



Rutland County Council

Catmose, Oakham, Rutland, LE15 6HP
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Ladies and Gentlemen,

A meeting of the **RUTLAND HEALTH AND WELLBEING BOARD** will be held in the Council Chamber, Catmose, Oakham, Rutland, LE15 6HP on **Tuesday, 4th December, 2018** commencing at 2.00 pm when it is hoped you will be able to attend.

Yours faithfully

Helen Briggs
Chief Executive

Recording of Council Meetings: Any member of the public may film, audio-record, take photographs and use social media to report the proceedings of any meeting that is open to the public. A protocol on this facility is available at www.rutland.gov.uk/my-council/have-your-say/

A G E N D A

1) APOLOGIES

2) RECORD OF MEETING

To confirm the record of the meeting of the Rutland Health and Wellbeing Board held on 18 September 2018 (previously circulated).

3) DECLARATIONS OF INTEREST

In accordance with the Regulations, Members are invited to declare any personal or prejudicial interests they may have and the nature of those interests in respect of items on this Agenda and/or indicate if Section 106 of the Local Government Finance Act 1992 applies to them.

4) PETITIONS, DEPUTATIONS AND QUESTIONS

To receive any petitions, deputations and questions received from Members of the Public in accordance with the provisions of Procedure Rule 93.

The total time allowed for this item shall be 30 minutes. Petitions, declarations and questions shall be dealt with in the order in which they are received.

Questions may also be submitted at short notice by giving a written copy to the Committee Administrator 15 minutes before the start of the meeting.

The total time allowed for questions at short notice is 15 minutes out of the total time of 30 minutes. Any petitions, deputations and questions that have been submitted with prior formal notice will take precedence over questions submitted at short notice. Any questions that are not considered within the time limit shall receive a written response after the meeting and be the subject of a report to the next meeting.

5) PHYSICAL ACTIVITY TO SUPPORT PEOPLE'S HEALTH

To receive Report No. 225/2018 from the Director of Public Health.
(Pages 5 - 22)

6) CARDIOVASCULAR DISEASE IN RUTLAND

To receive Report No. 228/2018 from the Director of Public Health.
(Pages 23 - 30)

7) RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2018

To receive Report No.229/2018 from the Director of Public Health.
(Pages 31 - 268)

8) ANY URGENT BUSINESS

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

9) DATE OF NEXT MEETING

The next meeting of the Rutland Health and Wellbeing Board will be on Tuesday, 5 March 2018 at 2.00 p.m. in the Council Chamber, Catmose.

Proposed Agenda Items:

- Public Health Annual Report
- Children and Young People Local Transformation Plan

DISTRIBUTION**MEMBERS OF THE RUTLAND HEALTH AND WELLBEING BOARD:**

1	Cllr Alan Walters	Rutland County Council
2	Cllr Gary Conde	Rutland County Council
3	Dr Hiliary Fox	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)
4	Fiona Taylor	Spire Homes
5	Helen Briggs	Rutland County Council
6	Will Pope	Healthwatch Rutland
7	Mike Sandys	Rutland County Council - Public Health
8	Rachel Dewar	Leicestershire Partnership NHS Trust
9	Roz Lindridge	NHS England Local Area Team
10	Simon Mutsaars	Community & Voluntary Sector Rep
11	Dr Tim O'Neill	Rutland County Council
12	Tim Sacks	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)

OTHERS FOR INFORMATION

14	Karen Kibblewhite	Rutland County Council
15	Mark Andrews	Rutland County Council
16	Sandra Taylor	Rutland County Council
17	Simon Pizzey	East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG)
18	Wendy Hoult	NHS England Local Area Team

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RUTLAND HEALTH AND WELLBEING BOARD

4th December 2018

Physical Activity to Support People’s Health

Report of the Leicestershire and Rutland Director of Public Health

Exempt Information	No	
Cabinet Member(s) Responsible:	Cllr Alan Walters, Portfolio Holder for Safeguarding - Adults, Public Health, Health Commissioning, Community Safety & Road Safety) Cllr Lucy Stephenson, Portfolio Holder for Culture & Leisure, Highways & Transport	
Contact Officer(s):	Mike Sandys Director of Public Health	0116 305 4239 mike.sandys@leics.gov.uk
	Robert Clayton Head of Culture & Registration	01572 758435 rclayton@rutland.gov.uk

DECISION RECOMMENDATIONS

That the Board:

1. Notes the contents of this report regarding the importance of physical activity to support people’s health
2. Notes the attached Rutland Performance Update on the LRS Physical Activity & Sports Strategy 2017-2021

1 PURPOSE OF THE REPORT

- 1.1 To inform the Board of the importance of physical activity opportunities to support people’s health.
- 1.2 To outline the work currently being undertaken in Rutland in pursuit of this agenda.

2 BACKGROUND AND MAIN CONSIDERATIONS

- 2.1 **Strategic Aim:** Safeguarding the most vulnerable and supporting the health & wellbeing needs of our community.
- 2.2 This Board received a report on 5th December 2017 outlining the Leicester Shire and Rutland Sport Physical Activity & Sports Strategy 2017 – 2021. This report includes an update on the local work undertaken in support of this strategy, attached as Appendix 1.

2.3 Leicester-Shire & Rutland Sport is the County Sport Partnership for the sub-region. It is a partnership of local authorities working together with schools, National Governing Bodies of Sport, clubs, coaches and volunteers.

2.4 The strategy provides a framework for local action, and acts to support local and national funding bids to support delivery of the vision, outcomes and ambitions. The Strategy focuses on delivering the Vision of making “Leicestershire, Leicester and Rutland the most physically active and sporting place in England”. This is underpinned by four Ambitions:

Get Active	Everyone, of all ages, having the opportunity to start participating in physical activity and sport
Stay Active	Supporting people to develop a resilient physical activity and sporting habit to ensure lifelong participation
Active Places	Facilities, playing pitches and informal spaces that encourage physical activity and sport that are high quality and accessible
Active Economy	Promoting Leicestershire, Leicester and Rutland as a premier, high performing location for undertaking the business of physical activity and sport

2.5 Delivering the strategy helps to achieve the local outcomes of **Better Health** (improved physical and mental wellbeing, especially for our most inactive people); **More People** (regularly taking part in physical activity and sport); and **Stronger Communities** (achieving more through physical activity and sport).

2.6 Sport England conducts a regular “Active Lives” survey of adults, with the most recent 2017/18 results showing that:

- **72.3%** of adults in Rutland reported being either active (150+ minutes of physical activity per week) or fairly active (30 – 149 minutes per week). This is below the England average of 74.8%, but similar to the levels of other authorities in the sub-region. This means **27.7%** of adults report being physically inactive.
- **76.2%** of adults took part in sport and physical activity at least twice in the 28 days before the survey (1.3% higher than the sub-region average but 1.3% lower than the England average)
- **14.1%** of adults volunteered to support sport and physical activity at least twice in the last year (similar to the sub-region and England average)

The Sport England summary report includes links to the local data tables:

<https://www.sportengland.org/media/13563/active-lives-adult-may-17-18-report.pdf>

2.7 It is clear that access to physical activity and sports is important to the population of Rutland, however despite these positive results, **41.2%** of our adults do not achieve the Chief Medical Officer guidelines for being active (150+ minutes of physical activity per week – see <https://www.nhs.uk/live-well/exercise/>). The Health and Wellbeing Board is therefore requested to note the progress update included as Appendix 1, which outlines work to tackle this deficit.

3 HIGHLIGHTS

3.1 The **Falls Prevention** work has continued to expand and reach more individuals at risk of falling. Two programmes, FAME and Steady Steps have been established, and have grown from two classes in 2016 with 28 attendees, to 6 classes operating throughout the County at full capacity with 15 attendees each. Steady Steps classes are operated with funding secured from the CCG which makes the provision free of charge to participants. FAME classes are now self-funding with attendees paying £4.50 per session. When they are ready, attendees are progressed to move on to other classes. We are looking to start a further class in January in Empingham.

3.2 The established **Exercise Referral** programme, where local GPs are able to refer patients to undertake structured exercise and fitness classes, continues to serve significant numbers of users, who benefit from a range of interventions. Reasons for referral include back pain, being overweight, rheumatoid arthritis, hypertension, depression, cholesterol, diabetes and osteopenia. The programme continues to receive increasing numbers of referrals:

2015: 315 referrals

2016: 350 referrals

2017: 479 referrals

2018: 468 referrals (to end of October)

The programme helps to build the habit of taking regular exercise, with Catmose Sports reporting that they have around 200 memberships relating to exercise referral classes, up from 56 in 2016. Exercise referral sessions take place in Oakham, Uppingham, the Active Rutland Hub, and Inspire2Tri at Manton. Attendances at these sessions in recent months are very strong and consistent:

April	1,131
May	1,224
June	1,272
July	1,162
August	1,134
September	1,261

3.3 The **School Games** programme comprises 143 different events in 12 locations across the county, providing a wide variety of opportunities for children to enjoy competitive sports and physical activity sessions. Over 1,000 attendances were recorded in the academic year 2017-18.

3.4 This year's **Rutland Walking and Cycling Festival** was once again very successful and brought together over 300 individuals to participate in 34 different sessions, with ages ranging from 0 to 75+. In addition the Rutland Round 65 mile circular walk around the County attracted over 127 attendances.

4 CONSULTATION

- 4.1 The LRS Strategy was developed collaboratively. Local officers, the Local Sport Alliance and the local School Sport and Physical Activity Network were all part of the extensive consultation across both Counties.
- 4.2 This update report has been developed in consultation between the Director of Public Health, the Director of Leicestershire & Rutland Sport, and the Rutland County Council Portfolio Holder for Culture. As this report is an update, further public consultation has not been undertaken.

5 ALTERNATIVE OPTIONS

- 5.1 The Board may wish to express views on the work being undertaken.

6 FINANCIAL IMPLICATIONS

- 6.1 Core funding for the Active Rutland team that delivers the physical activity strategy is provided through the Public Health grant received by Rutland County Council. Additional resources to deliver projects have been secured through creative bids to external sources, including CCG funding for the Steady Steps programme. The delivery outlined in the attached update is designed and scaled in accordance within the available resources.
- 6.2 Public Health funding to support the operation of the Active Rutland Hub is being removed from 2019/20. This has resulted in a £19,000 pressure on the budget, which will be considered as part of the budget setting process. It is hoped in due course the pressure will be offset by increased revenue generated from hires and bookings.
- 6.3 No additional funding is required from Rutland County Council to deliver the Strategy at this stage, however, ongoing provision is reliant on the continued allocation of Public Health funding to this priority.
- 6.4 Rutland contributes on an annual basis £17,900 to the LRS Partnership, which in 2017/18 resulted in £40,869 funding secured for local clubs, organisations and projects in the sports and physical activity sector:
<https://www.lrsport.org/uploads/lrs-annual-review-2017-18.pdf>

7 LEGAL AND GOVERNANCE CONSIDERATIONS

- 7.1 The Health and Social Care Act 2012 places a statutory duty on Rutland County Council to take steps to improve the health of the population. The Council is discharging its statutory duty by supporting healthy lifestyles, including physical activity, as these can have a positive impact on reducing ill health and early mortality.
- 7.2 The governance of Leicester Shire and Rutland Sport includes strong representation from Rutland. Mike Sandys, the Director of Public Health for Leicestershire and Rutland is the Vice Chair of LRS. Dr Mary Hardwick, Coach and Founding Director of Inspire2tri in Rutland, and Ben Solly, Principal of Uppingham Community College

are both on the LRS Board.

8 DATA PROTECTION IMPLICATIONS

- 8.1 A Data Protection Impact Assessments (DPIA) has not been completed because this report does not identify individuals, or raise any risks or issues to the rights and freedoms of natural persons.

9 COMMUNITY SAFETY IMPLICATIONS

- 9.1 No community safety implications have been identified relating to this report.

10 HEALTH AND WELLBEING IMPLICATIONS

- 10.1 Actions from the LRS strategy support the delivery of key corporate Strategic Aims, ensuring that our population stays healthier and more active for longer, which helps to reduce pressures on primary and secondary health care provision.

11 ORGANISATIONAL IMPLICATIONS

- 11.1 No organisational implications have been identified arising from this report.

12 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

- 12.1 In order to ensure the Health and Wellbeing Board is informed of the work being undertaken in this area, it is requested that the Board note the contents of this report.

13 BACKGROUND PAPERS

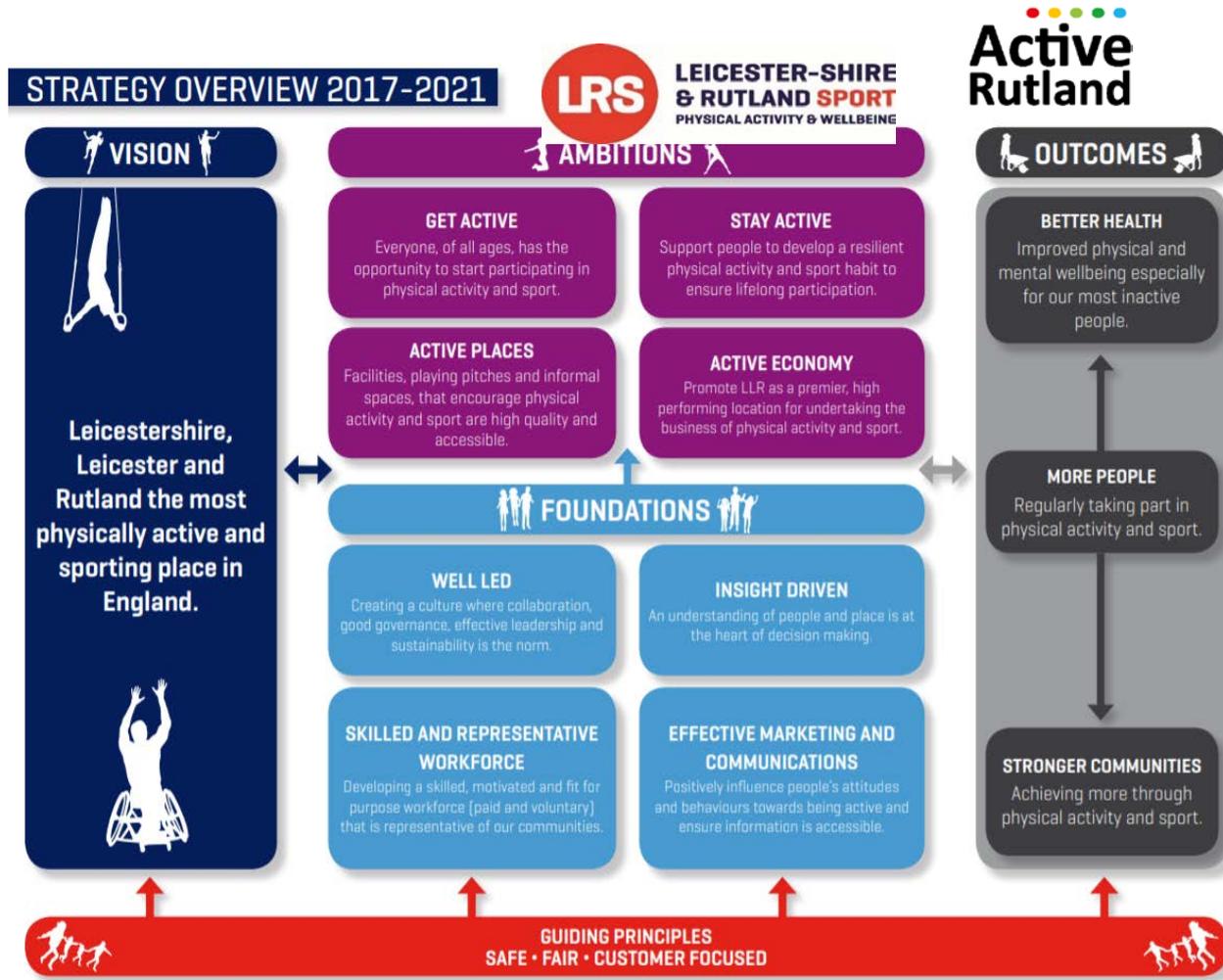
- 13.1 There are no additional background papers to the report.

14 APPENDICES

- 14.1 Appendix 1: Rutland Performance Update on the LRS Physical Activity & Sports Strategy 2017-2021

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

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RAG Rating	Criteria
Red	Not on track, area for concern and requires attention
Amber	In progress but not complete, a risk but not an issue yet
Green	Completed or on track to complete with no issues

Guiding Principle 1: Safe

Opportunities for taking part is important for all

**Lead Officer(s)**

Chris Thomas

Job Title

Active Rutland Manager

Progress Summary

November 2017 - October 2018	<p>High quality and safe School Games events organised by the team - excellent feedback from young people that attend. Events are insured via the local authority Public Liability insurance</p> <p>Active Rutland is GDPR compliant - documents updated and internal controls in place</p> <p>There has been significant consultation with primary and secondary schools to inform and develop the school games and whole school approach programmes</p> <p>Staff have attended Safeguarding workshops and undertaken online training</p>
Highlight	High quality, safe School Games programme organised, comprising 143 different events in 12 locations with over 1,000 attendances by children
Developing	Ensuring that Active Rutland designs activities suitable for all by evaluating programmes with the new Sport England performance management framework
Priority	Review and update event planning to ensure safe, robust and effective systems are in place

Guiding Principle 2: Fair

Equality of opportunity is at the heart of all physical activity and sport



Lead Officer(s)	Chris Thomas
Job Title	Active Rutland Manager

Progress Summary

November 2017 - October 2018	Active Rutland staff participate in the LRS wider workforce programme. Sessions planned for 2018/19 including Autism Awareness / Dementia Awareness / Mental Health Awareness
	The Care Homes Twilight Games programme has been established in two homes in Rutland.
	Public Health project funding has been secured for three major projects: Outdoor Fitness Area; Master Gardeners Programme; Whole School Approach
Highlight	Our work to upskill care workers has continued to grow, with 2 care homes brought together to compete against each other in the Twilight Games.
Developing	Expand the care home twilight games programme to further homes across the county.
Priority	Ensuring the evaluation and promotion of funded programmes enables the long term future of the projects.

Guiding Principle 3: Customer Focused

Decisions are based on the needs of our customers



Lead Officer(s)	Robert Clayton
Job Title	Head of Culture & Registration

Progress Summary

November 2017 - October 2018	We continue to develop the capability of the Active Rutland team and support our partners to identify customer needs
	We are working towards Quest accreditation for the Active Rutland Hub to ensure it is operated in a quality assured manner
	We continue to support community groups with developing projects and programmes, including bids to external funding streams and direct provision of small grants for training and equipment
	East Midlands Physical Activity and Sport Evaluation Toolkit is now available and will support the team to develop evaluation approaches, helping us to better understand the needs of our customers
Highlight	Staff team growing in confidence following an indepth insight project therefore having a better understanding of our demographics in order to tailor future projects based on need
Developing	Development of the LRS Insight Hub and the 3 supporting portals (Data and Stats, Research and Evidence, Tools and Resources) is progressing, local content needs to be added on a regular basis
Priority	Embedding a culture of knowing our customers as a start, middle and end point to the development of sport and physical activity

Ambition 1: Get Active	
Everyone, of all ages, has the opportunity to start participating in physical activity and sport	
Lead Officer(s)	Chris Thomas
Job Title	Active Rutland Manager



Progress Summary	
Overall RAG rating 2017/18	Green
November 2017 - October 2018	Exercise Referral programme, delivered in partnership with SLL, continues to go from strength to strength with participant numbers growing to 1,261 attendances in September 2018
	The Whole School Approach is a clear priority for many schools, and is being embedded into the work of the SSPAN and schools
	Active Rutland supports and promotes inclusive activity. With the support of the Local Sports Alliance, LRS, school games and clubs, Active Rutland encourages activities to be as inclusive to all participants as possible
	School engagement around physical activity and health and wellbeing is strong, with all Primary Schools signed up to the School Sport network
Highlight	Extension funding has been secured from East Leicestershire and Rutland Clinical Commissioning Group to extend the Steady Steps programme for an additional 2 groups from October 2018 – March 2019
Developing	To advocate and implement the Whole School approach in ALL schools and embed the philosophy and priorities
Priority	To continue to work on identified barriers to participation, such as accessing activities and clubs, aiming to ensure all clubs have provision to enable disabled persons' access

Action No.	Business Plan Actions	Lead Officer	Nov 17 - Oct 18	Nov 18 - Oct 19
1.1	Implement EYFS/KS1 Intervention programme across all schools	Chris Thomas	Amber	
1.2	Promote and implement Daily Mile principles across all schools	Chris Thomas	Amber	
1.3	Develop and advocate a consistent offer to all schools via the School Sport Champion Group	Chris Thomas	Green	
1.4	Support schools to adopt the LLR Whole School Approach into normal practice	Chris Thomas	Amber	
1.5	Work with partners to develop opportunities (especially for under represented groups) to participate in physical activity and sport	Glynn Attiwell	Green	
1.6	Ensure that Health and Physical Activity organisations working together to develop appropriate pathways targeting those whose health will benefit through regular participation in physical activity and sport e.g. exercise referral	Trish Crowson	Green	
1.7	Work with local organisations to develop targeted physical activity campaigns which encourage greater participation in physical activity and sport programmes amongst our inactive / low participating population	Danielle Adams	Green	

Ambition 2: Stay Active	
Support people to develop a resilient physical activity and sport habit to ensure lifelong participation	
Lead Officer(s)	Chris Thomas
Job Title	Active Rutland Manager



Progress Summary	
Overall RAG rating 2017/18	Green
November 2017 - October 2018	The School Games Programme is undertaking a transformational change, aligning to the Team Leicestershire programme, feeding in to an 'LLR Active Schools Competition Programme'. This will develop a new '3-tier approach' – 'Engagement', 'Development' and 'Performance', to ensure an offer for all young people, not just the 'sporty'
	Working with RCC Transport Team to develop the Active Travel agenda, linking to the work of the whole school approach
	Working across Rutland to support partners to embed family physical activity into their wider plans e.g. Children and Families Plan, Healthy Weight Strategy
	Active Rutland Local Sport Alliance develops community sport, school sport and physical activity across the county in order to increase participation. Alliance shares knowledge on funding, accreditation, training and new initiatives, and provides a platform for networking and information sharing. Clubs and organisations invited to attend from across Rutland
	Public health funding secured to deliver Fun Food Family Fitness project which encourages families to tackle obesity and integrate physical activity into their everyday lives
Highlight	Successful Walking and Cycling Festival brought together over 300 individuals to participate in 34 different sessions
Developing	Ensuring successful delivery of our Satellite Club KPIs
Priority	Maintaining responsive Local Sports Alliance network to support local clubs and organisations to promote physical activity

Action No.	Business Plan Actions	Lead Officer	Nov 17 - Oct 18	Nov 18 - Oct 19
2.1	Provide a high quality support service to our clubs and organisations, working in partnership with the Local Sports Alliance (LSA)	Danielle Adams	Green	
2.2	Coordinate a high quality and varied school games competition programme	Chris Thomas	Green	
2.3	Coordinate and implement a competition programme that caters for all children	Chris Thomas	Amber	
2.4	Collaborate with local and national organisations to sustain the core market	All	Green	
2.5	Work in partnership with local organisations to promote and deliver a variety of physical activity and sport intervention programmes within our schools and community settings	Chris Thomas	Green	
2.6	Work with local clubs and organisations to develop and sustain a core offer of Walking and Cycling	Danielle Adams	Green	

Ambition 3: Active Places
Facilities, playing pitches and informal spaces, that encourage physical activity and sport, are high quality and accessible



Lead Officer(s)	Robert Clayton
Job Title	Head of Culture & Registration

Progress Summary	
Overall RAG rating 2017/18	Green
November 2017 - October 2018	Participate in LRS Active Places Forum (includes planners and Sport England)
	Support the development of the FA's Local Football Facility Plans
	Seek to embed the use of the Active Design Guidance document produced by Sport England in all appropriate local developments
	Support local organisations to develop high quality sports and recreation facilities by facilitating access to funds and providing advice and network access
	Work with RCC Transport Team to develop the Active Travel agenda, linking to the work of the whole school approach
Highlight	Following significant investment in new sports facilities, the team are working to support embedding the use and growth of the new public / private facilities (Catmose Sports, Active Rutland Hub, Uppingham School Sports Centre, Inspire2Tri); Section 106 funding used to improve facilities in Ketton, Greetham and Oakham
Developing	Working with LRS to deliver the Active Places ambition which embeds physical activity options at the design stage of all developments
Priority	Investment through developer contributions is a major opportunity for improving access to healthy lifestyles and sporting opportunities. Working with planning and finance colleagues to identify potential opportunities to fund and improve facilities

Action No.	Business Plan Actions	Lead Officer	Nov 17 - Oct 18	Nov 18 - Oct 19
3.1	Work with local partners and providers to ensure that we protect and enhance our existing playing spaces	Robert Clayton	Green	
3.2	Influence planning policy to include consideration for cycle routes, walking routes, outdoor spaces, etc.	Robert Clayton	Green	
3.3	Offer support and guidance for future facility funding applications, supported by LRS	Robert Clayton	Green	
3.4	Highlight the importance of investing Section 106 funding into sport, recreation and physical activity improvements by publicising the beneficial schemes which have been delivered to date	Robert Clayton	Green	
3.5	Advise on the design of new facilities (including schools) to enable regular community use / access and to enhance the quality of peoples lives	Robert Clayton	Green	
3.6	Work with local partners to enhance and maintain existing local formal and informal community facilities and local spaces.	Robert Clayton	Green	
3.7	Ensure high quality contracts are in place with leisure operators to ensure that appropriate programmes that meet the needs of the community are delivered.	Robert Clayton	Amber	
3.8	Signpost community partners, including to clubs, to specialist facility maintenance advice	Robert Clayton	Green	
3.9	The development of the Master Gardeners Scheme delivered by Root and Branch Out to support local communities in the development of personal and communal areas	Danielle Adams	Amber	
3.10	Support partners to identify opportunities that capitalise on social good / value interventions e.g. Outdoor Exercise Areas	Glynn Attiwell	Amber	

Ambition 4: Active Economy	
Promote Rutland as a premier, high performing location for undertaking the business of physical activity and sport	
Lead Officer(s)	Robert Clayton
Job Title	Head of Culture & Registration



Progress Summary	
Overall RAG rating 2017/18	Amber
November 2017 - October 2018	Support the work of LRS-funded Sport and Economy post, which aims to engage with local businesses and support the growth of this sector
	Encourage participation in the LRS Business of Sport Network. Monthly newsletters circulated to partners and bookable events promoted
Highlight	Workplace Health support package "Wellbeing @ Work" promoted to local businesses, active internal RCC group seeking to make improvements in staff wellbeing
Developing	Capture the economic impacts of events to evidence the ROI of the cost of hosting events; reach out and connect with sports businesses in the private sector not already linked to existing networks
Priority	Rutland is home to a significant number of leisure orientated businesses, including all of the watersports related activity at Rutland Water. Seek to develop relationships with the commercial businesses and showcase the focus and energy behind this agenda

Action No.	Business Plan Actions	Lead Officer	Nov 17 - Oct 18	Nov 18 - Oct 19
4.1	Work with partners to promote physical activity as a part of their overall approach to providing a Workplace Health offer	Danielle Adams	Green	
4.2	Support LRS to develop a series of SME Sport Business seminars	Robert Clayton	Green	
4.3	Work with partners to identify opportunities to attract significant national events	Robert Clayton	Amber	
4.4	Work with tourism partners to explore how to position the leisure, physical activity and sport offer more explicitly as part of County's identity	Robert Clayton	Amber	



Foundation 1: Well Led
Creating a culture where collaboration, good governance, effective leadership and sustainability is the norm

Lead Officer(s)	Robert Clayton / Chris Thomas
Job Title	Head of Culture & Registration / Active Rutland Manager

Progress Summary	
Overall RAG rating 2017/18	Green
November 2017 - October 2018	All staff have participated in mandatory training including GDPR, and have updated procedures as appropriate
Highlight	Active Rutland team members participating in the ILM level 3 leadership and management apprenticeship course
Developing	Work is underway to achieve the Quest standard for the Active Rutland Hub
Priority	Ensuring that Active Rutland aligns its activities to the priorities of this strategy

Action No.	Business Plan Actions	Lead Officer	Nov 17 - Oct 18	Nov 18 - Oct 19
5.1	Deliver the shared objectives of the Leicester, Leicestershire and Rutland Physical Activity and Sport Strategy	All	Green	
5.2	Take the opportunity to present sport and recreation perspectives when invited to comment on local and national consultations	All	Green	
5.3	Ensure that any external bids, fundraising and other activities are clearly based around the priorities of this strategy	All	Green	
5.4	Achieve Quest accreditation for the Active Rutland Hub	Glynn Attiwell	Amber	

Foundation 2: Insight Driven	
An understanding of people and place is at the heart of decision making	
Lead Officer(s)	Robert Clayton / Chris Thomas
Job Title	Head of Culture & Registration / Active Rutland Manager



Progress Summary	
Overall RAG rating 2017/18	Amber
November 2017 - October 2018	Engage with the developing LRS insight function following its internal restructure
	Supported by the LRS Insight Officer, a Loughborough University Masters student has started to develop an online Insight Hub. This has 3 platforms to host data and statistics, research and evidence and tools and resources. This will make insight and information easily accessible and useable. Product launched at the LRS Conference in November
	Rutland's Legacy Maker has produced a local insight document, which will assist developing a greater understanding of our area, and enable us to make needs led decisions
	LRS has commissioned Derby University to develop a Standard Evaluation toolkit, which is being rolled out. Active Rutland will be using the toolkit to support its activities
Highlight	The development of the online Insight Hub, hosted on the LRS website
Developing	Building a deeper understanding of the physical activity and sport challenges / issues / supply and demand at a local level
Priority	Bringing together the tools and insight available to build a clear understanding of Rutland and our residents

Action No.	Business Plan Actions	Lead Officer	Nov 17 - Oct 18	Nov 18 - Oct 19
6.1	Work with LRS to build a more granular understanding of our communities (people and places)	Active Rutland Assistant	Amber	
6.2	Make use of the LRS insight hub now launched	Chris Thomas / Robert Clayton	Amber	
6.3	Develop the capability of staff to collect, interpret and utilise good insight	Chris Thomas	Green	
6.4	Utilise the East Mids Evaluation Framework (Sport England collaboration) at a Rutland level	Active Rutland Assistant	Amber	
6.5	Support local partners to understand how to share appropriate data that complies with GDPR (General Data Protection Regulations)	Danielle Adams	Green	



Foundation 3: Skilled and Representative Workforce	
Developing a skilled motivated and fit for purpose workforce (paid and voluntary) that is representative of our communities	
Lead Officer(s)	Chris Thomas
Job Title	Active Rutland Manager

Progress Summary	
Overall RAG rating 2017/18	Green
November 2017 - October 2018	Support local groups, organisations, volunteers and own staff to access high quality training opportunities, including providing small grant funding to support club development
Highlight	School Sports Leadership Academy has gone from strength to strength, now with 42 Bronze, 21 Silver and 5 Gold representatives all drawn from local schools
Developing	Understanding and compliance to operating standards for club and community settings
Priority	To support our local partners with any workforce development challenges they might have

Action No.	Business Plan Actions	Lead Officer	Nov 17 - Oct 18	Nov 18 - Oct 19
7.1	Support partners to access a broad range of CPD programmes	Chris Thomas	Green	
7.2	Support the local delivery of the LRS workforce development plan	Chris Thomas	Amber	
7.3	Continue to develop and improve the School Sports Leadership Academy	Active Rutland Assistant	Green	
7.4	Work specifically with under-represented groups to support them into leadership, activator and coaching roles	Danielle Adams / Glynn Attiwell	Amber	

Foundation 4: Effective Marketing and Communications
Positively influence people's attitudes and behaviours towards being active and ensure information is accessible



Lead Officer(s)	Danielle Adams
Job Title	Active Rutland Officer

Progress Summary	
Overall RAG rating 2017/18	Green
November 2017 - October 2018	Deliver major annual events, including the Community Sports Awards, to highlight the value and impact of sports and recreation
	Maintain and continue to develop the Active Rutland website, delivered in partnership with LRS
	Continue to generate positive media coverage of Active Rutland and the wider sector
	Promote specific programmes including GO GOLD, School Games, Exercise Referral and the Active Rutland Hub
Highlight	Community Sports Awards is a major success, fully funded by sponsors, and generating massive media interest and profile for the dedicated work of the sector, and the achievements of our local sportspeople
Developing	Review the user experience of the Active Rutland website and ensure information can be accessed easily and quickly
Priority	Target marketing and communication to appealing to inactive individuals

Action No.	Business Plan Actions	Lead Officer	Nov 17 - Oct 18	Nov 18 - Oct 19
8.1	Coordinate work with partners to ensure maximum impact of campaigns at a local level	Danielle Adams	Green	
8.2	Continue to improve the major annual events to maximise media impact and the profile of the sector	Danielle Adams	Green	
8.3	Use social marketing to positively influence people's physical activity and health behaviour	Active Rutland Officer	Green	

RUTLAND HEALTH AND WELLBEING BOARD

4th DECEMBER 2018

CARDIOVASCULAR DISEASE IN RUTLAND

Report of the Director of Public Health, Rutland County Council

Exempt Information	No	
Cabinet Member(s) Responsible:	Mr A Walters, Portfolio Holder for Safeguarding - Adults, Public Health, Health Commissioning, Community Safety & Road Safety	
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DECISION RECOMMENDATIONS

That the Board:

1. Approves further work on developing a joined up prevention system through Rutland County Council's Health and Care Board
2. Approves further work to enable an integrated communications system to support the prevention system in Rutland
3. Endorses the hypertension prevention programme being led by the Leicester, Leicestershire and Rutland Prevention Programme Board as part of the LLR STP

1 PURPOSE OF THE REPORT

- 1.1 The purpose of this paper is to summarise a profile of cardiovascular disease in Rutland and provide context within Rutland and at the STP system level as to the work going on around prevention and management of cardiovascular disease in Rutland.

2 BACKGROUND AND MAIN CONSIDERATIONS

Strategic Aim: Safeguarding the most vulnerable and supporting the health wellbeing needs of our community.

Prevalence of cardiovascular disease

- 2.1 Cardiovascular disease (CVD) is a general term for disease that affects the heart or

the blood vessels. It is usually associated with a build-up of fatty deposits inside the arteries and an increased risk of blood clots, and can result in damage to organs such as the brain, heart, kidneys and eyes. CVD includes angina, heart disease, heart attacks, strokes, transient ischaemic attacks (TIA or 'mini-stroke'), and peripheral arterial disease (usually affecting the legs). Cardiovascular disease is one of the main causes of death and disability in the UK, but it can often largely be prevented by leading a healthy lifestyle.

- 2.2 The most common cause of premature death in England is coronary heart disease. Coronary heart disease refers to the type of cardiovascular disease that specifically affects the heart. Proper management of the condition can reduce the risk of death from the disease, and improve the quality of life of the patients. The prevalence of coronary heart disease as recorded on GP registers in Rutland has remained stable for the past five years at 3.7%. The prevalence has remained significantly higher than the national prevalence throughout this time.
- 2.3 The death rate due to cardiovascular disease in East Leicestershire and Rutland CCG (ELR CCG) has decreased by 30.4% since 2004-2006. There were 368.7 admissions for cardiovascular disease per 100,000 people in ELR CCG in 2016/17. This is significantly lower than the England rate.
- 2.4 In Rutland, almost a quarter (24.5%) of all deaths were due to circulatory disease in 2016. This is similar to the national percentage of 25.5%. The percentage of deaths from circulatory disease in Rutland has significantly declined since 2004, a decline which is reflected nationally.
- 2.5 Mortality rates from cardiovascular disease in those aged under 75 years have remained significantly better than the national average for the last three time periods. In 2014-16, deaths from all cardiovascular disease for those aged less than 75 was 53.5 per 100,000 population aged less than 75 years, significantly better than the national rate of 73.5 per 100,000 population aged less than 75 years. In the same time period, deaths from cardiovascular disease considered preventable for those aged less than 75 was 37.4 per 100,000 population aged less than 75 years, similar to the national rate of 46.7 per 100,000 population aged less than 75 years.
- 2.6 As age increases, the percentage of deaths from circulatory disease also increases at a national level. However in Rutland in 2016, the highest percentage of deaths from circulatory disease (30.1%) was seen in the 75-84 age group whereas in the 85 year and over age group, less than a quarter of deaths (23.8%) were due to circulatory disease in Rutland. In both these age groups, over time there has been a significant decline in the percentage of deaths due to circulatory disease in Rutland.
- 2.7 However, prevention of cardiovascular disease is possible, with a current and real opportunity to address risk factors that can impact on the prevalence of cardiovascular disease. Smoking, being overweight or obese, being physically inactive, excessive alcohol use and having a high blood pressure are all factors that increase the risk of developing cardiovascular disease, or of further complications from cardiovascular disease if already diagnosed. Lifestyle services can help prevent cardiovascular disease, whereas optimal medical management, as well as lifestyle services, can reduce the risk of deterioration and complications of cardiovascular disease

Risk factors for cardiovascular disease

- 2.8 Smoking is the major cause of preventable ill health and premature mortality in England. In Rutland between 2012 and 2015, the smoking prevalence has remained significantly better (lower) than the national percentage. In 2016, 12.3% of adults in Rutland were current smokers, similar to the England proportion of 15.5%.
- 2.9 The percentage of physically active adults in Rutland has remained similar to the national average for the last two years. In 2016/17, 68.1% of adults in Rutland reported that they were physically active, that is, they engaged in at least 150 minutes of moderate intensity physical activity per week. This is similar to the England value of 66.0%.
- 2.10 In Rutland, in 2016/17, 60.2% of adults were classified as overweight or obese, this is similar to the England value of 61.3%. This has worsened since 2015/16, where the prevalence of excess weight in adults in Rutland was 58.0%.
- 2.11 Being overweight or obese is associated with a greater risk of developing type II diabetes. People with diabetes can lead healthy lives with correct management and monitoring of their condition. Diabetes increases the risk of developing cardiovascular disease. The percentage of patients aged 17 years and over with diabetes mellitus, as recorded on practice disease registers has been significantly increasing both nationally and locally. In 2016/17, 1,980 adults in Rutland had been identified on GP disease registers as having diabetes. This is a prevalence of 6.6%. The value for England was 6.7%.
- 2.12 In 2016/16, 16.8% of patients in Rutland were recorded as having hypertension (high blood pressure). This equates to 6,226 people in Rutland. This compares to a national prevalence of 13.8%.
- 2.13 Another common cause of premature death in England is following a stroke. Proper management of the condition can reduce the risk of death from the disease, and improve the quality of life of the patients. The percentage of patients with stroke or transient ischaemic attack (TIA), as recorded on practice disease registers (proportion of total list size) has remained significantly higher than the national percentage for the last five years. The latest data shows the prevalence of stroke or transient ischaemic attack as recorded on GP registers is 2.3% for Rutland in 2016/17. This is significantly higher than the England proportion of 1.7%. The significantly higher prevalence of stroke or transient ischaemic attack (TIA) in Rutland over time is likely to be affected by Rutland's proportionally older population compared to nationally.
- 2.14 One risk factor for stroke is atrial fibrillation, an abnormality of the heart's rhythm which gives an irregular heart rhythm and can be much faster than a normal heart rate. The diagnosed prevalence of atrial fibrillation in ELR CCG is 2.3%, with the estimated prevalence being 3.0%. There could be an additional 2,122 people with undiagnosed atrial fibrillation in the CCG.

