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Rutland County Council

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Meeting:	**PEOPLE (ADULTS & HEALTH) SCRUTINY PANEL**
Date and Time:	**Thursday, 1 December 2016 at 7.00 pm**
Venue:	**COUNCIL CHAMBER, CATMOSE, OAKHAM, RUTLAND, LE15 6HP**
Clerk to the Panel:	**Corporate Support 01572 720954** **email: corporatesupport@rutland.gov.uk**

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Helen Briggs
Chief Executive

A G E N D A

APOLOGIES FOR ABSENCE

1) RECORD OF MEETING

To confirm the record of the meeting of the People (Adults & Health) Scrutiny Panel held on Thursday, 22nd September 2016 (previously circulated).

2) 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.

3) 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 217.

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.

4) QUESTIONS WITH NOTICE FROM MEMBERS

To consider any questions with notice from Members received in accordance with the provisions of Procedure Rule No 219 and No 219A.

5) NOTICES OF MOTION FROM MEMBERS

To consider any Notices of Motion from Members submitted in accordance with the provisions of Procedure Rule No 220.

6) CONSIDERATION OF ANY MATTER REFERRED TO THE PANEL FOR A DECISIONS IN RELATION TO CALL IN OF A DECISION

To consider any matter referred to the Panel for a decision in relation to call in of a decision in accordance with Procedure Rule 206.

SCRUTINY

Scrutiny provides the appropriate mechanism and forum for members to ask any questions which relate to this Scrutiny Panel's remit and items on this Agenda.

7) POVERTY IN RUTLAND PROJECT

(Pages 5 - 26)

a) Health Inequalities

To receive a report from Trish Crowson, Senior Public Health Manager

The focus of the report and the following discussion will be on obesity and dental health

b) Access to Services

To receive a report from Sarah Iveson, General Manager, Healthwatch Rutland

The focus of the report and the following discussion will be on access to

primary and secondary heath care

COMMENT
Additional data is attached as requested by the Chair

8) HEALTHWATCH: ANNUAL REPORT

To receive Report No. 216/2016 from Jennifer Fenelon, Chair of Healthwatch Rutland
(Pages 27 - 58)

9) QUARTER 2 PERFORMANCE MANAGEMENT REPORT

To receive Report No. 194/2016 from the Chief Executive
(Report previously circulated under separate cover)

10) QUARTER 2 FINANCE REPORT

To receive Report No. 191/2016 from the Director for Resources
(Report previously circulated under separate cover)

11) PROGRAMME OF MEETINGS AND TOPICS

a) SERVICE USER MEETING

Service User Meeting: Friday, 13th January 2017

b) SCRUTINY PROGRAMME 2016/17 & REVIEW OF FORWARD PLAN

To consider Scrutiny issues to review - 2nd February 2017:

Poverty in Rutland Project

1. Vulnerable People
2. Home Care Service User and Carer Feedback

Copies of the Forward Plan will be available at the meeting.

12) ANY OTHER URGENT BUSINESS

To receive any other items of urgent business which have been previously notified to the person presiding.

13) DATE AND PREVIEW OF NEXT MEETING

Special Joint Scrutiny Panel: Thursday, 19 January 2017 at 7 pm

Proposed Agenda Items:

1. **Budget**

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TO: ELECTED MEMBERS OF THE PEOPLE (ADULTS & HEALTH) SCRUTINY PANEL

Mr G Conde (Chairman)
Mr N Begy
Mr W Cross
Mr A Mann
Mrs L Stephenson
Mr A Walters
Miss R Burkitt
Mr R Gale
Mr C Parsons
Miss G Waller

OTHER MEMBERS FOR INFORMATION

Report No: 207/2016
PUBLIC REPORT

PEOPLE (ADULTS AND HEALTH) SCRUTINY PANEL

1 December 2016

POVERTY IN RUTLAND

Report of the Director for People

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr Richard Clifton (Portfolio Holder for Adult Social Care and Health)	
Contact Officer(s):	Mark Andrews, Deputy Director for People's Services	Tel: 01572 758339 MAndrews@rutland.gov.uk
	Trish Crowson, Senior Public Health Manager	Tel: 01572 758268 Trish.Crowson@leics.gov.uk
	Sarah Iveson, General Manager, Healthwatch Rutland	Tel: 01572 720381 sarah.iveson@healthwatchrutland.co.uk
Ward Councillors	N/A	

DECISION RECOMMENDATIONS
That the Panel: 1. Considers the topics and related issues/questions covered in this report; 2. Identifies any further information or work it may wish to undertake; 3. Authorises the Chair to produce a written report of findings to feed back into the overall project.

1 PURPOSE OF THE REPORT

1.1 The Scrutiny Commission has agreed to undertake a review of Poverty in Rutland. The project objectives are:

- To develop an agreed definition(s) of Poverty in Rutland;

- To develop a Council policy in the form of a White Paper to be approved by Full Council that will outline for Rutland how the Council will act to positively impact on poverty within the County.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 Further to the initial workshop attended by Members on 13 September 2016, a list of areas was highlighted for further investigation by individual Scrutiny Panels. The following areas were identified for the People (Adults and Health) Scrutiny Panel to take forward:

- Health Inequalities
- Access to Services
- Vulnerable Adults

This report provides some information in relation the first two of those areas.

2.2 Scrutiny Commission have agreed the following timetable for this review:

Stage	Panel	Date
All member workshop		13th September 2016
Panel work to develop Green Paper	Adults and Health	1st December 2016 and 2nd February 2017
	Children's	17th November 2016 and 23rd February 2017
	Places	24th November 2016 and 9th February 2017
	Resources	10th November 2016 and 16th February 2017
Green paper to Cabinet	N/R	21st March 2017
Panel work on White Paper	Adults	6th April 2017
	Children's	4th May 2017
	Places	20th April 2017
	Resources	27th April 2017
White Paper to Cabinet	N/R	16th May 2017
White Paper to Council	N/R	June Council

2.3 Further to a meeting with the Chair of the People (Adults and Health) Scrutiny Panel, it was agreed that this Panel would focus on a number of key areas:

- Health Inequalities – focusing specifically on the relationship between of poverty with dental health and obesity, including related health issues such as diabetes
- Access to Services – how poverty in a rural setting affects the ability of people to access services, with a particular focus on health and social care services

2.4 To facilitate a discussion of each area, two short papers have been produced which are included as appendices to this report. The papers are not exhaustive but provide information to facilitate a discussion in each area. To assist the discussion there will be a panel of professional experts supporting the session and each area will be led by a key professional.

2.5 Further to the outcome of this meeting the Chair of the Panel will report back to the working group to consider next steps but this will be confirmed at the meeting.

3 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

3.1 This report gives further information requested by the initial Poverty project workshop.

4 BACKGROUND PAPERS

4.1 There are no additional papers.

5 APPENDICES

5.1 Appendix A – Health Inequalities

5.2 Appendix B – Access to Services

5.3 Appendix C – Additional Data - Citizens Advice and South Lincolnshire Food Bank

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

Appendix A. Health Inequalities

Report to People (Adults and Health) Scrutiny Panel

December 1st 2016

Poverty, inequalities and poor health

The link between poverty and poor health are well accepted. Social inequalities in health arise because of inequalities in the conditions of daily life and poverty is a key aspect of this. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives.

Health in Rutland is better than for most areas of the country and health outcomes are better than average as we have a comparatively affluent population and low levels of poverty compared to other areas. Currently

- 7.1% of children are in low income families in Rutland and this measure has been falling since 2008.[1]
- 7.9% Older people live in poverty in Rutland

However being poor in areas of affluence can provide additional strain. Some families may not be categorised as in poverty based on the national measures but just above the threshold.

Deprivation

Rutland is one of the most affluent counties in England; of 149 Upper Tier Local Authorities in 2010, Rutland ranked 148 (with 1 being the most deprived, and 149 being the least deprived).[2] In Health Profiles released by Public Health England (2013-15), Rutland has ranked first in the 10 best performing local authority districts for levels of deprivation. At a more granular level, there is variation across Rutland in levels of income and overall deprivation. In 2010, when placed in a national context, while there were no wards that ranked in the two most deprived quintiles nationally, two wards were in the middle quintile – Martinsthorpe and Oakham North West. However, in common with many rural areas Rutland has 65% of its areas measured as deprived in terms of access to local services and this will need to be factored in to any service planning. For those on modest incomes a greater proportion of their income will be spent on travel costs. Poor public transport means most families require a car. For poorer families this is a significant cost and impacts on older people no longer able to drive.

Deprivation is measured by the Index of Multiple Deprivation (IMD). *Please see appendix for description of IMD and the seven domains of deprivation that make up IMD.* In many cases pockets of deprivation and need can be hidden even when using IMD. The Index is therefore not a suitable tool for targeting individuals.

There are pockets of deprivation and disadvantage to be found in rural areas in Rutland. Rural deprivation has been described as "a set of economic and social conditions *... which excludes people from the styles of life open to the majority in the countryside* hence rural inequalities often remained hidden because of the way deprivation is measured.

In rural areas individuals may be classed as being deprived with or without a low income. Deprivation, as seen in urban areas, has traditionally been tackled in area-based initiatives, but in rural areas many people who experience deprivation live alongside the affluent, making it harder

[1] Public Health Outcomes Framework (PHOF) 2016

[2] Indices of Deprivation: 2010 by County Council

to target resources. Overall there are significant difficulties in collecting small area data and identifying deprivation in sparsely populated areas.[3]

Many indicators of health are measured at ward level. Almost all Rutland wards are similar to national levels or significantly better. However, contrary to this is Oakham NW where the Standardised Mortality Ratio (SMR)[4] for all causes, circulatory disease and stroke are significantly higher than the national average. There is also often a time lag in data and communities are changing all the time. In the case of Oakham NW there have been a significant number of new housing developments which is changing the overall demographic of the ward, such that it is no longer the most deprived ward in Rutland. *See map 1 in appendices.* However poorer and more deprived families continue to live within this ward.

Care has to be taken with data at a population level in Rutland not least because of small sample numbers meaning that data can vary significantly from year to year. Therefore confidence in the quality of data is affected and note should always be taken of the confidence intervals given for each data field.

Oral health, diet, obesity, diabetes and long term conditions.

To give a focus to poverty and inequalities in health this report focusses on a number of interlinked areas of oral health, obesity and diabetes and to look at data relating to these areas and links with poverty.

Being on a low income impacts on the food choices individuals and families can make and ability to access a healthy diet. At a national level there is clear evidence of the links between:

- deprivation and tooth decay
- higher levels of excess weight for social classes 3, 4 & 5[5]
- higher numbers of fast food outlets in poorer communities[6]

According to oral health surveys for 3 and 5 year olds there are high levels of tooth decay in Rutland. 2012 data for five year olds indicated that 40.3% of children sampled had decayed missing or filled teeth[7]. This dropped to 28.8 in 2015[8] – but is still well above national levels. Additional mapping of 2012 data did not show a clear link between those areas of Rutland identified as more deprived (according to IMD) and high prevalence of tooth decay.

Each year the National Child Measurement Programme measures children in reception class and year 6. From this robust information on the level of healthy weight and excess weight of children is determined. We have looked at this data over several years and compared it with data on tooth decay and families in poverty or claiming out of work benefits. This has shown some correlation between areas of high tooth decay and excess weight in year 6 and children in families in poverty or claiming out of work benefits as shown in the maps in the attached appendix. However, this is just a snap shot for 2015/16 and it should be noted that long term unemployment doesn't show similar correlation. Data indicates that few people appear to become long term unemployed in Rutland.

