and partner agencies. It requires the SAB to develop and actively promote a culture with its members, partners and the local community that recognises the values and principles contained in 'Making Safeguarding Personal'. It should also concern itself with a range of issues which can contribute to the wellbeing of its community and the prevention of abuse and neglect, such as:
    - the safety of people who use services in local health settings, including mental health
    - the safety of adults with care and support needs living in social housing
    - effective interventions with adults who self-neglect, for whatever reason
    - the quality of local care and support services
    - the effectiveness of prisons in safeguarding offenders
    - making connections between adult safeguarding and domestic abuse.

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

4. SABs have three core duties. They must:

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

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

5. The Annual Report of the LRLSCB and LRSAB was considered by Rutland Cabinet in October 2015 and emerging priorities for the new Business Plan for 2016/17 were discussed at that meeting. In addition views on future priorities were also considered by members of the People (Adults and Health) and People (Children's) Scrutiny Panels when they received the annual reports in September and October 2015. The views expressed by the Health and Wellbeing Board at that stage were fed into the formative process for the Plan and are reflected in the final version of the Plan which is attached as Appendix 1.

Background

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

7. The future improvement priorities identified in the Annual Report 2014/15 have been built into the Business Plans for 2016/17. In addition to issues arising from the Annual Report the new Business Plans' priorities have been identified against a range of national and local drivers including:
   a. national safeguarding policy initiatives and drivers;
   b. recommendations from regulatory inspections across partner agencies;
   c. the outcomes of Serious Case Reviews (SCRs), Serious Incident Learning Processes (SILPs), Domestic Homicide Reviews (DHRs) and other review processes both national and local;
   d. evaluation of the Business Plans for 2015/16 including analysis of impact afforded by our Quality Assurance and Performance Management Framework;
   e. best practice reports issued at both national and local levels;
   f. the views expressed by both service users and frontline staff through the Boards' engagement and participation arrangements.

8. The new Business Plan has been informed by discussions that have taken place in a number of forums since the autumn of 2015. These include:
   a. the annual Safeguarding Summit of chief officers from partner agencies held on 13th November 2015
   b. meetings of the Scrutiny Panels in both Leicestershire and Rutland at which both the Annual Report 2014/15 and future priorities for action have been debated;
   c. meetings of the Leicestershire and Rutland Health and Well-Being Boards at which both the Annual Report 2014/15 and future priorities for action have

been debated;
d. discussions within individual agencies.

9. Business Plan priorities were discussed and debated at a meeting of the Health and Wellbeing Board at their meeting held in October 2015. As stated above, all the issues raised at that meeting have been incorporated into the draft Business Plan attached.

10. The proposed strategic priorities, priority actions and key outcome indicators set out in the new Business Plans were formulated through the annual Development Session of the two Safeguarding Boards held on 25th November 2015.

Proposed Business Plans 2016/17

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

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

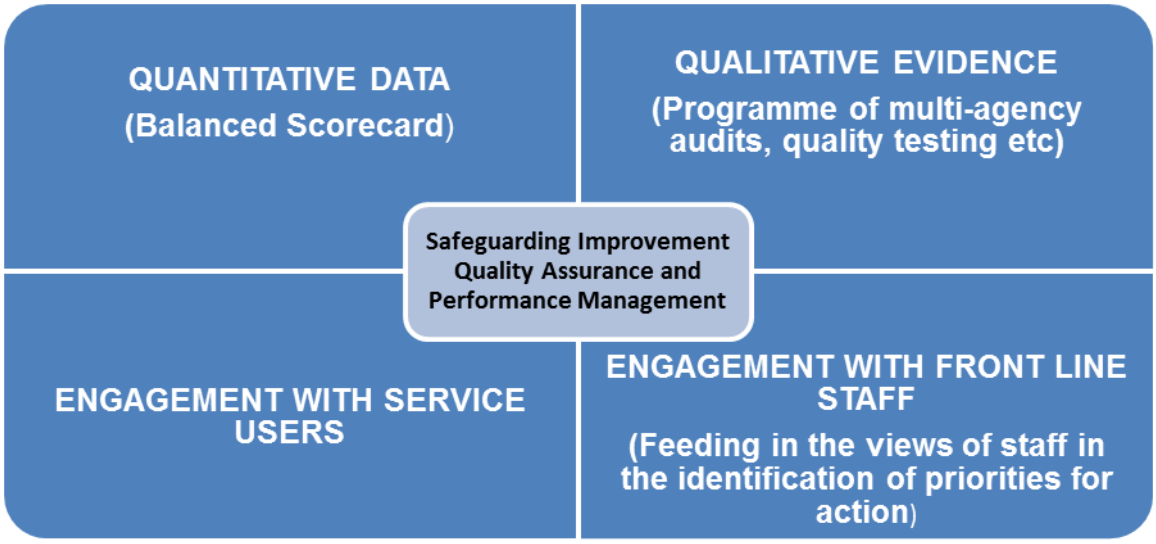
13. The priorities that have arisen for the part of the Business Plan shared with the LRLSCB are:
    - Domestic Abuse
    - Reducing safeguarding risk arising from mental health issues – including monitoring of the implementation of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)
    - PREVENT.

    Consideration is also being given to whether, in light of current international issues, we should include a priority that considers safeguarding risks that may be faced by refugees. It would be helpful for the Health and Wellbeing Board to express a view on this area of consideration.

14. Against each of these priorities the Board is in the process of identifying key outcomes for improvement and the actions that will need to be taken over the

next year to achieve these improved outcomes. These are set out in the draft Business Plans that are attached as Appendices 1 and 2 to this report.

15. The Quality Assurance and Performance Management Framework for the Board will be revised to ensure that it reflects the new Business Plan and enables ongoing monitoring of performance of core business that is not covered in the Business Plan. The final framework will be signed off by the Board at its meeting on 15th April 2016 but the Health and Wellbeing Board may wish to comment on specific indicators and evidence it would wish to include. Quality Assurance and Performance Management will continue to be framed around our 'four-quadrant' model as set out below:



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

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

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

17. The views of a range of forums are being sought on the Business Plans. This includes the Cabinets, Children and Adults and Scrutiny Committees and the Health and Well-Being Boards in both local authority areas.

Officer to Contact

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Relevant Impact Assessments

Equality and Human Rights Implications

18. Safeguarding vulnerable children, young people and vulnerable adults concerns individuals who are likely to be disadvantaged in a number of ways. The Annual Report sets out how the LSCB/SAB seeks to ensure that a fair, effective and equitable service is discharged by the partnership. Likewise the Annual Report and Business Plan 2014/15 extracts set out how the partnership will seek to engage with all parts of the community in the coming year.