Treatment and Prevention of Cardiovascular Disease

Healthy Lifestyle services

- 2.15 Rutland Community Wellbeing (RCWS) Service offers information, support and

advice to people in Rutland with a range of health and wellbeing needs. This includes self-help tools, and onwards referral to a variety of community support, through an interactive website, (<https://www.rutlandwellbeing.org.uk/>) single telephone number and drop-in services. They provide a wide range of assistance to help people to overcome some of the factors which may have a negative impact on their health and wellbeing, such as poor housing and debt. This includes help to access specialist military/veteran support. RCWS also provides support to help people around a range of lifestyle issues such as help to stop smoking, basic dietary and weight management advice and referral.

- 2.16 In 2016/17, there were 118 people in Rutland using stop smoking services and 69 people quit smoking as a result of attending stop smoking services. This equates to a rate of 1,747 per 100,000 smokers aged 16 and above which falls in the second lowest quintile nationally. In the same time period, of those who self-reported quitting smoking at 4 weeks, 39 had confirmation by carbon monoxide validation. This equates to a rate of 988 per 100,000 smokers aged 16 and above which falls in the lowest quintile nationally.
- 2.17 Active Rutland provides details of all the physical activities and sports available within the county, including those aimed at specific groups such as older people, young people with disabilities and those recovering from injury.
- 2.18 Rutland operates a Passport to Leisure scheme which allows specific groups the opportunity to access daytime services and facilities at the local sports centre at a discounted rate, including low income families, students and individuals with a disability or impairment.
- 2.19 The Exercise Referral Scheme is a programme for adults (16+) with health conditions, who could benefit from increased physical activity. It is a partnership between Public Health, Leicester-Shire and Rutland Sport, local authorities, GP practices and other healthcare professionals. It offers an opportunity for these individuals to exercise in a safe, supervised and structured environment.

NHS Programmes and services

- 2.20 In order to prevent heart disease, stroke, diabetes and kidney disease, everyone between the ages of 40 and 74 who has not been diagnosed with any of those conditions is invited to have an NHS Health Check every five years. The Health Check assesses the risk of a person developing any of these diseases and identifies interventions to be put in place to reduce their risk.
- 2.21 Work is currently being completed across Rutland to improve the overall quality and data accuracy of Health Checks. This includes implementing a clinical template onto the GP practice system to support consistent high quality Health Check delivery and utilising data software to audit the quality and eligibility of Health Checks.
- 2.22 The latest data shows in 2017/18, the proportion of the eligible population invited for an NHS Health Check in Rutland was 21.6%, this is better than the England value of 17.3%. The proportion of the eligible population who received an NHS Health Check in Rutland was 7.0%, this is significantly worse than the England value of 8.3%. The percentage of the eligible population in Rutland who were invited for and who received an NHS Health Check was 32.4%. This is significantly worse than the

England value of 47.9%.

- 2.23 Making Every Contact Count (MECC) is an approach to behaviour change, whereby day-to-day interactions between staff (from a wide range of organisations) and individuals are utilised to support them to make positive changes to their physical and mental health and wellbeing. Brief advice and information is offered, along with signposting or referral where appropriate, to assist with these changes. Many health, care and other professionals already utilise the principles of MECC and put these into practice in their day-to-day work. The MECC approach formalises this work, provides an opportunity to offer support and training to further assist staff in this work, alongside toolkits which can be used at organisational level as well as by individual staff members.
- 2.24 A 'hypertension project' is being taken forward by the three Clinical Commissioning Groups (CCGs) in Leicester, Leicestershire and Rutland and Public Health. This work aims to find patients with as yet undiagnosed hypertension (high blood pressure), and optimise the management of all patients with hypertension. It also includes work on prevention and self-care. The new hypertension pathway is in the final stages of development.
- 2.25 Work is underway on an end-to-end pathway review of cardiovascular disease management and cardiology services, including the parts of the pathways that sit in primary care. This is joint work between the three CCGs, primary care, secondary care, and Public Health.

3 CONSULTATION

- 3.1 The paper summarises the prevalence of cardiovascular disease in Rutland and current service provision and does not require consultation.

4 FINANCIAL IMPLICATIONS

- 4.1 The paper summarises the prevalence of cardiovascular disease in Rutland. Where the recommendations call for further action these will be met from within existing budgets.

5 LEGAL AND GOVERNANCE CONSIDERATIONS

- 5.1 The Health and Social Care Act 2012 places a statutory duty on Rutland County Council to take steps to improve the health of the population. By supporting healthy lifestyles, and its positive impact on a leading cause of ill health and death, the Council is discharging its statutory duty.

6 HEALTH AND WELLBEING IMPLICATIONS

- 6.1 Cardiovascular disease remains a major cause of mortality and morbidity within Rutland. A joined up approach to lifestyle service provision and additional focus on the key work outlined in this report will improve the health and wellbeing of the population.

7 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

- 7.1 In Rutland there is a higher prevalence of cardiovascular disease than the national average. This is likely to be due to Rutland's population being older, on average, than nationally. It could also be due to proactive case finding and diagnosis by GPs and primary care teams. Despite higher prevalence of these diseases, deaths from cardiovascular disease in those aged under 75 is significantly better than the national average, which suggests that cardiovascular disease is generally well managed in Rutland residents.
- 7.2 However there is more that can be done. Whilst smoking prevalence in Rutland is significantly lower than the national average, those who do smoke are at greater risk of developing cardiovascular disease and from dying from it. A substantial proportion of Rutland's adult population are obese. Being obese is a major risk factor in developing heart disease, type 2 diabetes, stroke, as well as some types of cancer. Tackling these risk factors now is crucial in preventing cardiovascular disease in the future.
- 7.3 There are a range of services and work programmes in Rutland, either at local, CCG or at Leicester, Leicestershire and Rutland level that are working on reducing risk factors, or optimising fitness and wellbeing after a diagnosis of cardiovascular disease. These will require ongoing investment and support as well as new initiatives to prevent cardiovascular disease and to reduce the effects of established disease.
- 7.4 Despite a higher prevalence of some cardiovascular diseases in Rutland compared to nationally, deaths due to cardiovascular disease continue to decrease or remain better than the national average. This implies that cardiovascular disease is successfully identified and appropriately managed and supported in Rutland's population in general. There are a range of services available in Rutland to support people with cardiovascular disease as well as prevent CVD by addressing a range of lifestyle factors. There is however scope for further improvement through reviewing the prevention pathway to make it even easier for people to access these services.
- 7.5 To focus our efforts on reducing the burden of cardiovascular disease we need a joined up prevention system. Work could be done to review the prevention pathway, so that the system works more efficiently with the resources and services that it already has. This could include how to optimise use of communications resources and channels to ensure that information about services and how to access them reaches Rutland's population in a range of ways.
- 7.6 It is recommended that the Board:
- i) Approves further work on developing a joined up prevention system through Rutland County Council's Health and Care Board
 - ii) Approves further work to enable an integrated communications system to support the prevention system in Rutland
 - iii) Endorses the hypertension prevention programme being led by the Leicester, Leicestershire and Rutland Prevention Programme Board as part of the LLR STP

8 BACKGROUND PAPERS

There are no additional papers to this report.

9 APPENDICES

There are no appendices to this report

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RUTLAND HEALTH AND WELLBEING BOARD

4th DECEMBER 2018

RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT

Report of the Director of Public Health

Exempt Information	No	
Cabinet Member(s) Responsible:	Mr Alan Walters, Portfolio Holder for Safeguarding – Adults, Public Health, Health Commissioning, Community Safety & Road Safety	
Contact Officer(s):	Mike Sandys, Director of Public Health	Mike.sandys@leics.gov.uk
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DECISION RECOMMENDATIONS

It is recommended that Health and Wellbeing Board members:

1. Agree and approve publication of the Rutland JSNA 2018 to be published by end December 2018

1 PURPOSE OF THE REPORT

- 1.1 This paper seeks approval by Rutland Health and Wellbeing Board of the Joint Strategic Needs Assessment (JSNA) 2018. The attached Chapters have been amended in light of comments from the Board and other stakeholders.

2 BACKGROUND AND MAIN CONSIDERATIONS

- 2.1 JSNAs are the statutory process by which a Local Authority and Clinical Commissioning Group assess the current and future health, care and wellbeing needs of the local community to inform local decision making. A JSNA integrates a range of data, on topics such as health, housing, transport, employment and education, to identify needs of strategic importance to health and wellbeing.
- 2.2 The purpose of the JSNA is to improve the health and wellbeing of the local community and reduce inequalities for all ages. It should be viewed as a continuous process of strategic assessment and planning with the aim to develop local evidence-based priorities for commissioning which will improve the public's health and reduce inequalities.
- 2.3 It will be used to help to determine what actions Rutland County Council, the local

NHS and other partners need to take to meet health, wellbeing and social care needs, and to address the wider determinants that impact on health and wellbeing. The JSNA informs and underpins the Rutland Joint Health and Wellbeing Strategy.

- 2.4 The last JSNA for Rutland was produced in 2015 at the below link. Once the JSNA 2018 is published, it will be available at the same link:

<https://www.rutland.gov.uk/my-services/health-and-family/health-and-nhs/joint-strategic-needs-assessment/>

3 RENEWING THE RUTLAND JSNA

- 3.1 A JSNA Reference Group has been overseeing the JSNA process and ensuring that the development of the JSNA meets the statutory duties of the Health and Wellbeing Board.

- 3.2 The subject-specific chapters have been amended following consultation. Each chapter gives an assessment of current and future health and social care needs. The chapters are:

- Rutland's Population
- The Best Start in Life
- Children and Young People – Staying Safe and Healthy
- Achieving Educational Potential
- Physical Health of Adults
- Mental Health of Adults
- Ageing Well

Infographic summary of each chapter will be available online. The online data dashboard will be updated on a quarterly basis to allow users to self-serve high level data requests.

- 3.3 The Chapters listed above are provided in the appendices. Each chapter makes recommendations for action in response to the current and future needs identified by the data. The Mental Health of Adults and Ageing Well Chapters have been further developed based on direction given by the Board at the September meeting including data on access to services and providing more focus on Ageing Well and physical and mental wellbeing rather than only data on illness and hospitalisation.

- 3.4 Once the JSNA 2018 is published, it is proposed, (where possible) to update the chapters, when new data is released. The JSNA Reference Group will be re-formed in late 2020 and the status of all chapters will be reviewed at this time.

- 3.5 The JSNA 2018 will be used to inform and refresh the Rutland Joint Health & Wellbeing Strategy (2016- 2020) and a report with recommendations will be brought to a future meeting of the Board.

4 ALTERNATIVE OPTIONS

- 4.1 There are no alternative options as development and publication of a JSNA is a statutory requirement.

5 CONSULTATION

- 5.1 Views on the draft chapters were sort from Adults and Health Scrutiny Panel, Children and Young Peoples Scrutiny Panel, Rutland Children’s Trust, Rutland Integration Executive as well as from the Health & Wellbeing Board.

6 FINANCIAL IMPLICATIONS

- 6.1 The JSNA contributes to sound financial management of public sector budgets by helping to ensure that service planning takes into account the evolving pattern of need for health and social care services.
- 6.2 The JSNA supports the matching of services to the population which in turn supports sound financial planning. It may highlight additional future financial pressures.

7 LEGAL AND GOVERNANCE CONSIDERATIONS

- 7.1 A JSNA Reference Group has been overseeing the JSNA process and ensuring that the development of the JSNA meets the statutory duties of the Health and Wellbeing Board.

8 DATA PROTECTION IMPLICATIONS

- 8.1 A Data Protection Impact Assessments (DPIA) has not been completed because this report does not identify individuals, or raise any risks or issues to the rights and freedoms of natural persons.

9 HEALTH AND WELLBEING IMPLICATIONS

- 9.1 The purpose of the JSNA is to assess the current and future health, care and wellbeing needs of the local community to inform local decision making. As such its major purpose is to contribute towards determining health and wellbeing needs so these can be addressed.

10 CONCLUSION

- 10.1 The report describes the process of development of the JSNA 2018 and how it is used to determine current and future health, care and wellbeing needs of the population. It will be used to ensure local evidence-based priorities for commissioning to improve the public’s health and to reduce inequalities. The Board is asked to approve publication.

11 BACKGROUND PAPERS

- 11.1 There are no additional background papers to the report.

12 APPENDICES

- 12.1 Appendix A - Rutland's Population
- Appendix B - The Best Start in Life
- Appendix C - CYP-Staying Safe & Healthy
- Appendix D - Achieving Educational Potential
- Appendix E - Mental Health of Adults
- Appendix F - Physical Health of Adults
- Appendix G - Ageing Well

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RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2018

RUTLAND'S POPULATION

DECEMBER 2018

Strategic Business Intelligence Team
Leicestershire County Council



Public Health Intelligence

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Produced by the Strategic Business Intelligence Team at Leicestershire County Council.

Whilst every effort has been made to ensure the accuracy of the information contained within this report, Leicestershire County Council cannot be held responsible for any errors or omission relating to the data contained within the report.

FOREWORD

The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Rutland, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs.

The JSNA offers an opportunity for the Local Authority, CCG and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCG and NHS England must be able to explain why.

EXECUTIVE SUMMARY

- The total population of Rutland in 2016 was 38,606, an increase of 1.5% since 2015. Rutland has an older population with almost a quarter (23.9%) of the population aged over 65 years, compared to 17.9% nationally.
- In 2016, the two wards with the highest populations are: Uppingham (4,788) and Oakham North West (4,461).
- The population of Rutland is projected to grow by 7.9% to 41,100 by 2039, an increase of 3,000 from 2016. Nationally the population is expected to increase at a faster rate, by 14.6% between 2016 and 2039.
- Nationally the over 65 population is predicted to grow by 53.5% and the over 85 population by 127.1% between 2016 and 2039. In Rutland, the over 65 population is predicted to grow at a slower rate than nationally, by 48.9% from 9,400 to 14,000 people, whilst the 85 and over population is predicted to grow at a faster rate than nationally, by 142.9%.
- The rise in Rutland's population is projected to gradually increase due to inward migration. The number of deaths is expected to exceed the number of births resulting in a fall in natural change.
- The military population accounts for 5.8% of the resident population in the county. In April 2018, there were 2,250 Armed Forces personnel and entitled civilian personnel registered in Rutland. 1,620 individuals (72%) were in the Armed Forces and 630 individuals (28%) were entitled civilian personnel. Entitled civilian personnel include service personnel family dependents and Ministry of Defence (MOD) employed civilian personnel who are entitled to care at MOD primary care facilities.
- HMP Stocken in Stretton, in the north east of the county, is a category C closed training prison. In December 2017, there were 841 male prisoners aged 21 and over in its care.
- The vast majority of Rutland residents live in less deprived areas; over 26,000 people (67.5% of the total population) live in neighbourhoods in the three least deprived deciles nationally. Just over 2,034 people live in neighbourhoods in the 50% most deprived deciles nationally, out of a total population of over 38,000.
- Overall, when looked at in the national context, Rutland is not particularly deprived. At a local authority level, using the overall Multiple Deprivation measure, the county is ranked 148th out of 152 upper tier authorities in England, where 1st is the most deprived.
 - Within the Index of Multiple Deprivation, the Barriers to Housing and Services

domain appears to show some of the most extensive deprivation on a national scale, with 7 Lower Super Output Areas (areas with fairly consistent areas) in each of the top decile in England. This may be a result of the more rural nature of the county, and issues around dispersed population being able to access services, in addition to housing affordability.

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1. Introduction

This chapter presents a comprehensive overview of the population in Rutland. The majority of indicators presented are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. We appreciate that this document uses technical language. This is due to the nature of the JSNA, which is intended for use by commissioning organisations such as local authorities and the NHS in developing their commissioning plans. One example is the use of statistical significance. A statistical significant result ensures the result is not likely to be caused by chance, for a given statistical significance level. Using these statistical tests improves the reliability of our evidence base which will help strengthen our commissioning based decisions

2. Local Context

Rutland is a sparsely populated county with two market towns. Oakham is the larger of the two with the highest population density and is the main service centre for Rutland. Uppingham is the smaller of the towns and has a more limited range of facilities and fewer employment opportunities. Rutland has over forty villages which range in size from small hamlets with a few houses and no facilities to larger villages with a school, shop, post office, GP surgery and some employment opportunities. The county has large areas of farmland and is dominated by Rutland Water, an Anglian Water reservoir located at the centre of the county.

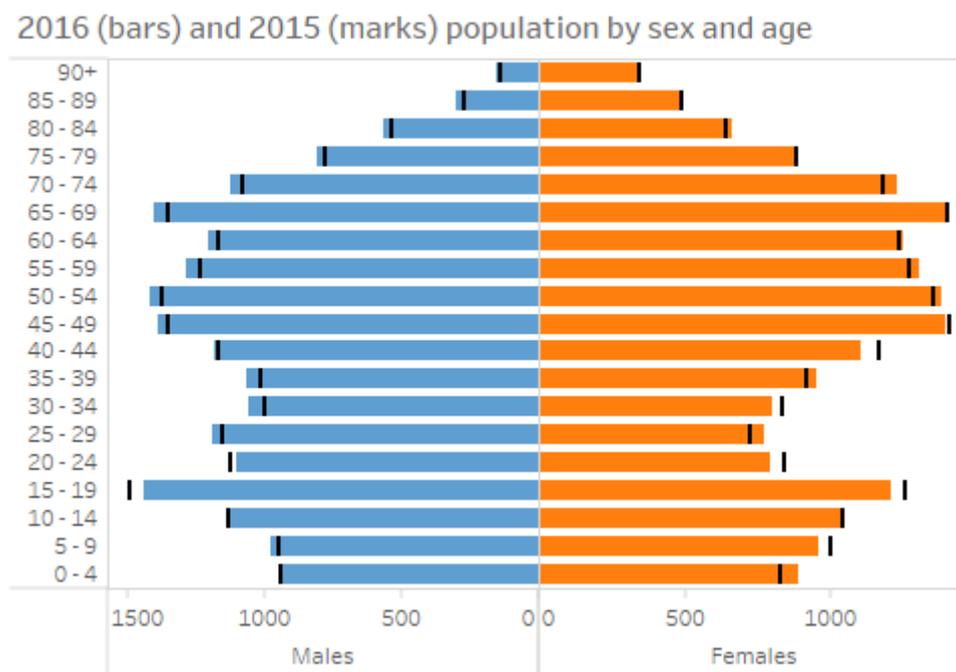
3. Population Estimates

The Office for National statistics released 2016 population estimates on the 22th June 2017. These figures are released annually and are available on the ONS website¹. The total population of Rutland in 2016 was 38,606, an increase of 1.5% since 2015. There are more males (19,744) than females (18,862) in Rutland. The population of males has risen by 1.8% and females by 1.1% since the previous year.

In 2016, 4.6% of the population was aged 0-4 (1,766 people), 18.0% was aged 5-19 (6,859 people), 53.4% was working age (20,320 people aged 20-64) and 23.9% was older than 65, this includes 3.3% of the total population that was aged 85 and over (1,249 people). Compared to nationally, Rutland has a higher proportion of the population aged over 65 and 85 respectively.¹

The population pyramid below displays the 2016 population estimates by gender and five-year age band.

Figure 1 – Rutland 2016 population estimate by gender and five-year age band



Source: ONS, 2017

The number of children aged 0-4 has increased by 3.9%. There has been an increase of 1.5% for working age population (aged 20-64) and 3.2% increase in the older population (aged 65 and over) since 2015.¹

From the population pyramid above, Rutland has a higher number of males in 0-4 and 15-44 years age bands, while the age bands 55 and over have higher number of females than males. The number of people in the 15-24 years of age band experienced a decrease for both genders since 2015. Age bands 5-9, 30-34 and 40-44 years of age all saw a decrease for females since 2015. The number of people aged 65 and over experienced an increase in both genders across the age bands (3.2%).¹

The 15-19 years of age band, the 45-54 years of age bands and the 65-69 years of age band have the highest population across all age bands. Rutland’s ageing population has more females than males in the 85 plus age band (844 females compared to 457 males).¹

3.1. Further information

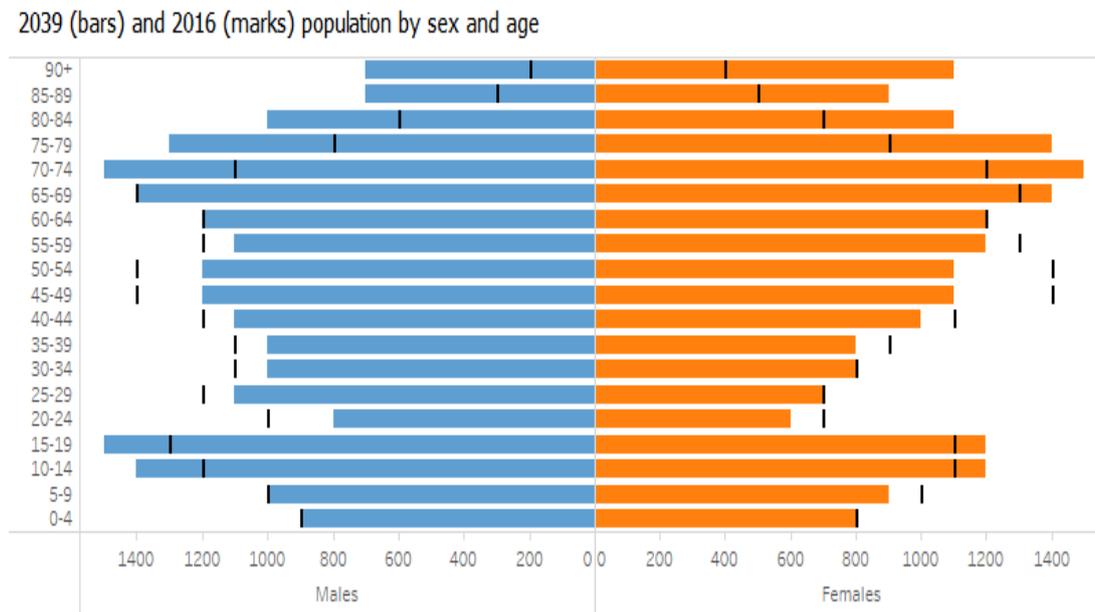
For more detailed population estimate data, please view the dashboard at the link below:
<https://public.tableau.com/profile/r.i.team.leicestershire.county.council#!/vizhome/2016DistrictPopulationEstimatesDashboard/2015-16PopulationEstimates>

4. Population Projections – 2016-39

The Office for National statistics released the 2014-based Subnational population projections on 25th May 2016². The 2014-based population projections provide population figures by every year up to 2039. These projections provide estimates of the future population of English regions, local authorities and clinical commissioning groups. The projections are trend-based and demographic assumptions are based on levels of births, changing economic circumstances or other factors that might have on demographic behavior. The trends for these projections take into account information from the 2011 Census.

The population of Rutland is projected to grow by 7.9% to 41,100 by 2039, an increase of 3,000 from 2016. Nationally the population is expected to increase at a faster rate than Rutland, by 14.6% between 2016 and 2039. In Rutland, the number of females will grow to 20,000, an increase of 8.1% by 2039, whilst the number of males will grow to 21,100, and increase of 7.7% by 2039. The population pyramid below shows the 2039 Rutland population projections by gender and five-year age band.²

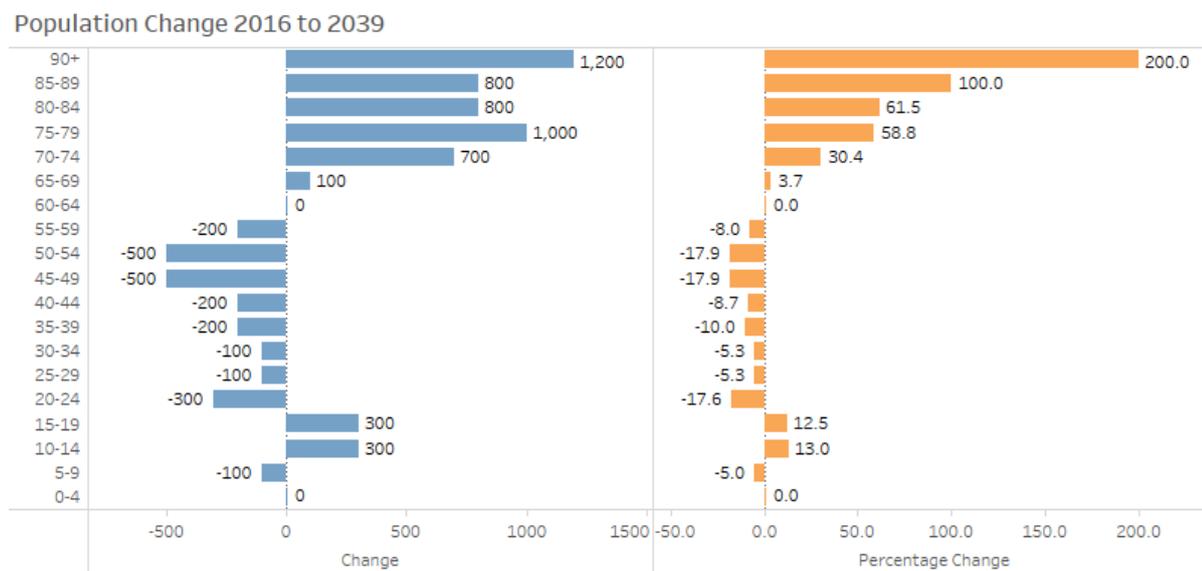
Figure 2 – Rutland 2039 population projection by gender and five-year age



Source: ONS, 2016

The chart below shows the actual and percentage change between 2016 and 2039 for Rutland by five-year age band.

Figure 3 – Rutland 2016-39 population change by five-year age band



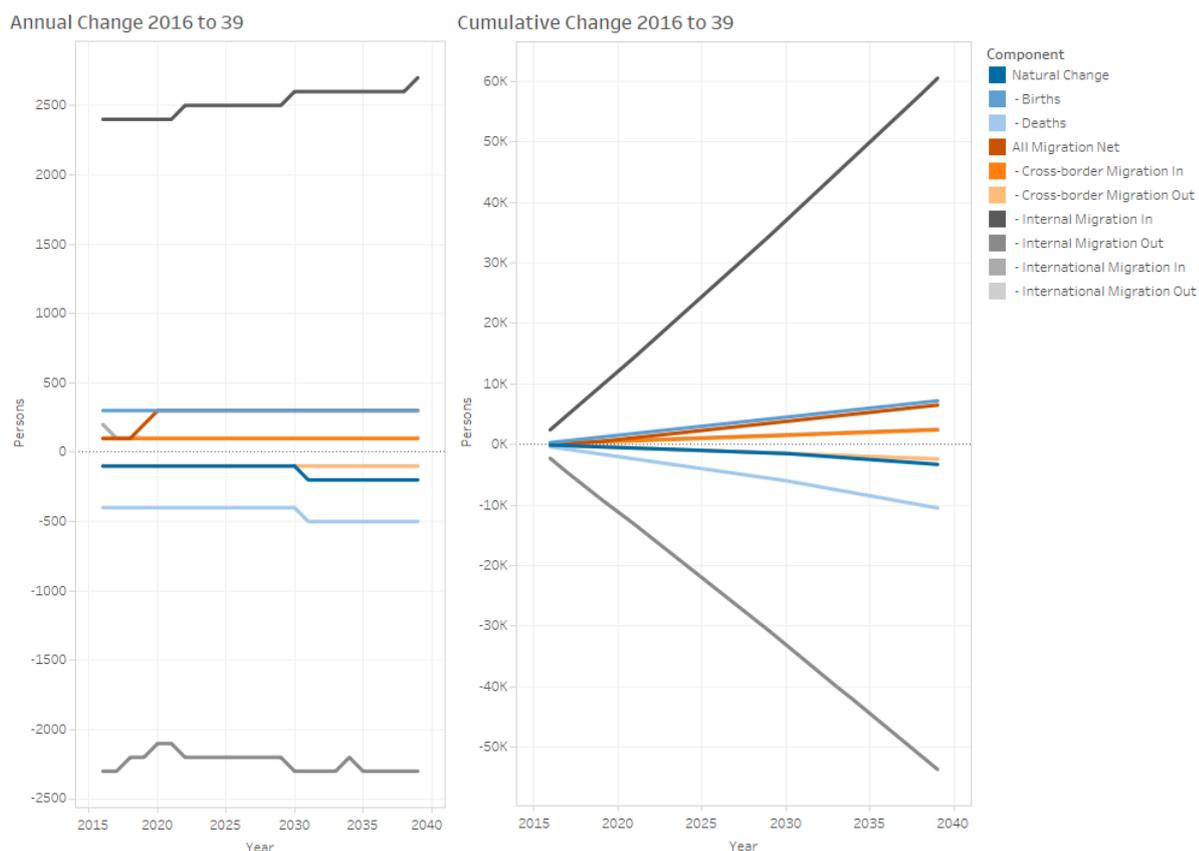
Nationally the over 65 population is predicted to grow by 53.5% and the over 85 population by 127.1% between 2016 and 2039. In Rutland, the over 65 population is predicted to grow at a slower rate than nationally, by 48.9% from 9,400 to 14,000 people, whilst the 85 and over population is predicted to grow at a faster rate than nationally, by 142.9%. The largest change in population is the age band 90 years and over, an increase of 1,200. The population 45 to 49 and the 50-54 age bands are both projected to decrease by 17.9%. The younger population, aged 10 to 14 years and 15 to 19 years are predicted to grow by 13.0% and 12.5% respectively.²

5. Components of Change – Population projections

The main components of population change are births, deaths, and migration.

Rutland’s population is projected to continue to rise gradually over the time between 2016 and 2039. The charts show the number of deaths exceeds number of births resulting in a fall in natural change. Natural change is the difference between the number of deaths and the number of births in a population. The number of births per year is projected to remain at 300 per year by 2039. The number of deaths per year is projected to rise from 400 to 500 (25.0%) by 2039.²

Figure 4 – Components of change



5.1. Migration

Net cross-border migration is due to rise from 100 to 300 per year by 2020 and then remain at this level. Whilst internal migration out is due to fluctuate over the years from 2,300 per year in 2016 to 2,100 in 2020 before settling at 2,300 per year in 2035. Internal migration is projected to rise from 2,400 in 2016 to 2,700 in 2039 (11.1%).²

It is expected that Brexit is likely to affect migration, but to what extent, is unknown. National figures from the ONS on long-term international migration showed that in 2016, 117,000 EU citizens emigrated (up 31,000 from 2015), the highest level for six years. The exodus was most marked among eastern Europeans, with a fall in immigration from the EU8 countries to 48,000 (down 25,000) and a rise in emigration to 43,000 (up 16,000).³

5.2. Impact of housing developments

The Local Plan sets out the planning policies for Rutland for the period to 2026. It is currently being reviewed and updated to extend the period to 2036. This will take into consideration the number of new homes needed within the county, which at October 2015 was set at c1500

(Housing Supply Background Paper, October 2015). Since this, the MOD confirmed plans to dispose of St Georges Barracks at North Luffenham. Rutland County Council is currently partnering with the MOD to look at a potential Garden Village development on this site, which would comprise of between 1500 and 3000 additional homes and align with associated infrastructure.

More information on the Local Plan Review and on the proposed St Georges Development can be found at:

<https://www.rutland.gov.uk/my-services/planning-and-building-control/planning/planning-policy/local-plan/>

<https://www.stgeorgesrutland.co.uk/>

5.3. Further information

For more detailed population projection data, please view the dashboard at the link below:

https://public.tableau.com/views/2014-basedPopulationProjections/2014-BasedPopulationProjections?:embed=y&:display_count=yes:showVizHome=no#

6. Births

In 2016 there were 336 live births in Rutland; this is a decrease of 4 births compared to the previous year. The General Fertility Rate (GFR) examines the number of live births occurring to females aged 15 years and over in the respective calendar year divided by female population aged 15-44 years in that area. Since 2014, the GFR in Rutland has remained stable and similar to the national average.⁴

The Total Fertility Rate (TFR) refers to the total number of children born or likely to be born to a woman in her life time if she were subject to the prevailing rate of age-specific fertility in the population. In 2016 the TFR was 2.01 in Rutland. This means in 2016, the average number of children born or likely to be born to a woman in her life time in Rutland was 2.01, higher than the national average of 1.81.⁵

6.1. Births by Age and Ethnicity

Both nationally and locally, mothers aged 30-34 years have had the highest birth rate over the last five years. Those aged 25-29 have the second highest birth rate, followed by those aged 35-39 years. In Rutland since 2013, the birth rate in those aged 35-39 has still remained higher than the national rate.⁵ In 2016/17, almost a quarter (23.7%) of deliveries (which takes place anywhere other than at home or a non-NHS hospital) were from those aged 35 years or above, a similar

percentage to the national average of 21.6%.⁴ Nationally the percentage of deliveries to women aged 35 years and above has increased year on year since 2014/15, however in Rutland the percentage has fluctuated. This is likely to be due to the small numbers involved.⁴

Mothers of black and minority ethnic (BME) background made up 6.7% of all deliveries in Rutland in 2016/17, this is around quarter the national average of 23.3%.⁴ The 2011 Census tells us the percentage of the population from BME groups in Rutland is 2.9% whereas nationally the percentage is 14.6%.⁶ This infers that both locally and nationally mothers of a BME background may be having more children than those from a non-BME background.

6.2. Births by Health Issues

The percentage of caesarean sections in Rutland has fluctuated since 2014/15 whereas nationally the rate has been increasing year on year. The latest data shows in 2016/17, caesarean sections accounted for 28.8% of all births in Rutland; this is similar to the national average of 27.1%.⁴

The percentage of all live births at term with low birth weight (<2.5kg) was 2.67% in Rutland in 2016, similar to the national average of 2.79%.⁴

Between 2014/15 and 2016/17, the rate of hospital admissions for babies under 14 days has fluctuated in Rutland due to small numbers, whereas the national rate has increased year on year throughout this time. In 2016/17 the rate of hospital admissions of babies fewer than 14 days old in Rutland was 64.1 per 1,000 deliveries, similar to the national rate of 71.0 per 1,000 deliveries. This equates to 20 hospital admissions locally.⁴

7. Deaths

Age-standardised mortality rates (ASMRs) are a better measure of mortality than simply looking at the number of deaths, as they take into account the population size and age structure. At a national level mortality rates have generally been decreasing. This is due to improved lifestyles and medical advances in the treatment and diagnosis of many illnesses and diseases. There have also been government initiatives to improve health through better diet and lifestyle.

Since 2004, the ASMR for all ages in Rutland has remained significantly lower than the national average. The latest data in 2015 shows when the ASMR is broken down into age groups, those under 65, between 65 and 74, between 75 and 84 and above 85 years all have a similar rate to the national average. This is likely to be due to Rutland's mortality rates based on relatively small populations, therefore rates are often subject to random fluctuations and are consequently less robust.

Compared to nationally, a smaller proportion of deaths occurred under to those aged under 65

and higher proportion of deaths occurred to those aged 85 and above. In 2015, one in ten (10.1%) of all deaths were from those aged under 65. This is significantly lower than the national percentage of 14.8% and has decreased year on year from 13.2% in 2012. Of all deaths in Rutland, almost half (46.6%) were from those aged 85 and above, this is significantly higher than the national percentage of 40.4%. The percentage of deaths in this age group has increased significantly over time.⁷

7.1. Deaths from causes considered preventable

The rate of mortality from causes considered preventable in Rutland has remained significantly lower than the national average over time, for both persons and males. In the last two recorded time periods for females (in 2013-15 and 2014-16), the rate of mortality from causes considered preventable has increased to similar to the national rate. This reflects an increase of 15 and 17 deaths compared to the counts of deaths in Rutland in 2012-14.⁸

7.2. Premature Mortality

Premature mortality is a high-level indicator of the overall health of a population, being correlated with many other measures of population health. Premature mortality examines all deaths under the age of 75. The rate of premature mortality in Rutland has remained significantly lower than the national average over time for both males and females. Both nationally and locally the rate for persons has decreased year on year from 2010-12.⁹

7.2.1. Deaths from Cancer

In Rutland, just under a third (30.1%) of all deaths were due to cancer in 2016. This is similar to the national percentage of 28.0%. In 2016 in the 65-74 age group in Rutland, just over half of deaths (53.4%) were due to cancer, this is similar to the national picture (44.1%). This is followed by 35.0% of deaths in those aged 75-84 years and a third (33.3%) of deaths in the under 65s in the county. Deaths from cancer in the 85 years and over age group accounted for 17.2% of all deaths in 2016.⁷

Mortality rates from cancer in those aged under 75 years have remained significantly better than the national average since 2001-03 (when the indicators were first recorded). Nationally, the rate of all premature deaths from cancer has decreased year on year since 2001-03, whereas the rate in Rutland has decreased year on year since 2011-13.⁸

The under 75 mortality rate from cancers considered preventable in Rutland has increased to perform similar to the national average for the two most recent time periods (2013-15 and 2014-16). In 2014-16, the rate of cancer deaths for those aged less than 75 was 100.0 per 100,000 population aged less than 75 years and the rate for those cancer deaths considered preventable

was 65.2 per 100,000 population aged less than 75 years. The difference in rate infers over half the cases of deaths from cancer are considered preventable in Rutland, this percentage is lower nationally.⁸

7.2.2. Deaths from Circulatory Disease

In Rutland, almost a quarter (24.5%) of all deaths were due to circulatory disease in 2016. This is similar to the national percentage of 25.5%. The percentage of deaths from circulatory disease in Rutland has significantly declined since 2004, a decline which is reflected nationally.⁷

As age increases, the percentage of deaths from circulatory disease also increases at a national level. However in Rutland in 2016, the highest percentage of deaths from circulatory disease (30.1%) was seen in the 75-84 age group whereas in the 85 year and over age group, less than a quarter of deaths (23.8%) were due to circulatory disease in Rutland. In both these age groups, over time there has been a significant decline in the percentage of deaths due to circulatory disease in Rutland. Across all age bands, the percentage of deaths from circulatory disease was similar to the national average.⁸

Mortality rates from cardiovascular disease in those aged under 75 years have remained significantly better than the national average for the last three time periods. In 2014-16, deaths from all cardiovascular disease for those aged less than 75 was 53.5 per 100,000 population aged less than 75 years, significantly better than the national rate of 73.5 per 100,000 population aged less than 75 years. In the same time period, deaths from cardiovascular disease considered preventable for those aged less than 75 was 37.4 per 100,000 population aged less than 75 years, similar to the national rate of 46.7 per 100,000 population aged less than 75 years. This infers a higher proportion of deaths from cardiovascular disease are considered preventable in Rutland compared to nationally.⁸

7.2.3. Deaths from Respiratory Disease

In 2016 in Rutland, 11.8% of all deaths were due to respiratory disease. This was similar to the national percentage of 13.7%. As age increases, the percentage of deaths from respiratory disease also increases at both a national and local level. In 2016 in Rutland, in the under 65s age group, the data for deaths from respiratory disease was suppressed due to small numbers. This percentage is 8.6% in the 65-74 age group, 11.7% in 75-84 age group and 13.9% in the 85 years and over age group. All age bands perform similar to the national percentage.⁷

Mortality rates from respiratory disease in those aged under 75 years have remained significantly better than the national average since 2001-03 (when the indicators were first recorded). However, the mortality rate from respiratory disease considered preventable for the latest two years (2013-15 and 2014-16) are similar to the national average. In 2014-16, respiratory deaths for

those aged less than 75 were 19.9 per 100,000 population aged less than 75 years and those considered preventable were 12.5 per 100,000 population aged less than 75 years. The difference in rate infers that over half of the cases of deaths from respiratory disease are considered preventable in Rutland and in England.⁸

7.3. Place of Death

Over a third (38.9%) of all deaths in Rutland in 2016 were in hospital, followed by in the home (27.7%) and in care homes (27.7%), hospices (3.2%) and other places (2.4%). This pattern of place of death is reflected nationally. The latest data shows Rutland has a significantly lower proportion of deaths occurring in hospital and a significantly higher proportion of deaths in care homes compared to nationally. Like nationally, in Rutland the trend is significantly decreasing over time for in-hospital deaths and significantly increasing over time for deaths in care homes, however hospitals are still the most common place to die in the county.⁷

In Rutland, over half (51.9%) of deaths in the under 65 years age group occurred in hospital in 2016, this is the highest percentage out of all age groups. The lowest percentage of in-hospital deaths occurred in those aged over 85 years. In 2016, less than a third of deaths (29.8%) in this age group were in hospital, significantly lower than the national percentage of 43.8%. The trend of in-hospital deaths has been significantly decreasing across the 65-74 age band and 85 and above age band over time.⁷

As age increases, the percentage of deaths in care homes increases. Almost half (45.7%) of all deaths in the 85 and above age bands occurred in care home, a significantly higher percentage to the national average (36.7%). The trend of care home deaths has been significantly increasing in the county across the 85 and above age band over time.⁷

Nationally the percentage of deaths at home decreases with age. In 2016 in Rutland, over a third (39.7%) of deaths in those aged 65-74 years died at home, similar to the national percentage of 30.3%. This was the highest percentage out of all age bands in Rutland residents. In those aged 85 and above, a quarter (24.5%) of all deaths were in the home. This is a significantly higher percentage compared to the national average (16.4%).⁷

In 2016, hospice deaths accounted for 3.2% of all deaths in Rutland, this is similar to the national percentage of 5.7%. In Rutland the trend is significantly increasing over time for deaths in hospices.⁷

8. Life Expectancy

8.1. Life Expectancy

Since 2010-12, life expectancy at birth for males and females in Rutland has remained significantly better than the national average.