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[3] www.ruralhealthgoodpractice.org.uk

[4] SMR **Standardized Mortality Ratio** is a **ratio** between the observed number of deaths in an study population and the number of deaths that would be expected, based on the age- and sex-specific rates in a **standard** population and the age and sex distribution of the study population

[5] National Obesity Observatory

[6] Angela Donkin UCL institute of Health Equity 2013

[7] Oral health survey of five-year-old children 2013 PHE

[8] Oral health survey of five-year-old children 2015 PHE

Given the issues outlined above regarding significant difficulties in collecting small area data and identifying deprivation in sparsely populated areas using IMD and small area data we also looked at Mosaic to see if it could shed any further light on family life. A description of Mosaic is contained in the appendix**.** The largest proportion of households (4654) in Rutland are categorised as – 'Country Living' – affluent households. This is followed by 'Rural Reality' - 3,756 households 9,464 people who live in rural communities and generally own their relatively low cost homes. Their moderate incomes come mostly from employment with local firms or from running their own small business – 20% of these earn under £15k per year. Rutland also has 558 'Vintage Value' households (939) people, described as elderly people who mostly live alone, either in social or private housing, often built with the elderly in mind. Levels of independence vary, but with health needs growing and incomes declining, many require an increasing amount of support. A further 329 'Family Basics' households - 851 people are families with children who have limited budgets and can struggle to make ends meet. Their homes are low cost and are often found in areas with fewer employment options. Whilst there are a greater proportion of Rural Reality households in those areas of higher tooth decay and some cross over with children with excess weight, care should be taken with drawing any significant link between the two. *Please see map 6 in appendix.*

Links between poor diet & ill health

Evidence shows that diets high in sugar are a cause of tooth decay and obesity. Last year insight work was undertaken in Rutland to look into the potential causes of high tooth decay in the area. The insight work identified grazing/ snacking throughout the day as a common health behaviour which means that teeth do not effectively get a break from damaging acids which form in the mouth every time a sugary snack is eaten and the acids continue to affect teeth for at least 20 minutes.

Portion size and diets high in calories and limited physical activity are causes of obesity.
Key risk factors for diabetes are being overweight or obese. Evidence shows low-income and poor people more likely to have diabetes, and once they have it much more likely to suffer complications. Diabetes and obesity increases risk of coronary heart disease and stroke and certain cancers.

67.3% of adults in Rutland are estimated to have excess weight (2016) significantly higher than national average (64.8)[9] . 6.75% Rutland population aged 17+ (1,954 people) are diagnosed with Diabetes. This is significantly higher than the England average of 6.4%. It is unclear as to the exact reason for this higher prevalence and it may be as a result of better diagnosis by local GP's.[10] However, there is evidence that the rate of diabetes is set to rise to over 10% in Rutland over the next few years. *See Appendix for chart 1*

Whilst data from the Active People Survey suggest that people in Rutland are more active than the national average encouraging sedentary people to be more active on a daily basis can reduce body weight by about 5% and could reduce risk of getting diabetes by more than 50%. [11]

Smoking, poverty and poor health

[9] Active People Survey 2016 -sample 1372 people
[10] 2014-15 Quality and Outcomes Framework Data
[11] NHS Choices - Reduce your diabetes risk

Smoking shows one of the clearest links between poverty/ low income and poor health and kills 80,000 people in England each year. Workers in manual and routine jobs are twice as likely to smoke as those in managerial and professional roles and unemployed people are twice as likely to smoke as those in employment. On average in Rutland, 14.1% of adults smoke, rising to 29.6% for 'Routine and Manual' workers[12]. *See map 7 in Appendices*

National data indicates that 3 out of 4 families who receive income support spend a seventh of their disposable income on cigarettes. Described another way; when expenditure on tobacco is taken into account, over half a million households, 850k adults and 400k children, are classified as in poverty in the UK compared to the official *Households Below Average Income figures*. Tobacco imposes a real and substantial cost on many low-income households. *This is clearly illustrated for Rutland in the chart 2 of Appendices to this report*.

In 2014/15, smokers in Rutland paid approx. £6.4m in duty on tobacco products. Despite this contribution to the Exchequer, tobacco still costs the local economy in Rutland roughly 1.5 times as much as the duty raised. This results in a shortfall of about £2m each year[13]

Research shows that smoking not only contributes to the social care bill but also has a significant impact on the wellbeing of smokers who need care on average nine years earlier than non-smokers. This is estimated to have cost circa £612k for social care for adults aged 50 plus 2012-13 in Rutland (622 individuals requiring additional social care)[14].

Helping disadvantaged smokers quit and interventions that focus on reducing levels of smoking are the best way to reduce health inequalities.

So what can a local authority achieve by reducing inequalities?

The Marmot Review on Inequalities [15] clearly identified that re-focusing solely on the most disadvantaged will not reduce health inequalities sufficiently and stated:

"To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism."

Marmot identified six policy objectives for action. These were:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention.

At a local level a range of services are provided to all on a universal basis and greater needs identified through universal services for those who need additional support. Examples either currently provided or planned include:

[12] PHOF February 2016

[13] ASH Ready Reckoner Dec 2015 update. Version 5.3 (15 Jul 2016)

[14] PHE – Key data sources for planning effective tobacco control in 2017-18

[15] 'Fair Society Healthy Lives' (Marmot Review) 2010

- 0-19 Healthy Child Programme. 5 universal contacts, targeted additional partnership plus for those with additional needs. Includes oral health as a high impact area.
- National child measurement programme all children and targeted support offered to those identified with excess weight. Activity and food club.
- Supervised tooth brushing in pre-school settings to establish good oral health routines, use of pre-school and school food policies
- Working with employers of Routine & Manual workers to support them to give up smoking.
- Exercise and physical activity programmes with referral for additional needs by primary care staff to FaME falls prevention and GP Exercise on referral programmes.

Local authorities are uniquely placed to tackle health inequalities, as many of the social and economic determinants of health, and the services or activities which can make a difference, fall within their remit and poor health affects the economy and local services. For example: in England, the cost of treating illness and disease arising from health inequalities has been estimated at £5.5 billion per year. In terms of the working-age population, it leads to productivity losses to industry of between £31–33 billion each year. Lost taxes and higher welfare payments resulting from health inequalities cost in the region of £28–32 billion[16]
The rise in the state pension age – to age 66 by 2026 and 68 by 2046 – means many people who are disadvantaged will have to continue working while experiencing ill health or a disability. See figure 1 below. Keeping people well for longer should be a key goal for local authorities and this is recognised in the Rutland draft Joint Health & Wellbeing Strategy.

Figure 1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003

Source: Office for National Statistics[5]

NICE outlines a number of areas where local authorities can achieve significant benefits for local people through their work to tackle poverty and inequalities[17] these include reducing premature deaths, improving the population health and creating happier healthier communities. A range of local authority services can help reduce social inequalities and improve health and wellbeing. These include environmental health, leisure, planning, education and transport. Interventions at

[16] 'Fair Society Healthy Lives' (Marmot Review) 2010
[17] NICE -HEALTH INEQUALITIES AND POPULATION HEALTH -LOCAL GOVERNMENT BRIEFING [LGB4] OCTOBER 2012

different stages of people's lives can make a real and measurable difference. For example, providing support for children and families during the early years of their children's lives can help break the cycle of deprivation and poor health. Local authorities can also encourage and support community-level action that strengthens positive relationships and networks by building trust and reciprocity ('social capital'). This can benefit everyone.
With healthier peoples there is potential to reduce costs to public services in the longer term with fewer people needing health and social care support.

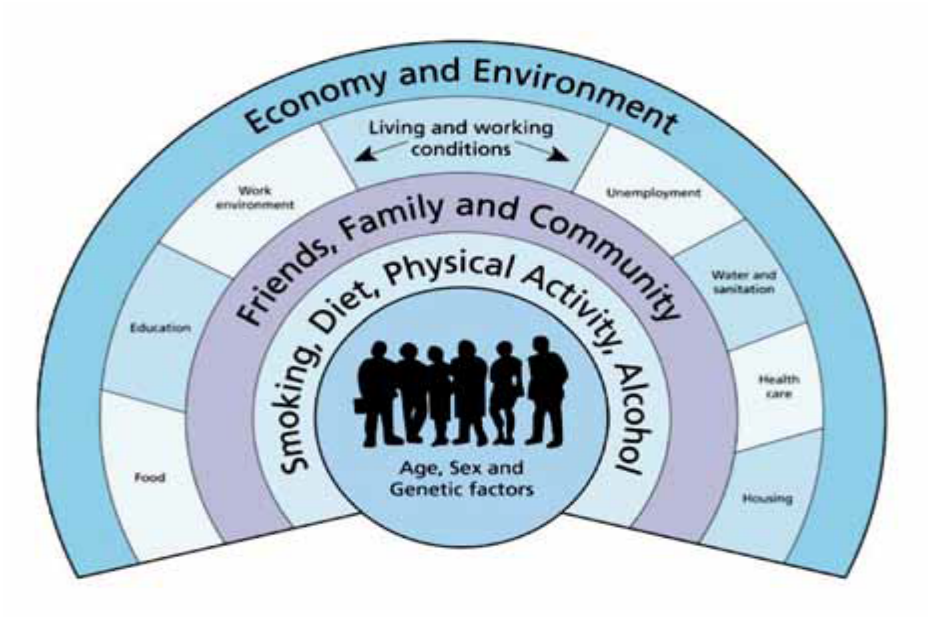
Areas to Consider

Scrutiny panel may wish to consider the following options for action in more detail:

- The balance of universal services versus targeted and 'proportionate universalism'
- Considering the role of the local authority as a leader on tackling health inequality, as an advocate for others to do so and as a partner with other agencies in achieving this. What and how might this happen?
- Ensuring that health is considered in all Rutland Council policies
- Incentives – e.g. free physical activity programmes or paying people to quit smoking
- Further ways the local authority can support communities to help themselves – social capital
- Physical activity as the best medicine – a cure for most ill's. Sedentary lifestyles – how to reach the most inactive and support the poorest to access these.

Appendix A (1) – backing data

The World Health Organisation defines health as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".*



1. **Factors that influence health** *Source: Dahlgren and Whitehead 1992*

Marmot 2010 Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.

2. Health Inequalities and how deprivation is measured

Health inequalities incorporate differences in how 'healthy' people are and not simply how long they live. Inequalities arise due to complex and interrelated factors such as upbringing, education, employment history, income, and lifestyle choices such as smoking. The wider determinants of health are described and measured within the English Indices of Deprivation. These are a group of measures which gauge different aspects of deprivation.
The Index of Multiple Deprivation (IMD) 2015 is the official measure of relative deprivation for small areas (or neighbourhoods) in England.
The IMD ranks every small area in England from 1 (most deprived area) to 32,844 (least deprived area). The small areas used are called Lower-layer Super Output Areas (LSOA). They are designed to be of a similar population size with an average of 1,500 residents each and are a standard way of dividing up the country.

The indices of deprivation use several measures in each of seven domains:
Income deprivation, including Income deprivation affecting children (IDACI) and Income deprivation affecting older people (IDAOPI);
Employment deprivation;
Health deprivation and disability;
Education, skills and deprivation;

Barriers to housing and services;
Crime domain; and
Living environment deprivation domain

The measures are combined into an overall measure of the amount of deprivation in an area called the Index of Multiple Deprivation (IMD). The IMD allows the identification of the most and least deprived areas in England and to compare whether one area is more deprived than another. They are collated by quintile where 1 is most deprived and 5 is least deprived.

