Report No. 160/2015

Report to Rutland Health and Wellbeing Board

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

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

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

The Scheme links to the following Strategic Objectives:

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

Progress to date:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Financial implications:

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

Recommendations:

That the board:

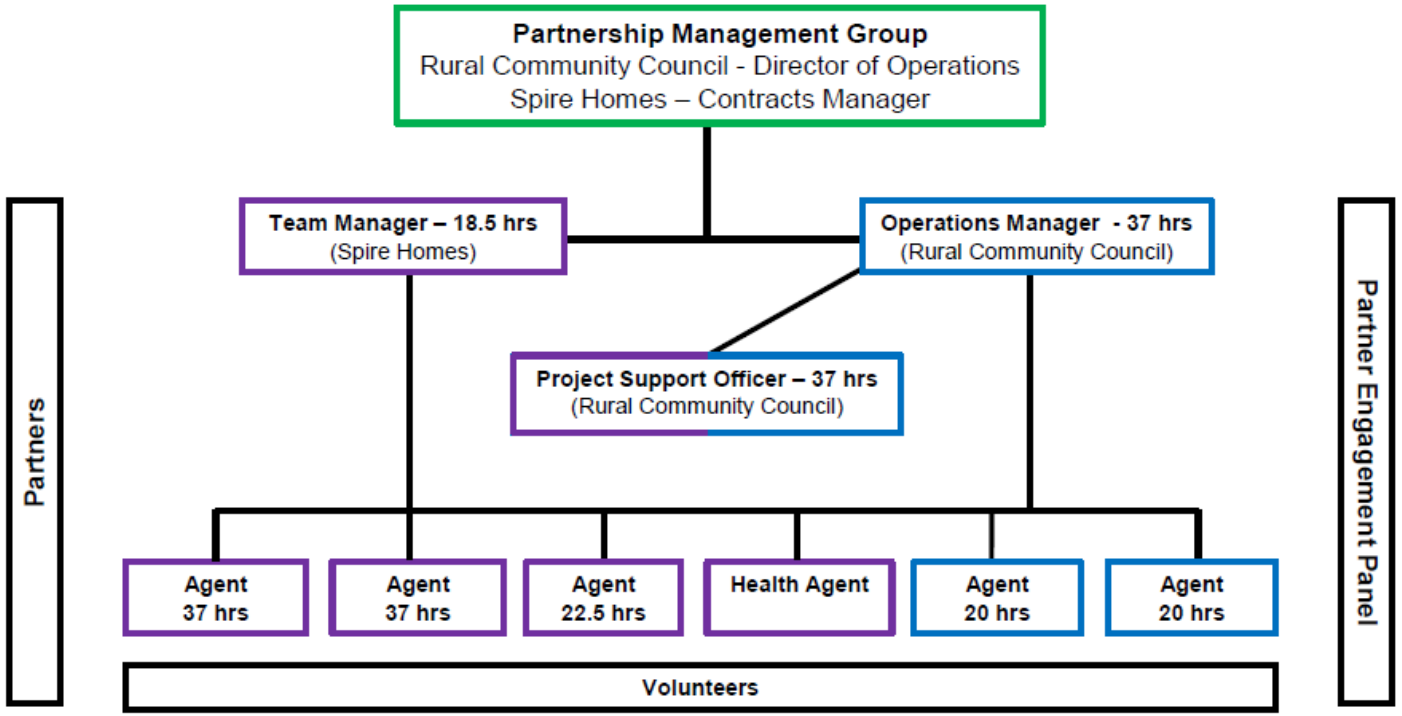
1. Note the contents of the report.
2. Provide any suggestions or comments to support further service development.

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

Appendix A

Rutland Community Agents

Delivery Structure



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

Funded by: Rutland County Council; LOTTERY FUNDED

Delivered by: spire HOMES; RCC

Appendix B

4 Key Communications

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

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

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

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

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

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

Appendix C

Rutland Community Agents
Monthly Service Report
July 2015

1. Service Counts

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

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

2. Incoming Referrals / Contacts

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

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

Breakdown of external agency referrals

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

Breakdown of referrals by wards

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

Note:

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

3. Equal Opportunity Monitoring

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

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

Gender	**No**
Female	13
Male	15

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

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

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

Needs Analysis

Individuals receiving 'One Off' information/advice:

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

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

Individuals receiving Outcomes Star Assessment:

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

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

Description of Support Area

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

Work, volunteering & activities:

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

Lifestyle:

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

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

Managing Money:

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

Progress made against Outcome Star Areas:

(Based on the 15 individuals exiting the service)

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

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

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

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

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

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

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

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

4. Exits (Closed Cases)

Number of exits this month	34

Reason for Move-on / Departure

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

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

5. Outgoing Referrals

Referrals to sub-contracted partners

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

Referrals to outside agencies

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

6. Refusals

No refusals in to service to report for July 2015.

7. Performance against KPI's

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

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

Partner performance

CAB

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

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

Age UK

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

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

The Bridge

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

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

Home Straight

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

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

8. Case Studies

Case study A

Hospital to Home Case Study

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

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

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

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

Summary of Health Link Agent's Intervention:

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

Case study B

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

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

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

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

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

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

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

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

9. Key Activities / Events

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

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

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

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

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

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

10. Engagement with Health & Social Care

Networking & meetings held and/or completed with:

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

11. Staff Training & Development

- BS attended an Autism training course.

12. Changes to Staff Team

No changes to report this month.

13. Significant Incidents (involving emergency services)

None to report for July.

14. Safeguarding Alerts

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

16. Partnership Working & New Partners

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

17. Complaints / Compliments

None to report for July.