Partnership Working and associated issues

19. Fffective safeguarding performance is dependent on the collaboration and cohesion across the partnership of services represented at the LRSAB and as set out in the Care Act 2014.

Financial implications:

20. The LRSLCB and LRSAB have a budget to which constituent agencies contribute. Agency contributions for 2016/17 are agreed at the same level as last year and the Business Plan will be delivered within these resources. Rutland County Council contributes £52, 250 to the costs of the LRLSCB (of a total budget of £335,525). In addition it contributes £8,240 to the costs of the Leicestershire and Rutland Safeguarding Adults Board (LRSAB) (of a total budget of £102,610).

Recommendations:

1. The Board is asked to consider the Business Plans and to make any comments or proposed additions or amendments to the Plans that will then be considered at the meeting of the Board due to be held on 29th January 2016.
2. The Board is asked to consider whether the Business Plan proposals should inform or impact on the Health and Well-Being Strategy for 2016/17.

Consultation

3. All members of the Boards and their Executive have had opportunities to contribute to and comment on the Business Plans. In addition, discussions have been held with service users in both local authority areas to enable them to contribute their views about safeguarding in Leicestershire and Rutland.

Conclusions

4. The Board should note and comment on the attached Business Plans for 2016/17.

Comments from the board:

Strategic Lead:	Paul Burnett, Independent Chair of the LRLSCB and LRSAB	
Risk assessment:		
Time	**L/**M/H	Progress on all elements of Board Business Plans is carefully monitored by relevant sub-groups, the LRLSCB/SAB Executive and by the Boards themselves on a quarterly basis. This includes not only checking that actions are completed to timescale but also that impact is secured through the quality assurance and performance management framework operated by the Boards.
Viability	**L**/M/H	As set out above, in engaging in the formulation of these Plans partner agencies have committed capacity both financial and human to the delivery of actions and will provide assurance of this commitment when the Plans are signed off in April.
Finance	**L**/M/H	The LRSLCB and LRSAB have a budget to which constituent agencies contribute. Agency contributions for 2016/17 are agreed at the same level as last year and the Business Plan will be delivered within these resources. Rutland County Council contributes £52, 250 to the costs of the LRLSCB (of a total budget of £335,525). In addition it contributes £8,240 to the costs of the Leicestershire and Rutland Safeguarding Adults Board (LRSAB) (of a total budget of £102,610).
Profile	L/M/H	The LRSAB became a statutory body on 1st April 2015. It is not clear whether any regulatory framework will be put in place to judge its performance. However, safeguarding performance has a major impact on organisational reputation. Safeguarding Adult Reviews and Domestic Homicide Reviews in particular can have significant impact on reputation and public confidence both in relation to individual organisations and the partnership of agencies as a whole.
Equality & Diversity	L/M/H	No formal equalities impact assessment is carried out on the LRLSCB and LRSAB Business Plans. However, performance data collected by the Board does include reference to gender, race/ethnicity, disability and other protected characteristics to ensure that the profile of safeguarding data is tested and any related issues identified and acted upon.

Timeline: April 2016 to October 2017

Task	Target Date	Responsibility
Comment on the proposed Business Plans prior to their approval by the LRSAB.	March 2016	Board members to comment and Independent Chair to revise proposed Business Plan to reflect

Determine whether the LRSAB Business Plan and joint Business Plan with the LRLSCB should inform/impact on the Health and Well-Being Strategy and action plans		comments.
Receive and comment on progress when reported by the Independent Chair. Consider any action required of the Health and Well-Being Board in response to any performance issues.	October 2016 and January 2017	All Board members to comment and consider any relevant actions to be taken.
Receive and comment on the Annual Report of performance that will be drafted in July 2017 and presented to the Health and Well-Being Board in the autumn of 2017	October 2017	All Board members to comment and consider any relevant actions to be taken.

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SAB

1st DRAFT

BUSINESS PLAN 2016/17

SAB Priority 1 Owner: TBC

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

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

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

SAB Priority 2 Owner – Jon Wilson

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

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

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

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

SAB Priority 4: Owner: TBC

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

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

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

SAB Priority 5 Owner: TBC

Develop a preventive framework to reduce incidence of neglect and omission

Strengthen frameworks for the identification, assessment and service response (both individual agency and collective) to acts of neglect and omission.

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

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

Report No. 24/2016

Report to Rutland Health and Wellbeing Board

Subject:	**LEICESTERSHIRE AND RUTLAND LOCAL SAFEGUARDING CHILDREN BOARD (LRLSCB) BUSINESS PLANS 2016/17**
Meeting Date:	**Tuesday 26th January 2016**
Report Author:	**Paul Burnett**
Presented by:	**Paul Burnett**
Paper for:	**Action/Discussion**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy: Themes 1, 2, 3 and 4

Purpose of report

1. The purpose of this report is to bring to the attention of the Rutland Health and Wellbeing Board the Business Plan 2016/17 for the Leicestershire and Rutland Local Safeguarding Children Board (LRLSCB). This is brought for consultation and comment. It is also intended to trigger consideration of any implications that these business plans may have for the health and well-being strategy and supporting action plans.

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

Policy Framework and Previous Decisions

3. The LRLSCB is a statutory body established as a result of Section 13 of the Children Act 2004 and currently operates under statutory guidance issued in Working Together 2015. There is no statutory requirement to report the annual Business Plan to the Health and Wellbeing Board but it has been considered best practice in the past so to do.

4. The Annual Report of the LRLSCB and LRSAB was considered by the Rutland Cabinet in October 2015 and emerging priorities for the new Business Plan for 2015/16 were discussed at that meeting. In addition views on future priorities were also considered by members of the People (Adults and Health) and People (Children's) Scrutiny Panels when they received the annual reports in September and October 2015. The views expressed by the Health and Wellbeing Board at that stage were fed into the formative process for the Plan and are reflected in the final version of the Plan which is attached as Appendix 1.

Background

5. As in 2015/16 the LRLSCB has formulated an individual Business Plan supplemented by a plan that addresses priorities it will share with the Leicestershire and Rutland Safeguarding Adults Board. This is intended to secure

a balance between achieving a strong focus on children's safeguarding issues and recognising that some safeguarding matters require approaches that cross-cut children and adults services and focus on whole family issues.