Mosaic segmentation

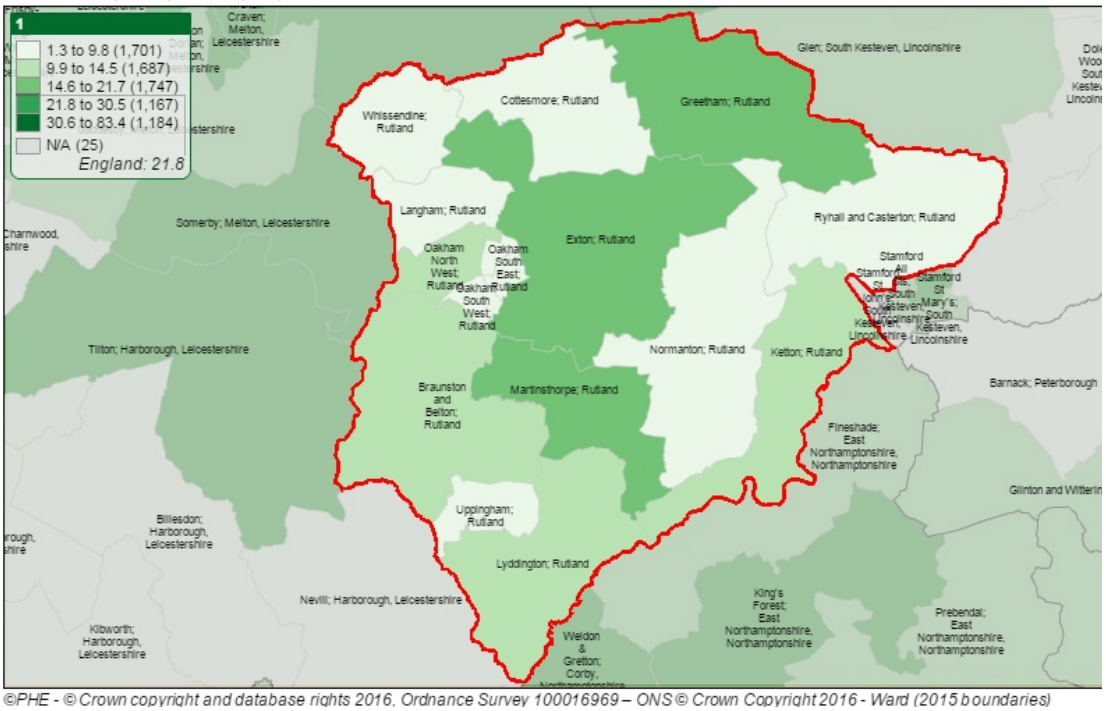
Produced by Experian Mosaic uses data from many sources to group and segment households into 15 groups and 66 types and updates constantly.

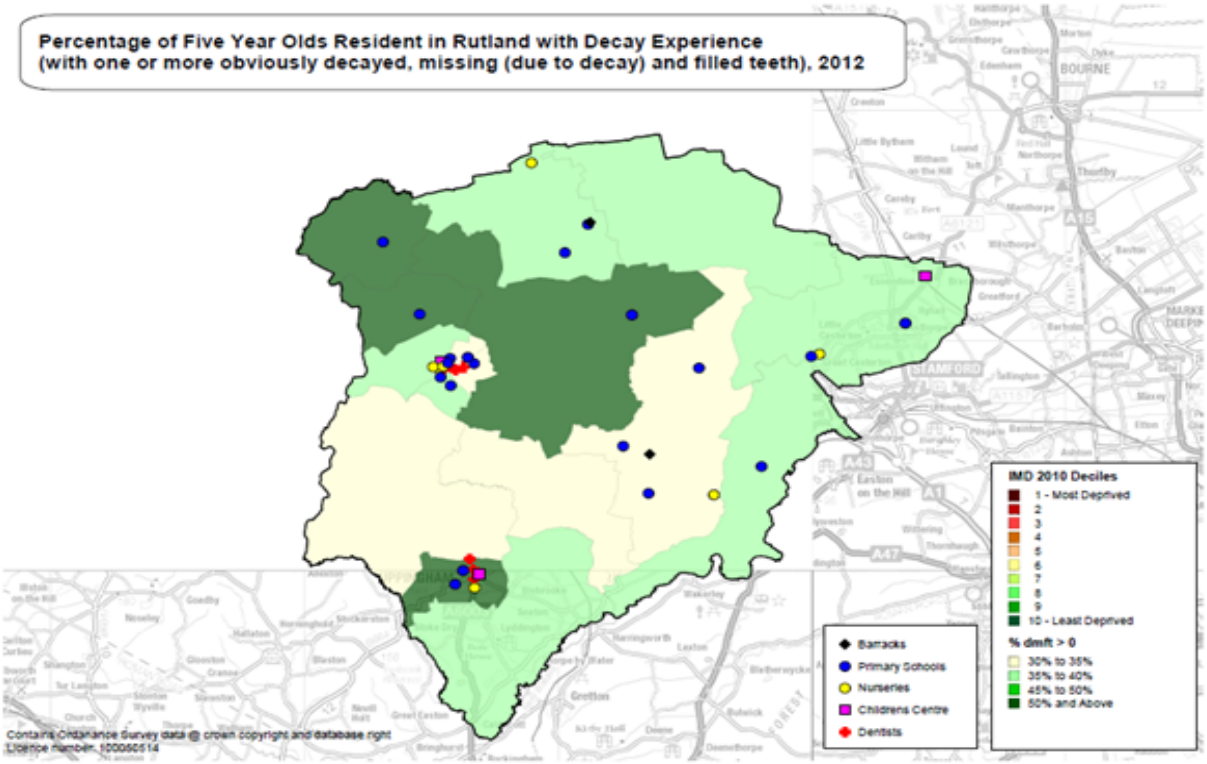
	Households	Population	Postcodes
A - Country Living	4,654	11,001	487
G - Rural Reality	3,756	9,464	256
H - Aspiring Homemakers	1,557	3,951	105
B - Prestige Positions	1,339	3,285	94
D - Domestic Success	1,100	2,757	40
U - Unclassified	0	1,704	74
E - Suburban Stability	456	1,073	18
L - Transient Renters	515	992	28
N - Vintage Value	558	939	31
M - Family Basics	329	851	10
F - Senior Security	399	781	26
J - Rental Hubs	199	316	16
K - Modest Traditions	145	315	9
I - Urban Cohesion	23	39	4
C - City Prosperity	3	8	1
O - Municipal Challenge	0	0	0

For more detail on each of the mosaic categories go to: http://www.experian.co.uk/marketing-services/knowledge/videos/mosaic-videos.html