In 2014-16, the average number of years a newborn in Rutland would survive if he or she experienced the age-specific mortality rates for that area and time period throughout his or her life was 82.1 years for males and 85.4 years for females. These figures are both better than the values for England (79.5 years and 83.1 years respectively).⁸

In 2014-16, life expectancy at birth for males in Rutland has shown a slight increase from 81.8 years in 2013-15 to 82.1 years in 2014-16. Life expectancy at birth for females in Rutland has shown a slight increase from 85.2 years in 2013-15 to 85.4 years in 2014-16. To note, life expectancy in females peaked in 2012-14 at 85.7 years. Nationally, life expectancy at birth has remained stable for males over the last two time periods and in females over the last three periods, at 79.5 and 83.1 years respectively.⁸

8.2. Healthy Life Expectancy

In 2014-16, healthy life expectancy (HLE) at birth in Rutland is significantly better than the national average for both males and females.

In males, HLE at birth has decreased from 71.1 years in 2013-15 to 68.8 years in 2014-16. Throughout this time the England average has fallen from 63.4 years to 63.3 years. The HLE at birth for females in Rutland has decreased from 70.6 years in 2013-15 to 70.2 years in 2014-16. Nationally the healthy life expectancy at birth in females has declined from 64.1 years in 2013-15 to 63.9 years in 2014-16. In 2014-16, the HLE at birth for females is now higher than males. This was not the case in 2013-15.⁸

8.3. Life Expectancy at 65

Since 2001-03 life expectancy at 65 for males and females in Rutland has remained significantly better than the national average.

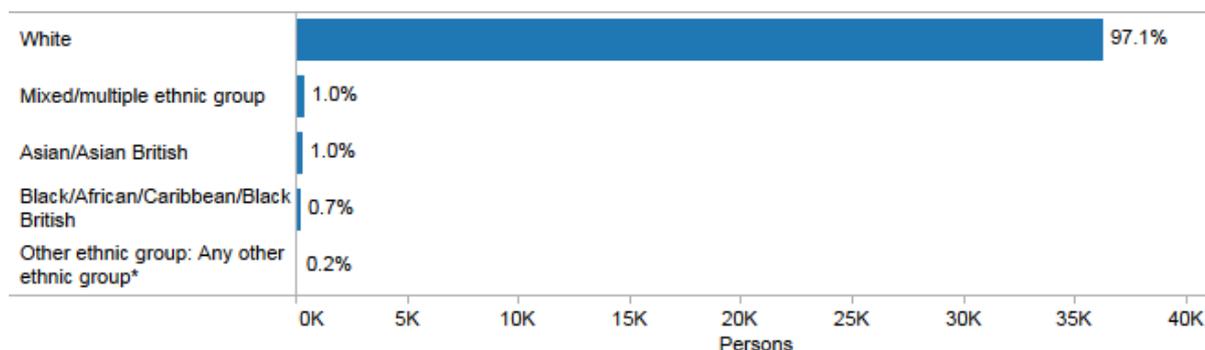
Life expectancy at 65 for males in Rutland has remained at 20.2 years in 2013-15 and 2014-16. Life expectancy at 65 for females in Rutland has remained stable for the last three time periods 23.0 years. Nationally, male life expectancy at 65 is increasing while female life expectancy is stabilising. Male life expectancy at 65 in England has increased year on year from 16.3 years in 2001-03 to 18.8 years in 2014-16. Female life expectancy at 65 in England has remained stable at 21.1 years for the last three time periods.⁸

9. Protected characteristics

9.1. Ethnicity

The chart below shows the proportion of Rutland’s population by broad ethnic group. The vast majority of the county population (97.1%) belong to White ethnicities, including White British and White Irish. This equates to almost 36,000 people. The next largest ethnic groups in Rutland are Asian and Mixed or Multiple Ethnic Group, which each constitute 1.0% of the population, followed by Black, with 0.7% and Other Ethnic Group with 0.2%.⁶

Figure 5 – Rutland population by broad ethnic group, 2011



Source: 2011 Census, ONS

9.1.1. Main Language

Of the 36,309 people over the age of 3 in Rutland, 35,654 (98.2%) have English as their main language. This is followed by Other European language (EU), with 0.8% and East Asian Language, with 0.3%.¹⁰

Table 1 – Rutland population by main languages, 2011

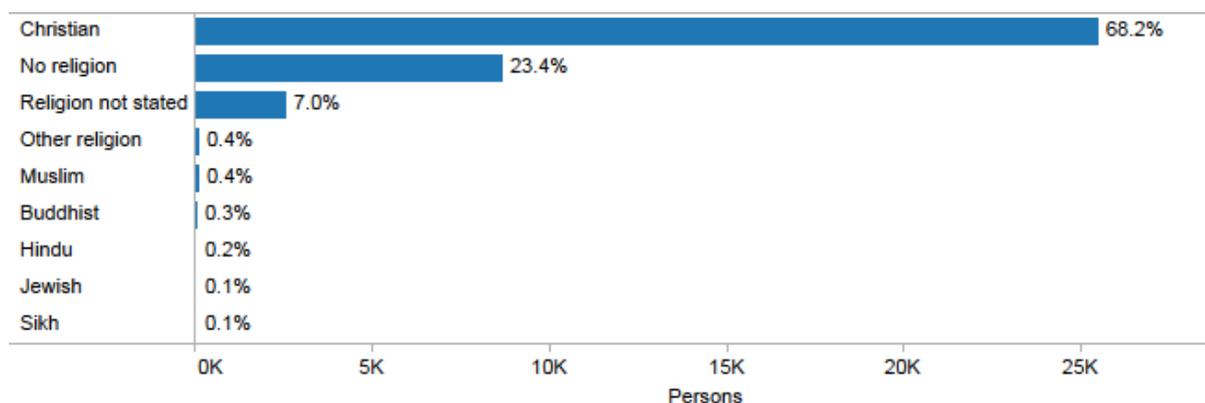
English (English or Welsh if in Wales)	35,654
Other European language (EU)	291
East Asian language	112
Other European language (non EU)	49
South Asian language	40
French	39
Spanish	33
Other language	30
African language	28
Portuguese	22
West/Central Asian language	11
Arabic	0

Source: 2011 Census, ONS

9.2. Religion

The chart below shows the proportion of Rutland’s population by religion. The largest religious group in the county is Christian, which constitutes 68.2% of the population. This is followed by No Religion, 23.4% and Religion not stated, 7.0%. Muslims and Other religion each constitute 0.4% of the Rutland population, followed by Buddhist (0.3%) and Hindu (0.2%).¹¹

Figure 6 – Rutland population by religion, 2011

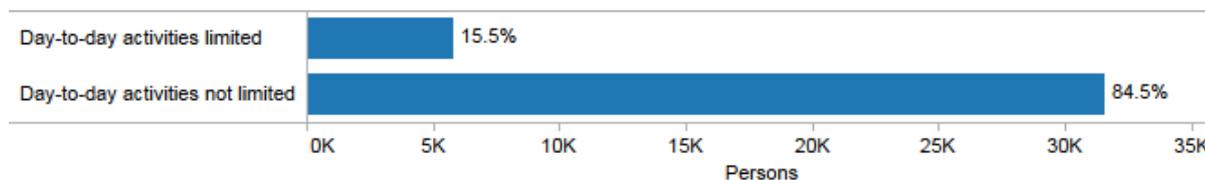


Source: 2011 Census, ONS

9.3. Disability

The chart below shows the proportion of Rutland’s population by self-reported limiting long term illness. This is commonly used as a proxy for disability. In 2011, 15.5% of the county population considered themselves to have a condition that limited their day to day activities.¹²

Figure 7 – Rutland population by limiting long-term illness, 2011



Source: 2011 Census, ONS

N.B. “Day-to-day activities limited” includes “limited a little/ limited lot”

9.4. Marriage and civil partnership

Marriage and civil partnership formation statistics are derived from information recorded when marriages and civil partnerships are registered as part of civil registration, a legal requirement. In 2015, there were 469 marriages and 2 civil partnership formations that took place in Rutland.¹³ Please note this data refers to the area of occurrence of the marriage or civil partnership rather than the couple’s area of residence.

9.5. Sexual identity

In 2016, 58,000 (1.6%) of the East Midlands population aged 16 and over identified themselves as lesbian, gay or bisexual (LGB), compared to 2.0% nationally. At a national level, more males (2.3%) than females (1.6%) identified themselves as LGB in 2016. The age range who were most likely to identify as LGB in 2016 were the 16 to 24 age group (4.1%). The population who identified as LGB in 2016 were most likely to be single, never married or civil partnered, at 70.7%.¹⁴ Applying the national prevalence estimates of LGB individuals to the Rutland population aged 16 and above in 2016 would estimate there were 377 LBG males and 252 LGB females.

9.6. Further information

For more detailed Census 2011 data, covering the whole range of topics, please view the dashboard at the link below:

https://public.tableau.com/views/LAKeyStatsDashboard/Dashboard?:embed=y&:display_count=no&:showVizHome=no

10. Military population

Two British Army barracks are located in Rutland, Kendrew Barracks in Cottesmore and St

George's Barracks in North Luffenham. The data presented examines summary statistics on the number of serving UK Armed Forces personnel and entitled civilian personnel with a Defence Medical Services (DMS) registration. Entitled civilian personnel include service personnel family dependents and Ministry of Defence (MOD) employed civilian personnel who are entitled to care at MOD primary care facilities. Personnel with a DMS registration have their primary care (GP services) provided by the MOD rather than the NHS.

The military population accounts for 5.8% of the resident population in the county. The military population is younger and has a higher proportion of males compared to the resident population of Rutland. In April 2018, there were 2,250 Armed Forces personnel and entitled civilian personnel registered in Rutland. 1,620 individuals (72%) were in the Armed Forces and 630 individuals (28%) were entitled civilian personnel. Of those in the Armed Forces, 85% were male compared to a third of the entitled civilian personnel.¹⁵

11. Prison population

NHS England Health and Justice is responsible for commissioning healthcare for children, young people and adults across secure and detained settings, which includes prisons, secure facilities for children and young people, police and court Liaison and Diversion services and immigration removal centres. The range of services which are directly commissioned for prisons include primary and secondary care services, public health including substance misuse services (under a Section 7a Agreement with the Department of Health), dental, ophthalmic services and mental health services.

HMP Stocken in Stretton, in the northeast of the county, is a category C closed training prison. The prison's operational capacity was 842 in October 2011.¹⁶ In December 2017, there were 841 male prisoners aged 21 and over in its care.¹⁷

The table below shows the ethnicity of the prison population in December 2017 by broad ethnic group. The largest ethnic group was White with 69.9%, followed by Black with 11.4%, Asian with 10.9% and Mixed and multiple ethnic groups with 10.9%.¹⁸

Table 2 – HMP Stocken population by broad ethnic group, December 2017

White	Mixed/ Multiple ethnic groups	Asian/ Asian British	Black/ African/ Caribbean/ Black British	Other ethnic group	Not stated	Not recorded
588	54	92	96	8	3	0

12. 2011 Rural Urban Classification

It is important to distinguish between rural and urban areas when analysing social and economic statistics as the populations and businesses can differ in their makeup (for example rural areas tend to have higher proportions of older people). The opportunities, challenges and barriers for businesses, the services people receive and their quality of life can also differ markedly between rural areas and larger towns and cities.

ONS, May 2015

The 2011 Urban Rural Classification (RUC2011) was released by the Office for National Statistics in October 2013. This data updates the classification produced for the 2001 Census. The RUC2011 allows for a consistent rural/urban view of datasets. A suite of classifications has been produced for use at a variety of geographic levels, including ward, Lower Super Output Area (LSOA) and output area (OA). RUC2011 is a revised version of the classification produced after the 2001 Census. It was created by the Department of Town and Regional Planning at the University of Sheffield on behalf of a government working group.

RUC2011 for Lower Super Output Areas is built up from the OA level classification, with assignment to urban or rural made by reference to the category to which the majority of their constituent OAs is assigned.

Lower Super Output Areas (LSOAs)

LSOAs were designed to improve the reporting of small area statistics and are built up from groups of output areas (OA). LSOAs have a minimum population of 1,000 people and a maximum population of 3,000. They contain a minimum of 400 households and a maximum of 1,200 households. Where possible, LSOA boundaries follow natural boundaries such as roads and rivers.

More information on the ONS Area Classifications can be found here:
<https://www.gov.uk/government/statistics/2011-rural-urban-classification>

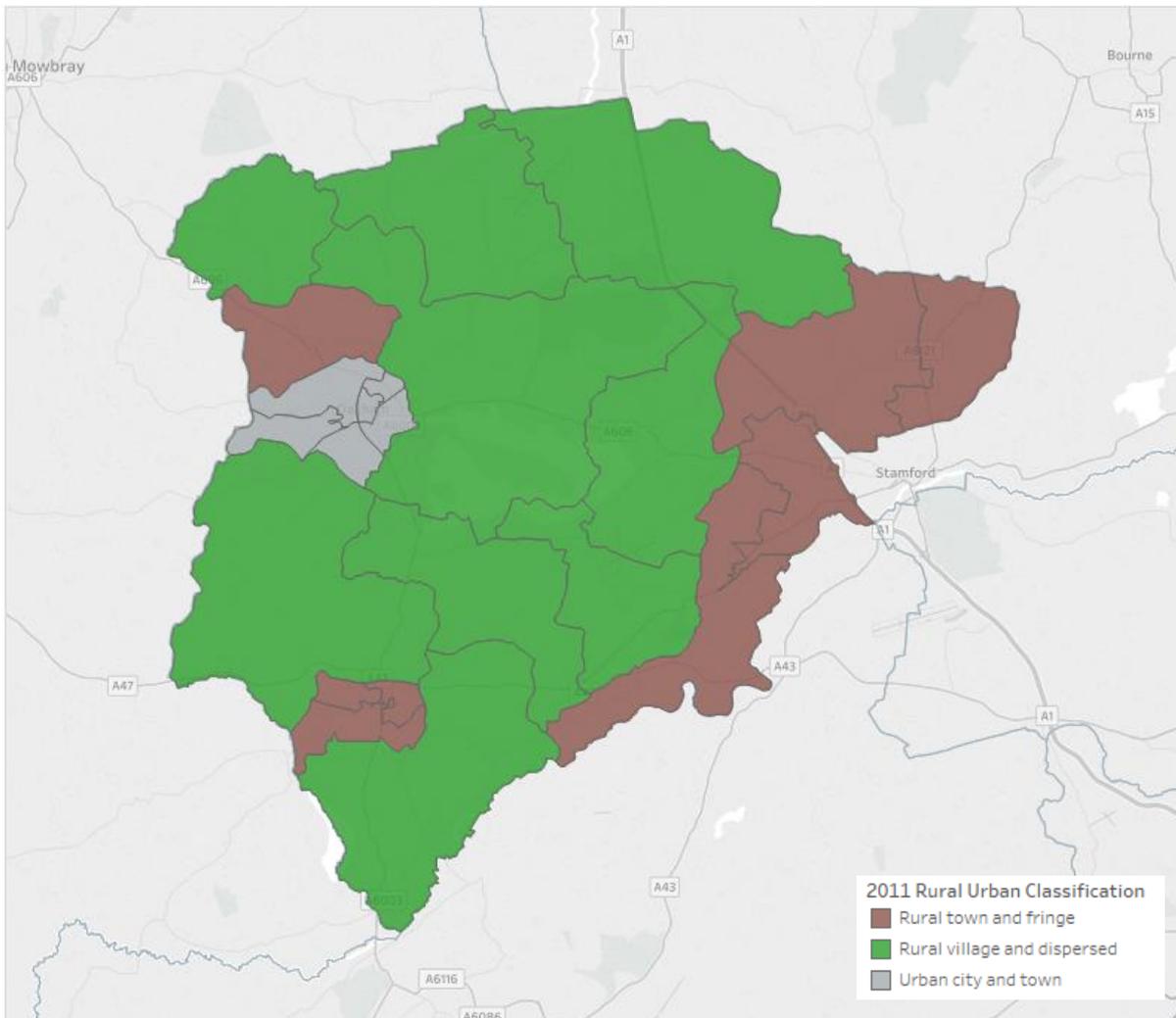
12.1. Exploring the Data

The map below displays 2011 Rural Urban Classification for Rutland at LSOA level. Rutland is predominantly rural by area. Overall, 3.3% of the total area of Rutland is classed as Urban City and Town, with a further 22.2% classed as Rural Town and Fringe and the remaining area (74.5%) classed as Rural Village and Dispersed.¹⁹

Urban areas (classified as areas with populations of 10,000 or more at the time of the 2011 Census) can be found in Oakham.

Rural Town and Fringe areas cover smaller settlements such as Uppingham, Langham, Ketton, Ryhall and Casterton. Finally, Rural Village and Dispersed parts of the classification cover the remaining areas of the county, encompassing small villages and hamlets.

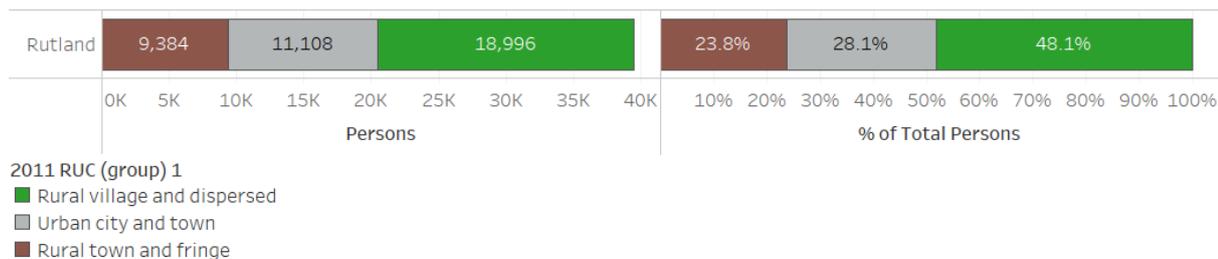
Figure 8 - 2011 Urban Rural Classification by LSOA



Source: 2011 Rural Urban Classification, ONS, 2013.

The chart below shows the total population of Rutland split by 2011 Rural Urban Classification. Looking at the population of Rutland by Rural Urban Classification, it is clear that while the county is rural in terms of area, half the population is concentrated within urban areas. Overall, 28.1% of the population of Rutland live in areas classed as Urban City and Town, while 23.8% live in Rural Town and Fringe and the remaining 48.1% live in areas classed as Rural Village and Dispersed.

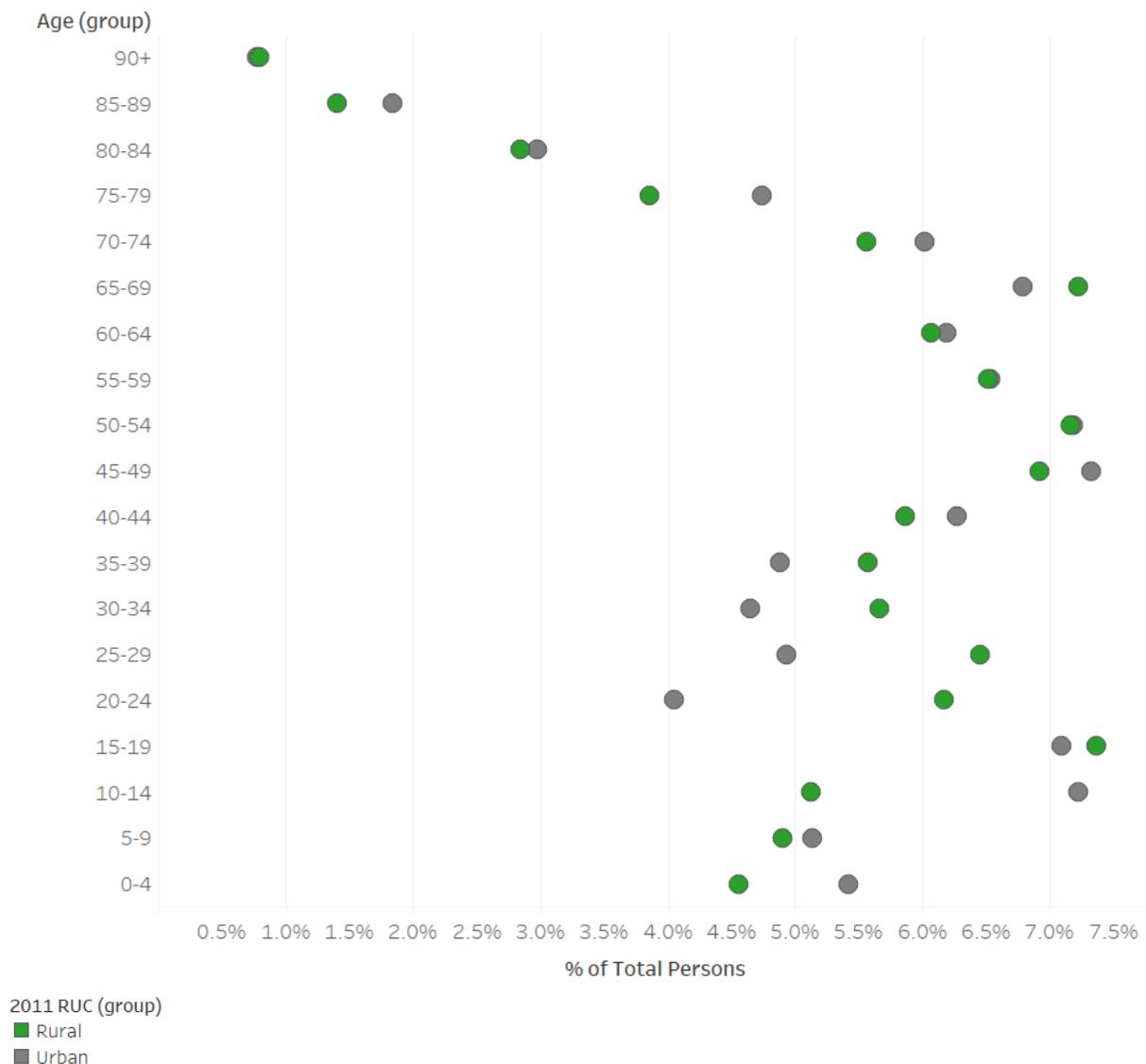
Figure 9- 2016 Population estimates by 2011 Rural Urban Classification



Source: 2011 Rural Urban Classification, ONS, 2013. 2016 mid-year population estimates, ONS, 2017.

The chart below shows the total Rutland population by age for Urban and Rural. Overall, rural areas tend to be the working age population. This is most noticeable in the 24-39 age bands. In comparison, urban areas tend to be either elderly or younger, with higher proportions in the 70-79 and 0-14 age bands. This is most noticeable in the 10-14 age band with 7.2% of the urban population falling within this band, compared with just 5.1% of rural areas. This is most likely due to the public schools in Oakham and Uppingham.

Figure 10- 2016 Population estimates by age by 2011 Rural Urban Classification



Source: 2011 Rural Urban Classification, ONS, 2013. 2016 mid-year population estimates, ONS, 2017.

12.2. Further Information

Access the 2011 Rural Urban Classification dashboard here:

https://public.tableau.com/views/2011RuralUrbanClassification/2011RUC?:embed=y&:display_count=yes:showVizHome=no#

13. 2011 Output Area Classification

In August 2014, the Office for National Statistics released the 2011 Output Area Classification (2011 OAC). This data updates the classification produced for the 2001 Census. The 2011 OAC categorises all UK output areas based on 2011 Census data on a wide range of socioeconomic and demographic topics. They aim to identify parts of the UK with similar characteristics using a defined set of supergroups, groups and subgroups.

13.1. Further information

Background information on the ONS Area Classifications can be found here:

<http://www.ons.gov.uk/ons/rel/regional-trends/area-classifications/2011-area-classification-for-output-areas/index.html>

13.2. Census Output Areas

Output areas (OAs) are created for Census data, specifically for the output of census estimates. The OA is the lowest geographical level at which census estimates are provided. They had approximately regular shapes and tended to be constrained by obvious boundaries such as major roads. OAs were required to have a specified minimum size to ensure the confidentiality of data. The minimum OA size was 40 resident households and 100 resident people but the recommended size was rather larger at 125 households. These size thresholds meant that unusually small wards and parishes were incorporated into larger OAs.

13.3. Further information

Background information on census output areas can be found here:

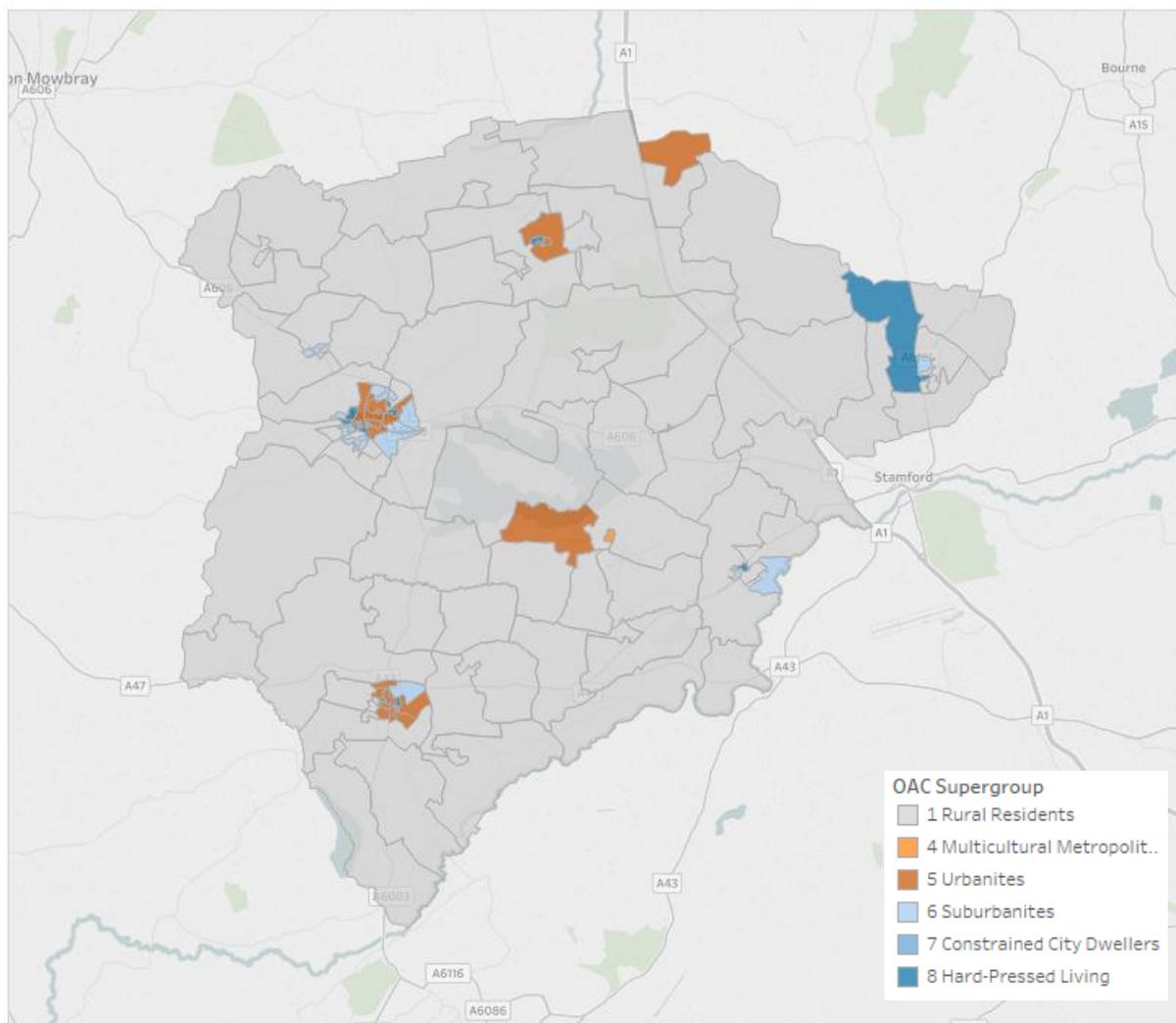
<http://www.ons.gov.uk/ons/guide-method/geography/beginner-s-guide/census/output-area--oas-/index.html>

13.4. Exploring the Data

The map below shows the distribution of 2011 OAC supergroups across Rutland. It is clear from the map that the majority of the area of Rutland is classified as Rural Residents, building on the analysis of rural classification above. In comparison, urban areas are more diverse in the types of

communities they contain.

Figure 11 - 2011 Output Area Classification by output area



Source: 2011 Output Area Classification, ONS, 2013.

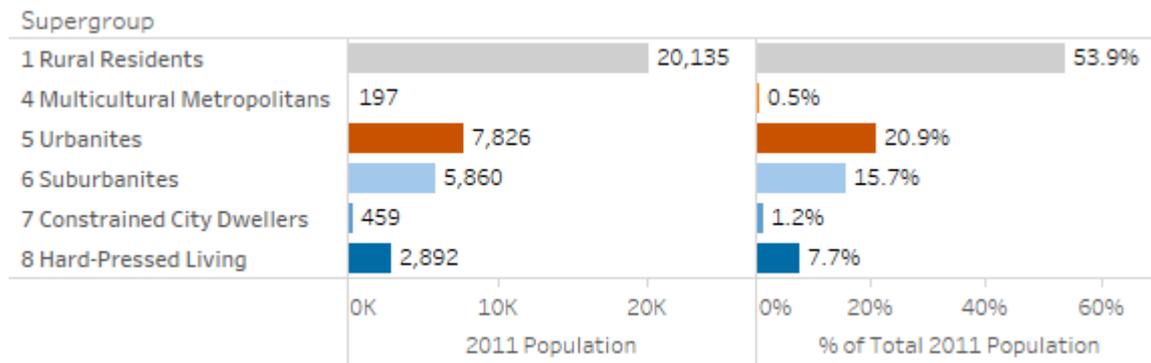
Areas classed as Urbanites can, unsurprisingly, be found across the county in more central urban areas, while Suburbanites cover parts of the county in more peripheral urban areas.

Hard-Pressed Living occupy more peripheral, suburban areas of Oakham and Uppingham as well as Cottesmore, Ketton, Ryhall and Casterton.

The chart below shows the proportion of the Rutland population by 2011 OAC supergroup. Echoing the analysis of rural classification above, the majority of the population (53.9%) live in the largest area of Rutland classified as Rural Residents. 20.9% of the population (7,826 people) live in areas classified as Urbanites, 15.7% of the population (5,860 people) live in areas classified as

Suburbanites, and 7.7% of the population (2,892 people) live in areas classified as Hard-Pressed Living,

Figure 12- 2016 Population estimates by 2011 Output Area Classification²⁰

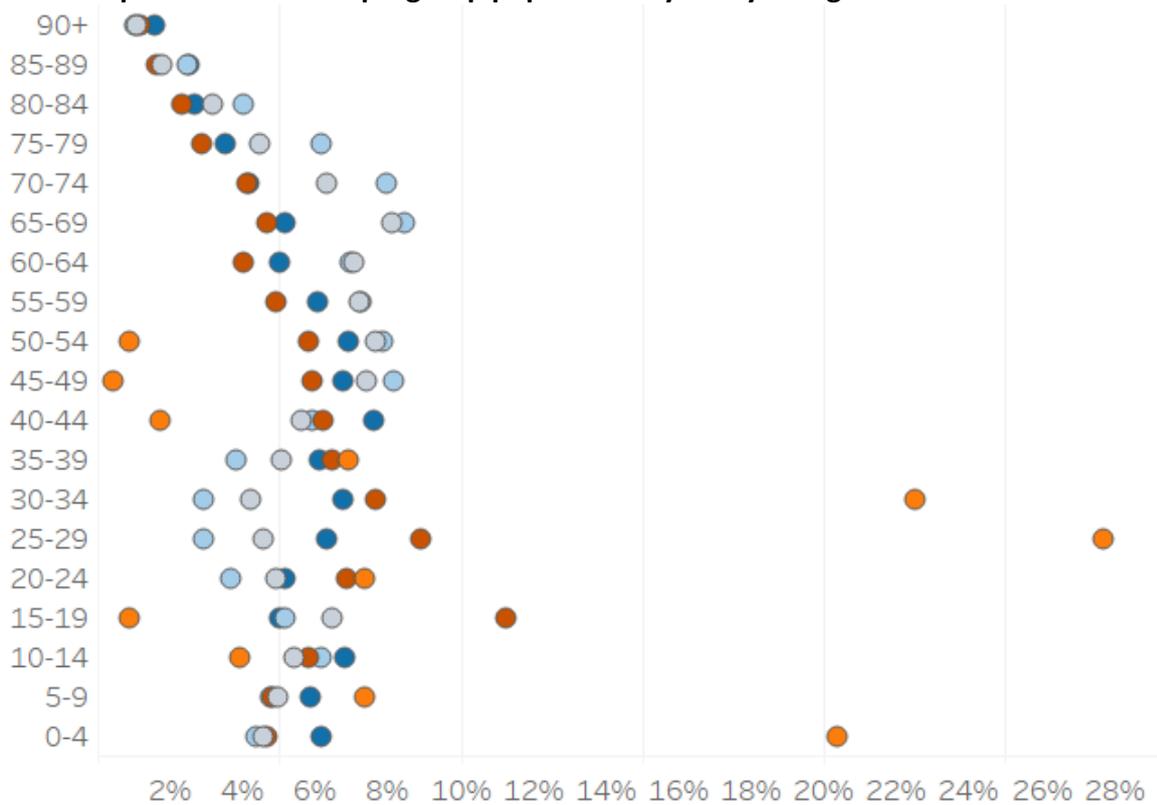


Source: 2011 Output Area Classification, ONS, 2013. 2016 mid-year population estimates, ONS, 2017.

In terms of the broad age structure by the main OAC supergroups, Rural Residents areas tend to have higher proportions in middle age groups (approximately 45-74) and smaller proportions amongst children and younger adults groups (specifically under 15s and 20-39). Multicultural Metropolitans - whilst making up a small proportion of the population of the county as a whole - contain higher proportions of younger age groups, with the 25-29 and 30-24 age groups making up over 27% and 22% of the population respectively of these areas, and the 0-4 age group making up 20%. Multicultural Metropolitans are also much less likely to contain older age bands compared against other supergroups.

Elsewhere, areas classed as Urbanites tend to have higher proportions from teenage and working age bands (15-59) and lower proportions from older adults (75+), while for Suburbanites, the opposite is generally true. Finally, Hard-Pressed Living areas have the highest proportions of the 10-14 and 40-44 age bands, and lower proportions of older adults (60-79).

Chart 5 - Proportion of each supergroup population by five-year age band



Source: 2011 Output Area Classification, ONS, 2013. 2016 mid-year population estimates, ONS, 2017. N.B. Excludes supergroups with <5% of total Rutland population

14. Pen Portraits

For the 2011 OAC, pen portraits describe the characteristics of the different supergroup/group/subgroup clusters, and the radial plots illustrate for each of these clusters the values for each of the final census variables, using a scale to represent the difference (either positive or negative) from the UK mean and parent supergroup/group (if applicable) for that variable.

14.1. Further information

Full information on the 2011 OAC pen portraits can be found here:

<http://www.ons.gov.uk/ons/guide-method/geography/products/area-classifications/ns-area-classifications/ns-2011-area-classifications/pen-portraits-and-radial-plots/index.html>

15. 2015 Indices of Deprivation

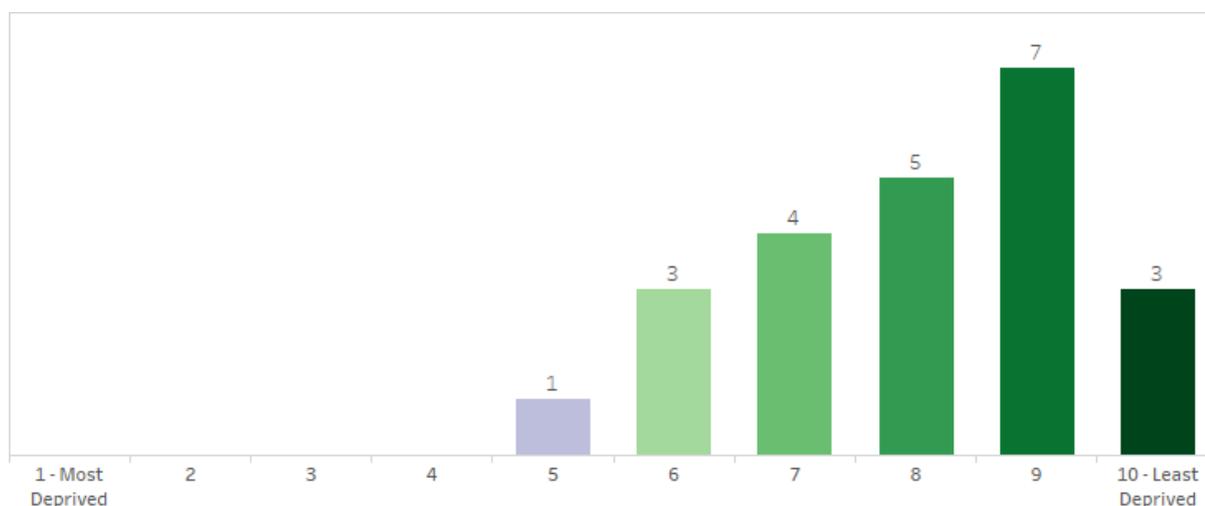
The English Indices of Deprivation 2015 (ID2015) are based on 37 separate indicators, organised across seven distinct domains of deprivation which are combined, using appropriate weights, to calculate the Index of Multiple Deprivation 2015 (IMD 2015).²¹ This is an overall measure of multiple deprivation experienced by people living in an area and is calculated for every Lower layer Super Output Area (LSOA), or neighbourhood, in England. Every such neighbourhood in England is ranked according to its level of deprivation relative to that of other areas. It is important to note that these statistics are a measure of relative deprivation, not affluence, and to recognise that not every person in a highly deprived area will themselves be deprived. Likewise, there will be some deprived people living in the least deprived areas.