6. The future improvement priorities identified in the Annual Report 2014/15 have been built into the Business Plans for 2016/17. In addition to issues arising from the Annual Report the new Business Plans' priorities have been identified against a range of national and local drivers including:
   a. national safeguarding policy initiatives and drivers;
   b. recommendations from regulatory inspections across partner agencies;
   c. the outcomes of Serious Case Reviews (SCRs), Serious Incident Learning Processes (SILPs), Domestic Homicide Reviews (DHRs) and other review processes both national and local;
   d. evaluation of the Business Plans for 2015/16 including analysis of impact afforded by our Quality Assurance and Performance Management Framework;
   e. best practice reports issued at both national and local levels;
   f. the views expressed by both service users and frontline staff through the Boards' engagement and participation arrangements.

7. The new Business Plan has been informed by discussions that have taken place in a number of forums since the autumn of 2015. These include:
   a. the annual Safeguarding Summit of chief officers from partner agencies held on 13th November 2015
   b. meetings of the Scrutiny Panels in both Leicestershire and Rutland at which both the Annual Report 2014/15 and future priorities for action have been debated;
   c. meetings of the Leicestershire and Rutland Health and Well-Being Boards at which both the Annual Report 2014/15 and future priorities for action have been debated;
   d. discussions within individual agencies.

8. Business Plan priorities were discussed and debated at a meeting of the Rutland Health and Wellbeing Board at their meeting held in October 2015. As stated above, all the issues raised at that meeting have been incorporated into the draft Business Plan attached.

9. The proposed strategic priorities, priority actions and key outcome indicators set out in the new Business Plans were formulated through the annual Development Session of the two Safeguarding Boards held on 25th November 2015.

Proposed Business Plans 2016/17

10. We have adopted a new approach to our business planning this year, moving away from the five strategic priorities that have been in place for the last three year and focusing on areas that we have identified as priorities for development and improvement. At the Development Session, Board members identified areas in which we had reached good levels of performance and agreed that these would not be included in the Business Plan but rather monitored through a core Quality Assurance and Performance Management Framework to ensure performance remained at levels judged to be good or better. By focusing the Business Plan on areas identified for improvement, we also hope better to target work on a reduced

number of priorities in recognition of the need to be SMART at a time of increasing pressures on capacity.

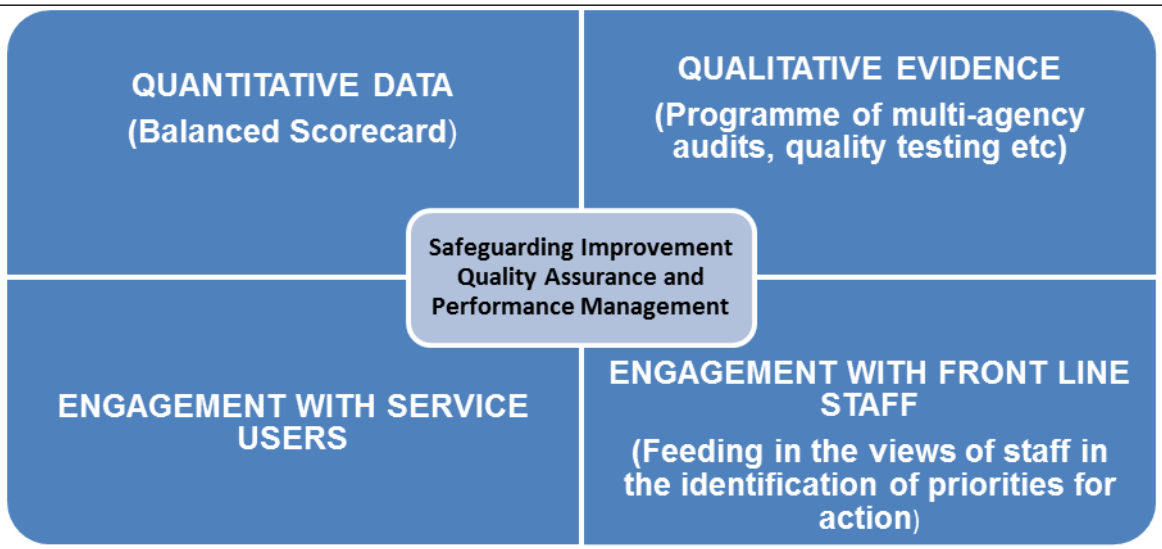
11. The specific priorities that have arisen for the LRLSCB are:
    - Early Help
    - Evidencing the impact of the threshold protocol and outcomes from our Learning and Improvement Framework (including Serious Case Reviews [SCRs] and Domestic Homicide Reviews [DHRs])
    - Signs of Safety
    - CSE
    - Neglect.

12. The priorities that have arisen for the part of the Business Plan shared with the LRSAB are:
    - Domestic Abuse
    - Reducing safeguarding risk arising from mental health issues – including monitoring of the implementation of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and its application to 16-18 year olds
    - PREVENT.

    Consideration is also being given to whether, in light of current international issues, we should include a priority that considers safeguarding risks that may be faced by refugees. It would be helpful for the Health and Wellbeing Board to express a view on this area of consideration.

13. Against each of these priorities the Boards are in the process of identifying key outcomes for improvement and the actions that will need to be taken over the next year to achieve these improved outcomes. These are set out in the draft Business Plans that are attached as Appendices 1 and 2 to this report.

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



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

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

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

16. The views of a range of forums are being sought on the Business Plans. This includes the Cabinets, Children and Adults Scrutiny Committees and the Health and Well-Being Boards in both local authority areas.

Officer to Contact

Paul Burnett, Independent Chair, Leicestershire and Rutland LSCB/SAB
Telephone: 0116 305 6306
Email: paul.burnett@leics.gov.uk

Relevant Impact Assessments

Equality and Human Rights Implications

17. Safeguarding vulnerable children, young people and vulnerable adults concerns

individuals who are likely to be disadvantaged in a number of ways. The Annual Report sets out how the LSCB/SAB seeks to ensure that a fair, effective and equitable service is discharged by the partnership. Likewise the Annual Report and Business Plan 2014/15 extracts set out how the partnership will seek to engage with all parts of the community in the coming year.

Partnership Working and associated issues

18. Safeguarding is dependent on the effective work of the partnership as set out in the Children Act 2004.

Financial implications:

20. The LRSLCB and LRSAB have a budget to which constituent agencies contribute. Agency contributions for 2016/17 are agreed at the same level as last year and the Business Plan will be delivered within these resources. Rutland County Council contributes £52, 250 to the costs of the LRLSCB (of a total budget of £335,525). In addition it contributes £8,240 to the costs of the Leicestershire and Rutland Safeguarding Adults Board (LRSAB) (of a total budget of £102,610).