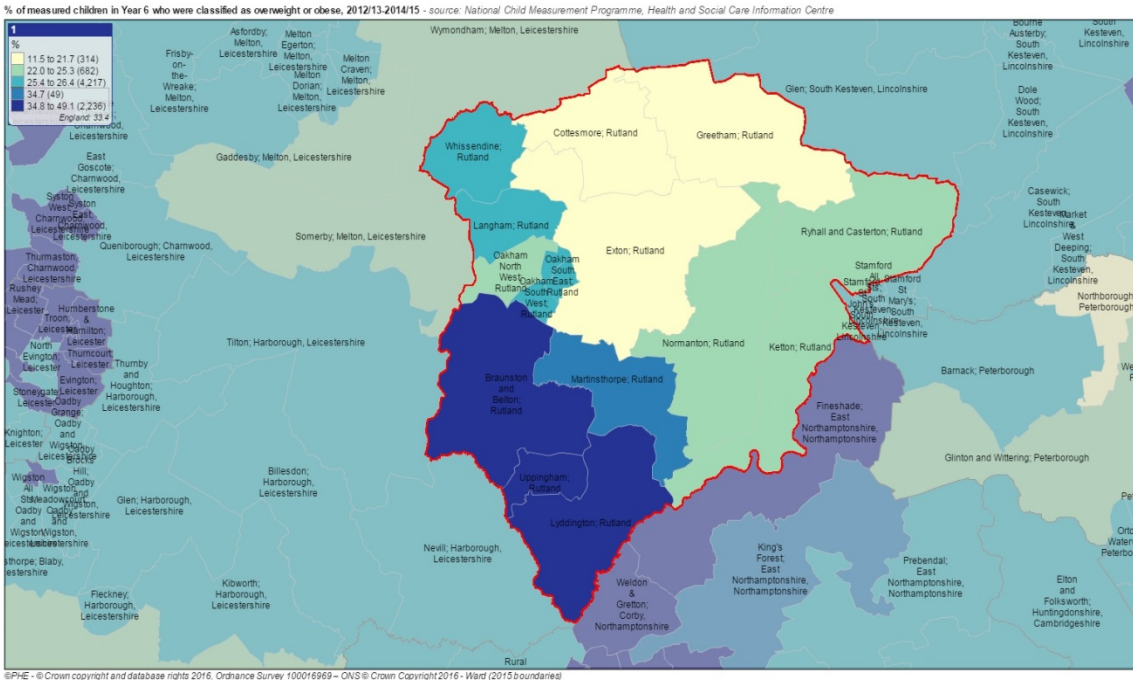
3. Maps

Index of Multiple Deprivation (IMD) Score 2015

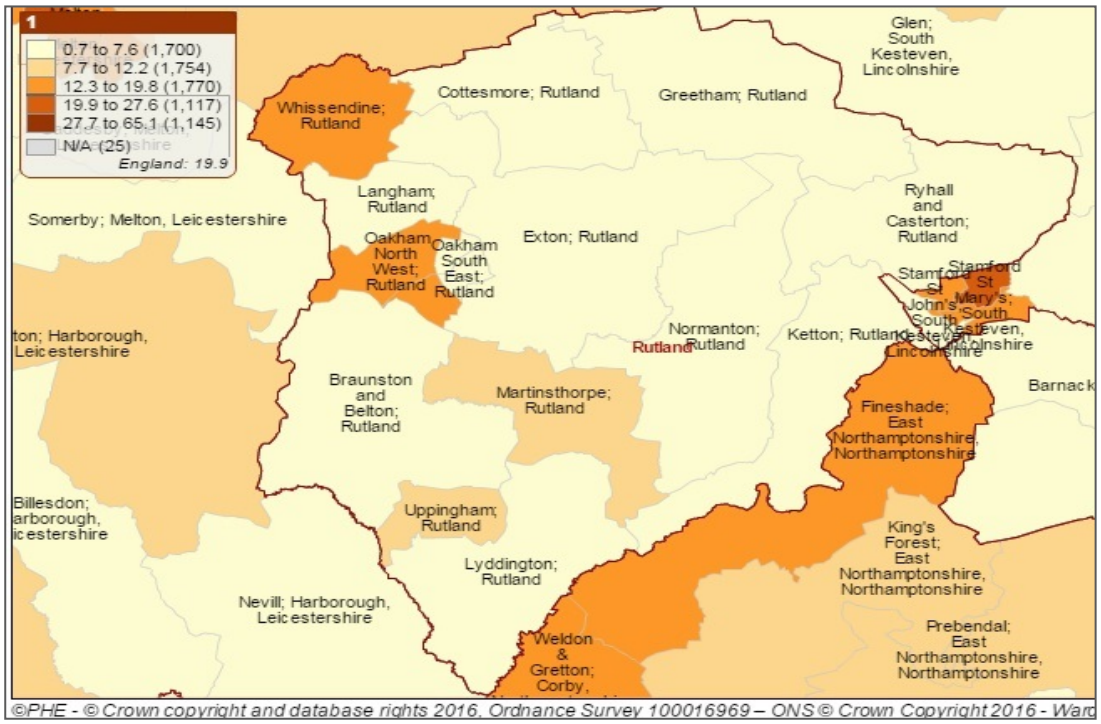




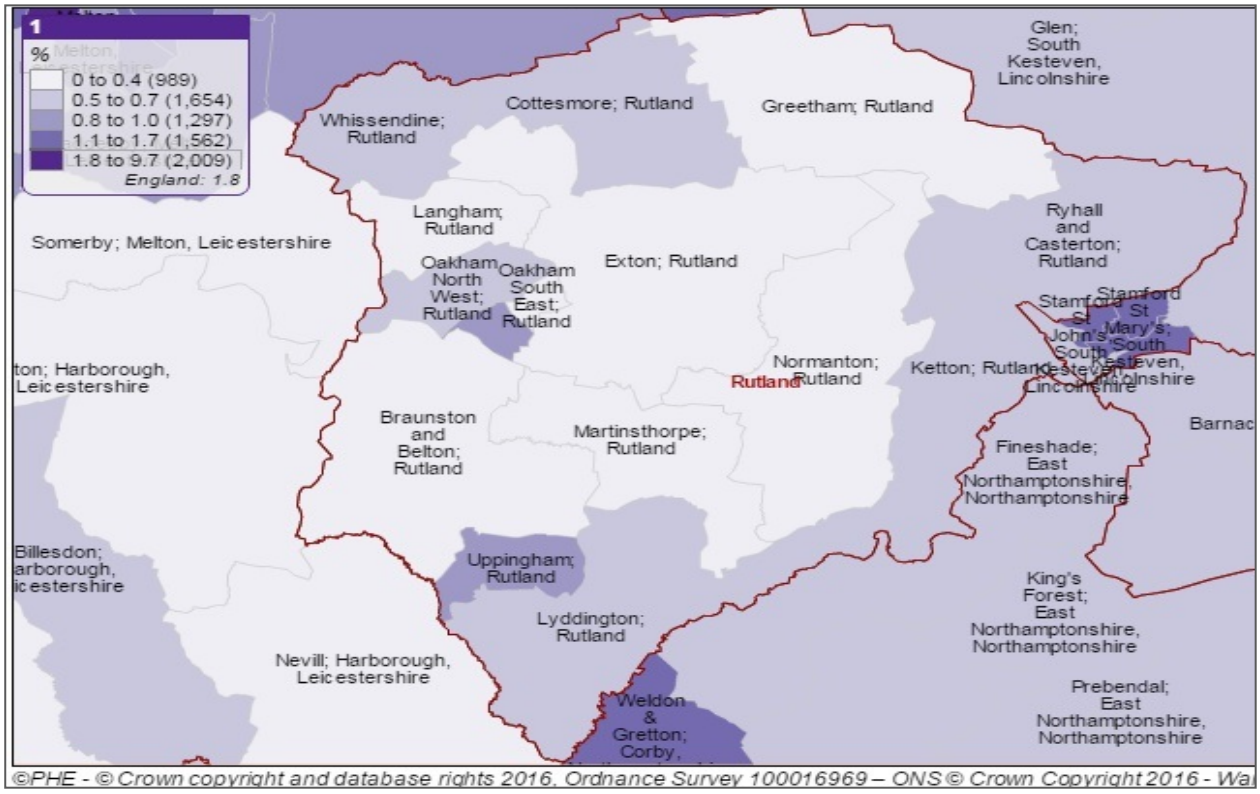
Map 3. % year 6 children with excess weight – 2012-13 – 2014-15



Map 4. Children 0-15 living in income deprived households 2015



Map 5. % of working age population claiming out of work benefit 2015/16



Map 6. Mosaic Map of Rutland Households

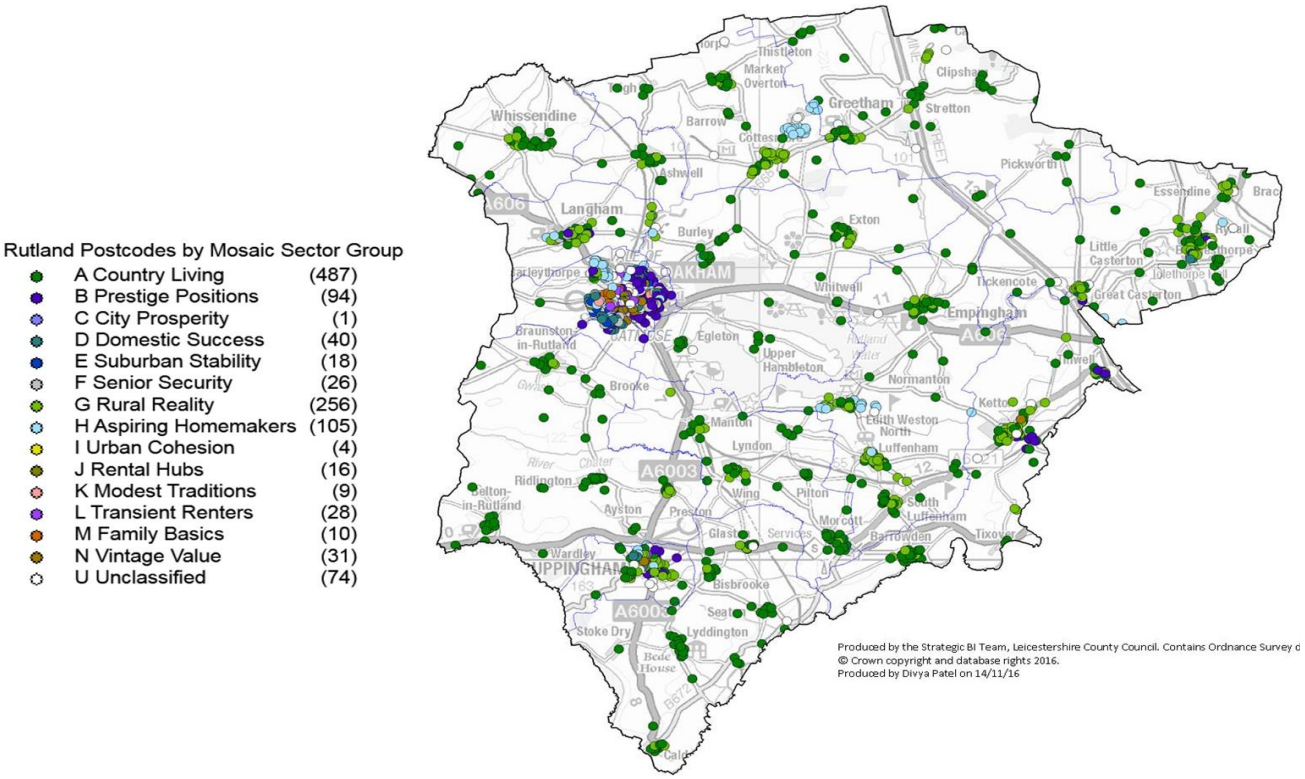
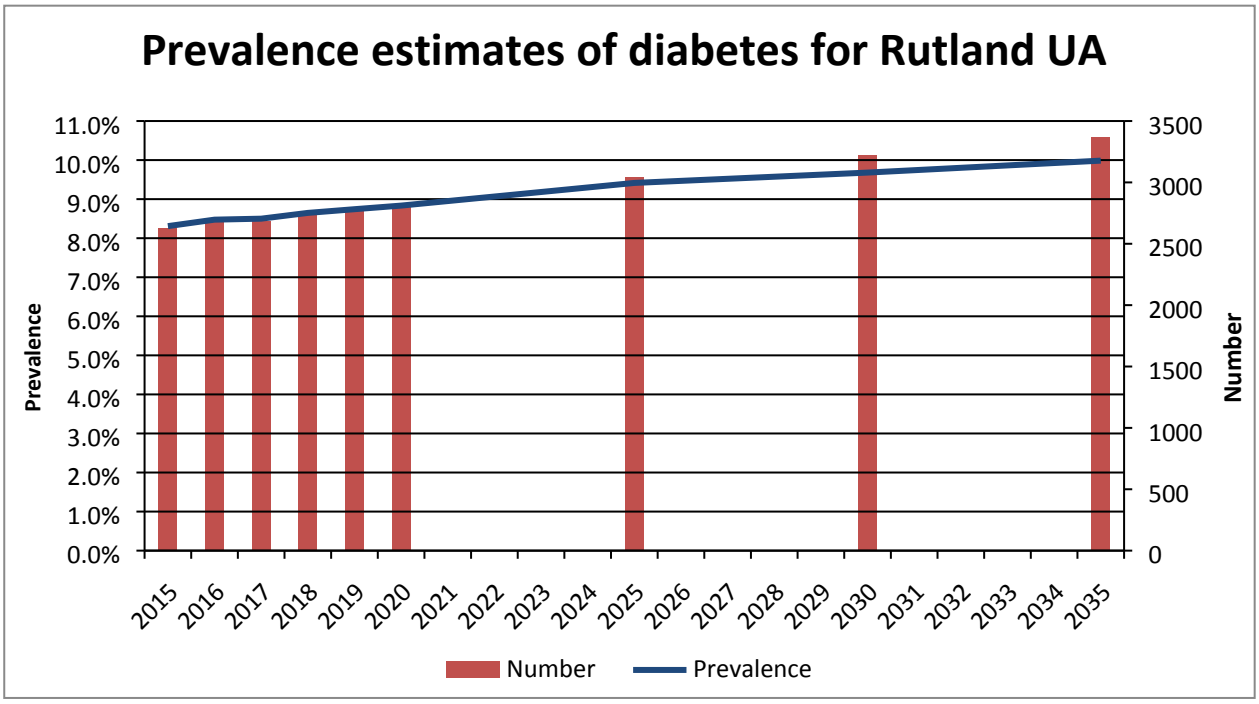