15.1. Exploring the Data

Overall, when looked at in the national context, Rutland is not particularly deprived. At a local authority level, using the overall Multiple Deprivation measure, the county is ranked 148th out of 152 upper tier authorities in England, where 1st is the most deprived.

The chart below displays the distribution of Rutland LSOAs nationally, using national rank for Multiple Deprivation to place each neighbourhood into deciles (10 percent bands), ordered from 1 (most deprived) to 10 (least deprived).

Figure 13 - ID2015 Multiple Deprivation national decile, LSOAs



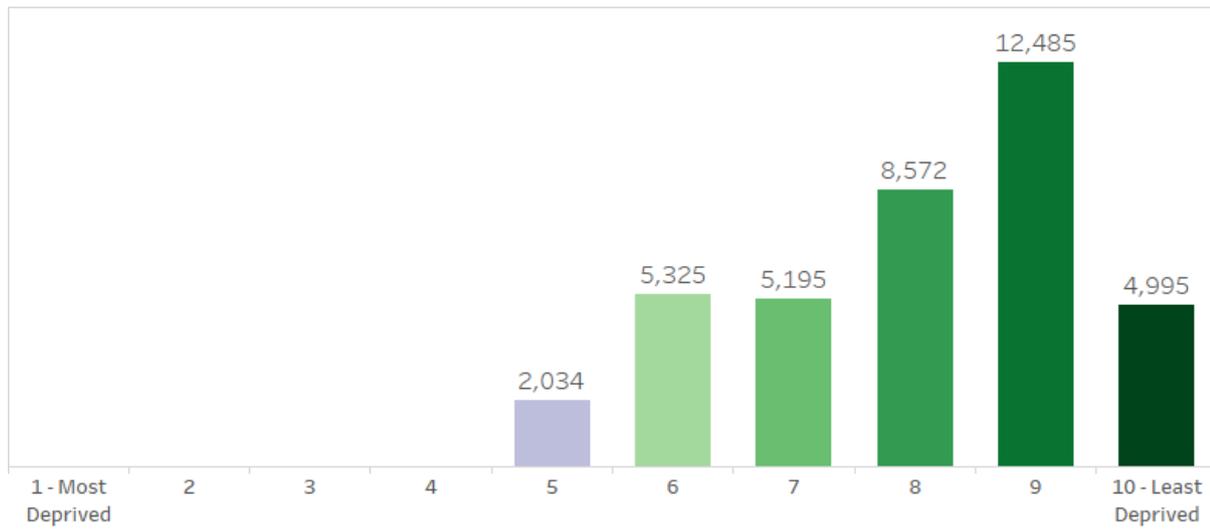
Source: Indices of Deprivation 2015, MHCLG, 2015.

From the chart, it is clear that overall, Rutland neighbourhoods fall in the less deprived deciles; 22

of the 23 LSOAs in the county fall within the 50% least deprived areas in England. However, while Rutland experiences low levels of deprivation overall, one neighbourhood in the county falls within the 50% most deprived in England. This area is Greetham LSOA.

The chart below displays the distribution of the Rutland population across national Multiple Deprivation deciles (10 percent bands), ordered from 1 (most deprived) to 10 (least deprived).

Figure 14- 2016 population by ID2015 Multiple Deprivation national decile, LSOAs

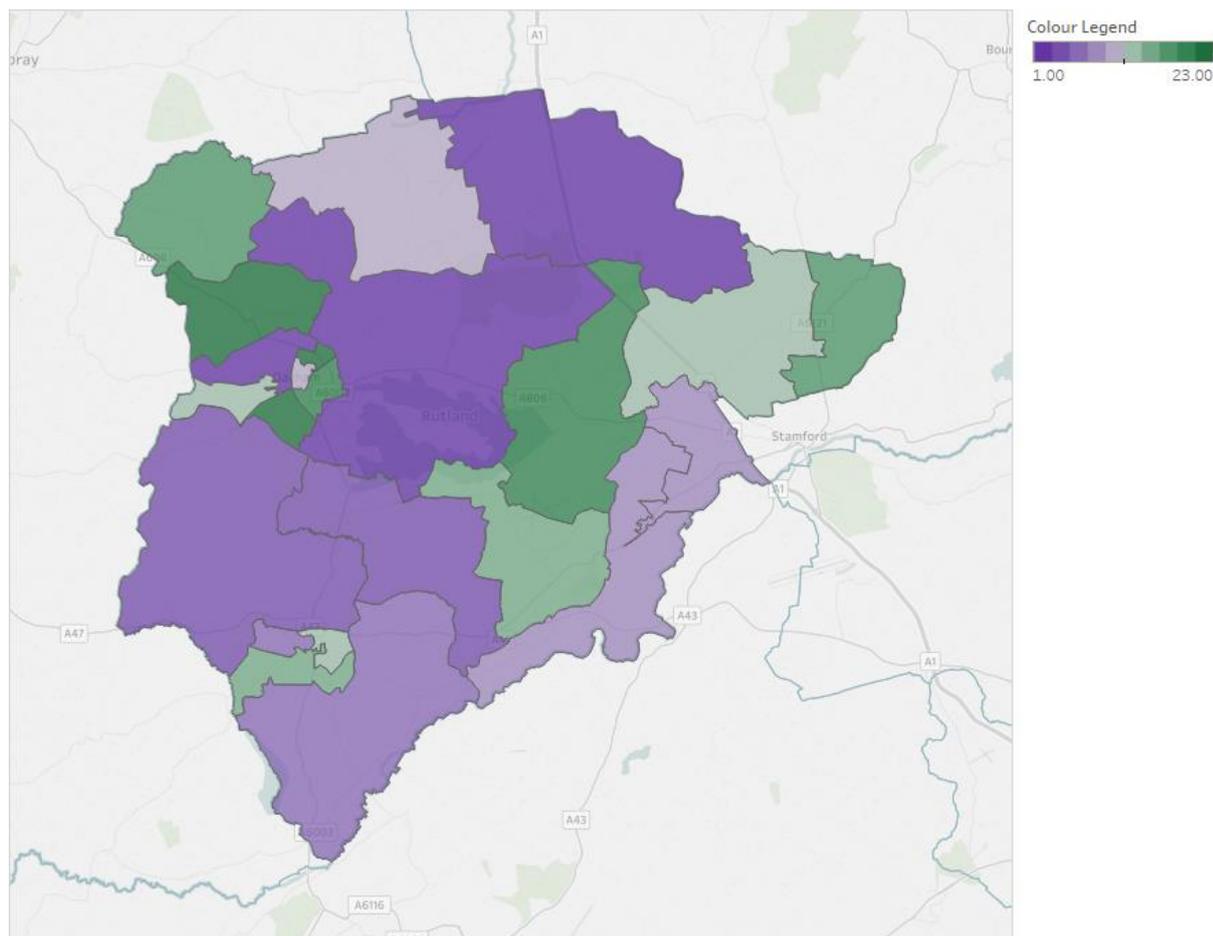


Source: Indices of Deprivation 2015, MHCLG, 2015. 2016 Mid-year population estimates, ONS, 2017.

As LSOAs have a fairly consistent population size (1,500 people on average), the distribution of the county population by national deciles is consistent with the distribution of LSOAs overall; just over 2,034 people live in neighbourhoods falling in the 50% most deprived deciles nationally, out of a total population of over 38,000. The vast majority of Rutland residents live in less deprived areas; over 26,000 people (67.5% of the total population) live in neighbourhoods falling in the three least deprived deciles nationally.

The map below displays the Multiple Deprivation rank for all Rutland LSOAs. This ranks each LSOA according to their overall score, from most (1) to least (23) deprived.

Figure 15 - ID2015 Multiple Deprivation county rank



Source: Indices of Deprivation 2015, MHCLG, 2015.

From the map, we can see that the LSOAs with the highest rank (dark purple) and therefore more deprived can generally be found in the main urban area such as Oakham North West as well as Exton, Greetham, Braunston and Belton, and Martinsthorpe. As LSOAs have broadly consistent populations and urban areas have higher population densities, these areas appear smaller on the map, compared with less densely populated rural areas.

In comparison, while some of the least deprived areas of the county can also be found in and around the main towns, such as Oakham South, Oakham North East, Oakham East, and in rural areas such as Normanton and Empingham, Langham, Ryhall and Whissendine.

15.2. Further information

Full information on the 2015 Indices of Deprivation can be found here:

https://public.tableau.com/views/ID2015DashboardFINAL/ID2015Dashboard?:embed=y&:display_count=yes&publish=yes:showVizHome=no#

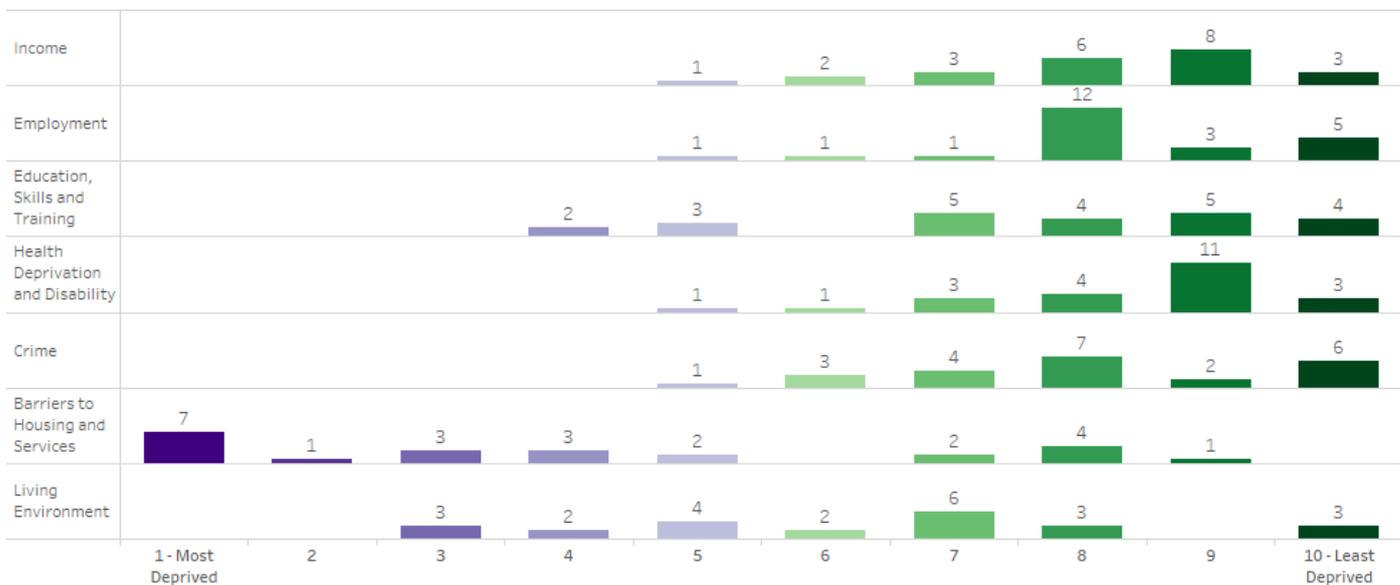
15.3. Deprivation Domains

The Index of Multiple Deprivation discussed above comprises of seven domains, each focusing on a specific aspect of deprivation. These domains cover:

- Income
- Employment
- Education, Skills and Training
- Health Deprivation and Disability
- Crime
- Barriers to Housing and Services
- Living Environment

Deprivation domains can be analysed in the same way as the Index of Multiple Deprivation. The charts below show Rutland LSOAs by their national decile for each of the ID2015 domains;

Figure 16- ID2015 Deprivation domain national decile, LSOAs



Source: Indices of Deprivation 2015, MHCLG, 2015.

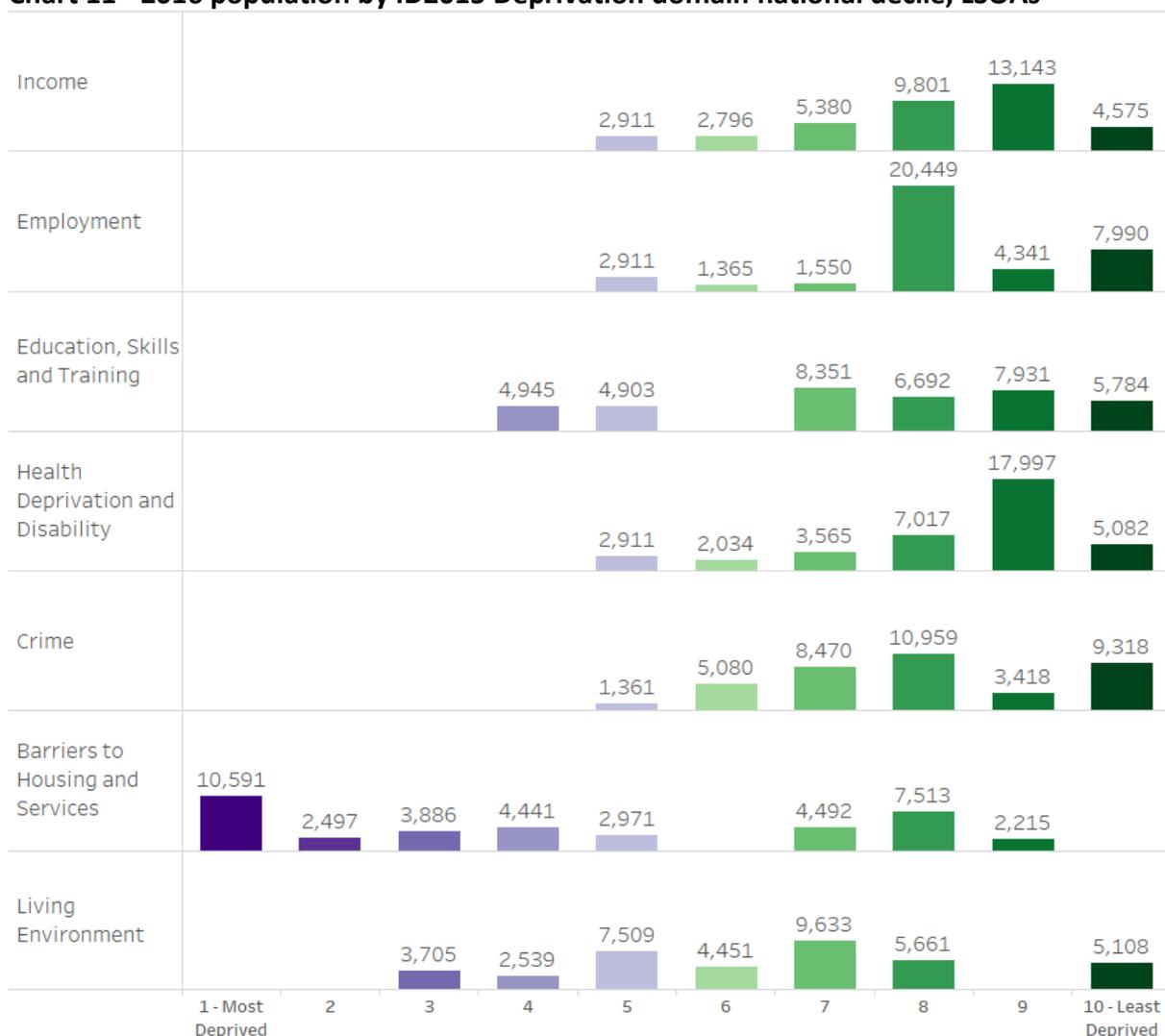
From the chart, it is clear to see that the same pattern is generally true for deprivation domains as for multiple deprivation; Rutland LSOAs tend to fall within lower national deciles, although there exists some pockets of significant deprivation within the county on a national scale.

For Income and Employment deprivation - as with multiple deprivation - there is one LSOA falling within the top 50% nationally. In comparison, Education, Skills and Training deprivation is somewhat more noticeable within the county; five LSOAs fall within the top 50% nationally.

The Barriers to Housing and Services domain appears to show some of the most extensive deprivation on a national scale, with 7 LSOAs in each of the top decile in England. The overall distribution is still skewed towards lower deciles, with 16 LSOAs in total in the top 50% nationally. This may be a result of the more rural nature of the county, and issues around dispersed population being able to access services, in addition to housing affordability.²²

The chart below displays the distribution of the Rutland population across national deciles (10 percent bands) for each of the ID2015 domains, ordered from 1 (most deprived) to 10 (least deprived):

Chart 11 - 2016 population by ID2015 Deprivation domain national decile, LSOAs



Source: Indices of Deprivation 2015, MHCLG, 2015. 2016 Mid-year population estimates, ONS, 2017.

As mentioned above, as LSOAs have fairly consistent population sizes, the distribution of

population closely follows the distribution of LSOAs across the deciles. The vast majority of the Rutland population live in neighbourhoods in the less deprived deciles, but despite this, large numbers of people can be found living in neighbourhoods in the most deprived deciles nationally; most notably over 10,000 people who live in areas within the most deprived 10 percent of neighbourhoods nationally for Barriers to Housing and Services deprivation, with a further 2,000 people living in the second most derived decile. Meanwhile, there are over 23,000 people living in the top two deciles nationally for Health Deprivation and Disability, over 17,000 people living in the top two deciles nationally for Income, and over 13,000 living in the top two deciles nationally for Education, Skills and Training deprivation.

15.4. More Information

Further information and full datasets for the 2015 Indices of Deprivation can be found here:

<https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>

16. Employment

Being unemployed for a long period is associated with both physical and mental health problems.

In Rutland in August 2016, 0.09% of people were in long-term unemployment. This is better than the England proportion of 0.37%. Meanwhile, 2.4% of Rutland's working age population were unemployed. This is better than the England value of 4.8%.

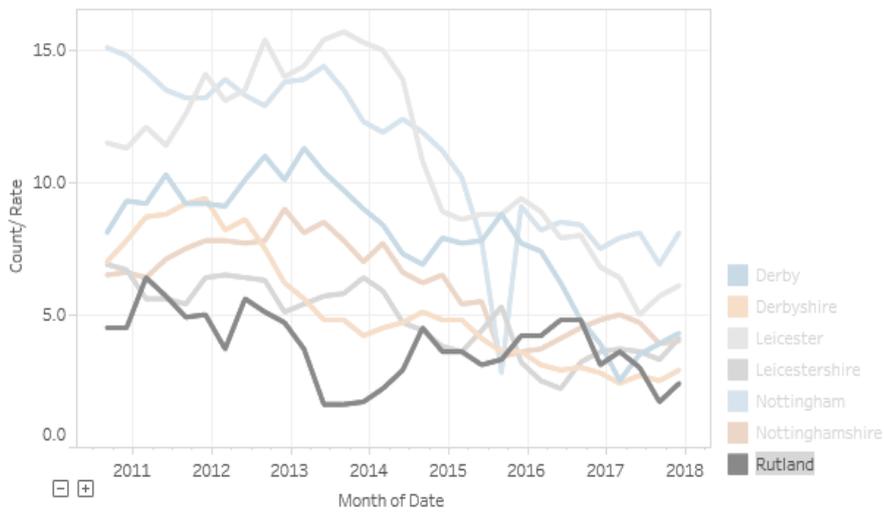
23 people aged 16-64 years in Rutland had been claiming Jobseeker's Allowance for more than 12 months. This equates to a crude rate of 1.0 per 1,000 population and is better than the England rate of 3.7 per 1,000 population.

In 2016/17, in Rutland, the gap in the employment rate between those with a long-term health condition and the overall employment rate was 30.1 percentage points. This is similar to the England value of 29.4 percentage points. For the same time period, the gap in the employment rate between those with a learning disability and the overall employment rate was 78.7 percentage points. This is worse than the England value of 68.7 percentage points.

In 2016, for Rutland, the ratio between the gross median hourly earnings for women and the gross median hourly earnings for men was 66.3% compared to England's value of 79.4%.

Rate of Unemployment in Rutland 2011-18²³

Upper Tier Authorities



	June 2017	September 2017	December 2017
Derby	3.5	3.9	4.3
Derbyshire	2.7	2.5	2.9
Leicester	5.0	5.7	6.1
Leicestershire	3.6	3.3	4.1
Nottingham	8.1	6.9	8.1
Nottinghamshire	4.7	3.9	4.0
Rutland	3.0	1.7	2.4
LLEP	4.0	4.1	4.8
East Midlands	4.4	4.3	4.5
England	4.7	4.6	4.5
United Kingdom	4.7	4.6	4.5

The International Labour Organisation has collated data which shows the rate of unemployment of Upper Tier Counties in the Midlands. The graph above highlights Rutland's consistently low rate of unemployment from 2011 to 2018 in comparison to National and Regional averages.

Job Seekers Allowance JSA Claimants from July 2010 - April 2018²³

Upper Tier Authorities



	February 2018	March 2018	April 2018
Derby	1.4	1.5	1.6
Derbyshire	0.8	0.8	0.8
Leicester	1.3	1.3	1.4
Leicestershire	0.5	0.5	0.4
Nottingham	2.5	2.6	2.6
Nottinghamshire	1.1	1.1	1.1
Rutland	0.2	0.2	0.2
LLEP	0.7	0.8	0.8
East Midlands	1.1	1.1	1.1
England	1.1	1.1	1.1
United Kingdom	1.1	1.1	1.1

The above chart shows the rate of people claiming Job Seekers Allowance (JSA) based on population.

An accurate measure to record the total amount of unemployment is by looking at the how many Job Seekers Allowance claimants there are.

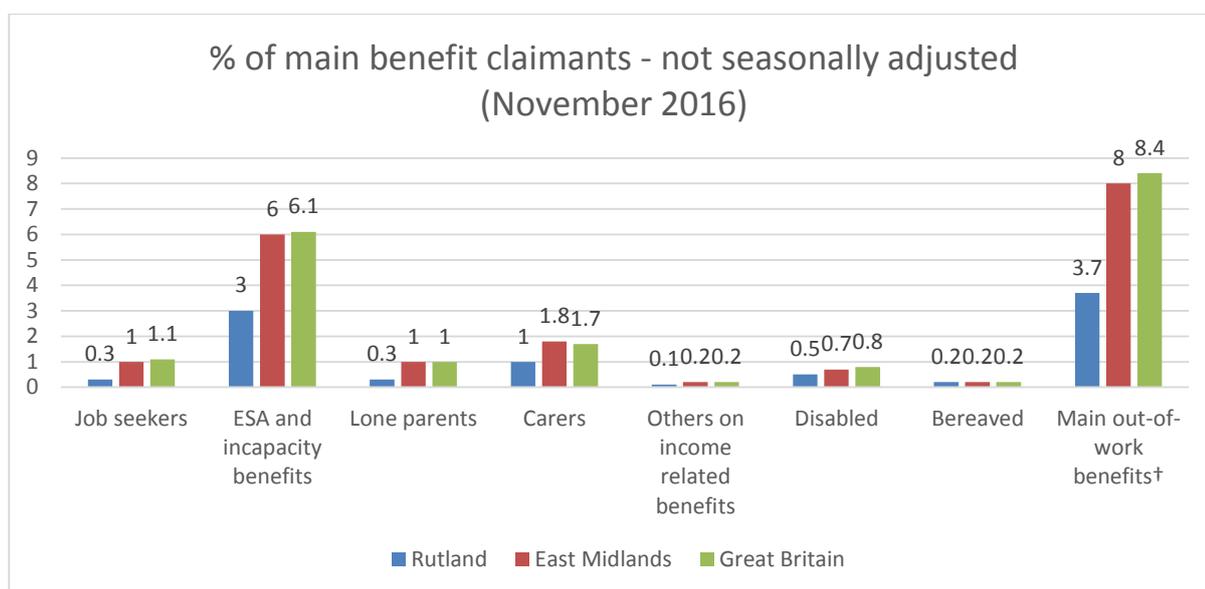
Job Seekers Allowance is a benefit which is paid to help with living expenses whilst the claimant is

actively looking for work. The claimant must be aged 18 or over.

The Education and Skills Act made education or training compulsory for school leavers until the age of 17 from 2013 and in 2015 the age went up to 18 years of age. This would explain the drastic drop of claimants between 2013 and 2015 across the Authorities in the above chart.

Rutland has generally had the lowest JSA claimant rate since 2011. Rutland's current rate for JSA claimants is 0.2, this is lesser than the current Regional and National rate of 1.1.

Benefit Claimants in Rutland, East Midlands and Great Britain November 2016²⁴



% is a proportion of resident population of area aged 16-64
 † - numbers are for those aged 16 and over, % are for those aged 16-64

From the above chart, it is clear that Rutland has a lower rate of benefit claimants in every Benefit category.

Rutland's percentage differences compared to the United Kingdom and the East Midlands:

Jobseekers Allowance: The rate of Job Seekers Allowance claimants in Rutland were 72% less than in the United Kingdom overall.

ESA (Employment and Support Allowance) and incapacity benefits: Rutland had a 50% less rate of claimants compared to the Midlands and United Kingdom.

Lone Parents Benefits: There was a 50% less rate of Lone Parent Claimants in Rutland compared to the Midlands and United Kingdom.

Carers Benefits: The rate of Carers claiming benefits in Rutland were 41% less than in the United Kingdom.

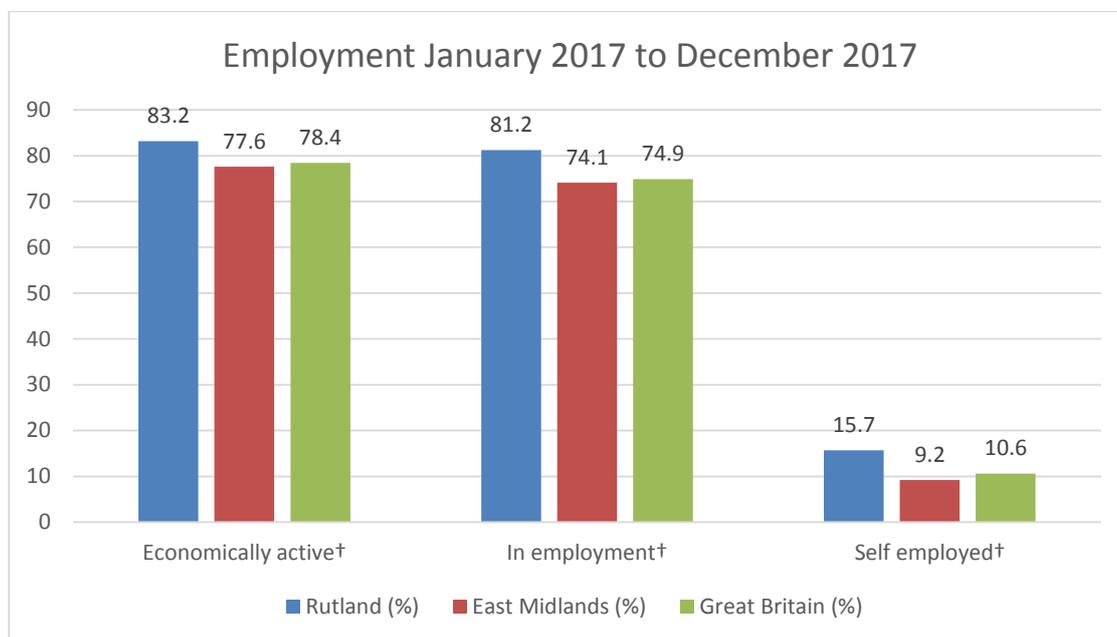
Income related benefits: There were only half as many Income Related benefit claimants in Rutland compared to the Midlands and United Kingdom.

Bereaved Claimants: The rate of Bereaved Claimants were the same across Rutland, Midlands and

United Kingdom.

Main out of work benefits: From the above findings we can conclude that overall Rutland had a much lower rate of benefit claimants than both the Midlands and United Kingdom in 2016.

Employment in Rutland, Midlands and Great Britain January 2017 – December 2017²⁴



† - numbers are for those aged 16 and over, % are for those aged 16-64

§ - numbers and % are for those aged 16 and over. % is a proportion of economically active

Economically active:

Rutland have a higher rate of being economically active than the East Midlands and Great Britain.

We can also see that a higher percentage of Rutland's residents were in employment compared to the Region and Nation.

In Employment:

Rutland also has a greater rate of people who are in employment aged between 16 to 64 years of age. Rutland have a 9.14% higher rate of employment compared the region and 8.07% greater compared to the United Kingdom.

Self Employed:

The rate of Self-employed residence in Rutland was noticeably higher with a rate which was 52.2% higher than the East Midlands and 39.78% higher when compared with the U.K.

Employees jobs in Rutland – 2016²⁴

The below table shows Rutland's working population aged 16-64 categorised by type of industry.

The table compares Rutland's percentage rate against the East Midlands and Great Britain. The percentage difference has been calculated to illustrate the variance.

Employee jobs by industry	Rutland	East Midlands	Great Britain
	(%)	(%)	(%)
Mining and quarrying	2	0.2	0.2
Manufacturing	11.7	13.1	8.1
Electricity, gas, steam and air conditioning supply	0	0.7	0.4
Water supply; sewerage, waste management and remediation activities	1.5	0.6	0.7
Construction	4	5	4.6
Wholesale and retail trade; repair of motor vehicles and motorcycles	16.7	17.1	15.3
Transportation and storage	3	5.3	4.9
Accommodation and food service activities	13.3	7.5	7.5
Information and communication	2.3	2.2	4.2
Financial and insurance activities	0.5	1.5	3.6
Real estate activities	0.8	0.9	1.6
Professional, scientific and technical activities	6.7	6.5	8.6
Administrative and support service activities	3	9.5	9
Public administration and defence; compulsory social security	5.3	3.9	4.3
Education	15	8.7	8.9
Human health and social work activities	6.7	13.1	13.3
Arts, entertainment and recreation	2.3	2.2	2.5
Other service activities	2	1.8	2.1

The Majority of Rutland's jobs were in the following Industries:

Wholesale and retail trade; repair of motor vehicles and motorcycles **16.7%**

Education **15%**

Accommodation and food service activities **13.3%**

Manufacturing **11.7%**

The four most common industries in Rutland accounted for 56.7% of the overall jobs. All four

industries were higher in percentage than in Great Britain.

The industries being higher than the national percentage may be a key factor for Rutland's low Unemployment rate.

17. Recommendations

- That further work is carried out to update population projections and changes in demographics, to inform future commissioning intentions and planning of services once more detail is known about the nature and extent of new developments.
- Carry out assessments of access to services and the likely impact on social care, health and wellbeing of Rutland's population as necessary once more detail is known about the nature and extent of new developments.

GLOSSARY OF TERMS

ASMR	Age-Standardised Mortality Rate
BME	Black and Minority Ethnic Groups
CCG	Clinical Commissioning Group
DMS	Defence Medical Services
GFR	General Fertility Rate
HLE	Healthy Life Expectancy
IMD	Index of Multiple Deprivation
LGB	Lesbian, Gay or Bisexual
LSOA	Lower Super Output Area
MOD	Ministry of Defence
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OAC	Output Area Classification
PHE	Public Health England
TFR	Total Fertility Rate

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RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2018

THE BEST START IN LIFE – AGED 0 TO 5 YEARS

DECEMBER 2018

Strategic Business Intelligence Team
Leicestershire County Council

NHS
East Leicestershire
and Rutland
Clinical Commissioning Group



Public Health Intelligence

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Whilst every effort has been made to ensure the accuracy of the information contained within this report, Leicestershire County Council cannot be held responsible for any errors or omission relating to the data contained within the report.

FOREWORD

The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Rutland, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs.

The JSNA has reviewed the population health needs for the people of Rutland in respect of a person's early years aged 0-4. This has involved looking at the determinants of health, the health needs of this population in Rutland, the impact of services, the policy and guidance supporting young children, and the existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

The JSNA offers an opportunity for the Local Authority, CCG and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCG and NHS England must be able to explain why.

EXECUTIVE SUMMARY

- This chapter presents a comprehensive overview of children (aged 0-5 years) in Rutland. There are many factors that influence the health of a child during their pre-school years. This is a vital time for development of a child whether that be physically, emotionally or socially, and many of the factors influencing a child's health at this time can have an impact on their later life.
- The majority of indicators presented are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included.
- There are proportionally fewer children known to social care in Rutland than in other local authorities in England with lower rates of Children in Need, Children Looked After and those subject to a Child Protection Plan in Rutland in 2016/17.
- School readiness is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally. 'Good level of development' is used to assess school readiness. School readiness starts at birth with the support of parents and other caregivers, as children start to acquire these skills. School readiness at age 5 (the end of reception year) has a strong impact on future educational attainment and life chances.¹ In 2016/17, 75.7% of children in Rutland achieved a good level development (GLD) at the end of Early Years Foundation Stage (reception) compared to the England value of 70.7%.
- From 2014/15 to 2016/17 there has been a significant improvement in the percentage of children with obvious dental decay in Rutland (28.8% to 15.6%).
- The overarching recommendation of this chapter is: to provide support to aim for all children in Rutland to have a happy and healthy childhood, targeting resources in proportion to need and to those who are most vulnerable.

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1. Introduction

This chapter presents a comprehensive overview of children aged 0-4 years in Rutland. The majority of indicators presented are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. We appreciate that this document uses technical language. This is due to the nature of the JSNA, which is intended for use by commissioning organisations such as local authorities and the NHS in developing their commissioning plans. One example is the use of statistical significance. A statistical significant result ensures the result is not likely to be caused by chance, for a given statistical significance level. Using these statistical tests improves the reliability of our evidence base which will help strengthen our commissioning based decisions.

2. Who is at risk?

There are many factors that influence the health of a child during their pre-school years. This is a vital time for development of a child whether that be physically, emotionally or socially, and many of the factors influencing a child's health at this time can have an impact on their later life.

2.1. Children in poverty

The Marmot Review (2010) suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. It therefore follows that reducing the numbers of children who experience poverty should improve adult health outcomes and increase healthy life expectancy.

In England in 2013, 20.2% of children aged 0 to 4 years of age were in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income). The figure for the East Midlands was 20.5% and the Rutland value was 9.6% which is significantly better than the England value.²

2.2. Homelessness

Homelessness often equates to severe poverty which is a social determinant of health. As a result, homeless children are often the most vulnerable in society.

Family homelessness (applicant households eligible for assistance (1996 Housing Act) unintentionally homeless and in priority need) in 2016/17 was 1.9 per 1,000 households for England, and 1.6 per 1,000 households for the East Midlands. Rutland's rate was 1.2 per 1,000 households (19 households) which is significantly better than the England value.³

2.3. Children's Social Care in Rutland

There are proportionally fewer children known to social care in Rutland than in other local authorities in England with lower rates of Children in Need, Children Looked After and those subject to a Child Protection Plan in Rutland in 2016/17.

The number and profile of Children Looked After (CLA) in Rutland has remained fairly stable over recent years with an average of around 40 children and young people in care at any one time and around 50-55 children looked after over the course of a year. The number of CLA has increased slightly over recent years in line with population growth and mirroring the national trend (although it is expected to show a decrease for 2017/18). The number of Care Leavers is also stable at around 23 over each of the last three years.

Rutland is the smallest local authority in England and faces a different set of challenges to larger authorities in ensuring the best possible provision of services for children looked after and those leaving care. The profile of CLA in Rutland – and the cost of service provision – can fluctuate considerably due to the relative low number of children in the cohort at any one time. As such, the impact of a small number of sibling groups moving in or out of care can have a disproportionately large impact on the profile of the cohort, for example, in relation to age, gender, ethnicity, category of need or legal status. The same is true for other cohorts such as children subject to Child Protection Plans and Care Leavers.

The sections which follow describe the latest comparative data for Rutland and England in more detail.

2.3.1. Children in need

In Rutland in 2016/17, 504 children under the age of 18 were classified as children in need. This equates to a rate of 573 per 10,000 population; better than the England average of 612 per 10,000 population.⁴

The proportion of children in Rutland in 2017 in need due to abuse, neglect or family dysfunction was 71.7%. This is higher than the England average of 68.3%.⁵

The rate of children under the age of 18 years in need due to child disability or illness in Rutland in 2017 was 27.2 per 10,000 population (21 children). This is similar to the England value of 31.2 per 10,000 population.⁶

2.3.2. Children who are Looked After

In Rutland on 31 March 2017, 40 children under the age of 18 were classified as looked after. This equates to a rate of 51.8 per 10,000 population. This is significantly better than the England

average value of 62.0 per 10,000 population.³ The rate of children who are looked after (CLA) per 10,000 children for Rutland has increased over the last five years from 40 per 10,000 in 2012 to 52 per 10,000 in 2017. The increase in the rate over the last five years has been greater for Rutland than for the national and regional comparators, with only a small increase regionally and the national figure remaining static over the last four years. This means that the increase over the last six years has brought Rutland's rate of CLA proportionate to its local population much closer to the regional and national pictures.

Rutland has the lowest number of CLA of any local authority in England; no other local authority has fewer than 100 CLA – Wokingham is the next smallest with 110 – and the average for a local authority is 649 children (average for all authorities over the last 5 years).

In 2017, 96.0% of eligible looked after school aged children (22 children) had an emotional and behavioural health assessment. This is higher than the England average value of 76.0%.⁴ The proportion of eligible children considered 'of concern' in 2016/17 was 59.0% (13 children). This is worse than the England value of 38.0%.⁴

In 2017, 100.0% of looked after children under the age of 5 in Rutland (6 children) had up-to-date development assessments⁴, and 100.0% of looked after children under the age of 18 (29 children) had an annual health assessment.⁴

In 2016/17, the rate of children leaving care for Rutland was 25.9 per 10,000 population. This is lower than the England average value of 26.5 per 10,000 population.⁴

In Rutland, the total spend on CLA increased by 56% over the last 5 years; up from £990,000 in 2011-12 to £1,546,000 in 2015-16. The spend on CLA in Rutland as a proportion of all spending on Children's Services over the same period (2011-12 to 2015-16) has gone up from 26.7% to 34.6%, so CLA now accounts for around a third of all spending on Children's Services in Rutland. However, it remains considerably lower than the comparative figure for the region (43.1%) or nationally (44.1%). The average cost per child looked after is also much lower in Rutland than the average for local authorities in England – around £14k lower – at £28,109 per child, compared to £41,785 per child nationally (2015/16). Thus, outcomes for CLA in Rutland are being achieved at a much lower cost than in other local authorities.