Recommendations:

1. The Board is asked to consider the Business Plans and to make any comments or proposed additions or amendments to the Plans that will then be considered at the meeting of the Board due to be held on 29th January 2016.
2. The Board is also asked to consider and identify any implications that these business plans may have for the health and well-being strategy and supporting action plans

Consultation

3. All members of the Boards and their Executive have had opportunities to contribute to and comment on the Business Plans. In addition, discussions have been held with service users in both local authority areas to enable them to contribute their views about safeguarding in Leicestershire and Rutland.

Conclusions

4. The Board should note and comment on the attached Business Plans for 2016/17.

Comments from the board:

Strategic Lead:	Paul Burnett, Independent Chair of the LRLSCB and LRSAB

Risk assessment:

Time	**L**/M/H	Progress on all elements of Board Business Plans is carefully monitored by relevant sub-groups, the LRLSCB/SAB Executive and by the Boards themselves on a quarterly basis. This includes not only checking that actions are completed to timescale but also that impact is secured through the quality assurance and performance management framework operated by the Boards.

Viability	**L**/M/H	As set out above, in engaging in the formulation of these Plans partner agencies have committed capacity both financial and human to the delivery of actions and will provide assurance of this commitment when the Plans are signed off in April.
Finance	**L**/M/H	The LRSLCB and LRSAB have a budget to which constituent agencies contribute. Agency contributions for 2016/17 are agreed at the same level as last year and the Business Plan will be delivered within these resources. Rutland County Council contributes £52, 250 to the costs of the LRLSCB (of a total budget of £335,525). In addition it contributes £8,240 to the costs of the Leicestershire and Rutland Safeguarding Adults Board (LRSAB) (of a total budget of £102,610).
Profile	L/M/H	The LRLSCB is a statutory body established under the Children Act 2005 and working within the frameworks laid out in Working Together 2015. The LRLSCB is subject to a review by Ofsted and its performance is critical to the reputation of both county councils and their partners. Safeguarding performance has a major impact on organisational reputation. Serious Case Reviews and Domestic Homicide Reviews in particular can have significant impact on reputation and public confidence both in relation to individual organisations and the partnership of agencies as a whole.
Equality & Diversity	L/M/H	No formal equalities impact assessment is carried out on the LRLSCB and LRSAB Business Plans. However, performance data collected by the Board does include reference to gender, race/ethnicity, disability and other protected characteristics to ensure that the profile of safeguarding data is tested and any related issues identified and acted upon.

Timeline:

Task	Target Date	Responsibility
Comment on the proposed Business Plans prior to their approval by the LRLSCB. Determine whether the LRLSCB Business Plan and joint Business Plan with the LRSAB should inform/impact on the Health and Well-Being Strategy and action plans	March 2016	Board members to comment and Independent Chair to revise proposed Business Plan to reflect comments.
Receive and comment on progress when reported by the Independent Chair. Consider any action required of the Health and Well-Being	October 2016 and January 2017	All Board members to comment and consider any relevant actions to be taken.

Board in response to any performance issues.		
Receive and comment on the Annual Report of performance that will be drafted in July 2017 and presented to the Health and Well-Being Board in the autumn of 2017	October 2017	All Board members to comment and consider any relevant actions to be taken.

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LRLSCB

1st DRAFT

BUSINESS PLAN 2016/17

Notes: Please read!

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

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

3 It is a first draft and therefore not complete.

4 It will require significant input from subgroups.

The consultation plan for the business plan will include:

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

LSCB Priority 1 Owner – TBC

Secure robust and effective arrangements to tackle Child Sexual Exploitation, Missing and Trafficking

PRIORITY	What are we going to do?	How are we going to do it?	Who is responsible?	When is it going to be done by?	Impact / what difference has it made?	Progress made
To broaden awareness raising activity in relation to CSE, trafficking and missing whilst targeting identified underrepresented groups	Implement the CSE, Trafficking and Missing Sub Group communications strategy Revise, update and deliver the training strategy	Develop a programme of communication activity and training initiatives appropriate and relevant to a wide range of individuals and groups	CSE, Trafficking and Missing Sub Group CSE Communications Coordination Group Training Sub Group CSE Coordinator SEG	September 2016	Improved levels of awareness Increased referrals from a wider range of agencies Increased levels of participation in training Increased reporting of concerns by underrepresented groups Improved public trust and confidence	
To reduce the number and frequency of missing episodes for children deemed to be at highest risk of harm	Partners meet their statutory duties in relation to children returning from missing episodes including where CSE is a potential or	Develop and implement a specialist response to those children at the highest risk Ensure learning from	CSE Sub Group SEG	December 2016	Improve the response to children and young people by understanding causes of missing episodes Reduce the number of	

	known risk factor	return interviews is collated and acted upon			repeat missing episodes Reduce impact of risky behaviours associated with missing episodes such as CSE, criminality and substance misuse	
To seek assurance that the implementation of the Strategic partnership Development Fund (SPDF) CSE programme leads to enhanced safeguarding outcomes for children	Implement the 13 projects linked to the programme arising from the SPDF Ensure linkage between implementation of the SPDF programme and the LSCB CSE, Trafficking and Missing Strategy	Identify audit opportunities to test improved safeguarding outcomes Monitor and review progress of programme implementation	CSE, Trafficking and Missing Sub Group CSE Executive Group SPDF Programme Board SEG	September 2016	Improved professional and public confidence.	
To provide effective support and recovery services for victims of CSE and their families that meet the spectrum of their needs	Post abuse services are sufficient and effective	Review current commissioning arrangements to determine whether they are well planned, informed and effective Assess and evaluate the sufficiency of current services to offer specialist interventions specifically post	CSE Executive Group	December 2016	Local services match local need	

		abuse Ensure the needs of children and young people are represented in the Health and Well-Being Strategy use support				
LSCB Priority 2 Owner – TBC **To maximise the impact of learning from SCRs and other reviews**						
PRIORITY	**What are we going to do?**	**How are we going to do it?**	**Who is responsible?**	**When is it going to be done by?**	**Impact / what difference has it made?**	**Progress made**
To ensure that recommendations from SCR and other reviews locally and nationally are disseminated, acted upon and positively impact on the quality of safeguarding services and their outcomes for children, young people and families. These would include	Identify the key learning and action points arising from local and national SCRs Disseminate relevant recommendations and learning points to those that need to implement and secure improvement. Ensure that appropriate workforce	Agree plan of action for improvement. Devise and implement communications and engagement activity to secure staff awareness. Trigger appropriate workforce development activity.	SCR Subgroup Communications and Engagement Subgroup Training and Development Subgroup	April/May 2016 June 2016 July 2016		

issues identified from both National and Local SCR's: • Young people 'Suicide and Self Harm • Bruising to non – mobile babies • Effective Information Sharing • Case Supervision • Vulnerable Looked after children • Transient families • Domestic Abuse in families with children	development takes place to ensure staff can implement required change. Agree a quality assurance and performance management framework to test impact on service quality and outcomes for children, young people and families.	Audit to test outcomes following implementation of recommendations. Hold Review learning events.	Safeguarding Effectiveness Group	Spring 2017		

LSCB Priority 3 Owner - TBC

To champion and support the extension of Signs of Safety (SoS) across the Partnership and secure assurance of the effectiveness of multi-agency processes/working and evidence of positive impact for service users.