Chart 1. Diabetes is set to rise



Map 7 Smoking Prevalence - Rutland

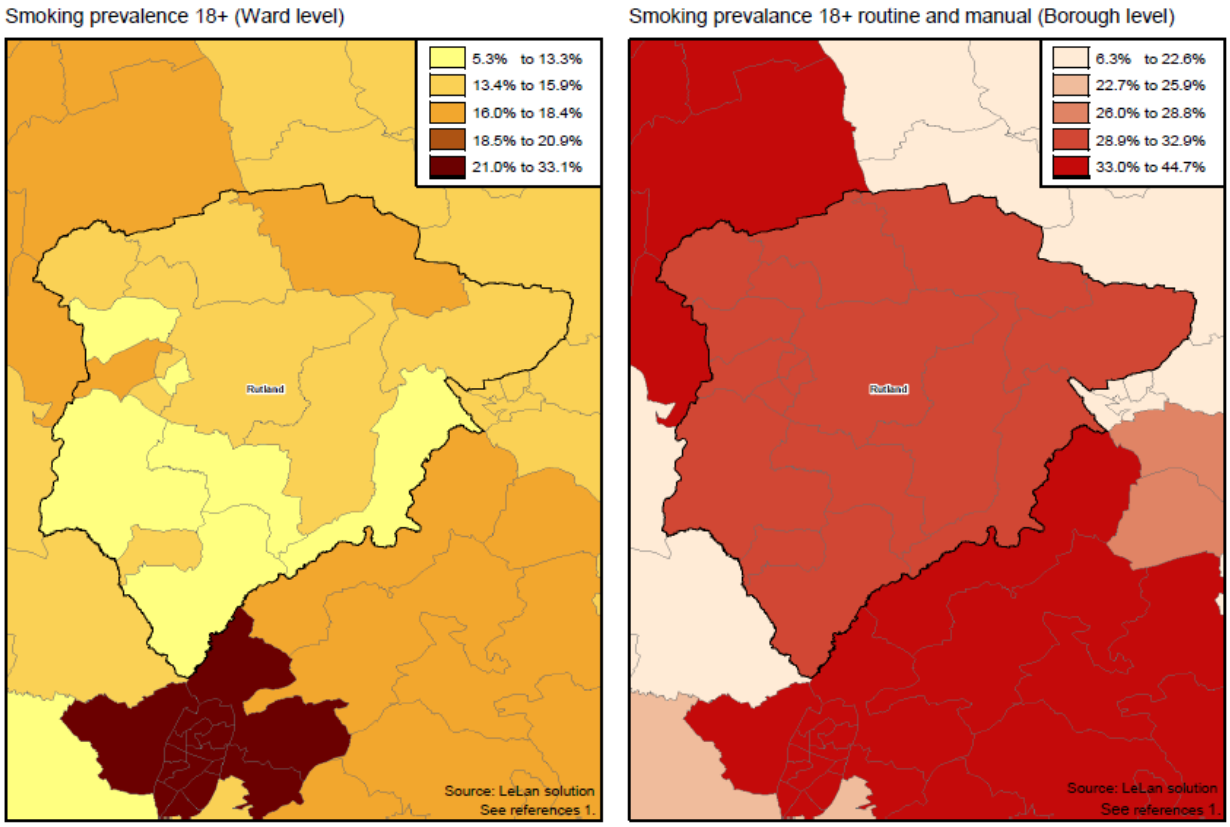
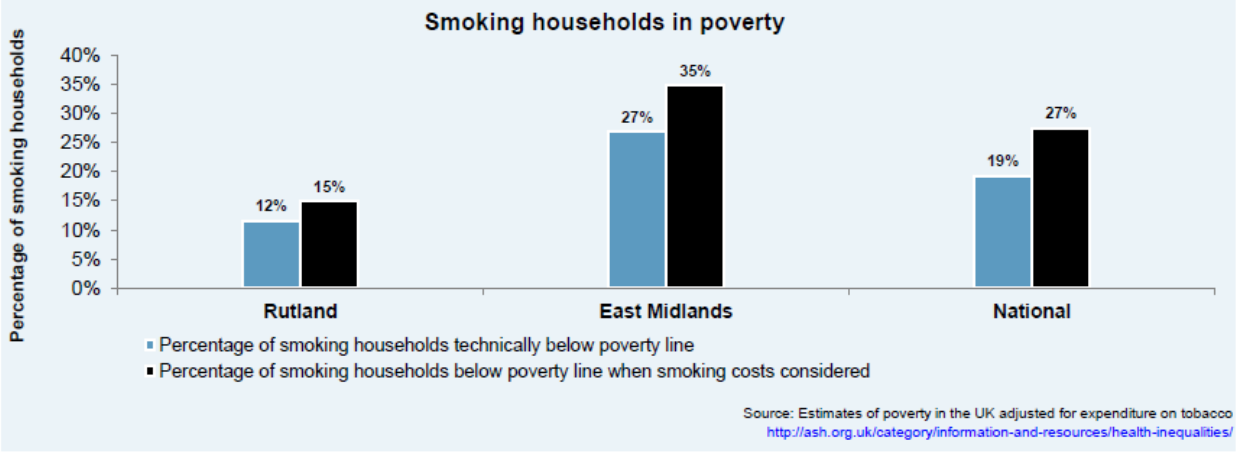


Chart 2



Source: Estimates of poverty in the UK adjusted for expenditure on tobacco
http://ash.org.uk/category/information-and-resources/health-inequalities/

Appendix B. Access to Services

People (Adults & Health) Scrutiny Panel meeting, 1st December 2016

Inequality of Access to Services

Discussion Provided by Healthwatch Rutland

Background

The Council have agreed to undertake a review of poverty in Rutland. Healthwatch Rutland, as the statutory function responsible for acting as an independent health and social care watchdog, has been asked to consider issues of inequality in accessing health and social care services.

According to The King's Fund 2015 report 'Inequalities in Life Expectancy'

"Our health as individuals, and as communities, is influenced by many factors – our family background, our lifestyles, the health and other services we receive and the wider physical, social and economic environment in which we are raised, live and work."

This discussion paper focusses on the health and other services we receive and the difficulties certain groups have in accessing these services in a Rutland context.

Definitions of Poverty – The Rutland Context

The rural nature of Rutland means that even when people live above national levels of poverty, the cost for them of accessing services from a distance can be prohibitive. This is compared to people on lower incomes able to access services in an urban environment more cheaply and easily.

With a demographically older population that than other nearby areas, the issue of older people's deprivation, in terms of accessing services must be considered. Again, this group of people may have incomes that are above national poverty levels, but living in a rural location, or having to travel further for acute hospitals and other services, may mean that accessing transport may be cost prohibitive or physically difficult.

The charity sector in Rutland has identified that being poor in an area such as this, where there is considerable affluence, can be an issue for people accessing services. Feeling disadvantaged can be a disincentive for people accessing services.

Living with disabilities in a rural environment can also add another layer of disadvantage.

Access to Information

Ensuring that information is received and used by hard to reach groups requires investigation into the best way of conveying this information; is it by written material, electronic resources, face to face via appropriate networks or in other ways?

There is often an assumption that everyone has access to internet services to find information on services. This means that anyone unable to access the internet, either

through a lack of equipment or a lack of knowledge, is at a disadvantage in gaining information on what services are available to them and how to access them.

There is also an important question around ensuring that information aimed at those at the lower levels of the economic scale can understand the information that is being shared. Health literacy can be defined as 'the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health.'(WHO, 2015). Research has shown that low levels of health literacy are linked to higher mortality and higher rates of illness. In addition, it has been shown that low health literacy levels are strongly linked to social determinants such as poverty (http://www.healthliteracy.org.uk/). Research published by the British Journal of General Practice in 2015 shows that between 43 percent and 61 percent of English working age adults do not understand health information (Rowlands et al, 2015). Are there sections of the population in Rutland with low health literacy who are not even aware of services that may be available to them?

Possible questions:

1. How do we ensure that people can access appropriate information about services?
2. How do we address issues of Health Literacy in the poorer and other sections of the community?

Social Isolation

“Most governments and policy makers define poverty by income. Yet poor people often define poverty more broadly, such as lack of education, health, housing, empowerment, employment, personal security and more. No one factor is able to capture all the aspects that contribute to poverty, making poverty a multidimensional concept. One dimension of poverty that has been often overlooked is connectedness. Social connectedness is an important missing ingredient of multidimensional poverty, with social isolation being a central component” (Samuels et al, 2014).

The very nature of rural communities can lead to social isolation. We know that social relationships, norms and networks, and the absence of them, have an impact on the development of and recovery from health problems such as heart disease (Kim et al 2014). Given the demographics of Rutland, the King’s Fund publication ‘Improving the Public’s Health’ (Buck and Gregory 2013) found that the corrosive effect of the lack of community and networks on the health of older people was a bigger risk factor for health for this group than either moderate tobacco smoking or obesity. Therefore, it can be seen that access to services to reduce isolation are important.

Possible Questions:

1. How do we access people who are isolated?
2. How do we ensure that isolated people are able to access services?

Transport

Public transport links in a rural population are minimal compared to an urban environment. Those living on lower incomes may not have access to a car, and public transport services may not be sufficient to allow people sufficient access to health and social care services.

In addition, those with a disability may encounter further barriers to transport. This includes those with hearing or sight impairments that may limit their ability to access transport information.

If the cost or difficulty of accessing transport is a factor for people accessing services, it becomes even more important for services to be joined up so that multiple journeys are not required.

Possible questions:

1. How do we address issues around transport to services for people living on limited incomes in rural locations?
2. How do we ensure people in rural locations are aware of transport services available for them to access health and social care services?
3. Are there opportunities for services to go to people with limited means to access transport themselves?

References:

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Buck D, Gregory S (2013). Improving the public's health: a resource for local authorities. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/improving-publics-health (accessed on 12th November 2016).

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Rowlands, G., Protheroe, J., Winkley, J., Richardson, M., Seed, P.T. and Rudd, R., 2015. A mismatch between population health literacy and the complexity of health information: an observational study. *Br J Gen Pract*, *65*(635), pp.e379-e386.

Samuel, K., Alkire, S., Hammock, J., Mills, C. and Zavaleta, D., 2014. *Social isolation and its relationship to multidimensional poverty* (No. ophiwp080). Queen Elizabeth House, University of Oxford.

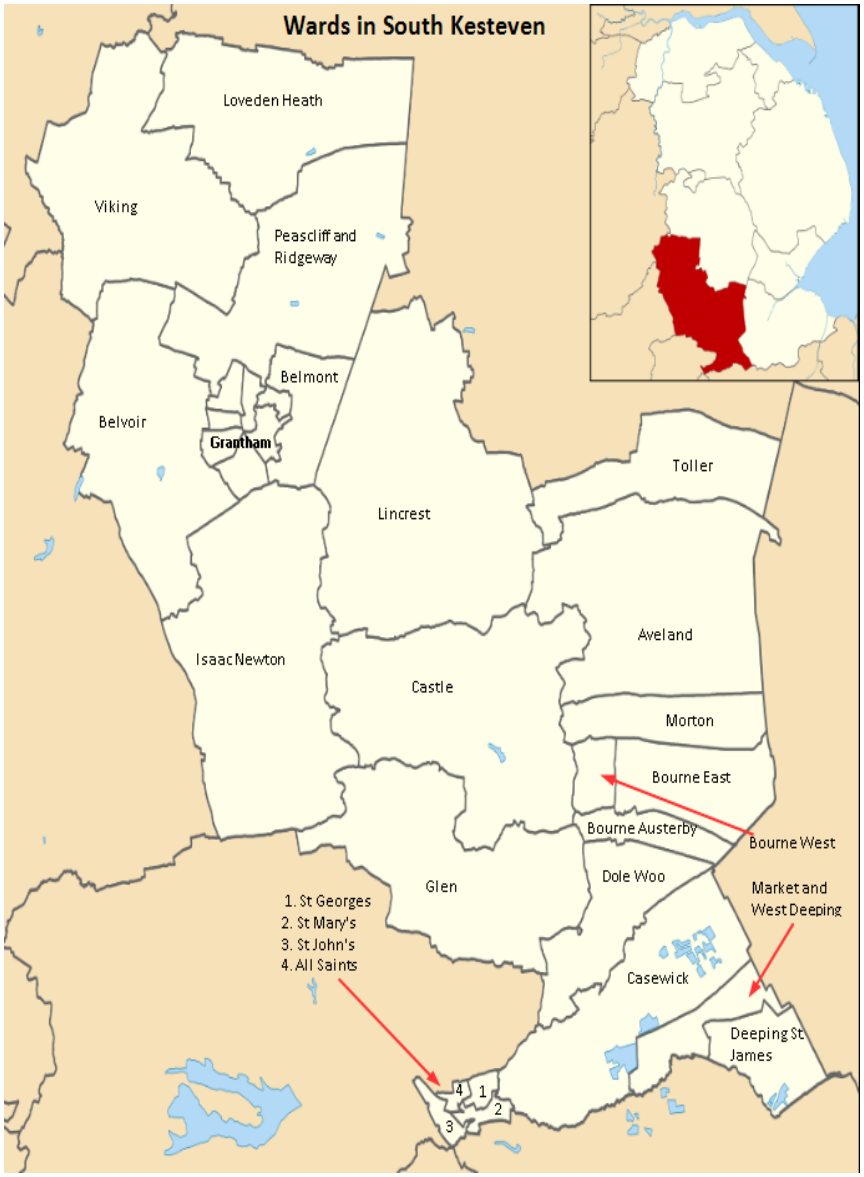
Appendix C. Additional Data - Citizens Advice and South Lincolnshire Food Bank