More detailed information on Children Looked After in Rutland is available in the Children Looked After and Care Leavers Strategy.⁷

2.3.3. Safeguarding of children

In Rutland at the end of March 2017, 20 children were subject of a child protection plan. This equates to a rate of 25.9 per 10,000 population. This is significantly lower than the England average value of 43.3 per 10,000 population.⁴

In Rutland during 2016/17, there were 32 new child protection cases for children aged less than 18 years of age, this is a rate of 46.6 per 10,000 population. This is lower than the England rate of 56.3 per 10,000 population.³ In Rutland, 36.1% of children aged under 18 years of age (13 children) became subject of a child protection plan for a second or subsequent time. This is higher than the England value of 18.7%.⁶

2.3.4. Children social care workforce

There have been a number of changes to the way in which children's social care is delivered across Rutland in 2017/18. There was been a focused effort on reducing the number of agency staff and increasing the number of permanent employees to support consistency of practice and continuity of support for children and families. This has seen the number of permanent staff increase from around 50% in 2017 to 85% in 2017 (with a further increase expected in 2018 data).

Changes to staff and structure have coincided with a halving of the absence rate. For the children's social care workforce, the staff absence rate for Rutland in 2016 was 7.1%, around twice the National average of 3.5% (in 2016). In 2017 the absence for Rutland dropped to just 2.4% - two-thirds lower than the previous year – bringing it below the National average of 3.1%.⁸

2.4. Maternal influences

Factors relating to the mother and method of delivery of a newborn child can have an influence on the health needs of a child.

2.4.1. Young mothers

A child's long-term health can be impacted on as follows: children born to teenage mothers have 60% higher rates of infant mortality and are at increased risk of low birthweight. The mental health effects for a teenage mother are that they are three times more likely to suffer from post-natal depression and experience poor mental health for up to three years after the birth – this may impact on the child's health and development. Living in poverty, is also an increased risk for teenage parents and their children.

In 2015, the number of births to mothers aged less than 20 years of age in Rutland was 9, a proportion of 2.6%. This is similar to the England value of 3.4%.⁹

2.4.2. Older mothers

Higher rates of antenatal depression and anxiety have been found amongst older mothers. This may add to the risks for the newborn child.¹⁰

In 2015, the number of births to mothers aged 40 years and over in Rutland was 17. This equates to 5.0% of all live births. This is similar to the England value of 4.3%.⁹

2.4.3. Caesarean section

When maternal or infant problems arise, there may be a need for a child to be delivered by caesarean section. Following delivery, there may be further health problems associated with the procedure for the newborn infant.

In Rutland, in 2016/17, 90 deliveries were made by caesarean section. This equates to 28.8% of the total number of deliveries. This is similar to the England value of 27.1%.³

2.4.4. Postpartum psychosis

Any mental health problems that a mother has may impact on her ability to care for her infant.

In 2015/16, 5 women in Rutland were estimated to have postpartum psychosis, 10 were estimated to suffer from a severe depressive illness in the perinatal period and between 35 and 50 women were estimated to suffer from a mild-moderate illness and anxiety in the perinatal period.⁹

2.4.5. Deliveries of new-born children to mothers from Black and Minority (BME) groups

In Rutland in 2016/17, 6.7% of deliveries were to mothers from BME groups (21 deliveries). This is lower than the England proportion of 23.3%.³ The 2011 Census tells us the percentage of the population from BME groups in Rutland is 2.9% whereas nationally the percentage is 14.6%. This infers that both locally and nationally mothers of a BME background may be having more children than those from a non-BME background.

2.5. School readiness

School readiness is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally. 'Good level of development' is used to assess school readiness. It is measured at the end of the reception year and covers: communication and language; physical development; personal, social and emotional development; literacy; mathematics; understanding the world; and expressive arts, designing and making. School readiness starts at birth with the support of parents and other caregivers, as children start to acquire these skills. School readiness at age 5 (the end of

reception year) has a strong impact on future educational attainment and life chances.¹¹

A child's performance in school is a key indicator of their early years' development. In 2016/17, 75.7% of children in Rutland achieved a good level development (GLD) at the end of Early Years Foundation Stage (reception) compared to the England value of 70.7%. Although attainment as measured by GLD remains above that seen nationally, however, there are inconsistencies in performance over time. Meanwhile, seven children with free school meal status achieved a good level of development at the end of reception (63.6%). This is similar to the England value of 56.0%.²

3. Level of need in Rutland

In 2016, Rutland's population of 0-4 year olds was estimated to be a total of 1,835 (887 females and 948 males). This is projected to stay the same by 2039.

Further information regarding Rutland's population can be seen in the JSNA Population chapter.

3.1. Infant mortality

Several factors can influence a baby's chance of survival at birth, in their first few weeks of life and beyond.

Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions.

Reducing the gap between the richest and poorest groups, and infant mortality overall are part of the Government's strategy for public health (Healthy Lives, Healthy People: Our Strategy for Public Health November 2010)

Rutland had 5 deaths under 1 year of age in the period 2014-16 – a rate of 4.9 deaths per 1,000 live births. This is similar to England's rate of 3.9 deaths per 1,000 live births.²

3.1.1. Low birth weight

One contributing factor to the risk of childhood mortality and a child's developmental problems and their health in later life is low birth weight. Low birth weight is defined as a weight under 2500g and a gestational age of at least 37 complete weeks at birth.

A high percentage of low birth weight babies may indicate lifestyle issues of the mothers and/or issues with maternity services which could also impact on the health of the newborn.

The proportion of low birth weight babies was 2.67% for Rutland in 2016 (8 babies). This is similar

to the England value of 2.79%.²

3.1.2. Smoking in pregnancy

Smoking in pregnancy has detrimental effects for the growth and development of the baby and health of the mother. The encouragement of pregnant women to stop smoking during pregnancy may also help them kick the habit for good, and thereby provide health benefits for the mother and reduce exposure to smoke by the infant.

Smoking during pregnancy can cause pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy.

The Tobacco Control Plan contains a national ambition to reduce the rate of smoking throughout pregnancy to 6% or less by the end of 2022.

The smokers at the time of delivery indicator is only available as a combined figure for Leicestershire and Rutland, due to the small numbers involved in Rutland. The proportion of mothers known to be smokers at the time of delivery for Leicestershire and Rutland combined was 8.6% in 2016/17. This is better than the England rate of 10.7%. This is line with the latest smoking prevalence figures in Rutland where 8.6% of the adult female population smoke. This is significantly better than the national female smoking prevalence of 13.0% in 2017.¹²

3.1.3. Breastfeeding

Breastfeeding has been shown to have positive effects on an infant's health and development. Not only does breast milk provide excellent nutrition for babies, breastfeeding is associated with lower levels of gastro-intestinal and respiratory infection, and therefore lower chance of hospitalisation for such infections. Children that are breastfed are also less likely to become obese.

Breastfeeding also has positive effects for the mother, as mothers that do not breastfeed have an increased risk of ovarian and breast cancers, and they may also experience more difficulty in achieving their pre-pregnancy weight.

In 2016/17, 81.1% of mothers breastfed their babies within the first 48 hours of delivery, this is significantly better than the England value of 74.5%. In 2014/15, 52.8% of infants due a 6-8 week check were being either totally or partially breastfed. This is significantly better than the England value of 43.8%.²

3.2. Immunisation

Vaccination is offered to infants in order to protect them from the diseases and associated

complication, and also to minimise the spread of the diseases within the wider population. Vaccination coverage is measured against benchmarked targets.

3.2.1. MMR

Vaccination to protect against the infectious diseases measles, mumps and rubella can prevent children from not only contracting those diseases, but also complications associated with the diseases, such as meningitis, encephalitis and deafness.

The population vaccination coverage for children having received two doses of the MMR vaccine at 5 years old was 93.8% for Leicestershire and Rutland combined for 2016/17. This is within the benchmarked target range of 90% to 95%.²

3.2.2. Hepatitis B

Mothers infected with the hepatitis B virus (HBV) are at risk of passing on the HBV infection to their babies. Hepatitis B can lead to cirrhosis of the liver and liver cancer, so vaccination of babies born to infected mothers is important. In 2016/17, no children aged 1 and 2 years old received the vaccine for hepatitis B in Rutland.² This is likely to be due the low numbers of infants born to hepatitis B virus infected mothers that are at high risk of acquiring HBV infection themselves.

3.2.3. Dtap/IPV/Hib

This combined vaccine (Dtap/IPV/Hib) protects against diphtheria, pertussis, tetanus, haemophilus influenza type B and polio.

In 2016/17, in Leicestershire and Rutland combined, 97.3% of children aged 1 year old and 98.2% of children aged 2 years old had received the combined vaccine of Dtap/IPV/Hib. These proportions are better than the benchmarked target of 90% to 95%.²

3.2.4. Men C

Protection against infection by meningococcal group C bacteria is provided by the Meningococcal C conjugate (Men C) vaccine. Infection by meningococcal group C bacteria can cause meningitis and septicaemia. Boosted immunisations in the infant's second year provide immunity that lasts into adulthood.

The population vaccination coverage for children having received the completed course of the Men C vaccine by their first birthday was 98.1% for Leicestershire and Rutland combined for 2015/16. This is above the benchmarked target range of 90% to 95%.²

For 2016/17, the population vaccination coverage for children having received the Haemophilus

influenzae type b (Hib) and Men C booster vaccine by their second birthday was 96.1% for Leicestershire and Rutland combined. This is above the benchmarked target range of 90% to 95%.²

3.2.5. PCV

The PCV vaccination protects against pneumococcal infections that can cause pneumonia, septicaemia and meningitis.

The population vaccination coverage for children having received the completed course of the PCV vaccine by their first birthday was 97.3% for Leicestershire and Rutland combined for 2016/17. This is above the benchmarked target range of 90% to 95%.²

The population vaccination coverage for children having received a dose of the PCV booster vaccine by their second birthday was 96.2% for Leicestershire and Rutland combined for 2016/17. This is above the benchmarked target range of 90% to 95%.²

3.2.6. Influenza

Vaccination against influenza can prevent illness and hospitalisation. Vaccination is offered to those at risk of developing serious complications if they catch the virus.

The population vaccination coverage for children aged 2-4 years old was 49.3% for Leicestershire and Rutland combined for 2016/17. This is within the benchmarked target range of 40% to 65%.²

3.3. Excess weight

Being overweight at ages 4 to 5 years old can lead to a person being overweight in later life. This can lead to ill-health and associated problems.

The proportion of overweight (including obese) children in reception was 24.0% for Rutland for 2016/17 (82 children). This is statistically similar to the England value of 22.6%.²

3.4. Tooth decay

Oral health problems in children are largely preventable. Oral health is an important aspect of a child's overall health status and is seen as a marker of wider health and social care issues, including poor nutrition and obesity. A combination of healthy diet and practising good dental hygiene can help to ensure a child has healthy teeth and gums.

3.4.1. Three year olds

The average number of decayed, missing or filled teeth in three year olds in Rutland in 2012/13

was 0.33. This is statistically similar to the England value of 0.36.

High levels of consumption of food and drinks containing sugar (particularly long term bottle use) can lead to incisor caries. The prevalence of incisor caries in three year olds in the same time period was 1.8. This is better than the England value of 3.9.¹³

Meanwhile, the proportion of three year olds free from dental decay was 85.1% for Rutland in 2012/13. This is statistically similar to the England proportion of 88.4%.¹³

3.4.2. Five year olds

In England, 23.3% of five-year-old children had experience of obvious dental decay (caries), having one or more teeth that were decayed to dentinal level, extracted or filled because of caries (%d3mft>0) in 2016/17. d3mft is the standard measure of dental decay and refers to teeth that are decayed, missing and/or teeth with fillings. In Rutland, the percentage of children with obvious dental decay is significantly better than the national average at 15.6%. From 2014/15 to 2016/17 there has been a significant improvement in the percentage of children with obvious dental decay (%d3mft>0) in Rutland (28.8% to 15.6%).¹³

In England, the average (mean) number of teeth per child affected by decay (decayed, missing or filled teeth (d3mft)) was 0.8. In Rutland, the average number of teeth per child affected by d3mft was 0.4, half the national average. From 2014/15 to 2016/17 there has been a significant improvement in the average number of decayed teeth per child in Rutland (0.7 to 0.4).¹³

Among the children with decay experience, the average number of decayed, missing (due to decay) or filled teeth (mean d3mft (% d3mft>0)) in England is 3.4. At upper-tier local authority level there is clear variation of this measure with affected children in Rutland and Wiltshire having only 2.3 teeth affected on average, while those in Harrow had 4.8.¹³

3.5. Hospital attendances

There are many reasons why an infant may attend hospital, some of which might be preventable if mothers and their infants followed more healthy lifestyles or accessed primary care services.

3.5.1. A & E attendances

Accident & Emergency attendance are often preventable for children aged 0 – 4 years. Reasons for attendance are largely due to accidental injury or to minor illnesses which could be treated in primary care.

In Rutland, the rate of attendances at any Accident & Emergency (including walk in centres) from infants aged 0 – 4 years who are resident in Rutland was 607.6 per 1,000 population in 2016/17.

This is similar to the England rate of 601.8 per 1,000 population.³

3.5.2. Emergency Admissions

A healthy start in life and access to care and support for parents should minimise the occurrence of the majority of childhood emergency admissions. For example, by encouraging breast feeding, good diet and hygiene, better support for parents in the management of illness in their homes and the provision of health advice through primary care services.

There were 103 admissions from children aged under 1 year old as an emergency in 2015/16, a rate of 300.3 per 1,000 population. This is similar to the England rate of 357.7 per 1,000 population. In the same time period, there were 147 admissions from children aged 1 - 4 years old as an emergency in 2015/16, a rate of 103.3 per 1,000 population. This is similar to the England rate of 106.5 per 1,000 population. As this is a count of admissions, a child will be counted more than once if they have more than one admission.¹⁴

3.5.3. Admissions of babies under 14 days

Admissions of babies under 14 days of age are often related to the quality of health assessments before discharge after birth or to postnatal care once home. Other reasons for admission are related to problems with feeding, such as dehydration and jaundice.

In Rutland in 2016/17, 20 admissions to hospital from babies under 14 days. This equates to a rate of 64.1 per 1,000 deliveries and is similar to the England rate of 71.0 per 1,000 deliveries. In 2015/16 the rate of admissions of babies under 14 days in Rutland was significantly worse than the national average, equating to 32 admissions to hospital in the age range specified. It is important to note the numbers of admissions are small and are likely to fluctuate year on year.¹⁵

3.5.4. Unintentional and deliberate injuries

Injuries are a major cause of mortality for children. They can also be a precursor to long-term health issues, including mental health conditions as a result of the experience(s).

They were 19 hospital admissions caused by unintentional and deliberate injuries in 0 – 4 year olds in 2016/17. This equates to a rate of 103.5 per 10,000 population. This is a similar rate to the England value of 126.3 per 10,000 population.²

3.5.5. Emergency admissions for falls

The rate of emergency admissions for falls for children aged 0 – 4 years was 391 per 100,000 population for Leicestershire and Rutland combined for the period 2014/15 – 16/17. This is better than the England rate of 509 per 100,000 population.

Meanwhile, the rate of emergency admissions for falls from furniture for children aged 0 – 4 years was 67.1 per 100,000 population for Leicestershire and Rutland combined for the period 2012/13 – 16/17. This is better than the England rate of 138.2 per 100,000 population.¹⁴

3.5.6. Emergency admissions for accidental poisoning

The rate of emergency admissions for accidental poisoning for children aged 0 – 4 years was 72.7 per 100,000 population for Leicestershire and Rutland combined for the period 2014/15 – 16/17. This is better than the England rate of 145.5 per 100,000 population.

Meanwhile, the rate of emergency admissions for poisoning from medicines for children aged 0 – 4 years was 52.5 per 100,000 population for Leicestershire and Rutland combined for the period 2012/13 – 16/17. This is better than the England rate of 101.5 per 100,000 population.

Children aged 0 – 4 years suffering poisoning may indicate safeguarding issues.¹⁴

3.5.7. Admissions for respiratory conditions

The risk of a child having a respiratory tract infection is increased due to damp housing conditions and smoking in the home.

There were 15 admissions for respiratory tract infections for infants under 1 year of age in 2015/16, a rate of 437 per 10,000 population. This is statistically similar to the England rate of 582 per 10,000 population.¹⁴

3.5.8. Admissions for gastro-intestinal conditions

Diet, hygiene and support in management of infections can all minimise the risk of infants contracting gastroenteritis.

In 2015/16, there were 8 admissions for gastroenteritis for children aged 2, 3 and 4 years in Rutland. This was a rate of 74.1 per 10,000 population and is statistically similar to the England rate of 53.7 per 10,000 population.¹⁴

3.5.9. Elective admissions

Elective admissions in infants are often related to congenital conditions, or complications relating to pregnancy and delivery. After a child's first birthday, dental caries are a significant reason for elective admission.

For Rutland, 51.5 per 1,000 children aged under 5 years were admitted electively in 2015/16. This is statistically similar to the England rate of 54.0 per 1,000 population.¹⁶ Of these elective admissions, over a third (36%) had a primary diagnosis of cancer and almost a fifth (18%) were due

to congenital malformations, deformations and chromosomal abnormalities. Over half (58%) of these admissions went to University Hospitals of Leicester NHS Trust and a quarter (25%) went to Peterborough and Stamford NHS Trust.

4. How does this impact?

A model developed in 2007, estimated that “the total cost of preterm birth to the public sector was £2.9 billion. The incremental cost per preterm child surviving to 18 years compared with a term survivor was £22,885. The corresponding estimates for a very and extremely preterm child were substantially higher at £61,781 and £94,740, respectively.¹⁷”

Increasing breastfeeding not only decreases the chance of the mother developing breast cancer, but it also decreases the chances of the infant developing gastrointestinal and respiratory tract infections.

“Treating the four acute diseases in children costs the UK at least £89 million annually. The 2009–2010 value of lifetime costs of treating maternal BC is estimated at £959 million. Supporting mothers who are exclusively breast feeding at 1 week to continue breast feeding until 4 months can be expected to reduce the incidence of three childhood infectious diseases and save at least £11 million annually. “

“The same increase could result in NHS savings of around £21 million related to breast cancer over the course of a first-time mothers' lifetime.¹⁸”

5. Policy and Guidance

The central piece of legislation guiding Children' Social Care is the 1989 Children Act. The key element of it for this chapter is its focus on a 'Child in need' and a 'Child in need of protection'. Section 17 of the Act places a general duty on all local authorities to 'safeguard and promote the welfare of children within their area who are in need.' A 'child in need' is a child who needs additional support from the local authority to meet their potential.

Section 47 of the Act requires the local authority to investigate the child's circumstances where they have 'reasonable cause to suspect that a child ... is suffering, or is likely to suffer, significant harm,' and to 'take any action to safeguard or promote the child's welfare'. Local authorities have a duty to provide a level and range of services to safeguard children and promote their welfare. Consequently, a local authority has to investigate any concerns or allegations that suggest a child is likely to suffer physical, emotional or sexual abuse, or neglect, and to take action to prevent this.

The way that agencies and organisations should work together to carry out their duties and responsibilities under the 1989 Children Act and other legislation is set out in a document called

Working Together to Safeguard Children.¹⁹ It sets out the responsibilities of all agencies in the protection of children. The Early Help Strategy²⁰ in Rutland draws on existing best practice locally and nationally, with a vision, shared by the partners of Rutland's Children's Trust, to improve outcomes for our children and young people.

The Children's Centre services are governed by statutory guidance from the Department for Education. This means that recipients must have regard to it when carrying out duties relating to children's centres under the Childcare Act 2006. Children's Centres currently have a key role to play in early intervention, particularly given their established work in the early years when the support has the biggest impact on long-term outcomes. Centres are also well placed to provide a wider range of services as Family Hubs, for any parent (including fathers) to access services or information about all family-related matters. The multi-agency Children's Centre Governance Group is exploring how the opportunities offered by the integrated Children Centre and Library can deliver the intentions of a Family Hub.

An integrated 0-19 (years) Healthy Child Programme service is now being delivered in Rutland, provided by Leicestershire Partnership Trust's 'Healthy Together Service'. The 5-19 healthy child programme services transferred from the former Primary Care Trust to Local Authorities in April 2013. More recently the 0-5 healthy child programme services transferred from NHS England to local authorities in October 2016. This enables coverage of the five mandated services described in legislation as universal health visitor reviews (antenatal, new birth, 6-8 weeks, 1 year and 2 to 2½ years). It also delivers the health outcomes as they as described in the Public Health Outcomes Framework where the data flows directly from health visiting activities, such as breast feeding at 6-8 weeks and an assessment of child development at 2 to 2½ years using the ages and stages questionnaire.

The 0-19 Healthy Child Programme recognises that the first years of life are a critical opportunity for building healthy, resilient and capable young people and adults. It follows Marmot's 'Life Course Approach' from the Marmot Review,²¹ and complies with the Chief Medical Officer view in the Annual Report (2012) 'Our Children Deserve Better: Prevention Pays'²²: events that occur in early life (indeed in foetal life) affect health and wellbeing later, so it makes sense to intervene early. Public Health England carried out a Rapid Review to update the evidence for the Healthy Child Programme²³.

6. Current services

The 0-19 Healthy Child Programme is delivered by Leicestershire Partnership NHS Trust's 'Healthy Together' team in Rutland, it is an evidence based programme delivered by Public Health Nurses (Health Visitors & School Nurses). It follows a 4-5-6 model: 4 Levels of Services, 5 Mandated Contacts, 6 High Impact Areas²⁴. Safeguarding is central to the 0-19 Healthy Child Programme. The

high impact areas for 0-5 year olds can make a valid contribution to providing children in Rutland with the 'Best Start in Life'. In addition Oral Health has been identified as a local high impact area for Rutland. There is also a focus on Children & Young People's Mental Health and Military families in Rutland.

The Early Start Programme (ESP) provides intensive early intervention and support for vulnerable first time parents with an infant 0-2 years living in Rutland. It is delivered by Public Health nurses (Health Visitors) to up to 10 families at a time in Rutland.

There is information on 'The Best Start in Life' issues on the 3 Healthy Together websites including:

Health for under 5's: <https://healthforunder5s.co.uk/>

Health For Kids: <https://www.healthforkids.co.uk/>

Health for Teens: <https://www.healthforteens.co.uk/>

6.1. Children's Social Care services

Children's Social Care will assess a child and their family's circumstances before the child can receive a service. The complexity of a child and family's situation determines the type and timescale of the assessment. Further assessments are repeated periodically to assess effectiveness of services and interventions and to respond to unmet or changes in need.

100% of all children under 5 years in Rutland are registered with the Children Centre. The Children's Centre also offers targeted early help to families in their homes and on the two MOD sites; this is delivered by family support practitioners. The Centre supports families to access their 2 year old childcare funding, which supports parents back to work and enables children's early education and preparedness for school.

The integration of the Special Educational Needs and Disability (SEND) and Inclusion service with Early Intervention results in the identification of children's needs at the very earliest stages.

7. Unmet needs/Gaps

Regular early health screening checks are in place but the area would benefit from the findings being formally shared routinely across the partnership to help join up responses to families. Although services are quick and responsive the impact of therapeutic services provided to children following referral is not always demonstrated as they are not yet routinely evaluated, this means we cannot be fully confident that some early support is effective in preventing the escalation of needs which is being addressed.

8. Recommendations

These recommendations reflect those in the Rutland's Health and Wellbeing Strategy, where applicable²⁵

- To provide support to aim for all children in Rutland to have a happy and healthy childhood, targeting resources in proportion to need and to those who are most vulnerable.
 - Providing early help through the Children's Centre and the 0-19 Healthy Child Programme
- Target resources in proportion to need to address the needs of any children living in poverty.
- Increase numbers of children being active, and encourage them to be active for longer.
- Outcomes should be measured in line with national outcome frameworks and commissioning reporting requirements. However other reporting requirements and measures need to be locally determined including outcomes regarding oral health and improving the health & wellbeing of children and young people from military families.
- Additional outcome measures (including the Local High Impact Areas) should not add burden to data collection, should be collected within current systems and align to national reporting requirements.
- Engagement with the whole family is an important component of the Healthy Child Programme and should apply across the whole system.
 - Support and encourage healthy behaviour in pregnancy and beyond including maternal smoking, alcohol use, healthy eating and physical activity.
 - Scale up support to families through parenting programmes and ensure that they are delivered to high quality standards.
- Consider a review of access to, and use of, maternity services by Rutland residents.

GLOSSARY OF TERMS

BME	Black and Minority Ethnic Groups
CCG	Clinical Commissioning Group
CLA	Children who are Looked After
ESP	Early Start Programme
GLD	Good Level Development
HBV	Hepatitis B Virus
Hib	Haemophilus influenzae type b
LSOA	Lower Super Output Area
Men C	Meningococcal C
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PHE	Public Health England
SEND	Special Educational Needs and Disability

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RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2018

CHILDREN AND YOUNG PEOPLE AGED 5 TO
18 YEARS - STAYING SAFE AND HEALTHY

DECEMBER 2018

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Whilst every effort has been made to ensure the accuracy of the information contained within this report, Leicestershire County Council cannot be held responsible for any errors or omission relating to the data contained within the report.

FOREWORD

The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Rutland, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs.

The JSNA has reviewed the population health needs for the people of Rutland in respect of a person's child and teenage years. This has involved looking at the determinants of health, the health needs of this population in Rutland, the impact of services, the policy and guidance supporting young children, and the existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

The JSNA offers an opportunity for the Local Authority, CCG and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCG and NHS England must be able to explain why.

EXECUTIVE SUMMARY

- In 2016/17, the proportion of pupils residing in Rutland with excess weight (classified as overweight or obese) in Year 6 (aged 10-11 years) (25.4%) was better than the national percentage (34.2%); this has been the case for four of the last six years. In contrast, the prevalence of overweight and obese Reception pupils in Rutland (24.0%) is similar to the England average (22.6%), and has increased each year for the last three years.
- Compared to last year, the prevalence of excess weight in Year 6 children in Rutland improved from 31.4% to 25.4%; this equates to a reduction in 20 pupils in the authority classified with excess weight. Whilst the proportions of both overweight and the obese categories fell between 2015/16 and 2016/17, the statistical significance of overweight pupils has remained similar to England, whereas the statistical significance of obese pupils became significantly better than the national average. The proportion of obese pupils in Year 6 in Rutland is 11.3%; this is the best performing percentage nationally.
- The rate of under 18 conceptions in Rutland has shown a significant decline in line with national and since 2013, has remained significantly better than the national rate.
- Rutland continues to perform significantly worse than the national percentage for proportion of the population aged 15-24 screened for chlamydia. Meanwhile in 2017, Rutland continues to perform significantly worse than the benchmarked goal rate of 1,900-2,300 per 100,000 population for chlamydia detection rate for 15-24 years olds but has seen a year on year increase since 2015.
- Regular drinking is defined as consuming an alcoholic drinking at least once a week. 7.0% of 15 year olds in Rutland said they were drinking regularly, similar to the England value of 6.2%. Meanwhile, 20.6% of 15 year olds in Rutland said they had been drunk in the last 4 weeks. This is worse than the England value of 14.6%.
- Rutland has a lower level of estimated prevalence of mental health disorders in children aged 5-16 years compared to England. In 2015, the estimated prevalence in Rutland was 8.2%, compared to 9.2% nationally.

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1. Introduction

This chapter presents a comprehensive overview of children and young people staying safe and healthy in Rutland. The majority of indicators presented are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. We appreciate that this document uses technical language. This is due to the nature of the JSNA, which is intended for use by commissioning organisations such as local authorities and the NHS in developing their commissioning plans. One example is the use of statistical significance. A statistical significant result ensures the result is not likely to be caused by chance, for a given statistical significance level. Using these statistical tests improves the reliability of our evidence base which will help strengthen our commissioning based decisions.

2. Who is at risk?

There are many factors that influence the health and care needs of a child during their pre-school years. This is a vital time for development of a child whether that be physically, emotionally or socially, and many of the factors influencing a child's health at this time can have an impact on their later life.

2.1. Children in poverty

The Marmot Review (2010)¹ suggests there is evidence that childhood poverty leads to premature mortality and poor health outcomes for adults. It therefore follows that reducing the numbers of children who experience poverty should improve adult health outcomes and increase healthy life expectancy.

Under the Child Poverty Act 2010, a household is said to be in relative poverty when their income is less than 60% of the current median income. This figure stands at 18.4% before housing costs have been considered.

Rutland are positioned within the 25 local authorities with the lowest levels of child poverty across the UK.

Table 1: Top 25 local authorities with the lowest levels of child poverty across the UK²

Local authority	% of children in poverty 2017 (after housing costs)
Isles of Scilly	5.17%
Shetland Islands	9.39%
Wokingham	10.76%
Hart	11.17%
South Northamptonshire	11.79%
Mole Valley	12.08%
Waverley	12.49%
South Oxfordshire	12.50%
Aberdeenshire	12.59%
Rushcliffe	12.89%
Ribble Valley	12.90%
South Cambridgeshire	13.07%
Uttlesford	13.17%
Harborough	13.34%
Mid Sussex	13.37%
West Oxfordshire	13.39%
Elmbridge	13.44%
Rutland	13.52%
Epsom and Ewell	13.56%
Surrey Heath	13.56%
Horsham	13.94%
Chiltern	14.06%
Winchester	14.08%
West Berkshire	14.27%
Fareham	14.27%

2.1.1. Homelessness

Homelessness often equates to severe poverty which is a social determinant of health. As a result, homeless children are often the most vulnerable in society.

Family homelessness (applicant households eligible for assistance (1996 Housing Act) unintentionally homeless and in priority need) in 2016/17 was 1.9 per 1,000 households for England, and 1.6 per 1,000 households for the East Midlands. Rutland's rate was 1.2 per 1,000 households (19 households) which is significantly better than the England value.³

2.1.2. Low income families

Low income families are those in receipt of out of work benefits or tax credits where the families' reported income is less than 60% median income.

In 2015, 7.2% of children under 16 years were in low income families (430 children). This is better

than the England value of 16.8%.⁴ In 2017, 4.6% of children attending state-funded schools in Rutland were eligible and claiming free school meals (256 children). This value is better than the England value of 13.9%.³

2.2. Children in Need

In Rutland in 2016/17, 504 children under the age of 18 were classified as children in need. This equates to a rate of 573 per 10,000 population. This is significantly better than the England average value of 612 per 10,000 population.⁵

Of those in need 71.7% were defined as in need due to abuse/neglect or family dysfunction. This is significantly worse than the England average value of 68.3%.⁵

Of those children in need, 21 children (a rate of 27.2 per 10,000 population) were defined as in need due to child disability or illness in Rutland in 2017. This is similar to the England value of 31.2 per 10,000 population.⁵

Self-harm was identified as risk in 4.5% of assessments of children in need, slightly higher than the national average of 4.1% during 2016/17.⁵

2.3. Special Educational Needs

In Rutland in 2017, there were 347 pupils of primary school age with special educational needs (SEN). This is 11.9% of the total number of pupils and is lower than the East Midlands proportion of 12.7% and the England proportion of 13.8%.⁵

For secondary schools, there were 374 pupils with special educational needs. This is 14.0% of the total number of pupils and is higher than the East Midlands proportion of 11.7% and the England proportion of 12.3%.⁵

Percentages of children receiving SEN support in Rutland have risen significantly from 8.5% in 2015 to 13% in 2018. The rate of SEN support is now ranked third in the East Midlands (of 9 authorities) having been lowest from 2009 to 2015.⁵

2.4. Children Looked After

In Rutland on 31 March 2017, 40 children under the age of 18 were classified as looked after. This equates to a rate of 51.8 per 10,000 population. This is significantly better than the England average value of 62.0 per 10,000 population. The rate of Children Looked After (CLA) per 10,000 children for Rutland has increased over the last five years from 40 per 10,000 in 2012 to 52 per 10,000 in 2017. The increase in the rate over the last five years has been greater for Rutland than for the national and regional comparators, with only a small increase regionally and the national

figure remaining static over the last four years. This means that the increase over the last six years has brought Rutland's rate of CLA proportionate to its local population much closer to the regional and national pictures.

Rutland has the lowest number of CLA of any local authority in England; no other local authority has fewer than 100 CLA – Wokingham is the next smallest with 110 – and the average for a local authority is 649 children (average for all authorities over the last 5 years).

In 2017, 96.0% of eligible looked after school aged children (22 children) had an emotional and behavioural health assessment. This is higher than the England average value of 76.0%. The proportion of eligible children considered 'of concern' in 2016/17 was 59.0% (13 children). This is worse than the England value of 38.0%.⁵

In 2016/17, the rate of children leaving care for Rutland was 25.9 per 10,000 population. This is significantly lower than the England average value of 26.5 per 10,000 population.

2.4.1. Health Assessments

Under the performance assessment framework, local authorities in England are monitored on the uptake of annual health checks for children who were being 'looked after'. Children who have been looked after for 12 or more months are expected to have a health assessment. The health checks are a key tool in ensuring the health needs of all looked after children are identified. Initial and annual health assessments are important to ensure prompt identification of pre-existing, emerging and changing health needs.

In 2017, 96.0% of eligible looked after school aged children (22 children) had an emotional and behavioural health assessment. This is higher than the England average value of 76.0%. The proportion of eligible children considered 'of concern' in 2016/17 was 59.0% (13 children). This is worse than the England value of 38.0%.⁵

In 2017, 100.0% of looked after children under the age of 5 in Rutland (6 children) had up-to-date development assessments, and 100.0% of looked after children under the age of 18 (29 children) had an annual health assessment.⁵

2.5. Safeguarding of children

In Rutland at the end of March 2017, 20 children were subject to a child protection plan. This equates to a rate of 25.9 per 10,000 population. This is lower than the England average value of 43.3 per 10,000 population.

In Rutland during 2016/17, there were 32 new child protection cases for children aged less than 18

years of age. This is a rate of 46.6 per 10,000 population. This is similar to the England rate of 56.3 per 10,000 population. Meanwhile, in Rutland, 36.1% of children aged under 18 years of age (13 children) became subject of a child protection plan for a second or subsequent time. This is higher than the England value of 18.7%.⁵

2.6. Trilogy of Risk

The term 'Trilogy of Risk' has been used to describe the issues of domestic abuse, mental ill-health and substance misuse which have been identified as common features of families where harm to adults and children has occurred. They are viewed as indicators of increased risk of harm to children and young people.

For detailed data on the Trilogy of Risk and its impact for Rutland children and young people please refer to the previous Toxic Trio Needs Assessment (2016), which will be updated in the latter part of 2018.⁶ Please note Toxic Trio is now examined under the terminology of Adverse Childhood Experiences (ACEs).

2.7. Child Sexual Exploitation

Child sexual exploitation (CSE) is a type of sexual abuse. Children in exploitative situations and relationships receive something such as gifts, money or affection as a result of performing sexual activities or others performing sexual activities on them.

Rutland has clear processes in place for addressing CSE aligned to the Local Safeguarding Children's Board and led locally by Children's Social Care.

There is no specific crime of child sexual exploitation. Offenders are often convicted for associated offences such as sexual activity with a child, and therefore it is not possible to obtain specific figures from statistics of sexual exploitation offences. National data suggests that almost 560 children were trafficked for sexual exploitation in 2017 under the National Referral Mechanism of the National Crime Agency.

The National Referral Mechanism is a victim identification and support process that is designed to make it easier for all the different agencies involved in a modern slavery case (for example, the police, UK Visa and Immigration, local authorities and non-governmental organisations) to cooperate, share information about potential victims and facilitate their access to advice, accommodation and support.

In 2017 the National Referral Mechanism (NRM) received a total of 5,145 referrals of potential victims of trafficking. 2,118 (41%) were children under the age of 18. The most prevalent exploitation types for children believed to have been trafficked were labour exploitation (1,026, 48% of all children believed to have been trafficked) and sexual exploitation (559, 26%). The

exploitation type of 414 (20%) of children believed to have been trafficked was recorded as unknown.⁷

These figures are likely to be under-estimates due to the difficulties in recognising and understanding that individuals have been victims of trafficking. It is also not mandatory for a professional to make a referral to the NRM.⁷

2.8. Education

A child's performance in school is a key indicator of their development. In addition to exam-related performance, engagement in other activities can provide opportunities to enhance a pupil's mental wellbeing. For more information on education, please refer to the 'Achieving Educational Potential' JSNA Chapter.

2.9. Youth Justice

It is common for children and young people who enter the youth justice system to have more unmet health needs than other children.

The combined figure for Leicestershire and Rutland for children who have formally entered the youth justice system was 2.5 per 1,000 children aged 10-18 years in 2016/17. This is better than the England value of 4.8 per 1,000 children.⁸

Meanwhile, the combined figure for Leicestershire and Rutland for first time entrants in the youth justice system was 163.4 per 100,000 children aged 10-17 years in 2016. This is better than the England value of 327.1 per 100,000 children.⁸

Numbers of children and young people from Rutland who access the Youth Offending Service are extremely low and consequently the data is suppressed. The numbers have remained consistent over the past three years.

2.10. Young Carers

In 2011, 60 children aged less than 15 years in Rutland provided 1 or more hours of unpaid care per week. This is 0.9% of the total number of children aged less than 15 years. This is similar to the England proportion of 1.11%.⁸

Three children aged less than 15 years in Rutland provided 20 or more hours of unpaid care per week. This is 0.04% of the total number of children aged less than 15 years. This is better than the England proportion of 0.21%.³

In 2011, 146 young people aged 16-24 years in Rutland provided 1 or more hours of unpaid care

per week. This is 3.6% of the total number of children aged 16-24 years. This is better than the England proportion of 4.8%.³

Meanwhile, 19 young people aged 16-24 years in Rutland provided 20 or more hours of unpaid care per week. This is 0.5% of the total number of children aged less than 16-24 years. This is better than the England proportion of 1.3%.³

The number of new young carers referred for assessment to children's social care was 9 in 2015-16, 26 in 2016-17 and 21 in 2017-18. The total number of young carers receiving support was 42 in 2015-16, 56 in 2016-17 and 65 in 2017-18.⁵

2.11. Household Issues

Households experiencing issues may have a negative impact on the quality of a child's housing and health.

2.11.1. Lone parent households

714 households in Rutland in 2011 had a lone parent with dependent children. This is 4.8% of the total number of households and is lower than the England proportion of 7.1%.⁹

2.11.2. No parents in employment

235 households in Rutland in 2011 had dependent children but no adult in employment. This is 1.6% of the total number of households and is lower than the England proportion of 4.2%.⁸

2.11.3. Long-term health problem

In 2011 there were 456 households in Rutland which had dependent children and at least one person (which could be an adult or a child) with a long-term health problem or disability. This is 3.04% of the total number of households and is lower than the England proportion of 4.62%.⁸

2.12. Risky Behaviours

Risky behaviours are those behaviours that are unhealthy as well as some which are illegal. As part of the 'What About YOUth' survey, 15 year olds were surveyed with respect to their lifestyle behaviours. The survey took place in 2014/15 and the unweighted base was 137 respondents in Rutland.