PRIORITY	What are we going to do?	How are we going to do it?	Who is responsible?	When is it going to be done by?	Impact / what difference has it made?	Progress made

Through Signs of Safety to secure improvement in multi-agency practice across the child's journey through early help, child protection and care to attain improved outcomes for the children and families supported	Quantify the means by which SoS can support improved safeguarding practice in areas previously identified as requiring improvement. Formulate a multi-agency programme of action to embed SoS across the partnership in both Leicestershire and Rutland possibly through a Multi-Agency Task and Finish Group Monitor and evaluate the impact of the Innovation Programme in Leicestershire and enable learning to be disseminated in support of the roll out of SoS in Rutland. Quality assure and performance manage SoS in both authorities to test the impact on key areas of targeted improvement	Undertake a deliberative enquiry session at Board to confirm key practice improvement priorities and multi-agency framework for collective delivery of SoS. Agree strategy and action plan for implementation of multi-agency delivery of SoS. Ensure the delivery and evaluation of a workforce development programme to support effective implementation and improvement thought SoS. Design and agree quality assurance and performance management framework to test	Board Development and Procedures Subgroup/Multi-agency Task and Finish Group Training and Development Group Safeguarding and Effectiveness Group	April 2016 July 2016 September 2016 – March 2017 July 2016		

		impact.				
LSCB Priority 4 – Owner: TBC **Be assured that thresholds for services are understood across the partnership and applied consistently.**						
Be assured that multi agency understanding of LA thresholds (Leicestershire and Rutland) is robust and that implementation is consistent across all agencies. These would include the following issues: • LCC – Early Help occasionally not escalating cases soon enough • LCC – Child Protection Conference repeats. • LCC – CSE. Higher level of consciousness required across service including First Response Children's Duty.	Test multi-agency understanding and application of safeguarding thresholds (Leicestershire and Rutland) through the four quadrant QAPM framework.	Audit referrals to First Response in Leicestershire and Childrens Duty and assessment Team in Rutland	Safeguarding Effectiveness Group	March 2017		

• Rutland – Joint working in respect of S. 47 • LCC/Rutland – Shared language and decision making regarding the use of 'No Further Action' to referrals						
LSCB Priority 5 – Owner:TBC **Be assured that Early Help Service are effectively coordinated across the LSCB partnership and secure outcomes that reduce pressure on child protection and care services**						
Be assured that Early Help services are coordinated effectively across the LSCB partnership in Leicestershire and Rutland to maximise impact on service quality and outcomes for children and families.	Review the map of service provision across early help in both local authorities and ensure there is coherence and co-ordination of provision. Test the impact of early help in terms of safeguarding service quality and outcomes for children and families through an agreed multi-agency QAPM framework . Identify any areas for improvement and secure assurance these are acted on.	Regular partnership reporting to the Executive on multi-agency performance in early help. Regular analysis of QAPM outcomes.	Safeguarding Effectiveness Group	March 2017		

LSCB Priority 6 – LLR lead is Rama Ramakrishnan (NSPCC)

To be assured that the LLR Neglect strategy increases understanding, identification, risk assessment and management of Neglect and reduces prevalence in Leicestershire & Rutland

(Identifying neglect earlier within families, supporting parents to enable change through partnership working, in order to reduce the impact of neglect on the emotional and physical wellbeing of children).

PRIORITY	What are we going to do ?	How are we going to do it?	Who is responsible ?	When is it going to be done by?	Impact / what difference will it make?	Progress made
Be assured that the LLR Neglect Strategy is effective in safeguarding children in Leics & Rutland	Develop and publish Neglect Strategy	Consultation with LLR Neglect Reference group members and national resources	LLR Neglect Reference Group Chair Rama Ramakrishnan (NSPCC)	March 2017	Create a standard to identify, risk assess and manage Child Neglect	Current draft completed 10/12/15
Seek assurance that the LLR Neglect Toolkit is effective in safeguarding children in Leics & Rutland	Development and Launch Neglect Toolkit	LLR-wide Frontline Practitioner Survey to gather evidence on existing ways in which neglect is identified, risk assessed and managed.	LLR Neglect Reference Group, Task & Finish Group Chair Julie Quincy (CCG Hosted Safeguarding Team)	Toolkit launch (early 2016)	Improved and consistent identifcation, risk asessment and management of Child Neglect across LLR partnership	

					agencies	
Seek assurance that LLR neglect procedures are effectively safeguarding children in Leics & Rutland	Procedures – promote LLR Practice Guidance to ensure buy-in of frontline practitioners Review and update LLR procedures	Promote LLR Practice Guidance Promote local dispute resolution process to consider neglect cases where appropriate protection is not achieved	LLR Neglect Reference Group Chair Rama Ramakrishnan (NSPCC)	March 2017		

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LSCB AND SAB

Joint section

1st DRAFT

BUSINESS PLAN 2016/17

Notes: Please read!

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

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

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

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

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

The consultation plan for the business plan will include:

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

Joint Priority 1 Owner – to be confirmed Domestic Abuse – To be assured that Domestic Abuse services incorporate effective safeguarding arrangements and that pathways to services are robust.						
PRIORITY	**What are we going to do?**	**How are we going to do it?**	**Who is responsible?**	**When is it going to be done by?**	**Impact / what difference have we made?**	**Progress made**
A) To scrutinise the new Domestic Abuse Pathway for services for victims (including children, young people and adults) is fit for purpose and embedded across the partnership. B) Ensure that there are effective information sharing arrangements in place to support the effective delivery of the pathway for services	Scrutinise and challenge the new pathway, agree a quality assurance and performance management framework with the Domestic Violence Strategy Group (DVSG) and, through regular reporting from DVSG, track and monitor its implementation.	Receive assurance that the work is completed and the pathway is effective; to be reported to the Executive Group every quarter Establish data set for performance report	Chair of DVSG via David Sandall?	March 2017		
C)To be assured that the Domestic Abuse Pathway incorporates services for	To ensure the DVSG delivers a robust pathway for perpetrators and test the impact of these	Receive assurance that the work is completed and the pathway is effective; to be	Chair of DVSG via David Sandall?	March 2017		

perpetrators and develop robust interventions as appropriate.	arrangements.	reported to the Executive Group every quarter Establish data set for performance report				