Council Tax Support – Total Number of claimants 2015-16			
Ward	**Pension Age**	**Working Age**	**Total**
Braunston and Belton	25	19	44
Cottesmore	59	52	111
Exton	41	36	77
Greetham	26	21	47
Ketton	72	53	125
Langham	37	24	61
Lyddington	23	16	39
Martinsthorpe	31	16	47
Normanton	66	42	108
Oakham North East	87	95	182
Oakham North West	118	193	311
Oakham South East	106	55	161
Oakham South West	62	62	124
Ryhall and Casterton	93	51	144
Uppingham	145	172	317
Whissendine	28	21	49
Total	**1019**	**928**	**1947**

Council Tax Support – Total Number of claimants with children 2015-16			
Ward	**Pension Age**	**Working Age**	**Total**
Braunston and Belton		6	6
Cottesmore		30	30
Exton		20	20
Greetham		9	9
Ketton	[redacted]	29	31
Langham		13	13
Lyddington		6	6
Martinsthorpe		8	8
Normanton		22	22
Oakham North East		39	39
Oakham North West		108	108
Oakham South East		25	25
Oakham South West		45	45
Ryhall and Casterton	[redacted]	37	38
Uppingham		77	77
Whissendine		14	14
Total	[redacted]	**488**	**491**

Housing Benefit – Total Number of claimants 2015-16			
Ward	**Pension Age**	**Working Age**	**Total**
Braunston and Belton	29	22	51
Cottesmore	59	53	112
Exton	42	33	75
Greetham	25	22	47
Ketton	73	56	129
Langham	37	25	62
Lyddington	23	17	40
Martinsthorpe	34	15	49
Normanton	67	41	108
Oakham North East	87	105	192
Oakham North West	114	221	335
Oakham South East	102	66	168
Oakham South West	64	67	131
Ryhall and Casterton	96	57	153
Uppingham	144	180	324
Whissendine	27	28	55
Total	**1023**	**1008**	**2031**

Housing Beneft – Total Number of claimants with children 2015-16			
Ward	**Pension Age**	**Working Age**	**Total**
Braunston and Belton		9	9
Cottesmore	[redacted]	30	31
Exton		17	17
Greetham		11	11
Ketton	[redacted]	34	36
Langham		15	15
Lyddington		8	8
Martinsthorpe		8	8
Normanton		25	25
Oakham North East		49	49
Oakham North West	[redacted]	125	126
Oakham South East		28	28
Oakham South West	[redacted]	47	48
Ryhall and Casterton		39	39
Uppingham		90	90
Whissendine		18	18
Total	[redacted]	**553**	**558**



Food vouchers issued by Ward from Stamford food bank – April 1st 2016 to October 1st 2016				
Ward	No. Vouchers	Adults	Childrens	Total
All Saints Ward	40	62 (59.62%)	42 (40.38%)	104
Fineshade Ward, East Northamptonshire	3	6 (40%)	9 (60%)	15
Dole Wood Ward	3	4 (66.67%)	2 (33.33%)	6
Ketton Ward, Rutland	3	8 (57.14%)	6 (42.86%)	14
King's Forest Ward, East Northamptonshire	4	5 (100%)	0 (0%)	5
Market and West Deeping Ward	2	2 (100%)	0 (0%)	2
Glen Ward	6	11 (84.62%)	2 (15.38%)	13
NFA	31	36 (87.8%)	5 (12.2%)	41
Northborough Ward, Peterborough	1	2 (100%)	0 (0%)	2
Oundle Ward, East Northamptonshire	5	5 (100%)	0 (0%)	5
Bourne Austerby Ward	2	4 (100%)	0 (0%)	4
Ryhall and Casterton Ward, Rutland	7	11 (61.11%)	7 (38.89%)	18
St. George's Ward	33	36 (52.17%)	33 (47.83%)	69
St. Mary's Ward	80	118 (80.27%)	29 (19.73%)	147
St. John's Ward	3	5 (45.45%)	6 (54.55%)	11
Casewick Ward	1	2 (100%)	0 (0%)	2
Unknown	6	7 (26.92%)	19 (73.08%)	26
Totals	230	324	160	484

Report No:
PUBLIC REPORT

SCRUTINY PANEL

11 August 2015

HEALTHWATCH ANNUAL REPORT

Report of the Chair of Healthwatch Rutland

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr R Clifton, Portfolio Holder for Health and Adult Social Care	
Contact Officer(s):	Mark Andrews, Deputy Director for People	01572 758339 mandrews@rutland.gov.uk
	Jennifer Fenelon, Chair of Healthwatch Rutland	01572 720381
Ward Councillors	All	

DECISION RECOMMENDATIONS
That the Panel: 1. Discuss and provide feedback on the Healthwatch Rutland Annual Report; and 2. Notes the contents of the Healthwatch Rutland Annual Report for 2015-16

1 PURPOSE OF THE REPORT

1.1 To provide the Annual Report 2015-16 for Healthwatch Rutland.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 Healthwatch Rutland is a statutory body which acts as a consumer watchdog on all aspects of health and social care for Rutland residents. The report attached at appendix A provides an overview of the work undertaken in the year 2015/16 and the work plan for the coming year.

3 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

3.1 To provide a summary of the work undertaken in the year 2015/16 by Healthwatch Rutland and the work planned for the coming year for discussion by the People (Adults and Health) Scrutiny Panel and to enable the members of that panel to provide feedback or request further information.

4 BACKGROUND PAPERS

4.1 There are no additional background papers to the report

5 APPENDICES

5.1 Appendix A – Healthwatch Rutland Annual Report 2015-16.

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

healthwatch

Healthwatch Rutland

Annual Report 2015/16

Contents

Message from our Chair

My first pleasure in introducing the 2015/16 Annual Report is to welcome Sarah Iveson to Healthwatch as our new General Manager and also Tracey Allan-Jones as our Office Manager. They are most welcome.

2014-15 was a year of change. Financial problems beset the NHS and social care system and it is clear that there will be major change in the way health and social care are delivered in the future.

In 2015, Healthwatch England carried out a poll which found that most people are very savvy about the financial situation and do understand the constraints facing public services. People recognise the need for change but they don't want solutions handed down to them – they want to be there in the room contributing as services are being redesigned.

We support that view completely and never cease to be impressed by the innovative solutions that users of services can produce.

> **"We call on all providers and commissioners of services to include the public in planning change."**

We believe their engagement and contribution is vital to successfully meeting their needs.

Better Care Together is the biggest ever review of health and social care in Leicester, Leicestershire and Rutland (LLR). The programme is a partnership of NHS organisations and local authorities across the area. People welcomed initial proposals from Better Care Together to bring services closer to people's homes Next year will bring proposals to deliver that objective and we will work to ensure that everyone has the opportunity to consider them.

In the meantime, we look forward to listening to as many people as possible about services both now and for the future.

Message from our General Manager

Sarah Iveson joined the Healthwatch Rutland team in March 2016. Her previous experience includes nearly 20 years in the Royal Air Force as an Air Traffic Control Officer, and 5 years in education as a primary school teacher. She is also currently studying for a Master's Degree in Psychology. She has a lot of volunteering experience with young people, including being an Independent Visitor with the National Youth Advocacy Service.

The people's voice needs to be heard by the decision makers in health and social care to inform their planning and provision of services. I strongly believe that in the current financial climate, it has never been more important that limited funds are spent wisely, and with patient/client care at their heart.

The commitment and dedication of our volunteers, who carry out the majority of our work, has impressed me immensly. Their passion for ensuring the best possible health and social care provision for the residents of Rutland is inspiring. My role is to ensure that their work is supported.

> **"The range of issues covered by Healthwatch Rutland is phenomenal."**

The breadth and depth of the job of Healthwatch Rutland is an immense challenge, but I believe that we do make a positive difference to the lives of people in Rutland. We are in a position to gather the views of people and to make sure that these views are used to influence decision makers. This is important for the provision of services currently and also in the future.

We are in a position to influence positive change. Our workplan for the coming year is challenging, but I am confident that this is achievable.

The year at a glance

Our most important role is to be the 'eyes and ears' of Rutland people on Health and Social Care matters. We are active all over Rutland listening to the issues that people are talking about.

We listened to over 1500 Rutland residents

We attended over 30 local events and held 20 meetings, workshops and focus groups at Healthwatch to listen to peoples' concerns

We kept our 300 members up to date with our work and sent them regular bulletins

We signposted the public to consultation events to gather people's views on a wide range of important topics

We conducted 4 Enter & View visits, highlighting recommendations for improvements to services to providers

Working to influence positive change

40 Partner organisations have asked us to join them to bring the voice of Rutland people to their organisations

We attended over 500 meetings to work with them in finding solutions

We hosted 10 conferences to bring the public perspective

We produced 17 reports making recommendations for improvement

Who we are

We exist to make health and care services work for the people who use them.

Everything we say and do is informed by our connections to local people. Our sole focus is on understanding the needs, experiences and concerns of people of all ages who use services and to speak out on their behalf.

We are uniquely placed as part of a national network, with a local Healthwatch in every local authority area in England.

Our role is to ensure that local decision makers and health and care services put the experiences of people at the heart of their work.

What we do

We are the statutory body which acts as a consumer watchdog on all aspects of health and social care for Rutland residents. We hold regular roadshows, public Board meetings and other events to hear what you have to say.

Our Mission

To make health and social care better for ordinary people

We also carry out projects on specific topics that we know are of concern to local people. This includes 'Enter and View' visits of health and social care services used by the people of Rutland.

We take note of best practice, make recommendations for improvement and monitor progress.

Our Vision

To put the views and experiences of Rutland residents at the centre of local service provision

It is important that people contribute to our activities and tell us about their concerns. This will make Healthwatch Rutland a stronger advocate for change and improvement.

How we work

We gather first-hand experiences from the people of Rutland and develop them into recommendations for health and social care authorities. The information we share helps them make important decisions about your local services.

We use the information we gather to identify important local issues and trends. We then carry out our own research into these issues. In particular, we want to make sure we represent the voice of the seldom heard, the vulnerable, and those in isolated communities.

And, most importantly, we have powers in law which give us influence. We feed back what we discover to the authorities. They have a legal responsibility to hear our views and answer any concerns we raise. You can be reassured that your views really do count.