In Rutland, 17.9% of 15 years olds reported having undertaken at least three of the following unhealthy behaviours: smoking, drinking, smoked cannabis, took other drugs, consumed fewer than five portions of fruit and vegetables, not active for 60 minutes or more in the week prior to the survey. Rutland's value is similar to the England proportion of 15.9%.¹⁰

3. Level of need in Rutland

In 2016, Rutland's population of 5-19 year olds was estimated to be a total of 6,752 (3,205 females and 3,547 males). This is projected to increase by 6.6% to around 7,200 by 2039.¹¹

Further information regarding Rutland's population can be seen in the JSNA Population chapter.

3.1. Child mortality

Deaths in children after their first birthday are mostly due to injuries and are therefore usually preventable. The mortality rate for children aged 1-17 years cannot be calculated for Rutland as there were only 3 deaths in this age group during 2014-16.³ Since 2010-12, the highest number of child deaths in a three year time period was 3.

3.2. Excess Weight

Excess weight in children can lead to excess weight into adulthood. Childhood obesity can lead to health problems such as: increased blood lipids, glucose intolerance, Type 2 diabetes, hypertension, increases in liver enzymes associated with fatty liver, exacerbation of conditions such as asthma and psychological problems such as social isolation, low self-esteem, teasing and bullying.

In 2016/17, the proportion of pupils residing in Rutland with excess weight (classified as overweight or obese) in Year 6 (aged 10-11 years) (25.4%) was better than the national percentage (34.2%); this has been the case for four of the last six years. In contrast, the prevalence of overweight and obese Reception pupils in Rutland (24.0%) is similar to the England average (22.6%), and has increased each year for the last three years.¹²

Compared to last year, the prevalence of excess weight in Reception children in Rutland has increased from 22.9% to 24.0%; this equates to an increase in four pupils in the authority classified with excess weight. This is mainly due to the increase in the prevalence of obese Reception pupils from 7.7% to 8.8%. However, the prevalence of overweight pupils in Reception remained reasonably stable at 15.2%.¹²

In contrast, the prevalence of excess weight in Year 6 children in Rutland improved from 31.4% to 25.4%; this equates to a reduction in 20 pupils in the authority classified with excess weight. Whilst the proportions of both of the overweight and the obese categories fell between 2015/16 and 2016/17, the statistical significance of overweight pupils remained similar to England, whereas the statistical significance of obese pupils became significantly better than the national average. The proportion of obese pupils in Year 6 in Rutland is 11.3%, this is the best performing percentage nationally.¹²

Compared to the national picture in 2016/17, the gap narrowed between the difference in prevalence of excess weight in Reception and Year 6 children in Rutland, and currently stands at +0.9 percentage points. In 2014/15 to 2015/16, this gap increased (+2.1, +8.4).

Most demographic groups demonstrated a higher proportion to England with regards to excess weight amongst Reception pupils in 2016/17. Whilst the biggest differences between the authority and the national average were found in the overweight category rather than the obese category, the proportion of obese Reception pupils appears to have been rising over the last three years at a quicker rate than the proportion of overweight pupils. In contrast, the corresponding proportions of overweight pupils in Year 6 were similar to the England average across different demographic groups, and the proportion of excess weight was significantly lower amongst a number of Year 6 demographic groups.

Although there was little evidence of an association between level of deprivation and prevalence of excess weight in either Reception or Year 6, the prevalence of excess weight in Reception in the least deprived areas of Rutland (IMD decile 10) has increased year on year since 2013/14, and has been (non-significantly) higher than the England average and Rutland average for the last three years.

3.2.1. Body perception

In Rutland in 2014/15, the percentage of 15 year olds who thought their body was the right size was 52.5%. This is similar to the England value of 52.4%.¹⁰ Over a third (35.9%) of respondents from Rutland felt they were too fat and 11.6% felt they were too thin. This is similar to the national percentages of 34.4% and 13.2% respectively.¹⁰

3.3. Physical activity

Regular exercise is beneficial to health. In addition to physical benefits, there are psychological benefits, such as reduced anxiety and depression. Over two-thirds (68.7%) of 15 year olds said they had about 7 or more hours of sedentary behaviours in their free time on a weekday in the previous week. This is better than the England value of 70.1%.¹⁰ Furthermore, 8.6% of 15 year olds said they were physically active for at least an hour per day, 7 days a week. This is worse than the England value of 13.9%.¹⁰

3.4. Smoking

Smoking in early adulthood is likely to impact on the health and health behaviours later in life. Smoking is known to cause preventable morbidity and premature death.

As part of the 'What About YOUTH' survey, 15 year olds were surveyed with respect to their

lifestyle behaviours. The survey took place in 2014/15. Regular smokers are those that said they smoked at least one cigarette a week. 4.5% of 15 years in Rutland said they were regular smokers. This is similar to the England value of 5.5%.¹⁰

Occasional smokers are those that said they sometimes smoked, but not as many as one a week. 5.0% of 15 year olds in Rutland said they were occasional smokers. This is statistically similar to the England value of 2.7%.¹⁰

13.1% of 15 year olds said they had tried other tobacco products. This is similar to the England value of 15.2%.¹⁰ 15.2% of 15 year olds said they had tried e-cigarettes. This is similar to the England value of 18.4%.¹⁰

3.5. Tooth decay

Oral health problems in children are largely preventable. Oral health is an important aspect of a child's overall health status and is seen as a marker of wider health and social care issues, including poor nutrition and obesity. A combination of healthy diet and practising good dental hygiene can help to ensure a child has healthy teeth and gums.

3.5.1. Five year olds

In England, 23.3% of five-year-old children had experience of obvious dental decay (caries), having one or more teeth that were decayed to dentinal level, extracted or filled because of caries (d3mft>0) in 2016/17. d3mft is the standard measure of dental decay and refers to teeth that are decayed, missing and/or teeth with fillings. In Rutland, the percentage of children with obvious dental decay is significantly better than the national average at 15.6%. From 2014/15 to 2016/17 there has been a significant improvement in the percentage of children with obvious dental decay (d3mft>0) in Rutland (28.8% to 15.6%).¹³

In England, the average (mean) number of teeth per child affected by decay (decayed, missing or filled teeth (d3mft)) was 0.8. In Rutland, the average number of teeth per child affected by d3mft was 0.4, half the national average. From 2014/15 to 2016/17 there has been a significant improvement in the average number of decayed teeth per child in Rutland (0.7 to 0.4).¹³

Among the children with decay experience, the average number of decayed, missing (due to decay) or filled teeth (mean d3mft (% d3mft>0)) in England is 3.4. At upper-tier local authority level there is clear variation of this measure with affected children in Rutland and Wiltshire having only 2.3 teeth affected on average, while those in Harrow had 4.8.¹³

The presence of substantial amounts of plaque compared with 'visible' or no plaque provides a proxy measure of children who do not brush their teeth, or brush them rarely. Such children

cannot benefit from the protective effects of fluoride in toothpaste on dental decay. A 'substantial amount of plaque' was recorded for 1.5% of volunteers in England compared to 0.0% in Rutland.¹³

At the age of five-years, nearly all oral sepsis will be the result of the dental decay process rather than originating from gum problems. A small number of cases will be linked to traumatic injury of teeth, but no diagnosis of cause was recorded during this survey. Oral sepsis was defined in the protocol as the presence of a dental abscess or sinus recorded by visual examination of the soft tissues. Oral sepsis was recorded for 1.1% of volunteers in England and 0.0% of volunteers in Rutland.¹³

It is useful to know what proportion of children had dental decay affecting one or more of their incisor (front) teeth. This type of decay is usually associated with long term bottle use with sugar-sweetened drinks, especially when these are given overnight or for long periods during the day. Overall, the national prevalence of incisor decay was 5.1%. In Rutland the percentage was 1.3%.¹³

3.5.2. Twelve year olds

The latest data available for 12 year olds was compiled in 2008/9: 12 year olds in Leicestershire and Rutland had an average of 0.85 decayed, missing or filled teeth. This is similar to the England value of 0.74. For the same time period, 58.1% of 12 years olds in Leicestershire and Rutland were free from dental decay. This is worse than the England proportion of 66.4%.¹⁴

3.6. NHS Dentistry

3.6.1. Access

A 12 month time period is used for access reporting to reflect National Institute for Health and Care Excellence (NICE) guidelines which recommend that the longest interval between oral reviews for children should be 12 months.¹⁵ In Rutland, 5,324 children saw an NHS dentist in the 12 months to 30 June 2017, representing 69.0% of all children resident in the county. Nationally the percentage was 58.2%.¹⁶

When examining by five year age bands, Rutland has a higher access percentage than the national average for 0-4 and 5-9 years. At 10-14 and 15-19 years, Rutland has a lower access percentage than the national average.¹⁷

3.6.2. Activity

NHS dental treatment is divided into patient charge bands depending on the level and complexity of treatment provided. Patient charge bands are associated with a Course of Treatment (CoT) as stated in Part 5 Treatment Category of the FP17. Dental care providers submit details of their activity on an FP17 form. There are three standard charge bands for all NHS dental treatments:

- Band 1 course of treatment: covers an examination, diagnosis (including X-rays), advice on how to prevent future problems, a scale and polish if needed, and application of fluoride varnish or fissure sealant.
- Band 2 course of treatment: covers everything listed in Band 1 above, plus any further treatment such as fillings, root canal work or removal of teeth.
- Band 3 course of treatment: covers everything listed in Bands 1 and 2 above, plus crowns, dentures and bridges.
- Urgent care is a separate Band 1 category.

In Rutland, there were 9,136 CoT delivered to children in 2016/17. Of these CoTs, 79.0% (7,221) were Band 1 treatments indicating children are more likely to receive a general check-up than correctional treatments. Aside from examinations, fluoride varnish was the most common Band 1 treatment provided to children, with 2,343 CoTs delivered. This represents a 66.3% increase (1,409) from 2015/16.¹⁶¹⁸ Between 2014/15-2015/16 a quarter (25.0%) of FP17 claims for children in Rutland included fluoride varnish. Nationally, fluoride varnish represents a third of all treatment types in this time period.¹⁷

The most common Band 2 treatment provided to children was permanent fillings and sealant restorations with 1,181 CoTs delivered. This represents a 7.9% decrease (1,282) from 2015/16. 'Other treatment' accounted for the most common Band 3 treatment for children in Rutland with 24 CoTs delivered.¹⁶¹⁸

3.7. Road traffic accidents

Vehicle speed and traffic volumes are seen as reasons why parents are wary of their children walking and cycling. By limiting walking and cycling, physical activity is limited.

During 2014-16, one child aged 6-10 years was killed or seriously injured in a road traffic accident in Rutland. This equates to a rate of 16.9 per 100,000 population and is similar to the England rate of 14.8 per 100,000 population.³

The crude rate of children aged 0-15 years killed or seriously injured in a road traffic accident during 2014-16 was 5.1 per 100,000 population (1 child). This is similar to the England rate of 17.1 per 100,000 population.³ In the previous time period of 2013-15, one child was also killed or seriously injured in a road traffic accident.

3.8. Sexual Health

3.8.1. HPV Vaccination

Vaccination to protect against the main cause of cervical cancer is offered as part of the human papillomavirus (HPV) immunisation programme. It is a two dose programme that is given to females in Year 8 and Year 9 of school.

The population vaccination coverage for females having received one dose of the HPV vaccine at 12 or 13 years old was 88.8% in 2016/17. This is similar to the benchmarked target range of 80% to 90%. Rutland has shown an increase when compared to the previous year, where the coverage was 86.6%. The national coverage increased slightly compared to the previous year to 87.0%.⁴

Meanwhile, the population vaccination coverage for females having received two doses of the HPV vaccine at 13 or 14 years old was 75.8% for in 2016/17. This is worse than the benchmarked target range of 80% to 90%. Rutland has shown a decrease since the previous year where the coverage was 85.2%, which was similar to the national benchmark (80%-90%).⁴

3.8.2. Teenage pregnancy

Teenage pregnancies are largely unplanned and about half end in an abortion. Having a child at an early age can be detrimental to both the teenage parent and child – in terms of the baby's health, the mother's emotional health and wellbeing and the likelihood of parent and child living in long-term poverty.

3.8.2.1. Conceptions

The rate of under 18 conceptions in Rutland has shown a significant decline in line with national, and since 2013, has remained significantly better than the national rate. In 2016, there were 4 conceptions for girls aged 15-17 years in Rutland. This equates to a rate of 4.7 per 1,000 females aged 15-17 years. This is better than the England rate of 18.8 per 1,000 females aged 15-17 years.¹⁹

3.8.2.2. Delivery of a newborn child

Factors relating to the mother and method of delivery of a newborn child can have an influence on the health needs of a child.

A child's long-term health can be impacted on as follows: children born to teenage mothers have 60% higher rates of infant mortality and are at increased risk of low birthweight. The mental health effects for a teenage mother are that they are three times more likely to suffer from post-natal depression and experience poor mental health for up to three years after the birth – this

may impact on the child's health and development. Living in poverty, is also an increased risk for teenage parents and their children.

In 2015, the number of births to mothers aged 15-17 years of age in Rutland was 3, a rate of 3.4 per 1,000 females aged 15-17 years of age. This is similar to the England value of 6.3 per 1,000 females aged 15-17 years of age.¹⁹

3.8.3. Chlamydia

Chlamydia is known to cause avoidable sexual problems – such as infections, pelvic inflammatory disease, ectopic pregnancy and tubal-factor infertility. The National Chlamydia Screening Programme recommends annual screening or on change of partner, whichever is more frequent.

Rutland continues to perform significantly worse than the national percentage for proportion of the population aged 15-24 screened for chlamydia. The percentage has decreased from 18.6% in 2016 to 16.2% in 2017, which equates to a decrease of 109 screenings in Rutland in 2017. Nationally the percentage screened has also decreased from 21.0% in 2016 and 19.3% in 2017.¹⁹

Meanwhile, in 2017 Rutland continues to perform significantly worse than the benchmarked goal rate of 1,900-2,300 per 100,000 population for chlamydia detection rate for 15-24 years olds, but has seen a year on year increase since 2015. In Rutland the chlamydia detection rate increased (improved) from a rate of 1,461 per 100,000 population aged 15-24 years in 2016 to 1,614 per 100,000 population aged 15-24 years in 2017.¹⁹

Like nationally, the chlamydia detection rate in females in Rutland is higher than in males, however, the difference in rate between males and females in Rutland is much smaller compared to nationally. Locally, males have seen a year on year increase in the detection rate since 2015 whereas in females, the rate has been declining throughout this time.

3.9. Substance misuse

3.9.1. Alcohol

Alcohol consumption in teenagers is associated with risky behaviour, particularly in respect of sexual activity and the likelihood of teenage pregnancy and contracting a sexually transmitted infection. Research has also suggested that people drinking at an early age drink more frequently and more in total. They are therefore more likely to develop alcohol problems in adolescence and adulthood. For this reason, the Chief Medical Officer for England recommended that under 15s should not drink alcohol at all.

As part of the 'What About YOUTH' survey, 15 year olds were surveyed with respect to their lifestyle behaviours. The survey took place in 2014/15. In Rutland, 74.4% of 15 years olds said they

had had an alcoholic drink. This is worse than the England value of 62.4%.¹⁰

Regular drinking is defined as consuming an alcoholic drinking at least once a week. 7.0% of 15 year olds in Rutland said they were drinking regularly. This is similar to the England value of 6.2%.¹⁰ Meanwhile, 20.6% of 15 year olds in Rutland said they had been drunk in the last 4 weeks. This is worse than the England value of 14.6%.¹⁰

The rate of hospital admissions for people aged under 18 years due to alcohol-specific conditions during 2014/15 - 16/17 are not available for Rutland as the numbers are too small.²⁰

3.9.2. Drugs

The usage of recreational drugs by young people can lead to mental health issues such as suicide, depression and disruptive behaviour disorders.

As part of the 'What About YOUTH' survey, 15 year olds were surveyed with respect to their lifestyle behaviours. The survey took place in 2014/15. In Rutland, 10.8% of 15 year olds had tried cannabis; this is similar to the England value of 10.7%. In comparison, 2.7% had taken cannabis in the last month. This is also similar to the England value of 4.6%.¹⁰ 0.9% of 15 year olds in Rutland had taken other drugs in the last month. This is similar to the England value of 0.9%.²¹

The rate of hospital admissions for people aged 15-24 years due to substance misuse for the past three time periods has remained similar to the national average, with a constant count on 10 admissions. During 2014/15 - 16/17 for Rutland was 68.1 per 100,000 population. This is statistically similar to the England rate of 89.8 per 100,000 population.²⁰

3.10. Mental health

The emotional health and wellbeing of young people can impact on their development and learning, in addition to their physical and social health.

As part of the 'What About YOUTH' survey, 15 year olds were surveyed with respect to their lifestyle behaviours. The survey took place in 2014/15. The proportion of 15 year olds with low life satisfaction in Rutland in 2014/15 was 9.5%, this is better than the England value of 13.7%.²¹

Bullying in any form can impact on a person's physical and mental health. It can also impact on educational attainment and can pose a suicide risk.¹⁰ The proportion of 15 year olds in Rutland in 2014/15 who said they had been bullied in the past couple of months was 60.2%, this is similar to the England value of 55.0%.¹⁰

Rutland has a lower level of estimated prevalence of any mental health disorders in children aged 5-16 years compared to England. In 2015, the estimated prevalence in Rutland was 8.2%,

compared to 9.2% nationally.²² The estimated prevalence of emotional disorders (anxiety disorders and depression) in children aged 5-16 years in Rutland in 2015 was 3.3%, lower than the England value of 3.6%.¹

Over the last three years Rutland has continued to have a significantly lower rate of children with autism known to state funded primary, secondary and special schools compared to the national rate. The latest data from 2017 shows there were 51 children in Rutland with autism known to schools, equating to a rate of 6.6 per 1,000 pupils. This is almost half the national rate of 12.5 per 1,000 pupils.²³

3.10.1. Eating disorders

The estimated prevalence of potential eating disorders in young people aged 16-24 years in Rutland in 2015 was 1.2%. The England value was 1.5%.²²

3.10.2. Admissions for self-harm

Between 2012/13 and 2015/16, the rate in hospital admissions as a result of self-harm in Rutland increased year on year, peaking in 2015/16, where there were 27 admissions. In 2016/17 the rate declined and 15 young adults aged 10-24 years old in Rutland were admitted to hospital as a result of self-harm. This equates to a rate of 230.9 per 100,000 population which is better than the England rate of 404.6 per 100,000 population.²⁰

3.11. Hospital attendances

Many emergency hospital admissions for children are preventable. Emergency hospital activity can be an indicator of other issues such as housing and transport, or mental health problems for the child or their parent.

3.11.1. Accident & Emergency (A&E)

Since 2010/11, the rate of A&E attendances for children and young people in Rutland has remained significantly better (lower) than the national average. In 2015/16, there were 2,719 attendances at Accident & Emergency for children and young adults in Rutland aged 0-19 years old. This equates to a rate of 315.2 per 1,000 population and is better than the England rate of 408.5 per 1,000 population.²⁰

3.11.2. Emergency admissions

In 2015/16, nationally, the highest rate of emergency admissions in children and young people were seen in the 15-19 age group, followed by the 5-9s and the 10-14s. In Rutland, the 5-9s have the highest rate, followed jointly by the 10-14s and 15-19s.

Across all age bands in 2015/16, Rutland has a significantly better (lower) rate than nationally. This equates to 58 emergency admissions for children in Rutland aged 5-9 years old, 61 emergency admissions for children in Rutland aged 10-14 years old and 77 emergency admissions for children and young adults in Rutland aged 15-19 years old.²⁰

3.11.3. Admissions for injuries

In addition to being a cause of premature mortality, injuries can cause long-term health and mental health issues.

Between 2013/14 and 2015/16, the rate of admissions due to unintentional and deliberate injuries in children aged 0-14 years was significantly better (lower) than the national average. In 2016/17, the rate increased to 101.0 per 10,000 population to perform similar to the England rate of 101.5 per 10,000. This equates to 60 children aged 0-14 years in Rutland admitted to hospital due to unintentional and deliberate injuries.²⁰

3.11.4. Admissions for asthma

The rate for hospital admissions for asthma has remained similar to national since 2013/14. The latest data shows in 2016/17, 10 people aged under 19 years in Rutland were admitted for asthma. This is a rate of 120.6 per 100,000 population and is statistically similar to the England rate of 202.8 per 100,000 population.²⁰

4. How does this impact?

People's health and emotional wellbeing have their roots in early childhood, by providing the right level of nurture and support, where needed, at an early stage we can enable children to thrive throughout school and into their adult lives. Caring and supportive environments that promote optimal early childhood development greatly increase children's chances of a successful transition to school. This, in turn, promotes children's chances of achieving better learning outcomes while at school and better education, employment and health after they have finished school.

£7.300 million per 10,000 children aged 0-17 years was spent on Local Authority children and young people's services (excluding education) in Rutland during 2016/17. This is lower than the England rate of £7.789 million per 10,000 children.

Of the above, £2.369 million per 10,000 children aged 0-17 years was spent on looked after children in Rutland during 2016/17. The England rate was £3.527 million per 10,000 children.

£2.310 million per 10,000 children aged 0-17 years was spent on safeguarding children and young people's services (excluding education) in Rutland during 2016/17. The England rate was £1.981 million per 10,000 children.

The planned spend on special schools in Rutland during 2017/18 was £1.282 million per 100,000 children. The England rate was £9.978 million per 100,000 children.

The expenditure on youth justice for children aged 0-17 years in Rutland during 2016/17 was £107,000 per 10,000. The England rate was £230,000 per 10,000 children.

5. Policy and Guidance

5.1. The Children and Families Act 2014

The Children and Families Act 2014 puts a much greater emphasis on bringing together support for children and young people up to the age of 25, focusing on outcomes beyond school or college. The Act also introduced major changes to support for children and young people with special educational needs (SEN), creating education, health and care (EHC) plans to replace SEN statements. Families with EHC plans are offered personal budgets for elements of their care. The Act also places a duty on local authorities to identify all children in their area who have SEN or disabilities.

The overall aim is to give families a greater involvement in decisions about their support and to encourage social care, education and health services to work more closely together in supporting those with special needs or disabilities. As part of the changes local authorities are required to publish a 'local offer' setting out what support is available to families with children who have disabilities or SEN. The local offer should also explain how families can request personal budgets, make complaints and access more specialist help. Details of Rutland's local offer can be found here: <https://www.rutland.gov.uk/my-services/schools-education-and-learning/send-local-offer/>

5.2. Rutland SEND and Inclusion Strategy 2017

The Council's SEND and Inclusion Strategy provides an opportunity to create a shared view of the challenges faced by children and young people. This Strategy enables the Council and other stakeholders together to identify the gaps in services, and challenge what needs to change and improve to achieve better outcomes for children and young people.

This Strategy sets out clear expectations of the Council and Clinical Commissioning Groups (CCGs), and other partners especially health and education providers, which reflects the statutory requirement under primary legislation, regulation and case law as set out in the SEND Code of Practice (2015), Section 28 Duty to Co-operate and the Local Safeguarding Board safeguarding procedures.

5.3. Future in Mind (2015)

The Department of Health and NHS England published 'Future in Mind: Promoting, protecting and improving children and young people's mental health and wellbeing' in 2015. Future in Mind sets out the Government's vision for children and young people's mental health.²⁴ The themes of Future in Mind include:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

5.4. The Green Paper²⁵

A Green Paper 'Transforming Children and Young People's Mental Health Provision': was published in December 2017. It builds on the government's vision for children and young people's mental health set out in Future in Mind in 2015, and provides the joint response of the Department for Health and Social Care and the Department for Education. The Paper contains three key announcements:

- To provide an incentive for every school and college to have a designated senior lead for mental health. All children and young people's mental health services should have a link for schools and colleges to better support them in delivering on child and young people mental health and wellbeing needs. They will do this through advice, consultation and signposting for children who need it.
- Funding for new mental health support teams, which will be supervised by NHS children and young people's mental health staff, to provide extra capacity for early intervention and ongoing help.
- A four week waiting time for access to specialist NHS children and young people's mental health services will be trialled.

5.5. The Five Year Forward View for Mental Health (2016)²⁶

In order to deliver on the vision set out in 2015's Future in Mind and 2016's Five Year Forward View for Mental Health, the government have:

- Legislated for parity of esteem between physical and mental health.
- Committed to make an additional £1.4 billion available for children and young people's mental health over five years.

- Committed to recruit 1,700 more therapists and supervisors, and to train 3,400 staff already working in services to deliver evidence-based treatments by 2020/21.
- Improved services for eating disorders, with, 70 new or enhanced Community Eating Disorder Teams, and the first ever waiting times for eating disorders and psychosis.
- Funded eight areas to test different crisis approaches for children and young people's mental health.

5.6. Prevention Concordat for Better Mental Health²⁷

The Prevention Concordat for Better Mental Health is underpinned by an understanding that taking a prevention-focused approach to improving the public's mental health is shown to make a valuable contribution to achieving a fairer and more equitable society. The concordat promotes evidence based planning and commissioning to increase the impact on reducing health inequalities.

It represents a public mental health informed approach to prevention, as outlined in the NHS Five Year forward view and promotes relevant NICE guidance and existing evidence based interventions and delivery approaches, such as 'making every contact count'.

The Concordat seeks to prevent mental health problems from developing and to promote good health through local and national action including addressing the wider determinants of mental health and focusing on prevention. It recognises the need to build capacity and capability of the workforce to prevent mental health problems and promote good mental health. A Prevention Concordat has been adopted for the East Midlands.

5.7. Suicide Prevention: Policy and Strategy (2018)²⁸

The Five Year Forward View for Mental Health recommends that all local authorities have multi-agency suicide prevention plans in place in 2017. These should target high-risk locations and support high-risk groups, including men and people in contact with mental health services. The local plans should be reviewed annually and supported by new investment.

The LLR Suicide Audit and Prevention Group (LLR SAPG) has been brought together to tackle the cause and the impact of suicide across LLR and has developed the LLR Suicide Prevention Strategy and Plan 2017-20. This plan includes the STOP Suicide Prevention Campaign, and the development of a Suicide Prevention website.

5.8. NICE Guidance

5.8.1. Social and Emotional Wellbeing in Primary Education PH 12

This guideline covers approaches to promoting social and emotional wellbeing in children aged 4 to 11 years in primary education. It includes planning and delivering programmes and activities to help children develop social and emotional skills and wellbeing. It also covers identifying signs of anxiety or social and emotional problems in children and how to address them.²⁹

5.8.2. Social and Emotional Wellbeing in Secondary Education PH20

This guideline covers interventions to support social and emotional wellbeing among young people aged 11–19 years who are in full-time education. It aims to promote good social, emotional and psychological health to protect young people against behavioural and health problems.³⁰

5.8.3. Social and emotional Wellbeing Early years PH40

This guideline covers supporting the social and emotional wellbeing of vulnerable children under 5 through home visiting, childcare and early education. It aims to optimise care for young children who need extra support because they have or are at risk of social or emotional problems.³¹

5.8.4. Young People’s Mental Health coalition Guidance³²

Published in 2015 ‘Promoting Children and Young People’s emotional health and wellbeing: a Whole School and College Approach guidance has also been included in the green paper. It includes a designated lead for mental health in a school or college who will have oversight of the whole school approach.

6. Current Services

6.1. Local Safeguarding Children’s Board

Under the auspices of the Local Safeguarding Children’s Board, Rutland has a clearly set out thresholds document which sets the level of type of interventions to be provided to children and young people depending on their level of need. It breaks down risk factors into developmental; family and Environmental; and parent and carers.

6.2. “Front door” of services

The Council provides the ‘front door’ through which parents and professionals can access additional support at any level, including early help advice and support. This includes a multi-disciplinary holistic approach that brings a range of professional skills and expertise to bear through a “Team Around The Family” approach; a relationship with a trusted Lead Professional

who can engage the child and their family, and/or co-ordinate the support needed from other agencies

The critical features of an effective Early Help Offer which have been identified nationally and on which Rutland's early help process is founded are:

The Early Help Offer recognises the crucial role that all family members – not just mothers and fathers, but step parents, grandparents, siblings and other extended family members and carers – play in influencing what children experience and achieve as well as the consequences when families are in difficulty.

The provision of early help services covers for levels of need:

Universal need - Services working with children and families, to promote positive outcomes for everyone; midwives, health visitors, schools and early year's settings, adult learning and community voluntary groups. Practitioners working in these services identify where children and families would benefit from extra help at an early stage.

Early Help and Targeted need - Services focus on children, young people and families who may need support either through a single service or through an integrated multi-agency response, for example, housing, youth options, and community safety. They work with families where there are signs that without support a child may not achieve good outcomes and fulfil their potential.

Specialist need - Services, such as social care, adult mental health services, focus on families with individual or multiple complex needs, who are at risk of significant harm or significant impairment to their health or development, including where help has been requested through Section 17 - a child in need or where a specific disability or condition is diagnosed, and Section 47 – where there is a need to investigate a significant safeguarding concern.

By law, Children's Social Care has to give priority of service to children with specific categories of need:

- Those at risk of serious harm and who may need a protection plan
- Those who are, or may need to be, looked after by Children's Social Care and are unable to remain living at home (birth to 18 years including unaccompanied asylum seeking children and young people)
- Private Fostering - such arrangements have to be notified to the local authority (Children's Social Care)
- Those aged 16 or over who are leaving the care of Children's Social Care or have previously left care and are eligible for Leaving Care services
- Where Children's Social Care involvement is required by the courts

Specialist services include:

- The recruitment, assessment and supervision of foster carers
- Placing and supporting children with foster carers
- Placing children in residential care for children who are no longer able to live at home and where that is the appropriate option
- Supervising children who are privately fostered
- Supporting young carers Adoption services are provided on Rutland's behalf by Leicestershire County Council.

6.3. Social Care teams and partners

The Social Care teams work in partnership with, and may refer to, other services, including education, health, housing, and the police to provide interventions and support on a multi-agency basis. Social Care provision is delivered by three teams:

Referral, Assessment and Intervention Service who provide the front door service including; advice and guidance, screening of contacts made to the service and recommendations as to appropriate support for families, complete reports requested by the courts for families in Private Family Law matters, complete assessments under section 17 and initial child protection investigations under section 47.

Permanency and Protection Service – this service is split in to two teams, one working with the complex child in need work under section 17 and families subject to child protection plans, the other working with children looked after by the Local Authority and any other court work required of the Local Authority.

Fostering, Adoption and Care Leavers Service who provide support to current foster carers and recruitment of new carers, care leavers, children in care who require a Personal Advisor, and matters relating to adoption.

The Local Offer sets out information about services for children and young people with Special Educational Needs and Disabilities (SEND) with information for parents/carers, children and young people as well as for professionals. <https://www.rutland.gov.uk/my-services/schools-education-and-learning/send-local-offer/>

6.4. Promotion of Mental Health and Wellbeing

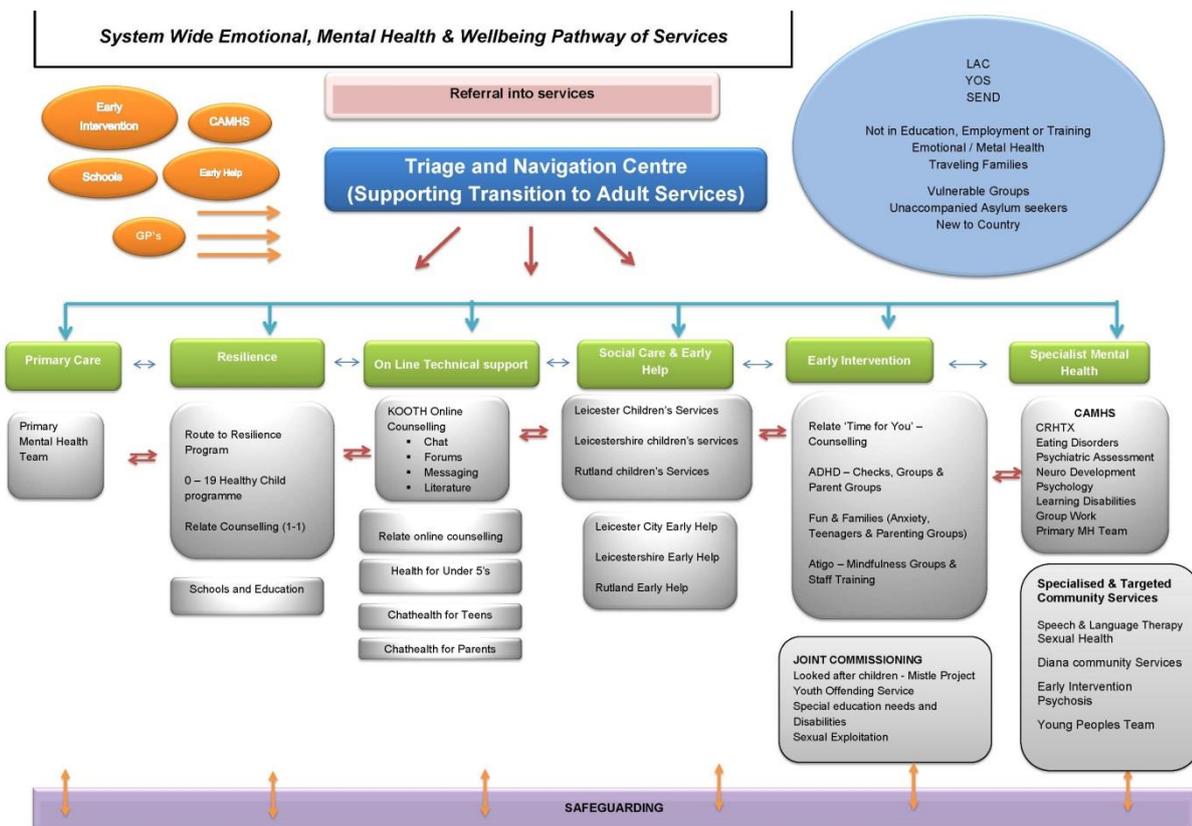
Services to promote mental health and wellbeing and to identify and support those who are experiencing mental health problems need to be co-ordinated and integrated. Locally this has been described as a whole system pathway across Leicester, Leicestershire and Rutland, called the

Social, Emotional, Mental Health and Wellbeing pathway.

6.5. Future in Mind commissioned services

A number of services have been commissioned directly as part of the Future in Mind programme. These services have been designed to augment and improve pre-existing mainstream services. This is the list of the **Future in Mind commissioned services** (Commissioned by Leicester City Clinical commissioning Groups on behalf of all 3 CCGs across Leicester, Leicestershire and Rutland):

Figure 1: System wide pathway of services



- Targeted Early Intervention Emotional health and wellbeing Service for LLR
- Route to Resilience in Schools - a whole school approach to resilience in schools programme
- Xenzone - Kooth deliver an Online Counselling service
- Enhanced Access to Childhood and Adolescent Mental Health Service (CAMHS)
- Eating Disorders Service
- Crisis and Home Treatment Service

- Place of safety
- CAMH Service
- Primary Mental Health Team

6.6. Child and Adolescent Mental Health Service (CAMHS)

The CAMHS service is an LLR wide service and links with the Future in Mind services described above. CAMHS help children and young people who have been referred by another healthcare professional. CAMHS website: <http://www.leicspart.nhs.uk/OurServicesAZ-ChildandAdolescentMentalHealthServiceCAMHS.aspx>

Referrals are made if it's thought the child or young person has emotional and/or behavioural difficulties at a level which requires specialist support. The range of services includes initial assessments, therapy, group work, emergency assessments and in-patient care. CAMHS also links with other children's services to offer a multi-agency approach. The team is made up of doctors, nurses and therapists who specialise in child mental health. The support we provide varies according to need, from a one-off appointment to a programme of on-going care which lasts until the child or young person feels better and is felt to be safe.

- **CAMHS Crisis Resolution and Home Treatment team** provides rapid assessment and treatment at home for children and young people in mental health crisis and support for their families, providing no physical medical intervention is required. Once a referral is received, the team aims to make telephone contact with a family within two hours and to assess the child or young person within 24 hours. The service is operational from 8am until 10pm. Outside of these times, support is provided by the adult crisis team.
- The **Primary Mental Health Team** works between primary care - for example GPs and public health (school) nurses - and specialist CAMHS outpatient teams. The team treats young people having difficulties with their mental health or emotional wellbeing, and who may be at risk of developing a mental health disorder.
- The **Young Peoples Team** works particularly with vulnerable young people in care and those who are involved with the youth offending service.
- The **CAMHS Learning Disability Team** provide services for children with a moderate to profound learning disability as defined in International Classification of Disease 10 presenting with mental health and or associated behavioural problems.
- The **CAMHS Eating Disorders Team**, based at Mawson House in Leicester, offers specialist outpatient assessment and treatment to young people and their parents affected by eating

disorders, and manages around 100 new referrals each year. Treatment usually lasts between 12 and 18 months, though early intervention is crucial to recovery.

- The **Paediatric Psychology Team**, based at Artemis House, offers specialist psychological assessment and treatment to children, young people and their families who are psychologically affected by living with physical health conditions or disabilities. Referrals are from Consultant Paediatricians only

6.7. Healthy Child Programme

The programme helps to build resilience and support emotional health and wellbeing of children and young people and maternal mental health. Children's mental health has been included as high impact areas in the delivery of the 0-19 Healthy Child Programme. In this context, Public Health nurses (Health Visitors and School Nurses) provide brief interventions, advice, and support for children, young people and their families on emotional health and wellbeing.

0-19 Healthy Child Programme have also developed a number of packages of care and support and pathways in response to need including: anxiety, emotional health and self-harm, emotional health, behaviour management 0-5/5-19, domestic abuse safeguarding, child sexual exploitation referral pathways.

Public health nurses provide face to face support through drop in clinics for young people in secondary schools and for parents in primary schools

Young people can also text a public health nurse to access confidential advice via a secure messaging service, ChatHealth. In Leicestershire and Rutland, young people can text 07520 615387

The ChatHealth service is also available for parents and carers if they have concerns about their child's health, and would like to contact a health professional. In Leicestershire and Rutland: 07520 615382

6.7.1. Early Start Programme

The Early Start Programme provides intensive early intervention and support for vulnerable first time parents with an infant 0-2 years. Informed by an outreach health visiting model, ESP is delivered by health visitors, early childhood practitioners and family nursing support staff and provides families with bespoke support. Support can start from 16 weeks pregnancy until the child's second birthday.

The Aim of the Programme is to ensure all children have the best start to life and prepare and equip vulnerable parents for parenthood providing them with skills, knowledge, confidence and

capability to enable them to give their children the best possible start.