Joint Priority 2 - Owner: to be decided **To be assured that Mental Health Services incorporate robust arrangements to reduce safeguarding risk to children and adults in particular areas e.g. Suicide, Self-Harm, Emotional Wellbeing, Adolescent Mental Health, those supported through MCA/DoL's and the Learning Disability Pathway**						
PRIORITY	**What are we going to do?**	**How are we going to do it?**	**Who is responsible?**	**When is it going to be done by?**	**Impact / what difference have we made?**	**Progress made**
A) **Suicide** - Seek assurance from the Suicide Prevention Strategy Group that the strategy is reducing risk.	Review the existing local suicide prevention plan to assess its effectiveness in relation to children, young people and adult safeguarding. Develop an appropriate action plan to address any identified weaknesses,	This column to be determined in collaboration with the Better Care Together Programme Board and LSCB/SAB lead in conjunction with a board officer.	Rachel Garton	March 2017 March 2017		
B) **Self Harm** - Seek assurance that current	Agree with the Better Care Together Programme Board the means of securing	This column to be determined in collaboration with		March 2017		

information and resources available to children, young people and adults on Self Harm is used across the LSCB and SAB partnership	action on key elements of this priority. Understand the current information and resources available to children, young people and adults on Self Harm, including what to do if someone you know is self-harming.	the Better Care Together Programme Board and LSCB/SAB lead in conjunction with a board officer.				
C) **MCA DoLS** – to be assured that there is appropriate understanding and implementation of the requirments of the Mental Capacity Act and Deprivation of Liberty Safeguards across the LSCB and SAB partnerships.	Agree with the Better Care Together Programme Board the means of securing action on key elements of this priority. For the subgroup to ensure that the workforce across both Childrens and Adults services have an appropriate understanding of mental capacity act and deprivation of liberty safeguards	This column to be determined in collaboration with the Better Care Together Programme Board and LSCB/SAB lead in conjunction with a board officer.		March 2017		
D) **Emotional Health and Wellbeing** pathway – to be assured that the pathway is robust	To be assured that the safeguarding elements of the transformation plan for mental health and wellbeing, overseen by the Better Care Together Programme,	This column to be determined in collaboration with the Better Care Together Programme Board		March 2017		

and fit for purpose.	effectively safeguards children, young people and adults (including transitions)	and LSCB/SAB lead in conjunction with a board officer.				
E) **CAMHS** – To be assured that the CAMHS review includes improved safeguarding outcomes.	To seek assurance that the CAMHS review will result in better safeguarding outcomes for children and young people.	This column to be determined in collaboration with the Better Care Together Programme Board and LSCB/SAB lead in conjunction with a board officer.		March 2017		
F) **Learning Disability pathway** – to be assured that the pathway includes safeguarding outcomes.	The LLR Health and Social Care Learning disability pathway planned within the BCT programme is being developed. The Board needs assurance that the safeguarding elements of services and pathway are robust.	This column to be determined in collaboration with the Better Care Together Programme Board and LSCB/SAB lead in conjunction with a board officer.		March 2017		

Joint Priority 3 Owner – TBC To be assured that the Prevent Strategy is effective and robust across Leicestershire and Rutland.						
PRIORITY	**What are we going to do?**	**How are we going to do it?**	**Who is responsible?**	**When is it going to be done by?**	**Impact / what difference have we made?**	**Progress made**
Prevent – Be assured that the prevent strategy is effective across Leicestershire and Rutland.	Clarify and articulate the safeguarding priorities to be incorporated into the PREVENT strategy and action plan. Seek assurance that the Prevent actions agreed by the Boards (shown on the right) are delivered effectively.	The Joint LSCB/SAB receive quarterly reports on Prevent; Bespoke training be offered to members of the LSCB/SAB Board, Executive and Subgroups; That LSCB/SAB members promote WRAP sessions to educational institutions and other identified areas where radicalisation may be identified as a risk		March 2017		

Report No. 25/2016

Report to Rutland Health and Wellbeing Board

Subject:	**Rutland Sexual Health Needs Assessment (Executive Summary) and Strategy**
Meeting Date:	**26th January 2016**
Report Author:	**Vivienne Robbins/Mike Sandys**
Presented by:	**Vivienne Robbins/Mike Sandys**
Paper for:	**Approval**

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

The Rutland sexual health needs assessment (executive summary) triangulates national and local policy with quantitative and qualitative data to provide a comprehensive understanding of the needs, demands and supply of sexual health services across Rutland. The needs assessment produces a number of recommendations for action. The executive summary will form a chapter of the Rutland Joint Strategic Needs Assessment.

The SHNA recommendations have been categorised and translated into a draft Rutland Sexual Health Strategy 2016-19. This will be need further public and stakeholder consultation including submission to Health Overview and Scrutiny committee and Health & Wellbeing Board before approval by Cabinet in early 2016. A detailed action plan will then be developed following results from the consultation and work with officers for wider implementation across Rutland County Council.

N.B. The executive summary is a Rutland specific documents produced from a more detailed Leicestershire and Rutland Sexual Health Needs Assessment. The full SHNA report is nearly 150 pages, hence is available on request.

Financial implications:

The results of the SHNA and draft strategy propose changes to current sexual health prioritises, commissioning intentions and service provision. Specific service implications include;

- Working with local clinical commissioning groups (CCGs) and NHS England commissioners to reduce fragmentation across the system. Developing a bi-annual sexual health commissioners meeting.

- Agree a local tariff arrangement for out of area specialist sexual health services in particular Peterborough services.

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

- Reduction in opportunistic chlamydia screening and conversion into a full

online STI screening service.

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

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

• Increased focus on relationship and sex education across Rutland schools, including utilisation of the Leicestershire and Rutland RSE toolkit.

• Increased access to HIV testing for at risk groups (including men who have sex with men).

Recommendations:

That the board are recommended to;

1. Approve the Rutland SHNA and comment on the proposed recommendations.

2. Support implementation of the recommendations across portfolio areas (in particular CCG support, children's, substance misuse etc.)