Listening to people who use health and care services

Gathering experiences and understanding people's needs

We have listened to and gathered the experience of a wide range of people, including:

- Young people (under 21)
- Older people (over 65)
- Children
- The Military
- Carers

They have told us of concerns about a number of issues. We explored in workshops, public meetings and focus groups. We produced reports on a plethora of issues to try to influence positive change with service providers. This included:

- Young People's Mental Health
- Dementia Care
- Ambulance Services
- Accident and Emergency Services
- Dentistry
- Falls
- Community Health Services
- Continuing Health Care
- Community Care Act
- Social Care Charges

What we've learnt from visiting health and social care services

Enter and View visits are a key tool to allow patient experience to be given to the decision makers. Unlike inspections carried out by bodies such as the Care Quality Commission (CQC), Enter and View visits focus entirely on patient experience. Each report highlights good practice from a patient's point of view and recommendations for change to improve the experience for people.

This year we undertook four Enter and View visits on local services. These were undertaken following concerns or questions raised by members of the public. Reports on Enter and View visits can be found on our website:

- Rutland Memorial Hospital In-Patient services
- Oakham Medical Practice
- Urgent Care Centre – Rutland Memorial Hospital
- Younger Disabled Unit

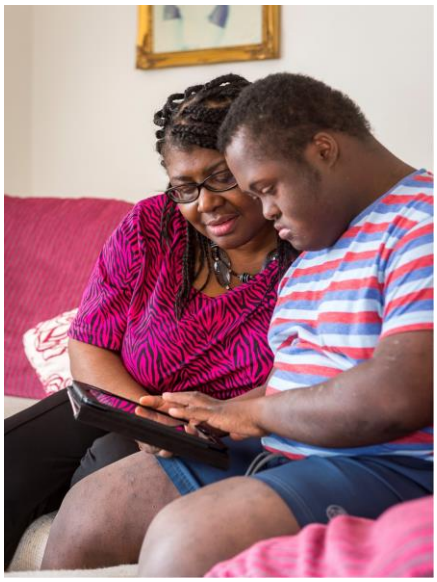
Service providers responded to the recommendations we provided. They made a commitment to improvements where needed.

These people are trained and authorised to carry out Enter and View visits for Healthwatch Rutland:

J Darlington, S Jackson, D Murphy, P Hurford, B Hellyer, C Stanesby, J Fenelon, B Taylor-Harris, B Henson, S Henson-Amphlett, C Spark, M Demaine, S Iveson, B Godfrey, B White.

THE VITAL ROLE OF UNPAID CARERS

As we talk to Rutland people, we have been struck by the large band of largely unsung and unpaid carers who provide dedicated but silent support.



We felt that our annual report should shine a light not only on their excellent and unpaid work but also on the frustrations they face. We asked Karen from Oakham, to give us her reflections on her life as a carer.

Karen not only supports three very dependent people but finds time to help others in the community. This is her real life story as told to us and it is very powerful.

Case Study - A Carer's Tale

"It is 1am, I have time to respond to you now, to detach myself enough to perhaps put things down in writing. We carers don't work 9-5 Monday to Friday, I am happy to share my early morning ramblings as I may not actually have more than 5 precious moments to myself later in the day.

I have cared for my mentally ill husband for over 24 years.

He thrives on routine, on no stress, on things running smoothly. From the outside looking in, his life is steady, he has survived cancer and is in remission, but has the after effects of chemo such as fatigue, and many other issues.

I work hard to keep our life smooth, peaceful, routine, to battle the things that everyone faces daily, but to smooth the way so there isn't a gap, or a worry for him to face, because one small thing is all it takes for him to spiral.

My life feels like constantly spinning plates to stop them crashing to the ground, maybe a dozen at a time to live our life.

We care and support our disabled son. He has a brain injury. I do a lot of background work to make sure things run smoothly for us and our son. We visit him daily as part of our routine.

I sort all medical and DWP stuff for hubby and son, forms then more forms, appeals, doctors, hospitals, everything. Nothing is smooth or easy, one wrong box ticked, it is suspended, and I still have to keep the plates spinning smoothly...perhaps another 6 plates for my son. This is lessening, as he's now psychologically stronger, and my previous hard work has sorted benefits, so each year things get a little easier... but 12 plates plus 4/5

plates for him is still a lot to keep spinning constantly day, after day, after day, after day.

Since July 2014 I also have my disabled brother's life to manage. He lives in Leicestershire and has had three strokes over ten years. The last one left him more physically and mentally damaged than before.

I now have 12 more plates to spin to run his life - bills, finances, benefits, day to day everything. I also run his direct payments and organise his care package which is a nightmare logistically as he lives 15 miles away in a rural area.

I am running more plates than I can imagine. I am on my knees, every avenue has challenges, which I am expected to smooth to satisfy one or another person, I hardly have time to sleep.

The additional strain on me from my brother is affecting my ability to keep things smooth, keep my own plates spinning. Despite supporting three people, the government pay me one set of carer's allowance, would getting more change anything? Who knows...

Last year the Council in my brother's area assessed my needs as a carer and awarded me £200 which I took as a two-day break - two days because it's all I could be away for without everything collapsing, and my brother continued to call me despite me being away.

But I'm too exhausted to fight the system.

I employed a care agency which failed my brother. I took up the complaint with the company, involved CQC, and contacted the social worker. The care agency eventually terminated their contract just before they were inspected.

I'm left dejected and forced to return to a more expensive service which swallows all the budget. People who sit at desks pay lip-service to us but don't know what life is like as a carer.

The little care available is scant in rural areas and he needs more than 15 min thoughtless arse wiping or flannel flicking. Agencies can be born, registered, and dissolve before CQC can inspect. Clients are dumped if they complain.

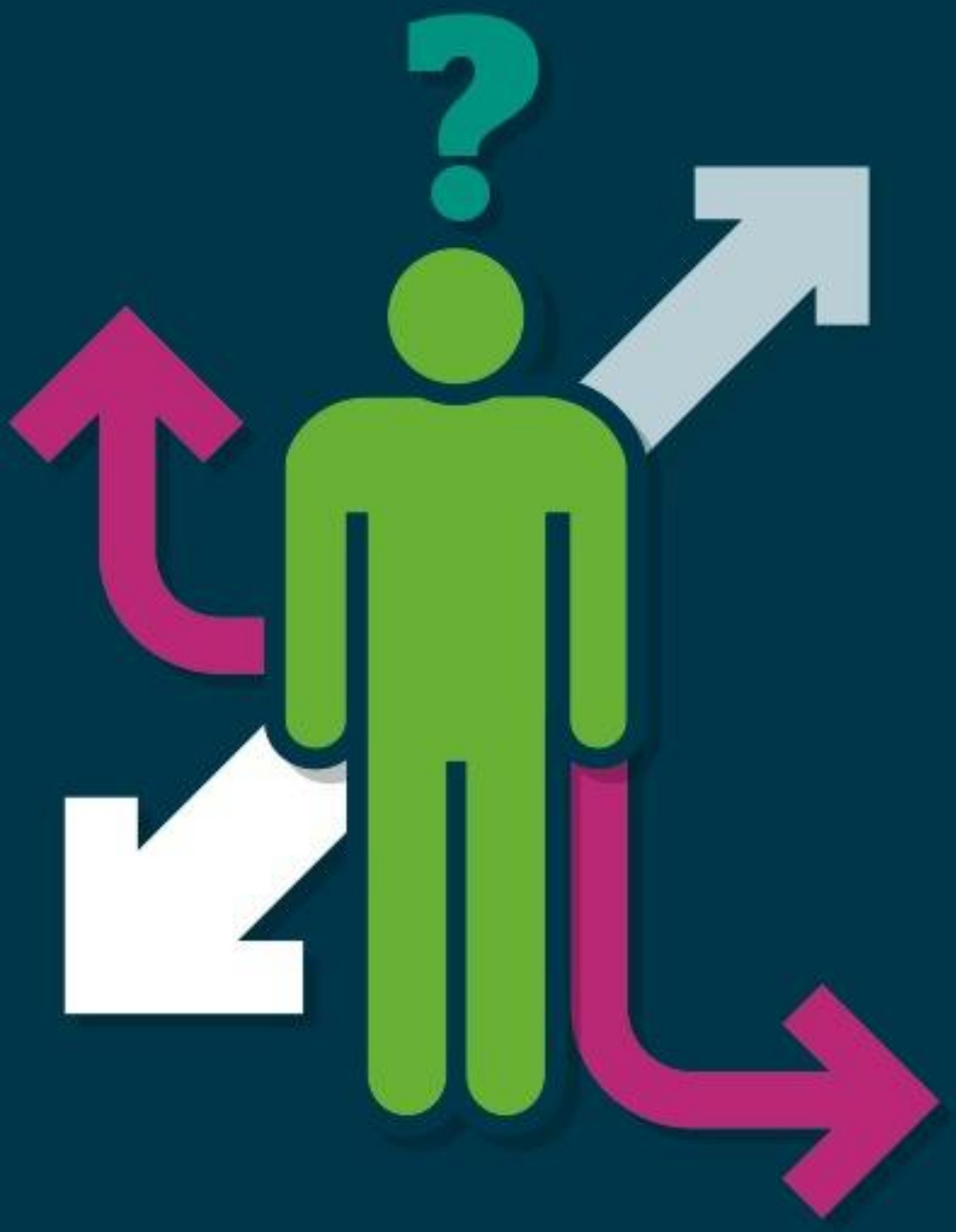
The alternative is a care home but he is 63 not 93. He has a right to independence and care and protection of the state, in his own home...but he doesn't get it. He has been waiting for adaptations since discharge from hospital. He has slept on a sofa downstairs since September 2014. I complained to Director of Social Services about the cuts to his care package and chivvied occupational therapist assessment and its failure after failure.

So because of these failures I am still embroiled in his life but I *CAN'T* do it any longer or my world will crumble or I will be destroyed and then who will keep things smooth for my husband?

And now I need to sleep, it is 2.20 am..."

Carers' Week in June 2016 reported that 3 in 4 carers don't feel their caring role is understood or valued by the community

Giving people advice and information



Helping people get what they need from local health and care services

Signposting Guide

Healthwatch Rutland have produced a comprehensive signposting guide to services in Rutland.

This signposting document has been made available at local pharmacists, GP surgeries and libraries across the area. It is also available on our website: www.healthwatchrutland.co.uk

We have based our source data on the NHS Choices, information from the East Leicestershire and Rutland Clinical Commissioning Group ELRCCG) and Rutland County Council.

We endeavour to keep this information as up to date as possible.

Online Support

In 2016/17 we will be upgrading our website to include a 'Find a Service' function to allow people to access this information online easily.

Staff in our office are available to help to signpost people who call in to the relevant service or support network, allowing those without access to a computer to have this support.

This year we have been able to signpost people to a range of services. These include NHS dentists in the area and contacts for voluntary support services. We have been able to direct people to PowHer, which is the charity that offers advocacy for people when complaining about the NHS. They can help people to navigate the formal complaints process.

How we have made a difference

Our reports and recommendations

We have used our reports, and our position on a number of committees, to recommend how people's health and care services might be improved. This year these issues have included:

- Young People's Mental Health
- Dementia Care
- Ambulance Services
- Accident and Emergency Services
- Dentistry
- Falls
- Community Health Services
- Social Care Charges

Working with other organisations

Healthwatch Rutland works collaboratively with a wide range of service providers to help to improve services.