There is information on Emotional health and wellbeing and mental health issues on the 3 Healthy Together websites including:

Health for under 5's: <https://healthforunder5s.co.uk/>

Health For Kids: <https://www.healthforkids.co.uk/>

Health for Teens: <https://www.healthforteens.co.uk/>

7. Unmet needs/Gaps

7.1. Needs of children and young people

The evidence of local needs, current and emerging indicates:

- There are increasing numbers of referrals to early intervention services and CAMHS for children and young people with mental health and emotional health and wellbeing problems e.g. self-harm, anxiety.
- There are increasing numbers of children and young people who are exposed to domestic abuse and other adverse childhood experiences. Research states that children who experience domestic abuse have a fourfold increased risk of experiencing mental and emotional health issues. Therefore, there are a significant number of children in Leicestershire who may be experiencing and/or witnessing domestic abuse; however their emotional and mental health needs are not necessarily being catered for³³.
- Public health nurses (school nurses) are also seeing an increasing number of children who are self-harming and experiencing anxiety.
- The age at which children and young people are presenting to services with emotional and mental health problems has lowered to primary school age.
- A significant number of referrals to CAMHS are related to behaviour which is taking up significant time and resources. It is hoped that the new system wide emotional, mental health and wellbeing pathway will help to divert these referrals away from CAMHS, if appropriate. The care of children and young people with behavioural issues is better served if it is multidisciplinary and focused on the child's needs rather than a medical diagnosis.
- There is also emerging recognition that many of the referrals to services are caused by attachment issues, therefore there should be an increased focus on parenting programmes through the 0-19 healthy child programme the Children and Family Service's early help

service and voluntary sector programmes.

- A recent national 'Time to change' survey³⁴ revealed that 90% of young people said that they have experienced stigma and discrimination as a result of their mental health issues. This has prevented them in some cases, from doing every day activities that they enjoy. Stigma and discrimination can also stop people from seeking help and socialising with friends and discussing their problems with family or friends because they fear a negative reaction.

7.2. Mental Health Promotion and Prevention of Mental Health problems and Early Intervention

- Across the system there is recognition that there needs to be a greater emphasis on mental health promotion, prevention of mental health problems and early intervention, identifying emotional and mental health problems early in order to 'break the cycle'.
- Resilience also needs to be systematically promoted within all schools through the route to resilience programme and through the delivery of personal social health education (PSHE) including how to build mental resilience and wellbeing. All schools will have to deliver compulsory health education from September 2020.
- Self Help: There may be scope and potential to help and support young people to manage emotional health and wellbeing issues themselves.
- There needs to be more emotional and mental health training and support provided to universal services (e.g. Schools, Primary Care (GPs), Health Visiting and School Nursing Services) due to sheer numbers of children and young people accessing these services.
- It is recognised that schools need to be helped to take on a greater role in promoting emotional health and wellbeing as well identifying children who are at risk of emotional and mental health problems. However, in order to do this they need training and support to feel competent and confident. Part of compulsory health education (from September 2020) will include the need to ensure that children and young people will know how to recognise when they and others are struggling with mental health issues and how to respond

7.3. Provision of CAMHS Services

There are still significant blockages in terms of access to treatment at every level of CAMHS. However, it is also recognised that there have been recent improvements.

7.4. Emerging gap between children with ADHD and autism with mental health

services

A gap in the current commissioned services around children and young people with a diagnosis of Autism has been identified. The gap focusses specifically on those children and young people with a diagnosis of Autism, but do not also have a diagnosis of a mild to moderate learning disability. The children with Autism with mild learning disability are not picked up until situations escalate i.e. in:

- Care and Treatment reviews
- Children with medical need (education meeting)
- Not in education, employment or training (NEET)
- Youth offending Services

7.5. Children in Care (Looked after Children)

Children in care have particular emotional needs, related to their earlier experiences before they were looked after. These earlier experiences have an influence on brain development and attachment behaviour. Rates of: emotional, behavioural and mental health difficulties are at four to five times higher amongst children in care (looked after children) than the wider population.

A Whole System Approach to promoting good emotional health of children in care (looked after children) is needed (see NSPCC's 'Achieving Emotional Wellbeing for Looked after Children' (2015)³⁵ the priorities for change within the system should include:

- Embed an emphasis on emotional wellbeing throughout the system
- Take a proactive and preventative approach
- Give children and young people a voice and influence
- Support and sustaining children's relationships
- Support care leavers' emotional needs

8. Recommendations

- Target resources in proportion to need to address the needs of any children living in poverty and those most vulnerable.
- Increase numbers of children being active, and encouraging them to be active for longer

- Promote child visits to dentists and increase levels of fluoride varnish treatments to prevent tooth decay.
- Work with NHS England, commissioners of human papillomavirus (HPV) vaccination programme, to improve uptake of second dose.
- Better promote the range and availability of Tier 1 and 2 support available in Rutland to professionals, young people and parents via the Rutland Information Service, School websites and parent training.
- Support training for school staff to assist them with compulsory requirements for all schools to provide: relationship education (primary school) and sexual health and relationship education (secondary schools) from 2019, and to enable them to deliver health education which becomes compulsory from September 2020.
- Adversity and trauma informed care for children and young people should be prioritised for those who have Adverse Childhood Experiences (ACEs). ACEs include: parental separation, domestic abuse, mental illness, alcohol misuse/ drug use. This should form part of an overarching partnership strategy and cover both primary and secondary prevention. The ACEs model should be used to identify young people and families who perhaps do not reach the threshold for a referral into statutory services.

GLOSSARY OF TERMS

A&E	Accident & Emergency
ACEs	Adverse Childhood Experiences
CAMHS	Child and Adolescent Mental Health Service
CCG	Clinical Commissioning Group
CLA	Children Looked After
CoT	Course of Treatment
CSE	Child Sexual Exploitation
d3mft	decayed, missing or filled teeth
EHC	Education, Health and Care
HPV	Human Papilloma Virus
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LSOA	Lower Super Output Area
NEET	Not in education, employment or training
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NRM	National Referral Mechanism
PHE	Public Health England
SEN	Special Educational Needs
SEND	Special Educational Needs and Disabilities

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RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2018

ACHIEVING EDUCATIONAL POTENTIAL – CHILDREN AGED 4 TO 18 YEARS

DECEMBER 2018

Strategic Business Intelligence Team
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Business Intelligence

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Whilst every effort has been made to ensure the accuracy of the information contained within this report, Leicestershire County Council cannot be held responsible for any errors or omission relating to the data contained within the report.

FOREWORD

The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Rutland, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs.

The JSNA has reviewed the data relating to educational attainment in Rutland, from early years through to school leaving age. The processes used to oversee progress are outlined and unmet needs and recommendations that have arisen from this needs assessment are discussed.

The JSNA offers an opportunity for the Local Authority, CCG and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCG and NHS England must be able to explain why.

EXECUTIVE SUMMARY

In this chapter we examine how pupils in Rutland's state-funded schools perform in comparison with pupils nationally in Early Years Foundation Stage, Key stage 1, Key stage 2 and Key stage 4 statutory assessments. The chapter includes data trends over the past 5 years to evaluate performance over time. It is important to note that Key stage 1, 2 and 4 had a change of assessment measures between 2014-15 and 2015-16 which impacts on data patterns.

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1. Introduction

This chapter presents a comprehensive overview of how Rutland's state-funded schools perform. The majority of indicators presented are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. We appreciate that this document uses technical language. This is due to the nature of the JSNA, which is intended for use by commissioning organisations such as local authorities and the NHS in developing their commissioning plans. One example is the use of statistical significance. A statistical significant result ensures the result is not likely to be caused by chance, for a given statistical significance level. Using these statistical tests improves the reliability of our evidence base which will help strengthen our commissioning based decisions

2. Level of need in Rutland

It is recognised that many factors impact on children's educational potential being achieved and it is well known that lower educational outcomes are further associated with poorer outcomes in later life. More detail on these wider determinants of health are available in the 'Children and Young People Staying Safe and Healthy Joint Strategic Needs Assessment'.

2.1. Early year's foundation (EYFS)

2.1.1. Good Level of Development

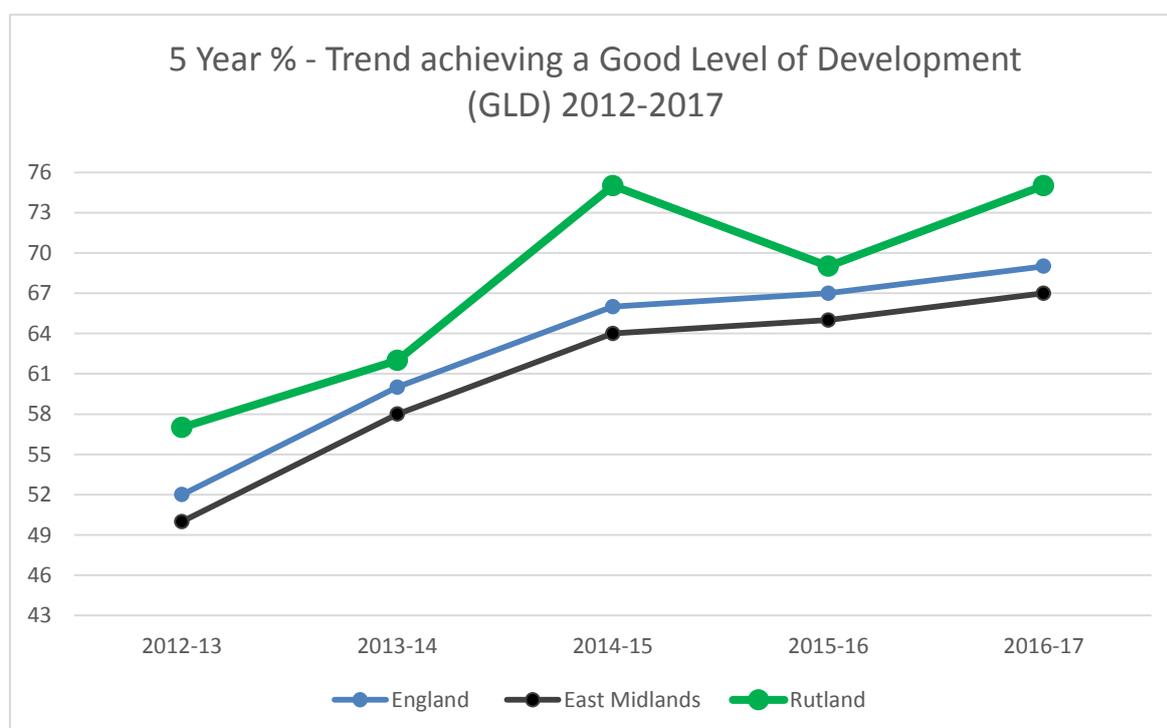
Performance at the end of the Early Years Foundation Stage (EYFS) is measured by the Good Level of Development (GLD) which measures a child's attainment across the first 12 Early Learning Goals.

School readiness is a measure of how prepared a child is to succeed in school cognitively, socially and emotionally. 'Good level of development' is used to assess school readiness. It is measured at the end of the reception year and covers: communication and language; physical development; personal, social and emotional development; literacy; mathematics; understanding the world; and expressive arts, designing and making. School readiness starts at birth with the support of parents and other caregivers, as children start to acquire these skills. School readiness at age 5 (the end of reception year) has a strong impact on future educational attainment and life chances.¹

Rutland's scores for 'Good Level of Development' remains above that seen nationally. There are inconsistencies in performance over time, however indications are that this may be

influenced by the characteristics of the cohort. For example, in 2014 the cohort was made up of a high proportion of summer born children and in 2016 the cohort had a high percentage of boys. However, there will be continued challenge to those Early Years providers where performance is not at a level that would be expected for that cohort, with LA commissioned programmes to support the development of a curriculum to meet the needs of all groups of pupils.

Figure 1: Percentage of reception children achieving a good level of development, 2012-2017²



2.1.2. Phonics Screening

In 2016/17, 83.3% of Year 1 pupils in Rutland achieved the expected level in the phonics screening check. This is similar to the England value of 81.1%. Meanwhile, 11 children with free school meal status achieved the expected level in the phonic screening check (61.1%). This is similar to the England value of 68.4%.³

2.2. Key Stage 1 SATs

Key stage one performance in reading, writing and mathematics is measured through teacher assessment at the end of Year Two. The performance of pupils in Rutland state-funded schools has been consistently above national average for a number of years in all subjects although the gap between the local authority and national Key Stage 1 outcomes have narrowed in 2017 to broadly in line with pre-2016 levels. Note the change in

assessment methods in 2015-16. Prior to that date, attainment had been measured in Levels, with Level 2 being expected. This is now referred to as Expected Standard; the percentages refer to those children attaining Expected Standard or better.

Table 1: KS1 SATs – Year on year comparison against National – Expected Standard⁴

Key Stage 1		2012-13			2013-14			2014-15			2015-16			2016-17		
		L2+	% point difference		L2+	% point difference		L2+	% point difference		EXS +	% point difference		EXS +	% point difference	
Reading	Rutland	91%	2%	↑	91%	1%	↑	93%	3%	↑	80%	6%	↑	79%	3%	↑
	National	89%			90%			90%			74%			76%		
Writing	Rutland	88%	3%	↑	88%	2%	↑	90%	2%	↑	70%	5%	↑	72%	4%	↑
	National	85%			86%			88%			65%			68%		
Maths	Rutland	94%	3%	↑	95%	3%	↑	96%	3%	↑	78%	5%	↑	78%	3%	↑
	National	91%			92%			93%			73%			75%		

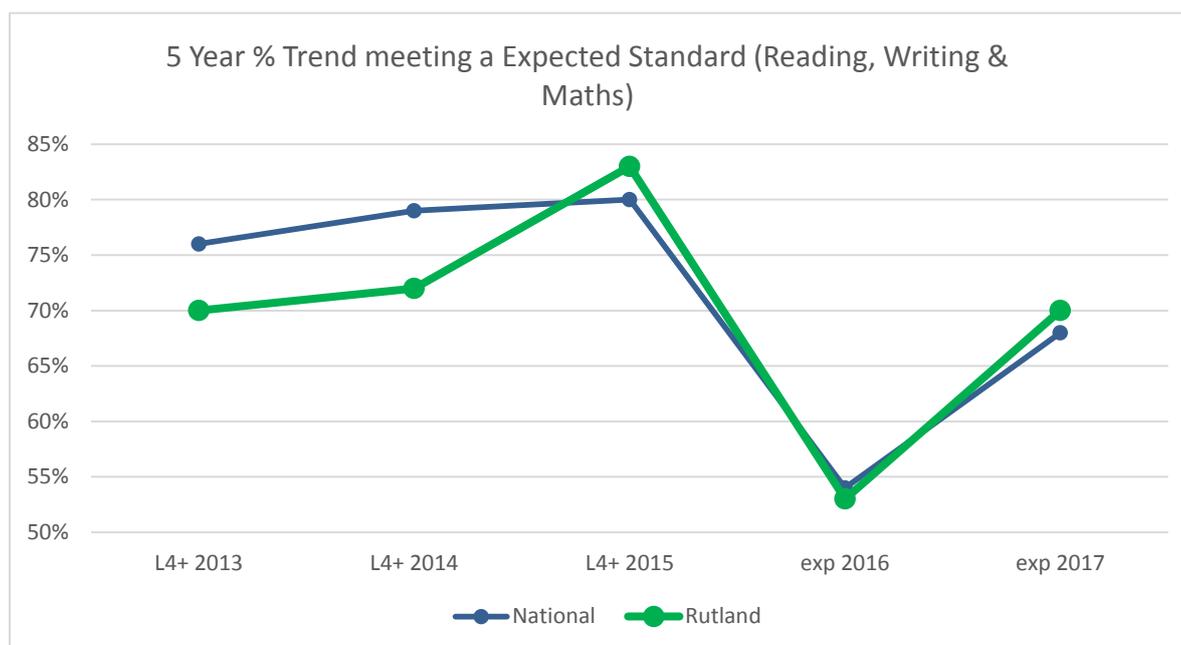
2.3. Key Stage 2 SATs

Key stage two performance is measured at the end of year 6. Writing is measured through teacher assessment whilst reading, grammar, punctuation and spelling, and mathematics are measured by standard assessment tests (SATs). The 2017 Rutland average for combined Key Stage 2 Reading, Writing and Mathematics attainment at expected standard at 67% is higher than the national average of 61.0%. Improvement from 2016 in combined Reading, Writing and Mathematics attainment is at a rate higher than that seen nationally, with the percentage of children in Rutland schools 14% higher than in 2016 compared with 8% improvement nationally.

Performance in Rutland schools has considerably improved from 2013 and 2014 when LA percentage of expected standards being met across all three subjects were lower than national results. Rutland scored higher than the National average in 2015 and 2017.

Note the change in assessment methods in 2015-16. Prior to that date, attainment had been measured in Levels, with Level 4 being expected. This is now referred to as Expected Standard; the percentages refer to those children attaining Expected Standard or better.

Figure 2: Key Stage 2 SATs - Expected standard in Reading, Writing & Maths (combined)⁵



2.4. Key Stage 4 GCSEs and Progress 8

As of summer 2016, Key Stage 4 is measured through GCSE examination, the Attainment 8 score, the Progress 8 score and the English Baccalaureate (EBacc). Prior 2016 the main method of measuring of a schools performance was by calculating the percentage of pupils who got five or more A* to C grades. Attainment 8 measures the achievement of a pupil across 8 qualifications. Progress 8 measures the progress students make between the end of Key Stage 2 and Key Stage 4 based on performance in eight qualifications. The headline EBacc attainment measure in 2017 is the percentage of pupils in a school gaining a grade 5 or above in English and maths, and a grade C or above in other subjects.

Figure 3 shows the last 5 years average of expected standard for schools in Rutland.

Rutland has exceeded the National average by at least 6% every year. In 2014-15 Rutland scored 13.4 percentage points higher than the National average, this was the highest difference over the 5 years.

Rutland and England both seem to follow a downwards trend from the year 2016 onwards. However, this reflects the changing assessment criteria of Attainment 8. Despite the descending line Rutland comfortably sits above the National Average in each year.

Figure 3: Key Stage 4 GCSEs and Attainment 8 - Five year trend of expected standard⁶

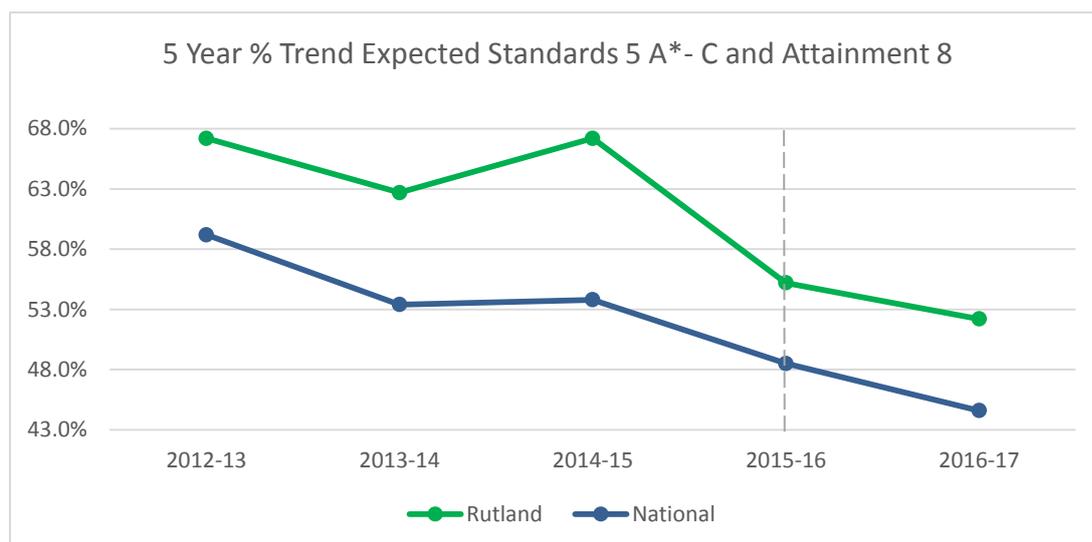


Table 2: Key Stage 4 GCSEs and Attainment 8 Scores

Table 2 shows the percentage point difference per year between the National Average and Rutland.

Key Stage 4	5+ A*-C GCSEs including Maths and English						Attainment 8								
	2012-13		2013-14		2014-15		2015-16		2016-17						
	GCSEs	% Point difference	GCSEs	% Point difference	GCSEs	% Point difference	A8	% Point difference	A8	% Point difference					
Rutland	67.2	8%	↑	62.7	9.30%	↑	67.2	13.40%	↑	55.2	6.70%	↑	52.2	7.60%	↑
National	59.2			53.4			53.8			48.5			44.6		

Table 2: Key Stage 4 GCSEs and Attainment 8 Scores⁶

Progress 8 is a new measure of progress children make between the end of primary school and the end of secondary school. A positive score means the school has made better progress than expected. A score below -0.5 will trigger an inspection and a score of 1+ will exempt the school from an inspection for a year. Rutland schools' Progress 8 score of 0.32 compares very favourably with the national score of -0.0 in 2016-17. Rutland schools' Progress 8 score of 0.32 compares very favourably with the national score of -0.0 in 2016-17.

2.5. Attendance and absences in state-funded Rutland Primary and Secondary Schools

Absence from Rutland schools is well below that seen nationally and regionally, however this remains a focus of discussion with school leaders to ensure the safeguarding of children and young people.

Table 3: Absences in primary schools, 2016/17⁷

Pupil absence 2016/17	Percentage of sessions missed			Persistent absentees	
	Overall absence	Authorised Absence	Unauthorised absence	Number	Percentage
England	4.0%	3.0%	1.1%	325,230	8.3%
East Midlands	4.0%	2.9%	1.1%	27,655	8.2%
Rutland	2.8%	2.4%	0.4%	81	3.2%

Table 4: Absences in secondary schools, 2016/17⁷

Pupil absence 2016/17	Percentage of sessions missed			Persistent absentees	
	Overall absence	Authorised Absence	Unauthorised absence	Number	Percentage
England	5.4%	3.8%	3.8%	392,200	13.5%
East Midlands	5.3%	3.8%	1.5%	34,155	13.6%
Rutland	3.5%	2.8%	0.8%	151	6.0%

2.6. Exclusions

Rutland has had 2 permanent exclusions in 2017/18: one primary phase child, which was dealt with as a managed move, and one secondary phase young person. There have been no appeals considered by Independent review panels by reason for exclusion. Rutland County Council had a part time Social Inclusion Officer, (SIO) who conducts school meetings and visits to the home. The SIO conducts fortnightly meetings with the 3 secondary schools in

Rutland to discuss cases that may be at risk of coming off roll or at risk of exclusion. Rutland does not have any Pupil Referral Unit places in the county.

2.7. Ofsted Ratings – Primary and Secondary Schools in Rutland

This section identifies the number of schools in each Ofsted category based on their most recent inspection (at August 2018). The education function of the local authority has a duty to ensure there are sufficient high quality school places and works closely with school leaders to achieve the aim for all children to attend good or outstanding state-funded schools. This is articulated through Rutland County Council’s Corporate Plan 2017-20 which sets out the ambition for all children and young people to be able to access high quality education within settings where every individual matters equally and is encouraged to aim high and achieve their very best.

Table 5: Ofsted ratings for primary schools and secondary schools in Rutland, 2018⁸

School Type	Number of schools	Schools Rated Outstanding	Schools Rated Good	Number of children attending
Primary Schools	17	4	13	2915
Secondary School	3	1	2	2481
Total	20	5	15	5594

The local authority complies with the DfE Schools Causing Concern Guidance which clearly identifies the expectations for local authorities to utilise their powers of intervention to those schools maintained by the local authority which are underperforming; where an academy or free school is of concern to the local authority, this Guidance must be followed. Strong working partnerships have been established with the Department for Education and the Regional Schools Commissioner’s office in sharing intelligence about academies within Rutland and challenging DfE officers where concerns over the performance of an academy or multi academy trust may have been identified.

2.8. Elective Home Education

Section 7 of Education Act 1996 requires that parents/carers must “cause the child to receive efficient full time education suitable to his or her age, ability and aptitude and to any special needs he or she may have either by regular attendance at school or otherwise.” In most cases parents are happy with their children’s education being provided by a school. Occasionally however, parents/carers prefer to make arrangements for their child to be

educated otherwise than in school, in many cases providing lessons at home.

There is no legal obligation for a parent/carer to register their child as being home schooled with the local authority. Rutland County Council operates a voluntary registration scheme for pupils undergoing elective home education (EHE) informed by the Council's Education Otherwise Policy. Local Authorities have no statutory duties in relation to monitoring the quality of EHE on a routine basis. However, under Section 437 (1) of Education Act 1996, local authorities can intervene if it appears that parent/carers are not providing a suitable and efficient education. Once registered with the council for home education a home visit is arranged to meet with the child and parent/carer. Information and guidance will be offered at this point followed by further visits to monitor the child's progress and the implementation of the home education programme. As well as their educational needs, the local authority will be mindful of a child's personal, health, safety and welfare needs at all times.

In Rutland the number of children electively home education (EHE) is small and there is no obvious trend emerging. At the end of the academic year 2015/2016 there were no children recorded as elective home educated; however through the year the number went up to 5 pupils. These consisted of 1 primary phase (awaiting a place at an independent school) and 4 secondary phase children. The reasons presented by parents and the schools included, for example, moving into Rutland and awaiting a place at the school of choice, moving into out-of-county schools.

At the end of the academic year 2016/2017 there were less than 5 primary school age child electively home educated. During the academic year, 4 of the children who were electively home educated were Year 11 pupils. The reasons presented by the parents and schools included, for example, to progress a music programme at a Conservatory of Music, or to take up home tuition, using a virtual school learning site. All of these families allowed Rutland County Council's Social Inclusion officer (SIO) contact at home. At the end of the 2017/2018 academic year there were no children electively home educated.

It should be noted that Rutland County Council operates an 'Education Otherwise' programme of support. This supports children who have significant needs that are not electively home educated and are children who need a different intervention to mainstream school. These children include those who are permanently excluded or are at risk of permanent exclusion, have medical needs, or are undertaking a managed move and include children who present as anxious school refusers. This may be diverting some children and parents from resorting to EHE as an alternative to mainstream school. Rutland currently has 21 children accessing Education Otherwise support. The Education Otherwise budget is £110,000.

The Local Authority is aware of some children in Rutland who are out of school and have chosen not to have contact with the LA or not to have ever registered with a school, some due to cultural or faith reasons, and therefore, under the current national guidance, the Local Authority has no statutory right to conduct visits or make contact. There have been no cases of EHE children being investigated (under s.436A of the Education Act 1996 or otherwise) to find if children are receiving suitable education and no school attendance orders have been issued with regard to children found to be receiving unsuitable EHE (or who have been claimed to be receiving EHE).

2.9. NEET

Young people who are not in education, employment or training (NEET) are more likely to suffer from poor health, depression or early parenthood.

In 2015, 2.1% of 16-18 years old in Rutland were not in education, employment or training (20 people). This is better than the England value of 4.2%.³

2.10. Special Educational Needs

In Rutland in 2017, there were 347 pupils of primary school age with special educational needs (SEN). This is 11.9% of the total number of pupils and is lower than the East Midlands proportion of 12.7% and the England proportion of 13.8%.

For secondary schools, there were 374 pupils with special educational needs. This is 14.0% of the total number of pupils and is higher than the East Midlands proportion of 11.7% and the England proportion of 12.3%.

Percentages of children receiving SEN support in Rutland have risen significantly from 8.5% in 2015 to 13% in 2018. The rate of SEN support is now ranked third in the East Midlands (of 9 authorities) having been lowest from 2009 to 2015.

The demand for, and the spending on, services and support for children with SEND in Rutland has grown significantly. This represents 3% of the total number of pupils in all Rutland schools, compared with the England benchmark of 2.8%. However, this figure is predicted to rise due to the increase in the number of pupils requiring an Education, Health and Care Plan (EHCP) as a result of earlier diagnosis and consequent referrals for support, particularly for those with social, emotional and mental health needs.

The spending on Special Educational Needs and Disabilities (SEND) services and support in Rutland (funded mainly from the Dedicated Schools Grant - High Needs block) has grown by 16% in the past 3 years, rising from £3,061,000 in 2013/14 to £3,545,000 in 2016/17, and

continues on an upward trajectory.

Children with Communication and Interaction (C&I) needs, which includes ASD, and those with Social Emotional and Mental Health (SEMH) needs (20% of the population) have some of the highest cost education placements.

2.11. Learning Disabilities

In Rutland in 2017, there were 385 pupils with a learning disability. This is 6.9% of the total number of pupils and is higher than the England proportion of 5.6%.⁹

Further data on the learning disabilities is detailed in the Learning Disability Market Position Statement (link still to be added).

A recent review of the Special Educational Needs and Disabilities population identified that Autistic Spectrum Disorder (ASD) accounts for almost a quarter of all SEND children in Rutland (87 children or 24%). This is the largest category of disability and this proportion is significantly larger than seen nationally.

2.12. Behavioural, emotional and social support needs

In Rutland in 2014, there were 86 pupils with behavioural, emotional and social support needs. This is 1.14% of the total number of pupils and is lower than the England proportion of 1.66%.¹⁰

3. Policy and Guidance

Local Authorities have a series of statutory responsibilities for education which are set out in sections 13 and 13a of the Education Act 1996 and the Childcare Act 2006. The local authority also complies with the DfE Schools Causing Concern (February 2018) which is guidance for local authorities and Regional Schools Commissioners on how to work with schools to support improvements to educational performance, and on using their intervention powers.

The Admissions Code December 2014 sets out the statutory guidance that schools must follow when carrying out duties relating to school admissions into primary school at reception year and secondary school at year 7 in September each year.

The Children and Families Act 2014 requires every local authority in England to appoint an officer employed by the authority to make sure that its duty to safeguard and promote the welfare of its children looked after (CLA) by the authority is properly discharged. That officer is referred to as the Head of the Virtual School.

4. Current Services

At the heart of the education framework for Rutland is a commitment to encourage successful autonomous schools and to promote the activity of these and wider partners, including Single and Multi-Academy Trusts and Teaching School Alliances, to secure:

- the best possible levels of attainment and progress;
- outstanding leadership including effective governance;
- safety, fairness and equity for all pupils and staff;
- value for money and the capacity for continuous improvement within a self-improving system.

All Early Years providers in the Private, Voluntary, Independent sector and schools work in close partnership with the local authority Early Years' Service. Inspection outcomes are monitored and systematic review (as outlined in the Education Improvement Prioritisation and Entitlement document) is undertaken. Local authority support is targeted to early years' providers in inverse proportion to success to ensure that resources are used effectively, with the aim for good practice within the sector to be shared and built upon. All Early Years providers delivering the Early Years Foundation Stage (EYFS) are entitled to an offer of 'core support' from Rutland County Council Early Years' Service. This includes Keep in Touch visits to each early years setting, Private, Voluntary or Independent provider, school and childminder; access to three EYFS networks; Lead Early Years Providers training day and a programme of training.

An overview of the performance of Rutland schools is maintained through an agreed and transparent process articulated through the Education Improvement Prioritisation and Entitlement document. The Learning and Skills Service meets at least three times per year to undertake a School Quality Assurance (SQA) desktop review of school effectiveness. At this meeting a range of evidence is considered and a prioritisation agreement made about each primary and secondary maintained school or academy. Schools are informed of the resulting priority status, with opportunities offered to maintained schools and academies to discuss the basis of the outcome and to review further evidence as required. The prioritisation enables the local authority to understand where there is potential vulnerability and to work with maintained schools and offer support to academies to address issues swiftly, including supporting these schools to build meaningful school improvement networks with others.

The Head of the Virtual School Head is also responsible for managing pupil premium funding

for the children they look after and for allocating it to schools as well as managing the early years' pupil premium and for allocating the premium to the early years' providers that educate CLA who are taking up the free early education entitlement for 3- or 4-year-olds.

It is a statutory requirement that admissions into primary school at Reception Year and Secondary School at Year 7 for September each year are co-ordinated by the local authority; parents of Rutland resident children apply to Rutland County Council for places. Applications for other year groups throughout the academic year, known as in-year admissions, are administered by the admission authority for the preferred school. In 2018:

- 97% of Rutland resident children have received an offer at their first preference primary school
- 96% of Rutland resident children have received an offer at their first preference secondary school
- 100% of Rutland resident children have received an offer at one of their preferred primary schools
- 100% of Rutland resident children have received an offer at one of their preferred secondary schools

The admissions team works in partnership with the Business Intelligence Team and Property Services to ensure there are sufficient school places available in Rutland and to monitor the available capacity within schools over the year.

5. Unmet needs/Gaps

Rutland County Council produces a Learning and Skills Service Annual Review (LaSSAR) which acts as both a summary of the previous year's actions to address previous priorities as well as acting as a blueprint for future plans. The LaSSAR draws together a range of self-evaluation activities including internal and external review, data analysis, feedback and judgements and progress towards addressing local, regional and national priorities. This process enables the Learning and Skills Service to celebrate and build on from successes as well as to identify emerging issues and areas for improvement. It is through this annual process that unmet needs or gaps would be identified (see section 5).

6. Recommendations

The Learning and Skills Service identifies areas for further improvement in the Annual Education Improvement Plan (AEIP) which is compiled following the annual self-review process undertaken at the end of each academic year. The AEIP expresses the key actions

required for ensuring the service to schools is effective in supporting and challenging schools leaders to sustain educational improvements. The impact of the AEIP is monitored through Rutland County Council's Education Performance Board, performance reports to Children and Young People's Scrutiny Panel and the Learning and Skills Service routine self-evaluation processes.

The 2018-19 Annual Education Improvement Plan will be completed when school performance data becomes available, however early indications are that it will include:

- Continuing to strengthen the capacity of systems leadership across the Local Authority through commissioned and brokered CPD programmes for leaders at all levels, including governors, and through partnership working with systems leaders to develop rigorous processes to secure robust sector-led, and delivered, school improvement.
- Utilising effective challenge and support mechanisms to increase schools' focus on effective provision for all groups of children and young people so that they are achieving their best possible standards, taking account of their starting points.

GLOSSARY OF TERMS

AEIP	Annual Education Improvement Plan
CCG	Clinical Commissioning Group
CLA	Children Looked After
DfE	Department for Education
EYFS	Early Years Foundation Stage
EBacc	English Baccalaureate
GLD	Good Level of Development
LA	Local Authority
OFSTED	Office for Standards in Education
LaSSAR	Learning and Skills Service Annual Review
SATs	Standard Assessment Tests
SQA	School Quality Assurance

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RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2018

MENTAL HEALTH OF ADULTS – AGED 18 TO 64 YEARS

DECEMBER 2018

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Whilst every effort has been made to ensure the accuracy of the information contained within this report, Leicestershire County Council cannot be held responsible for any errors or omission relating to the data contained within the report.

FOREWORD

The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Rutland, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs.

The JSNA has reviewed the population health needs for the people of Rutland in respect of an adult's mental health, substance abuse, sexual violence and domestic violence. This has involved looking at the determinants of health, the health needs of this population in Rutland, the impact of services, the policy and guidance supporting the population, and the existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

The JSNA offers an opportunity for the Local Authority, CCG and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCG and NHS England must be able to explain why.

EXECUTIVE SUMMARY

- The Annual Population Survey 2015/16 estimates that over three-quarters (76.6%) of Rutland's population report a high happiness score. This is higher than the England average of 74.7%. In 2016/17, just over one fifth (21.8%) of Rutland's residents reported a high anxiety score, this is similar to the England value of 19.9%.
- The Quality Outcomes Framework shows the recorded prevalence for depression in the GP registered population aged 18 or over has increased year on year both nationally and locally since 2013/14. The latest data in 2016/17 shows the recorded prevalence for depression in the GP registered population aged 18 or over is 7.9% for Rutland's population. This is significantly lower than the England average of 9.1%.
- The Adult Psychiatric Morbidity Survey 2014 found mixed anxiety and depression to be the most prevalent common mental health problem in England, with 7.8% of the population estimated to be affected by it in any given week. The IAPT service data shows that in 2016/17, 34.1% of the referrals entering treatment for ELR CCG were diagnosed with mixed anxiety and depression, accounting for 1,145 people. This was the most common recorded diagnosis for ELR CCG.
- The latest data for Rutland shows that the percentage of people with severe mental illness (0.69%) on GP Practice registers is significantly lower than England (0.92%) in 2016/17. Nationally the trend over time is increasing, whereas locally the trend has stabilised. Acute mental health admissions recorded at Leicestershire Partnership Trust are significantly lower than England average; however acute mental health bed days are significantly higher than the England average. This suggests that although less people are going into hospital compared to the England average, those that do go in stay there for longer than average. This may be associated with the significantly low percentage of Rutland's adults who were in contact with secondary mental health services and lived in stable and appropriate accommodation (23.0%) compared to nationally (54.0%).
- The latest data for hospital admissions for self-harm shows Rutland performs significantly better than the national rate. Since 2014/15, the rate of admissions for intentional self-harm in Rutland have decreased year on year, while the national rate has fluctuated.
- In Rutland, a similar proportion of the population are dying by suicide compared to England. As seen in national trends, the rate of suicides in males is at least three times higher than the rate of suicides in females.

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1. Introduction

This chapter presents a comprehensive overview of Mental Health in Adults in Rutland. The majority of indicators presented are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. We appreciate that this document uses technical language. This is due to the nature of the JSNA, which is intended for use by commissioning organisations such as local authorities and the NHS in developing their commissioning plans. One example is the use of statistical significance. A statistical significant result ensures the result is not likely to be caused by chance, for a given statistical significance level. Using these statistical tests improves the reliability of our evidence base which will help strengthen our commissioning based decisions.

A wide range of terminology is used when talking about mental health and wellbeing and mental ill health. The national mental health charity Mind use the phrase 'mental health problems' as they have found that many people can relate to this and find it helpful. This phrase has therefore been used where appropriate in this chapter.

Two other phrases are used in this chapter. 'Severe mental illness' is a phrase that is used by mental health professionals to indicate when a patient has severe and long-lasting mental health problems; these patients are likely to be under the care of a community mental health team and a psychiatrist. 'Common mental health disorders' is a phrase that is used in some data sources such as the Fingertips profiles, as well as National Institute of Health and Care Excellence guidance.

2. Who is at risk?

Almost 1 in 4 people in the UK experience at least one mental health problem each year, with 1 in 6 experiencing a common mental health problem, such as anxiety or depression, in any given week. The proportion of disease burden, as measured by the number of years lived with disability due to mental health problems and self-harm, is 30.3% in the UK. This means, on average, people will spend almost a third of their life living with a mental health problem. This figure is thought to be a significant underestimate as it excludes several types of mental health problems.

2.1. Protected characteristics

2.1.1. Long term health problems or disabilities

People with a long-term health problem or disability are two to three times more likely to develop mental health problems, particularly anxiety and depression.