3. Review the Rutland Sexual Health Strategy and provide feedback on the current draft.

4. Approve the Sexual Health Needs Assessment and draft strategy for public consultation.

Comments from the board:

Strategic Lead:	Mike Sandys/ Vivienne Robbins

Risk assessment:

Time	M	Sexual Health Strategy due to go to Cabinet for formal sign off in March 2016. A public consultation will therefore need to take place early 2016.
Viability	M	Strategy will be implemented using a programme approach utilising existing task and finish groups. An LLR sexual health commissioners meeting will be established to coordinate commissioning decisions. Key risk will be wider stakeholder engagement in delivery of the strategy.
Finance	M	See financial implications above. Sexual health is a significant proportion of the public health grant, this strategy aims to reduce costs in the specialist service.
Profile	M	Strategy will impact on neighbouring local authorities (for example jointly commissioned specialist service with Leicester City and

		Leicestershire County), clinical commissioning groups and NHS England.
Equality & Diversity	L	A number of at risk groups have been specifically reviewed as part of the SHNA and a key recommendation has been to ensure all sexual health services regularly complete an equality impact assessment. However a full equality impact assessment will be completed as part of the wider strategy consultation process.

Timeline:

Task	Target Date	Responsibility

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Rutland County Council

Rutland Sexual Health Strategy

2016-2019

Introduction

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

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

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

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

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

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

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

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

Current sexual health progress across Rutland

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

Demography of Rutland

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

Groups at high risk of poor sexual health

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

Sexually Transmitted Infections (STIs)

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

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

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

Human Immunodeficiency Virus (HIV)

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

Sexual Reproductive Health

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

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

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

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

Sexual Abuse

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

Engagement

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

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

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

Mike Sandys, Director of Public Health

Read more

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

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

Cross cutting themes

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

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

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

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

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

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

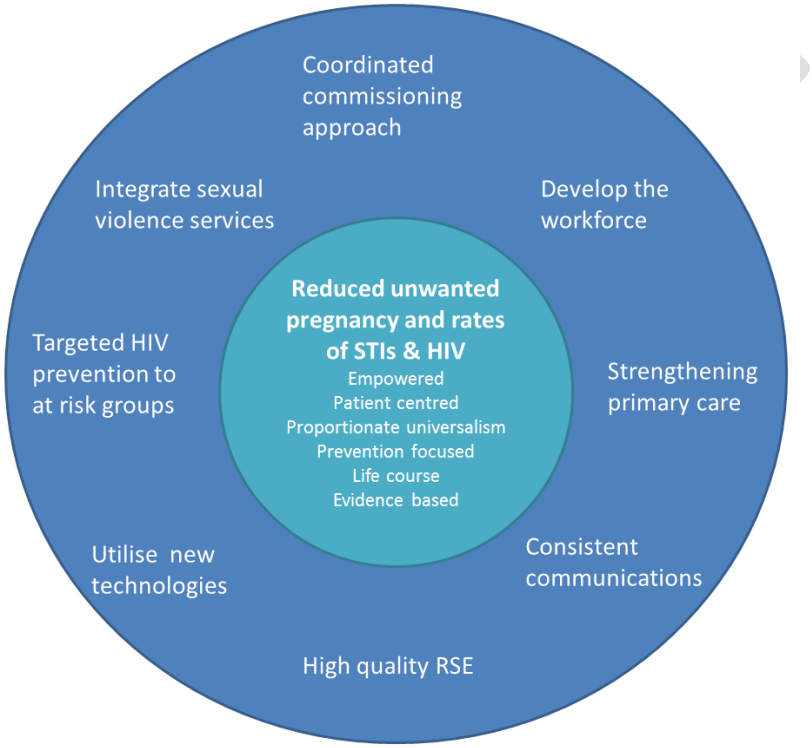
- **Evidence based-** The sexual health needs assessment will be the key resource to ensure services are commissioned to meet the local sexual health needs. All sexual health services must be commissioned using the latest national evidence and standards including National Institute for Health and Care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

Our strategic approach

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

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

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



1. Coordinated approach to sexual health commissioning and partnership work

Where are we now?

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

What do we want to achieve?

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

How will we get there?

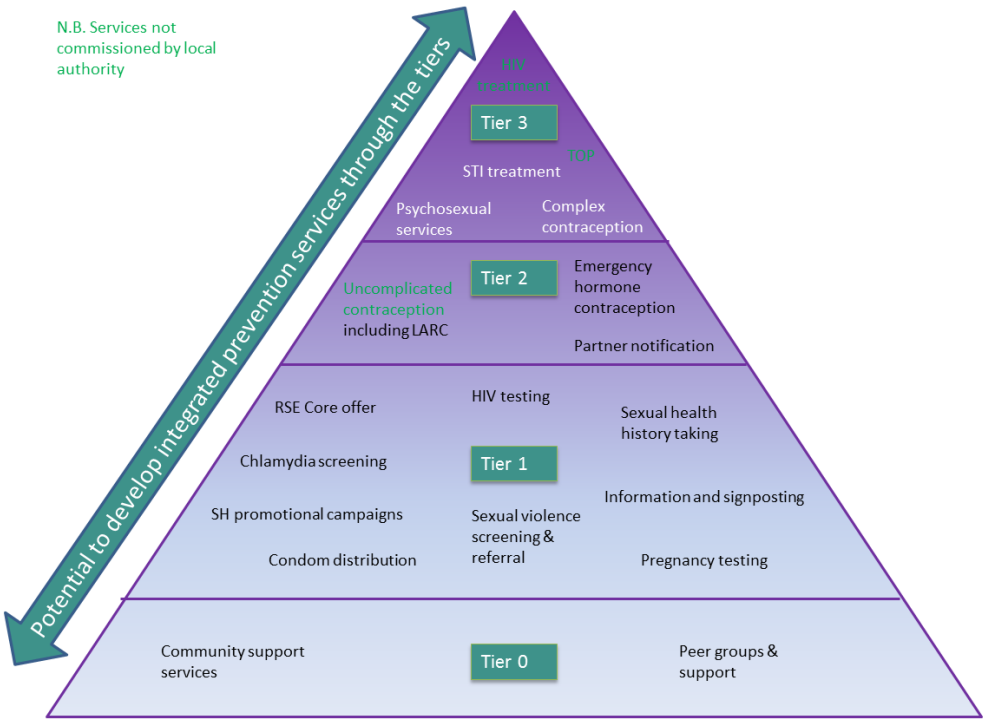
- An agreed, endorsed Rutland strategic approach to commissioning and delivery of sexual health services over the next 3 years. This will be aligned with Leicestershire County and Leicester City.
- Establish a biannual Leicester, Leicestershire and Rutland sexual health commissioners meeting to review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

2. Develop a highly skilled local workforce

Where are we now?

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

Figure 2: Tiers of sexual health workforce training.



What do we want to achieve?

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

How will we get there?

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

3. Strengthen the role of primary care

Where are we now?

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

What do we want to achieve?

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

How will we get there?

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

4. Coordinated, consistent sexual health communications

Where are we now?

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

What do we want to achieve?

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

How will we get there?