The following are some of the agencies we work with to ensure that the patient voice is at the heart of what they do:

- We share evidence and information with the Care Quality Commission (CQC).
- This relationship has allowed our activity to complement and support local CQC monitoring, inspection and regulatory activity.
- Our local evidence and insight has been shared with Healthwatch England and used in national reports.
- We work with the local Clinical Commissioning Group (CCG) to discuss the provision of clinical services in our area.
- Our relationship with Rutland County Council allows us to influence change in the provision of services through input to the Health and Wellbeing Board and its subgroups such as the Children's Trust.
- We work with voluntary organisations who help us to gather the views of people they support.

Involving local people in our work

All service providers and commissioners now promise to ensure that the patient voice is central to their decision making.

> **"ELR CCG wants to truly involve local people in decisions about healthcare."**
>
> East Leicestershire and Rutland CCG Website, 19 June 2016

Healthwatch Rutland ensure that all service providers truly involve the public in their decision making processes.

This may be by running events ourselves, such as focus groups or workshops, or by carrying out our own surveys. We also work to ensure that service providers carry out their own surveys to accurately gather public opinion on proposed changes. This is becoming ever more important due to current pressures on the Health and Social Care system and the changes that are required to keep it sustainable.

Our work in focus

Our work in focus: Dementia

10 KEY MESSAGES FROM THE PEOPLE OF RUTLAND.

We have now published the results of listening to what the people of Rutland feel about services for those with dementia.

Locally we have many excellent services but there are also gaps. We wanted to hear the experiences of users and carers. We also drew on the valuable insight of about 300 professionals, voluntary organisations and planners.

Our report was prepared for both providers and commissioners.

East Leicestershire and Rutland CCG is leading the development of a revised dementia strategy for the Better Care Together programme.

The numbers of those with dementia in Rutland is expected to more than double between now and 2030 from around 650 at present (Source JSNA update 2015).

People told us they want a coherent whole care system. Ten powerful messages from our report capture their views.

1. DECIDING TO SEEK A DIAGNOSIS - More could be done by organisations working together across the whole community to raise awareness of memory loss in Rutland and dispel the stigma and fear of " dementia".

2. GOING TO THE GP FOR HELP - GPs would welcome help to support families to come forward to seek a diagnosis. The Rutland diagnosis rate is still below target.

3. GETTING A DIAGNOSIS - There is lack of clarity about the many routes people can take to obtain a diagnosis. The system feels slow, cumbersome and confusing to those in it.

4. GETTING TREATMENT - Those getting treatment also found the system confusing and fragmented.

5. INFORMATION - Getting the right information tailored to each stage is very important but does not happen.

6. SUPPORT AT HOME AFTER STARTING TREATMENT (Clinical & Social) - People feel that system of care coordinators is needed to help those less able to find their way around such a complex mix of statutory, voluntary and commercial services. Linking these services in a more cohesive way is now being addressed and is vital.

7. CARE HOMES & DOMICILIARY CARE - Relatives struggle to find residential and domiciliary care of suitable quality. They feel this shortage will get worse as demand rises and if new services are not provided.

8. SHORT BREAKS - Carers value respite care and short breaks but it can be stressful for all concerned. Carers would like more flexibility both in the packages on offer and financial arrangements.

9. HOSPITAL - Hospital admission is best minimised for those with dementia but remains the largest source of referral for diagnosis. Considerable improvements have been initiated with government funding in surrounding hospitals and need to be evaluated. People in Rutland attend many different hospitals and the problems of delayed and inappropriate discharges continue to bedevil us.

10. END OF LIFE - We will be looking at end of life care for all people and have not yet undertaken this critical work.

The Future

We will continue to listen to the needs of Rutland people with regards to dementia care and to work with Commissioners and the Local Authority to influence improvements to services in this area.

For a copy of our report email info@healthwatchrutland.co.uk or call 01572 720381. It is also available on our website www.healthwatchrutland.co.uk

Our work in focus: Young People Drive Change in Mental Health Services in Rutland

CASE STUDY - YOUNG PEOPLE'S CHAMPIONS TAKE A KEY ROLE IN IMPROVING MENTAL HEALTH IN RUTLAND

Healthwatch Rutland is here to enable the voices of people to be heard and that includes our young people. We helped them to describe their concerns about mental health. Not only did they put their case effectively but a new breed of champions has emerged. They have gone on to develop real leadership skills by pioneering new approaches. They have mobilised their peers and now work with health, social care and education leaders on implementing solutions. We are extremely proud of what they are doing and we highlight here the work of one of our champions, Tim Amor.

Tim speaks out then helps lead the drive for improvement

Tim is one of our leading champions. He doesn't say much about his treatment as an inpatient for depression in CAMHS (Children and Adolescent Mental Health Service) apart from the fact that he wishes no one will ever have to go through his experience.

As our young people gathered around to help drive the case for improvement Tim was able to bring his first-hand experience and his passion for an improved service. Tim said:

> **"Through my dissatisfaction with CAMHS, I knew change needed to happen. Too many times I was let down by a service that couldn't deliver. Often, I felt like I was shoved in a corner and had no say in the treatments I received. So, rather than sit around and be passive, I became active in encouraging change wherever possible so that mental health services can provide the best possible care not only for current generations, but for future ones too."**

Tim's modesty does not allow him to expand on his role in helping to change the lives of young people in Rutland.

He became a leading spokesman for the young people in Rutland, working alongside Healthwatch Rutland and the Local Authority. He challenged the stakeholders in public meetings, held a major role within his College to bring about awareness and remove the stigma around mental health, then moved on to a regional role in the redesign of CAMHS (Children and Adolescent Mental Health Service). He was a leading voice in the film commissioned by Healthwatch England and made by Healthwatch Rutland which has been praised by the Duchess of Cambridge in her role as champion for the support for children and young people.

Tim, through speaking out, his dedication and perseverance, is really making a difference. He leaves no one in doubt "you *must* make change happen".

Healthwatch Rutland is now recognised as a national leader in bringing the voice of young people into decision making. Their messages have been clearly heard by all professionals and organisations responsible for providing services.

Some of the many young mental health champions together with Rutland health social care and education leaders

Future Plans

The Government programme "Future in Mind" has allocated extra funding to meet the dire need for support to mental health services all over the country. Work is underway to redesign and implement a plan for Leicester, Leicestershire and Rutland. We play an active part in bringing the views of young people into redesigning the whole service.

Our plans for next year

Future priorities

In 2016/17 our priorities are to ensure the people of Rutland are heard on the major changes to Health and Social Care planned through the Better Care Together Programme. In addition, we are planning projects on Ambulance Services, Adult Mental Health (including Dementia), Transfer of Care (from Hospital to Social Care) and Youth Mental Health.

Better Care Together (BCT)

We await Better Care Together proposals. Our challenge will be to ensure that as many Rutland people as possible are aware of the consultation and have an opportunity to help shape services for future years

Ambulance Services

Response times in Rutland remain a serious concern as they are the worst in the region. Healthwatch Rutland have worked hard to raise these concerns with the East Midlands Ambulance Service (EMAS) and Commissioners.

The trust was working hard to improve response times for emergency calls but these were consistently below the national target. *(Source CQC Inspection report of EMAS May 2016.)*

We are organising an event in July 2016 for EMAS to listen to the people of Rutland. We will continue to monitor response times and to try to influence positive change to this vital service.

Adult Mental Health

Mental health problems are a growing public health concern, with 1 in 4 people experiencing a mental health problem in any given year. The care of people with mental health problems has received a lot of media coverage in recent times. Much of the focus has been on the need to prevent problems in the first place and to remove the stigma and discrimination that people with mental health problems can experience.

Timely access to effective, good quality, evidence-based mental health treatment and therapies in response to need, always in the least restrictive setting, was a primary concern. (*Source: The Five Year Forward View Mental Health Taskforce: public engagement findings*)

This current focus on mental health care has been described as a once-in-a-generation opportunity to transform services and support for people with mental health problems. We want to find out about the experience of Rutland residents who access these services. The project will enable us to find out what is available for local residents and what they think about those services. This will allow us to influence positive change with the providers where needed.

Transfer of Care

We have heard from Rutland residents concerns around the transfer of people from hospital to home with social care support or to social care homes. These concerns include delayed transfer of care. This is where people are spending too much time in hospital because the support they need to be discharged is not in place. Also we have heard about people being released from hospital too soon without suitable support so that a future hospital admission is more likely. There is also concern that people are being discharged without the support they need at home.

Poorly managed transfers of care harm people. (*Source: Right Place, Right Time Better Transfers of Care: A Call to Action, NHS Providers.)*

There is a lot of work being done by the Local Authority and the NHS to address some of these issues, and we feel it is vital that they make any decisions based on patient experience and feedback. Therefore, this project aims to gather the experience of people who have used these services and report to the decision makers in the Local Authority and NHS to try and influence positive change.

Youth Mental Health

Healthwatch Rutland has been running a highly successful Youth Mental Health project for 18 months (see Our Work in Focus). Following on from this we will continue to influence providers to put in place preventative measures that have been identified as vital for our young people. These measures may include resilience training for school staff. We will monitor the provision of these services and ensure that commissioners continue to give these issues the priority it requires.

Listen and Watch Groups

Volunteers ensure that issues are monitored. Any issues that are highlighted to us are raised with the relevant authority:

- Primary Care (GPs)
- Community and Social Care Services
- Dental Health Services
- Pharmacy Services
- Services for Older People
- Services for People with Learning Disabilities
- Services for People with Physical Disabilities
- Maternity and Neonates
- Planned and Elective Care
- Urgent Care
- Services for Carers
- The Military
- End of Life

If there are any other health or social care issues that you think we should be listening to and watching, please let us know.

Our people

Our Volunteers

Healthwatch Rutland relies on the help and support of volunteers across all activities. There are always opportunities for people to give as little or as much time as they can spare. Our volunteers come from all walks of life. They bring with them a wealth of personal experience and skills.

> *"I got involved with HW Rutland because I wanted to make a positive difference within my local community. It gives me great satisfaction to know that we are giving the people of Rutland a voice and helping to ensure that they feel listened to, involved and empowered to help influence better health and social care services."*

Nicola D, Healthwatch Rutland

There's good evidence that volunteering brings benefits to both the person volunteering and the people and organisations they support.

Our volunteers help at events, showcasing the work we do and listening to the public's views on Health and Social Care services.

> *"The provision of good health care is now almost the number one issue in the minds of the people. Volunteering with HWR means having a chance to influence and maybe change for the better how that is done here in Rutland"*

Bart H, Healthwatch Rutland

Our volunteers also take the lead on projects, ensuring that the views, concerns and experiences of people are captured so that they can be reported to service providers. They undertake Enter and View visits to report on the patient experience and give recommendations for the improvement of these services.

If you are interested in volunteering with us, please get in contact.

Our finances

INCOME	£
Funding received from local authority to deliver local Healthwatch statutory activities	65,000
Additional income	
Total income	65,000
EXPENDITURE	
Operational costs	26,438.31
Staffing costs	28,024.42
Office costs	8,649.63
Total expenditure	63,112.36
Balance brought forward	1,887.64

Get in touch

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The Healthwatch Rutland contract is held by Rutland County Council, Catmose, Oakham, Rutland, LE15 6HP

We will be making this annual report publicly available by 30th June 2016 by publishing it on our website and circulating it to Healthwatch England, CQC, NHS England, Clinical Commissioning Group/s, Overview and Scrutiny Committee/s, and our local authority.

We confirm that we are using the Healthwatch Trademark (which covers the logo and Healthwatch brand) when undertaking work on our statutory activities as covered by the licence agreement.

If you require this report in an alternative format, please contact us at the address above.

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