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

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

Where are we now?

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

What do we want to achieve?

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

How will we get there?

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

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

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

6. Utilise new technologies to support sexual health delivery

Where are we now?

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

What do we want to achieve?

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

How will we get there?

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

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

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

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

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

Where are we now?

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

What do we want to achieve?

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

How will we get there?

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

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

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

- Regular equality impact assessment for all sexual health services.

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

8. Increase links between sexual violence and sexual health services

Where are we now?

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

What do we want to achieve?

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

How will we get there?

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

Key activities to deliver this approach

To ensure the strategic approach is delivered we will;

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

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

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

How will we know we have made a difference?

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

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[i] WHO. Defining sexual health. Report of a technical consultation on sexual health, 28-31 January 2002. (2002).

[ii] Department of Health. A Framework for Sexual Health Improvement in England. 1–56 (2013).

[iii] Public Health England. Making It Work – A guide to whole system commissioning for sexual health, reproductive health and HIV. (2014).

[iv] Mercer, C. H. et al. Changes in sexual attitudes and lifestyles in Britain through the life course and over time: Findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal). Lancet 382, 1781–1794 (2013)

[v] The Marmot Review. Fair Society, Healthy Lives. (2010).

Leicestershire and Rutland Sexual Health Needs Assessment

Executive Summary for Rutland

October 2015

Rutland County Council

Executive Summary

1. Introduction

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

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

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

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

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

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

2. Methodology

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

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

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

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

3. Demography of Rutland

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

Implications for sexual health services

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

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

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

4. Groups at high risk of poor sexual health

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

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

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

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

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

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

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

Implications for sexual health services

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

5. Sexually Transmitted Infections (STIs)

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

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

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

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

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

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

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

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

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

Chlamydia screening

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

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

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

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

GUM access overall

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

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

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

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

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

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

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

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

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

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

Implications for sexual health

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

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

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

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

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

6. Human Immunodeficiency Virus (HIV)

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

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

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

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

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

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

Implications for sexual health

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

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

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

7. Sexual Reproductive Health

Contraception

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

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

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

Emergency Contraception

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

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

Psychosexual services

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

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

Teenage Pregnancy

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

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

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

Abortion

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

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

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

Implications for sexual health

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

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

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

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

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

8. Sexual Abuse

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

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

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

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

Implications for sexual health services

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

9. Engagement

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

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

Implications for sexual health

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

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

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

10. Conclusion

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

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

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

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

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

11. Recommendations

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

11.1 Sexual Health Commissioners

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

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

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

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

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

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

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

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

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

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

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

11.2 Sexual health services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.3 Training

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

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

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

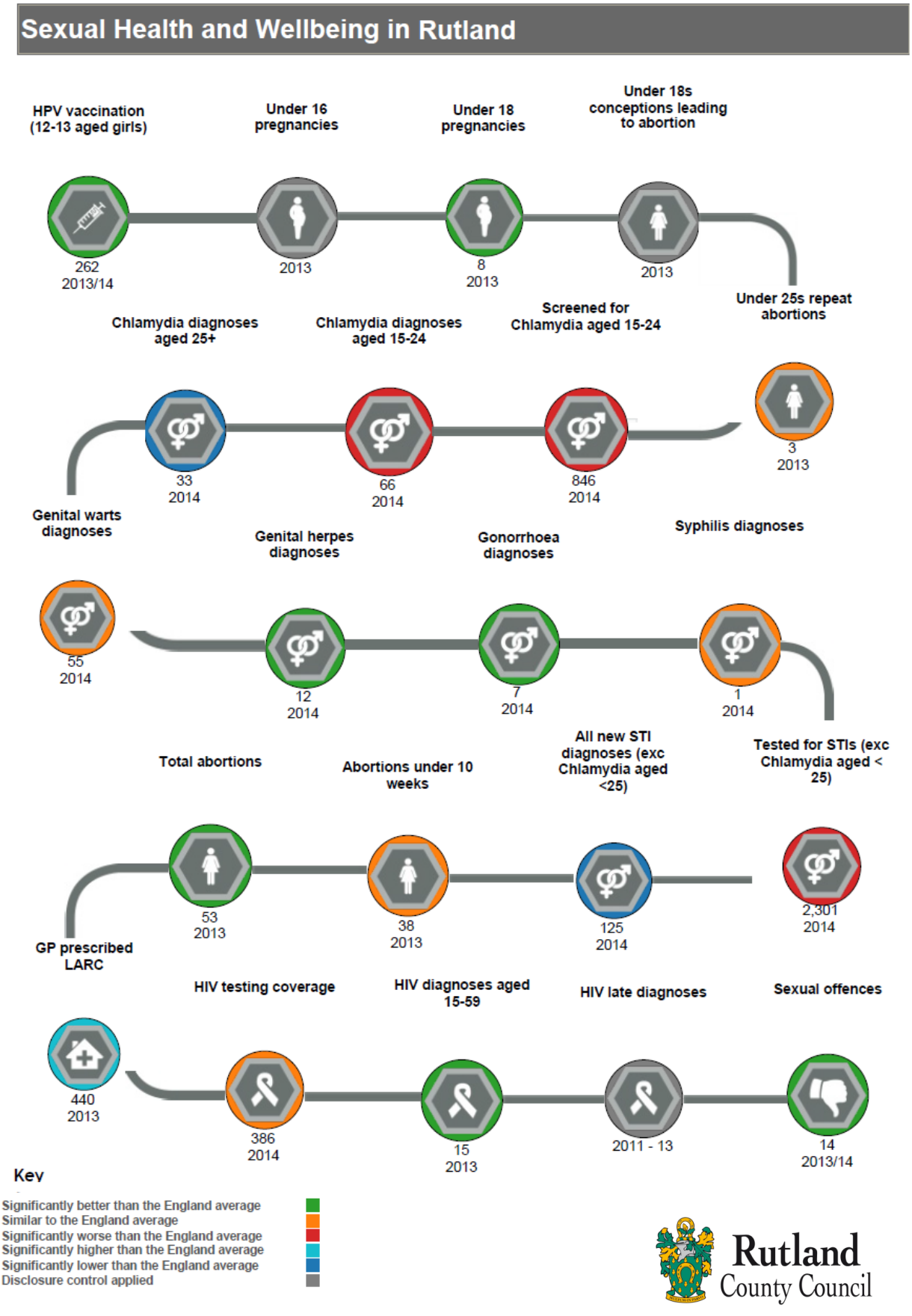
29. **CSE and domestic abuse training should be accessed by key staff from all sexual health providers** to ensure that practitioners can identify and understand local support pathways available.

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

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

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

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



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