According to the 2011 Census, 15.5% of Rutland's population were found to have a long-term health problem or disability that limited their day-to-day activities. This is lower than the England average of 17.6%.¹

2.1.2. Learning disabilities

Adults with a learning disability are estimated to experience double the risk of depression and a three-fold increase in the risk of schizophrenia.¹ The Quality Outcomes Framework (QOF) indicates that in 2016/17, 2.03% of Rutland's population were recorded on a GP register as having a learning disability. 60.7% of eligible adults with a learning disability received a GP health check. This is similar to the England proportion of 48.9%.²

2.1.3. Gender reassignment and sexual orientation

There is an increased likelihood of certain mental health problems occurring in the lesbian, gay, bisexual, transgender or others that do not feel they fit into any traditional categories of gender or sexuality (LGBTQ+) population. For example, LGBTQ+ people are 1.5 times more likely to develop depression and anxiety compared to the rest of the population.³ They are also more likely to self-harm.⁴

When comparing all the common sexual identity groups, bisexual people were found to have increased risks of depression, anxiety, self-harm and attempting suicide.⁵ When comparing to the rest of the population, gay and bisexual men were found to be four times more likely to attempt suicide across their lifetime.³ For females, suicidal thoughts and self-harm were also more prevalent in the lesbian and bisexual women populations compared to the general population.⁶ When considering age groups in the LGBTQ+ population those aged under 26 were found to be more likely to attempt suicide and self-harm compared to older populations.⁷

A transgender mental health study showed that 88% of transgender people had experienced depression and 84% had thought of ending their life.⁸

Despite research showing the link between mental health and the LGBTQ+ population, it is difficult to estimate what percentage of the population this effects. This is because there

has been no definitive data collection on numbers of the population who identify as LGBTQ+. However, the Office for National Statistics produced experimental statistics on sexual identity in the UK by region, and estimates that those people identifying as LGB make up 1.6% of the East Midlands population in 2016. When considering the UK population, those aged 16 to 24 were most likely to identify as LGB with 4.1% doing so. Males were also more likely to identify as LGB than females at 2.3% compared to 1.6% respectively.⁹

2.1.4. Race

The 2011 Census shows 2.9% of the population in Rutland are from black and minority ethnic (BME) backgrounds. Examining the population by each ethnic group shows in 2011 in Rutland there were 389 residents from Mixed ethnic group (1.0%), 365 from Asian ethnic group (1.0%), 251 from Black ethnic group (0.7%) and 63 residents from Other ethnic group (0.2%). Research indicates mental health problems are more prevalent in BME populations. For example, rates of schizophrenia are 5.6 times higher in the black Caribbean population, 4.7 times higher in the black African population and 2.4 times higher in Asian groups.¹⁰ Black populations have the highest rates of Post-Traumatic Stress Disorder (PTSD), suicide attempt, psychotic disorder and any drug use/dependence while white populations have highest rates for suicidal thoughts, self-harm and alcohol dependence.

The 2011 Census reported that 1.8% of the population (655 persons) in Rutland did not speak English as their main language. This is lower than the national percentage of 8.7%.¹¹

2.1.5. Pregnancy and maternity

Perinatal mental health is defined as the antenatal period (during pregnancy) and the postnatal period (up to one year after childbirth). Mental health issues that arise during the perinatal period can vary in severity from anxiety and depression through to PTSD and postpartum psychosis. For women who have had a history of bipolar disorder, there is an increased risk of a relapse at this time. Mental health problems in perinatal women can affect the foetus, baby, family and the mother's physical health.¹² An estimated 10% to 20% of women will be affected by mental health problems at some point during their pregnancy or the first year after childbirth.¹³ It is recognised that some fathers may also suffer from mental health problems over this period however there is very little data available to evidence this.

2.1.6. Marriage and civil partnerships

Being happily married or in a stable relationship appears to have a positive impact on mental health. A 2008 study found that high marital quality was associated with lower stress

and less depression. However, participants who were single had better mental health outcomes than those who were unhappily married.¹⁴ The 2011 Census showed that 11.3% of Rutland's adults' marital status was separated or divorced. This is similar to the England average of 11.6%.¹

2.2. Education, learning and development

Low levels of education can impact on stable employment and income opportunities and widen health inequalities: these are factors known to influence mental wellbeing and common mental health problems. As with other risk factors, it is difficult to determine cause and effect as mental health problems during adulthood can lead to poorer outcomes in educational achievement, but lower educational achievement can lead to poorer mental health.^{15,16}

The 2011 Census showed that 29.9% of Rutland's population aged 16 and above had no qualifications or a low level of education. This is significantly lower than the England average of 35.8%.¹

2.3. Childhood

Half of all lifetime mental health problems (except dementia) arise by the age of 14. This increases to over three quarters of all mental health problems by the age of 24.¹⁷ However, only a minority of those with mental health problems (except psychosis) receive treatment during childhood and adolescence, meaning mental health problems in childhood are likely to transfer into adulthood. For children and adolescents who do receive treatment, an estimated 70% have not had appropriate interventions at a sufficiently early age.¹⁸

2.4. Lifestyle

Mental health problems are associated with a higher prevalence of risk taking behaviours and increased dependency on the use of substances. This includes a lack of exercise, smoking, drinking and drug use.¹⁹

Data from the Active Lives Survey in 2015/16 suggests that over a fifth (20.5%) of Rutland's population aged 19 or over, were classed as inactive. Inactivity is defined through achieving less than 30 minutes of moderate intensity exercise, or equivalent, per week, as opposed to the Chief Medical Officer guidelines of above 150 moderate intensity equivalent minutes of physical activity per week. This is similar to the England average.²⁰

Smokers are significantly more likely to have a mental health problems compared to non-

smokers. The Annual Population Survey estimated that 12.3% of adults in Rutland smoked in 2016, significantly lower than the England proportion of 15.5%.²⁰

Having a history of alcohol or drug use has been recorded in 54% of all suicides in people experiencing mental health problems with only 11% of these in touch with drug treatment services at the time of death.²¹ In 2014/15, Rutland's estimated prevalence of opiate and crack/cocaine use amongst 15-64 year olds was 2.9 per 1,000 population. This is significantly lower than the England rate of 8.6 per 1000 population.²² Data on numbers of people who have co-morbid mental health problems and substance misuse is not available, however estimate of national prevalence rates suggest 20-37% in secondary mental health services and 6-15% in substance misuse settings.²³

2.5. Employment and economic factors

Unemployed individuals, benefits claimants and those living in households with lowest incomes are considered to be at increased risk of common mental health problems, such as depression.²⁴

In Rutland in 2016, 2.4% of the working age population were unemployed. This is significantly lower than the national proportion of 4.8%. In August 2016, 0.09% of the working age population were classed as long term unemployed in Rutland, significantly lower than the England average of 0.37%.¹

Out-of-work benefits include Employment Support Allowance (ESA). ESA can be claimed by those out of work due to illness or disability. The 2014 Adult Psychiatry Morbidity Survey (APMS) also found two thirds of the working age population in receipt of ESA had a Common Mental Health Disorder (CMD) compared with one in six who were not in receipt of ESA (66.1% compared to 16.9% respectively). Of women in receipt of ESA, 81.0% had a CMD, compared to 21.1% of those who were not in receipt of ESA. For males, figures were 55.8% and 12.7% respectively.²⁴ Further analysis revealed that ESA claimants also had a higher prevalence of personality disorder, suicidal thoughts and suicidal attempts.

In 2017, the percentage of Rutland's working age population claiming ESA, incapacity benefit or severe disablement allowance was 3.0%, significantly better than England's average of 5.7%.²⁵

Further detail on Employment in Rutland is included within the Population Chapter.

2.6. Housing

Homelessness and poor quality housing result in an increased risk of mental health problems. The national Joint Commissioning Panel for mental health estimates that 27% of homeless people have probable psychosis.²⁶

In 2015/16, the rate of statutory homelessness in Rutland is 2.2 per 1,000 population. The England average is 2.5 per 1,000 population.¹

In 2016/17, 23% of Rutland's adults who were in contact with secondary mental health services lived in stable and appropriate accommodation. This is significantly lower than England's 54%.²⁰

2.7. Crime

2.7.1. Sexual violence

Perpetrators of sexual violence often either have existing mental health or substance misuse problems. The victims of the crimes can also suffer from mental health problems following the crime.

Between 2010/11 and 2016/17, Rutland has seen a significant increasing trend of sexual offences per 1,000 population. The latest data from 2016/17 shows there were 32 sexual offences reported in Rutland, this equates to a rate of 0.8 per 1,000 population. The rate for England was 1.9 per 1,000 population.²⁰ The directly standardised rate of hospital admissions for violent crime (including sexual violence) was 30.0 per 100,000 population during 2014/15 – 16/17 (31 violent crimes). This is better (lower) than the England rate of 42.9 per 100,000 population.²⁰

2.7.2. Domestic abuse

Domestic abuse can take a variety of forms – psychological, physical, sexual, financial or emotional. Perpetrators of domestic abuse often either have mental health and/or substance misuse problems. Furthermore, the victims of the crimes may also suffer from mental health problems following the crime. The crude rate of reported domestic abuse-related incidents and crimes in Rutland in 2016/17 was 18.7 per 1,000 population, lower than the England rate of 22.5 per 1,000 population. This has increased from 2015/16, where the rate was 14.7 per 1,000 population.²⁰

2.8. Vulnerable Groups

Pockets of the population can be missed in overarching statistics. These subgroups, who have not been mentioned in key statistics above, are more exposed and vulnerable to the unfavourable social, economic, and environmental circumstances encompassed in the above risk factors. They are therefore at a higher risk of mental health problems than the general population.

2.8.1. Prisoners

Prisoners suffer from mental health problems at rates in excess of those in the general population. In England and Wales, 54% of women and 34% of men in prison say they are affected by emotional wellbeing or mental health problems.²⁷ It is estimated that over a third of men and over half of women (33% and 51% respectively) in prison experience depression. Just over one fifth of males and just under one third of females (21% and 32% respectively) are estimated to have anxiety, whilst personality disorder is estimated to be prevalent in 14% of male prisoners, and 50% of female prisoners.²⁸

Annual self-harm incidents in prison have increased by nearly two-thirds since 2011, while self-inflicted deaths have doubled in the same time period.^{29,30} In 2016, more than a third of all prison deaths in England and Wales were self-inflicted.³¹ Released prisoners further have a significantly higher risk of suicide compared to the general population.²⁸

In England in 2016/17, 9.2% of people in prison were on a care programme approach plan, hence diagnosed with a severe mental illness.²⁰ There is one prison in Rutland. As of December 2017, HMP Stocken in Stretton contained 841 males aged 21 and over.³²

2.8.2. Victims of crime

Being a victim of crime, through exposure to unsafe environments, violence, or domestic abuse, increases the risk of developing mental health problems. People with mental health problems are estimated to be three times more likely to be a victim of crime than the general population and five times more likely to be a victim of assault; this increases to ten times more likely for women.³³

Victimisation among people with severe mental illness (SMI) is more prevalent and associated with greater psychosocial morbidity than victimisation among the general population. Women with SMI are at particularly high risk of both domestic and community violence.³⁴ Violence prevention for people with SMI is likely to require an integrated response by mental health professionals, third-sector organisations and the Criminal Justice System.³⁴

2.8.3. Migrants

Migrants, including refugees, asylum seekers, economic migrants, spouses and students may be at increased risk of mental health problems prior to, during or after migration to the UK. Refugees, asylum seekers and economic migrants have PTSD, anxiety, depression and phobias at rates five times higher compared to the general population.

In 2016, the rate of migrant GP registrations in Rutland was 6.0 per 1,000 population, significantly lower than the England average of 12.9 per 1,000 population.¹

2.8.4. Carers

Research has shown that the stress and worry, lack of time for one's self, isolation, money worries, lack of sleep, feelings of frustration, guilt and low self-esteem can impact on carers' mental health and wellbeing. This can lead to depression, anxiety and obsessive compulsive disorder (OCD).³⁵

Results from the Personal Social Services Carers Survey show that in Rutland in 2016/17, 31.1% of adult carers had as much social contact as they would like, meaning over two-thirds of carers were not having as much social contact as they would like. The proportion having as much social care as they would like was similar to the England average of 35.5%.²⁰

2.8.5. Adult social care users

The Adult Social Care Users survey estimated that 46.5% of adult social care users in Rutland in 2016/17 felt they had as much social contact as they would like. This is similar to the England average of 45.4%.²⁰

2.8.6. Living alone

Whilst not all people living alone would be considered to be socially isolated, or considered lonely, the Adult Psychiatry Morbidity Survey (APMS) 2014 shows that people of working age who were living alone were significantly more likely to have a common mental health disorder compared to those who lived with others.

The 2011 Census showed that 12.0% of Rutland's population were living alone, significantly lower than the England average of 12.8%.²²

Meanwhile, 6.26% of households in Rutland were occupied by a single person aged 65 and over. This was higher than the national average of 5.24%.²²

2.8.7. Loneliness

Whilst 'loneliness' does not account for a specific segment of the population, it is important to acknowledge the risk loneliness plays in poor mental wellbeing. Loneliness is defined by an individual's subjective emotional state, based on their personal and subjective sense of lacking closeness, affection and social interaction with others.³⁶

The Community Life Survey shows that 5.4% of people in England reported feelings of loneliness often or always in 2016/17. Variations were observed by age group, with 10% of 16-24 year olds being the highest group to report loneliness, followed by 6% of 25-34 year olds. The groups that had the lowest percentage reporting loneliness were the 65-74 and 75 and over populations with only 3% reporting feeling lonely often or always.³⁷ The 2014 APMS further supports this: the study found that the prevalence of CMDs in the 75+ population was half the rate of their younger counterparts.

3. Level of need in Rutland

3.1. Mental wellbeing

Data from the Annual Population Survey 2015/16 estimates that 76.6% of Rutland's population report a high happiness score. This is higher than the England average of 74.7%.²² In 2016/17, just over one fifth (21.8%) of Rutland's residents reported a high anxiety score, this is similar to the England value of 19.9%.²⁰

Data from the GP Patient Survey in 2015/16 estimated that 3.8% of Rutland's GP registered population considered themselves to have a long-term mental health problem. This is similar to the national value of 5.2%.²²

3.2. Common mental health problems

3.2.1. Overall common mental health problems

Common mental health problems, also known as common mental disorders (CMD) or neurotic disorders, encompass different types of depression and anxiety, including generalised anxiety disorder (GAD), phobias, obsessive compulsive disorder (OCD) and panic disorder. While they do not affect cognition, they do cause emotional distress and can interfere with a person's day to day life.

In 2014/15, it was estimated that 12.2% of ELR CCG's registered population, aged 16-74 had a common mental health disorder.³⁸ The Adult Psychiatric Morbidity Survey 2014 estimates 1 in 6 people (15.7%) to have a common mental health problem in England, with 1 in 12

reporting severe symptoms of common mental health disorders. Self-reported prevalence is higher in females (1 in 5 or 19.1%) compared to males (1 in 8 or 12.2%). Over a third of respondents (35.6%) were identified by the survey as currently having a CMD, although they had never been diagnosed with one. Symptoms were most prevalent in the working age population, with them being twice as likely to have symptoms compared to those aged over 65. All anxiety disorders in the survey were more common among young women aged 16 to 24 (GAD 9%, phobias 5.4%, OCD 2.4%, panic disorder 2.2%) than in any other age-sex group. CMD symptoms peaked in the 16-24 age group for females, at a rate almost 3 times higher than males (26% compared to 9%). Symptoms remained stable for men during their working age and then tailed off after 65. However, a second although less pronounced peak for females was evident between the ages of 45-54.

Improving Access to Psychological Therapies (IAPT) is the largest national service to provide therapies for those with low level mental health problems, notably common mental health disorders. Published data on IAPT referrals for 2016/17 shows that 6,100 referrals were received for ELR CCG. In the same time period, 3,355 referrals entered treatment for ELR CCG. Upon receipt of referral, the most common identified diagnosis was 'unspecified' making up 57.3% (3,495) of ELR CCG referrals. Upon entering treatment, 28.9% (970) of diagnosis for ELR CCG were classed as 'unspecified'.³⁹ For this reason, the following IAPT diagnosis data is based only upon those entering treatment.

3.2.2. Depression

Depression is characterised by persistent low mood and a loss of interest and enjoyment in things which are normally considered enjoyable. Symptoms can be emotional, physical or behavioural and can include sleep disturbance, change in appetite, loss of energy, poor concentration, low feelings of self-worth and thoughts of suicide. Depressive episodes can range from mild to severe.⁴⁰

The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. The QOF shows the recorded prevalence for depression in the GP registered population aged 18 or over has increased year on year both nationally and locally since 2013/14. Over this time period, the prevalence in Rutland has remained significantly lower than the national average. The latest data in 2016/17 shows the recorded prevalence for depression in the GP registered population aged 18 or over is 7.9% for Rutland's population. This is significantly lower than the England average of 9.1%.

Incidence looks at the rate of new, or newly diagnosed, cases of a particular disease, illness

or health problem. The QOF shows the recorded incidence for depression in the GP registered population aged 18 or over has increased year on year both nationally and locally since 2013/14. In Rutland, the recorded incidence of depression in the 18 and above age group in 2016/17 is 1.3% for Rutland. This is significantly lower than the England average of 1.5% in 2016/17.¹ This shows new cases of depression are being diagnosed at a slower rate in Rutland compared to nationally.

The IAPT service data shows that in 2016/17, 12.1% of the referrals entering treatment for ELR CCG were diagnosed with depression, accounting for 405 people. This was the third most common recorded diagnosis for ELR CCG.³⁹

3.2.3. Generalised anxiety disorder (GAD)

GAD is an anxiety disorder characterised by excessive worry, with individuals experiencing difficulty in controlling that worry. Symptoms include restlessness, difficulties with concentration, irritability, muscular tension and disturbed sleep.⁴⁰

The Adult Psychiatry Morbidity Survey (APMS) 2014 found GAD to be the second most commonly identified CMD in England, with an estimated 5.9% experiencing it in the past week. The prevalence in females is statistically significantly higher than in males (6.8% compared to 4.9% respectively). The highest age-sex prevalence group was females aged 16-24 (9.0%) followed by females aged 45-54 (8.5%), followed by females aged 35-44 (7.0%). For males the highest prevalence was in the 35-44 age group at 6.8%. The lowest prevalence for both males and females was estimated to be in the 75+ population (0.9% and 3.6% respectively).

In 2012, Public Health England estimated that GAD was prevalent in 2.8% of Rutland's population aged 16-74. There are some concerns regarding the quality of this data and it should be noted that the estimate was created as an indication of caseload for psychological therapy services, hence based on numbers likely to be diagnosable at the time.¹

The IAPT service data shows that in 2016/17, 9.1% of the referrals entering treatment for ELR CCG were diagnosed with GAD, accounting for 305 people. This was the fourth most common recorded diagnosis for ELR CCG.³⁹

3.2.4. Mixed anxiety and depression

The APMS 2014 found mixed anxiety and depression to be the most commonly identified CMD in England, with 7.8% of the population estimated to be affected by it in any given week. Prevalence is statistically significantly higher in females than males. For males, it is

estimated that the highest prevalence is in the 25-36 age group, with 7.9% being affected. For females, the 45-54 age group followed by 16-24 age groups are estimated to have the highest prevalence (11.8% and 11.3% respectively), both more than two times higher than males which were 5.6% for both these age groups.

The IAPT service data shows that in 2016/17, 34.1% of the referrals entering treatment for ELR CCG were diagnosed with mixed anxiety and depression, accounting for 1,145 people. This was the most common recorded diagnosis for ELR CCG.³⁹

Of the referrals received by IAPT, unspecified diagnosis was the most common. If unspecified diagnoses are removed from analysis, mixed anxiety and depression was the most commonly diagnosed disorder upon receipt of referrals for ELR CCG. For ELR CCG 1,240 of the 6,105 referrals received were for mixed anxiety and depression (20.3%).

The 2015/16 GP Patient Survey found that 8.9% of the 18+ population in Rutland felt anxious or depressed. This is lower than the England value of 12.7%.²²

3.2.5. Panic disorder

People with panic disorder experience repeated and unexpected attacks of intense anxiety. There is a marked fear of future attacks and this can result in avoidance of situations that may provoke a panic attack. Symptoms include a feeling of overwhelming fear and apprehension often accompanied by physical symptoms such as nausea, sweating, heart palpitations and trembling.⁴⁰

The APMS 2014 found panic disorder to have the lowest prevalence of all surveyed CMDs in England, with 0.6% reported symptoms in the past week. The youngest age group, 16-24 year olds, were estimated to have the highest prevalence (1.2%), with the majority attributed to females with 2.2% and 0.4% for males. For all other ages, prevalence remained stable between 0.3% and 0.7%. Overall, prevalence was statistically significantly higher in females than males. While panic disorder prevalence is estimated to be lower than other CMDs, of those identified with any CMD 44.6% mentioned having panic attacks. 30.2% reported this had been diagnosed by a professional, meaning almost 70% of panic attacks were not diagnosed.

In 2012, the estimated prevalence of panic disorder in 16-74 year olds in Rutland was 0.35%. This is lower than the England prevalence of 0.65%.¹

The IAPT service data shows that in 2016/17, 2.1% of the referrals entering treatment for ELR CCG were diagnosed with panic disorder, accounting for 70 people.³⁹

3.2.6. Phobias

The APMS 2014 estimated 2.4% of England's population to have phobia symptoms in any given week. Prevalence is statistically significantly higher in females than males. (3.0% compared to 1.8% respectively). Phobias were more common in the working age population in 2014 than in previous years increasing from 1.8% in 1993 to 2.1% in 2007 to 2.9% in 2014.

In 2012, the estimated prevalence of all phobias in 16-74 year olds in Rutland was 0.96%. This is lower than the England prevalence of 1.77%.¹ The IAPT service data shows that in 2016/17, 2.2% of the referrals entering treatment for ELR CCG were diagnosed with phobias, accounting for 75 people.³⁹

3.2.7. Obsessive compulsive disorder (OCD)

OCD is an anxiety condition characterised by the presence of either obsessions (repetitive, intrusive and unwanted thoughts, images or urges) or compulsions (repetitive behaviours or mental acts that a person feels driven to perform), or both.

The AMPS 2014 found 1.3% of England's population to have experienced symptoms in the past week. While prevalence is higher in females than males, the difference is not statistically significant. (1.5% compared to 1.1% respectively). Only 13.2% of people who identified as having OCD had been diagnosed by a professional.

The IAPT service data shows that in 2016/17, 1.8% of the referrals entering treatment for ELR CCG were diagnosed with OCD, accounting for 60 people.³⁹

3.3. Suicide and self-harm

3.3.1. Self-harm

Self-harm is defined as an intentional act of self-poisoning or self-injury irrespective of the type of motivation or degree of suicidal intent. However, following an episode of self-harm, there is a significant and persistent risk of suicide.²⁰

In Rutland in 2016/17, the directly standardised rate of emergency hospital admissions for intentional self-harm for all ages was 102.8 per 100,000 population (37 admissions). This is significantly better than the England average of 185.3 per 100,000 population. Since 2014/15, the rate has decreased year on year in Rutland whereas the national rate has fluctuated.²⁰

3.3.2. Suicide

Suicides and injury undetermined is seen as an indicator of underlying rates of mental ill-health. The definition of suicide includes all deaths from intentional self-harm for persons aged 10 and over, and deaths where the intent was undetermined for those aged 15 and over. Due to small numbers, suicide rates are measured across five year periods.

In Rutland the rate of suicides in males is almost four times higher than in females. The crude rate for suicides in males aged 35-64 years in Rutland for 2011-15 was 21.6 per 100,000 population, this is similar to that of England which had a rate of 20.8 per 100,000 population. Meanwhile, the crude rate for suicides in females aged 35-64 years in Rutland for 2011-15 was 5.5 per 100,000 population. The rate is similar to that of England which had a rate of 6.0 per 100,000 population.⁴¹

When considering method of suicide, UK figures for 2016 show that the most common method used was hanging/suffocation/strangulation, accounting for 58.7% percent of males' and 42.8% females' deaths. The second most common method of suicide for both males and females was poisoning, with proportions of 18.3% and 36.2% respectively.⁴²

It is important to note this data is based on those who completed suicides and does not account for all suicide attempts.

3.4. Severe and enduring mental illness

3.4.1. Overall SMI

The QOF severe mental health register is a count, for each GP practice, of the total number of patients with schizophrenia, bipolar disorder and other psychoses. The percentage of people with severe mental illness on GP Practice registers was 0.69% in Rutland in 2016/17, significantly lower than England's 0.92%. Nationally the trend over time is increasing, whereas locally the trend has stabilised.²²

The rates of adult acute mental health admissions are only published by NHS Trust. To understand patient flows, all hospital inpatient data from Rutland residents in 2016/17 was examined. This shows 44.5% of activity took place at North West Anglia Foundation Trust, 30.8% at University of Leicester NHS Trust followed by 7.6% at Kettering General Hospital NHS Foundation Trust. Please note North West Anglia Foundation Trust acquired Hinchingsbrooke Health Care NHS Trust on 1st April 2017. Prior to this acquisition, the trust was known as Peterborough and Stamford Hospitals NHS Foundation Trust.

Rutland residents may choose to travel east to use the services of Cambridge and Peterborough NHS Trust. In 2015/16, Cambridge and Peterborough NHS Trust recorded 272 acute mental health admissions per 100,000 population aged 16-64. This is significantly higher than the England average of 220 per 100,000 population. The Trust also recorded 5,624 acute mental health bed days per 100,000 population aged 16-64, significantly lower than the England average of 7,063 per 100,000 population.³⁸ This suggests that although more people are going into hospital compared to the England average, those that do go in stay there for a shorter time.

In 2015/16, Leicestershire Partnership Trust (LPT) recorded 169 acute mental health admissions per 100,000 population aged 16-64. This is significantly lower than the England average of 220 per 100,000 population. LPT also recorded 7,574 acute mental health bed days per 100,000 population aged 16-64, significantly higher than the England average of 7,063 per 100,000 population.³⁸ This suggests that although less people are going into hospital compared to the England average, those that do go in stay there for longer.

In 2016/17, in the Leicestershire, Leicester and Rutland Sustainability and Transformation Plan (STP) area, there were 60 detentions under the Mental Health Act giving a crude rate of 5.7 per 100,000 population. This is the lowest of all STP areas.⁴³ As of 31st March 2016, LPT reported 270 people subject to the Mental Health Act 1983. Of these, 190 were detained in hospital on 31st March 2016, while 80 people were subject to Community Treatment Orders.⁴⁴ There may be some data quality issues with these figures.

Evidence suggests that people with severe mental illness such as schizophrenia, die between 15 and 25 years earlier than the average for the general population. In 2014/15, the excess under 75 mortality rate in adults with a severe mental illness in Rutland was 247.8% (expressed as a percentage). This percentage is showing that deaths in the population with severe mental illness are almost two and a half times higher than that of the general population.²⁰

Data from the Quality Outcomes Framework (QOF) shows that in 2016/17 50.6% of people with SMI had a comprehensive care plan in the East Leicestershire and Rutland CCG area. This is significantly lower than England average of 79.0%.²²

3.4.2. Psychosis

The estimated incidence of new cases of psychosis in 2011 among those aged 16-74 was 17.0 per 100,000. This is significantly lower than the national rate of 24.2 per 100,000 population.²²

3.4.3. Schizophrenia

Schizophrenia is associated with increased mortality from all disease and a reduced life expectancy of around 21 years for men and 16 years for women. It is also linked to increased risk of suicide and self-harm.⁴⁵

In Rutland during 2009/10-11/12, the rate of emergency admissions for schizophrenia, schizotypal and delusional disorders was 12.0 per 100,000 population aged over 18 years. This is significantly lower than the England value of 57.0 per 100,000 population.⁴⁶

3.5. Perinatal mental health

Perinatal mental health is defined as the antenatal period (during pregnancy) and the postnatal period (up to one year after childbirth). Mental health issues that arise during the perinatal period can vary in severity from anxiety and depression through to post traumatic stress disorder and postpartum psychosis. For women who have had a history of bipolar disorder, there is an increased risk of a relapse at this time. Although these conditions can affect anyone with mental health problems, the concern with mental health problems in perinatal women is that it can affect the foetus, baby, family and the mother's physical health.⁴⁷ It is believed that between 10% and 20% of women will be affected by mental health problems at some point during their pregnancy or the first year after childbirth.⁴⁵

In Rutland, 312 women gave birth in 2016. Table 2 shows that in 2016, the most prevalent disorder affecting postpartum women in Rutland was adjustment disorders and distress, affecting between 16.0% - 30.4% of mothers. This equates to between 50 and 95 mothers in the county. Mild-moderate depressive illness and anxiety was the second most prevalent condition affecting between 11.2% - 16.0% of mothers in Rutland. It is estimated that severe depressive illness affected 3.2% of postpartum woman (10) in Rutland.⁴⁸ It is important to remember that failure to treat perinatal depression can result in a prolonged and harmful effect on the relationship between the mother and baby. Evidence suggests that postnatal depression "may be associated with lower cognitive and language achievements" in young children.

Table 1 Estimated number of mental health conditions of postpartum women in Rutland in 2016⁴⁸

	Count*
Estimated number of women with adjustment disorders and distress (upper estimate)	95
Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate)	50
Estimated number of women with adjustment disorders and distress (lower estimate)	50
Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate)	35
Estimated number of women with severe depressive illness	10
Estimated number of women with PTSD	10
Estimated number of women with postpartum psychosis	5
Estimated number of women with chronic SMI	5

Source: NHS Digital, Hospital Episode Statistics

*Figures must not be added together to give an overall estimate as some women may suffer from more than one condition

Post-traumatic stress disorder can be associated with mental health disorders when experiencing birth related traumas, whether it is from a traumatic birth including complications either physically or mentally as well as stillbirth or the death of a baby or sometimes from an uncomplicated delivery. It is estimated there were 10 women in Rutland who suffered from PTSD in the perinatal period in 2015/16.⁴⁸

3.6. NHS funded secondary mental health, learning disabilities and autism services

Freely available data relating to Rutland residents using NHS funded secondary mental health services are presented below. More detailed data was unable to be provided by LPT due to data quality issues.

In 2016/17, 1,365 people from Rutland were known to be in contact with secondary mental health, learning disabilities and autism services at some point in the year, 235 (17.2%) of these were under 18 years of age. Of people known to be in contact with secondary mental health, learning disabilities and autism services, 1.1% (15) spent time in hospital as part of being in contact with these services during 2016/17.

6.0% (85) of all persons known to be in contact with secondary mental health, learning disabilities and autism services had been treated under the Care Programme Approach at some point during 2016/17. The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or

a range of related complex needs.⁴⁹ More information can be found at: <http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/care-programme-approach.aspx>

4. How does this impact?

While poor mental health affects individuals, it also affects society as a whole through costs to public services, including the NHS, social care and employers. Calculations attempting to quantify costs have varied dependent on the mental health problems and impacts considered.⁵⁰⁵¹ However, all estimations to date have “failed to take into account the additional value to society of improving mental wellbeing or the adverse effects of physical health.”⁵² Further, while studies endeavour to account for costs to mental health service usage, additional costs to other services, such as chronic illness, are not always considered, resulting in underestimation.⁵²

The health, social and economic consequences of poor mental health are substantial. In England, it has been estimated that the government spends around £19 billion every year within and beyond the health system on dedicated services for people with mental health needs. The NHS alone spent almost £9.2 billion in 2015/16 on mental health problems.

In 2014 NHS England developed a programme with a set of commitments to promote parity of esteem, with the aim of 'valuing mental health equally with physical health'. One of the commitments was that CCGs should increase their mental health spending in real terms, by at least the same proportion as their overall budget increase (Parity of Esteem funding commitment). With the publication of the Five Year Forward View for Mental Health, this funding commitment was reiterated as the 'Mental Health Investment Standard' in the NHS Operational Planning and Contracting Guidance published in September 2016. The Mental Health Dashboard shows that NHS England's actual spend on mental health was 12.5% of their total CCG budget in 2015/16, and 12.7% in 2016/17. Locally for 2017/18 the planned spend on mental health was 11.9% for ELRCCG.⁵³

These budgetary costs under-estimate the full impact of poor mental health as it also increases the risks of poor physical health and poor management of pre-existing physical health problems. Studies in the UK and elsewhere indicate that people living with severe mental health problems may die up to 20 years younger than the general population.⁵⁴ ⁵⁵ These impacts are also felt well beyond the health care system, mainly due to lost economic productivity as a result of reduced participation in work, education and community activities. There is also the increased risk of premature mortality mainly due to poorer physical health but also linked with self-harm and suicide.

“The economic benefits of mental wellbeing are not as well established as the costs of mental illness.” However, the impacts that positive mental wellbeing can have, both on a personal and societal level, through reduced healthcare utilisation and lower morbidity and mortality, presents a strong case for investment in mental wellbeing through promotion and prevention.⁵²⁵⁶

The case for seeking to support physical and mental health in a more integrated way is compelling, and is based on four related challenges: – high rates of mental health problems among people with long-term physical health problems – poor management of ‘medically unexplained symptoms’, which lack an identifiable organic cause – reduced life expectancy among people with the most severe forms of mental illness, largely attributable to poor physical health – limited support for the wider psychological aspects of physical health and illness. Collectively, these issues increase the cost of providing services, perpetuate inequalities in health outcomes, and mean that care is less effective than it could be.⁵⁷

More information

For further information on spend by local authority or CCG, please visit:

<https://www.gov.uk/government/publications/spend-and-outcome-tool-spot>

2013/14 CCG Programme Budgeting Marketing Tool – showing how much CCG’s spend on different healthcare conditions, please visit:

<https://www.england.nhs.uk/resources/resources-for-ccgs/prog-budgeting/>

For further information on commissioning cost-effective services for the promotion of Mental Health and Wellbeing and Prevention of Mental Ill-Health, please visit:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/640714/Commissioning_effective_mental_health_prevention_report.pdf

For further information on this analysis and return on investment through mental health promotion and mental illness prevention please visit:

<https://www.gov.uk/government/publications/mental-health-services-cost-effective-commissioning>

http://eprints.lse.ac.uk/32311/1/Knapp_et_al_MHPP_The_Economic_Case.pdf

5. Policy and Guidance

5.1. No Health Without Mental Health; A cross government mental health outcomes strategy for people of all ages (2011) - Department of Health⁴

Sets out the Government’s ambition to mainstream mental health, and establish parity of esteem between services for people with mental health problems and physical health

problems. The strategy looks to communities as well as the state, to promote independence and choice, and a wide range of partner organisations to deliver the strategy. These include user and carer groups, service providers, including NHS providers, local government and central government departments.

The strategy sets out six shared objectives to improve mental health outcomes for individuals and the population as a whole as follows;

- i) More people will have good mental health
- ii) More people with mental health problems will recover
- iii) More people with mental health problems will have good physical health
- iv) More people will have a positive experience of care and support
- v) Fewer people will suffer avoidable harm
- vi) Fewer people will experience stigma and discrimination

5.2. Better Mental Health For All: A Public Health approach to mental health improvement (2016)¹⁹

Commissioned from the Mental Health Foundation by the Faculty of Public Health (FPH). The report is intended as a resource for public health practitioners. It focuses on what can be done to enhance the mental health of individuals, families, and communities by using a public health approach.

5.3. NICE (National Institute for Health and Care Excellence) Guidance Documents

NICE has published a number of relevant guidelines and guidance documents including;

Common Mental Health Disorders : Identification and Pathways to Care-NICE CG 123 (2011)

Depression in Adults; recognition and management – NICE CG 90 (2009)

Generalised anxiety disorder and panic disorder in adults: management NICE CG 113 (2011)

Obsessive-compulsive disorder and body dysmorphic disorder: treatment NICE CG 31 (2005)

Social anxiety disorder: recognition, assessment and treatment NICE CG 159 (2013)

Post-traumatic stress disorder: management NICE CG 26 (2005)

Antenatal and postnatal mental health: clinical management and service guidance NICE CG 192 (2014)

Transition between inpatient mental health settings and community or care home settings NICE NG27 (2016)

5.4. Five Year Forward View for Mental Health (2016) report of the Mental Health Taskforce⁵³

Sets out a ten year transformation plan. It outlines priority actions for the NHS, and recommendations for wider action including decent housing, employment opportunities, and community engagement. The report focuses on tackling inequalities, recognising that mental health problems disproportionately affects people living in poverty, those who are unemployed and those who already face discrimination.

5.5. Care Act 2014 – Department of Health⁵⁸

The Care Act sets out duties for local authorities and their partners, new rights for individuals and carers, and the requirement to integrate care and support offered by local authorities with that of health services. There is now also a requirement to consider an individual's 'wellbeing'. This is a comprehensive and detailed document. An Easy Read version is available.

5.6. LLR Sustainability and Transformation Plan 2017 (STP) Mental Health Workstream⁵⁹

The aspiration for mental health is to promote recovery from mental illness by developing a patient's understanding of their illness and supporting them to manage their condition more effectively. The workstream aims to support people to stay well at home and be independent but also have better access to emergency and crisis services when they need them.

5.7. Improving Physical Healthcare for People living with SMI in Primary Care: Guidance for CCG's (2018) NHS England⁶⁰

National guidance to improve the quality of physical healthcare for people with SMI in primary care, aimed at reducing risk from preventable serious illness, including cancer, heart disease, and diabetes. The guidance details the action and collaboration required by commissioners and providers in primary and secondary care to improve access to and the quality of physical health checks and ensure appropriate follow-up care is given.

5.8. Preventing Suicide in England: third progress report HM Government (2017)⁶¹

The Five Year Forward View for Mental Health recommends that all local authorities have multi-agency suicide prevention plans in place in 2017. These plans should target high-risk locations and support high-risk groups, including men and people in contact with mental health services. The local plans should be reviewed annually and supported by new investment.

The All Party Parliamentary Group on Suicide and Self-Harm Prevention (2013) recommended that Health and wellbeing boards:

- i. Ensure that suicide and self-harm are addressed in the Joint Strategic Needs Assessment beyond being a measure.
- ii. Ensure that the local suicide prevention plan is written into the local health and wellbeing strategy and includes provision for bereaved families.
- iii. Investigate opportunities for developing links with neighbouring local authorities to co-ordinate work through a regional group that could pool resources and expertise.

A Leicester, Leicestershire and Rutland Suicide Prevention Strategy and Plan 2017-20 is in place. In addition the LLR Suicide Audit and Prevention Group (LLR SAPG) has been brought together to tackle the cause and the impact of suicide across Rutland. The LLR SAPG is a sub-group of the LLR Better Care Together Mental Health Partnership Group and it also feeds into the LLR Crisis Concordat. In addition it reports into local authority Health and Wellbeing Boards.

5.9. Other related documents

Mental Health; How do you know if your council is doing all it can to improve mental health. Local Government Association (2018)

Creative Health; The Arts for Health and Wellbeing Inquiry Report. APPG (2017)

Thriving at Work; the Stevenson/Farmer review of mental health and employers. DWP/DoH+SC (2017)

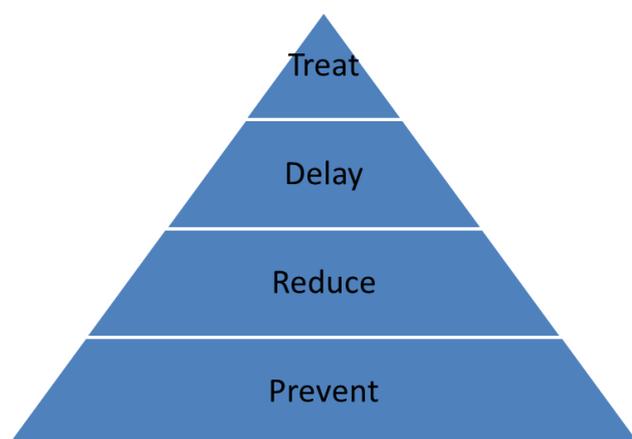
6. Current Services

6.1. Overall service Provision

There is partnership work currently ongoing at a strategic level to deliver improvements

across mental health services with the aim of shifting the focus to prevention and recovery, and delivering services on a locality based model. The strategic direction driven by the national Five Year Forward View for Mental Health, and the local Leicestershire Partnership Trust (LPT) Transformation Programme is to ensure the right level of care in the right place at the right time, with the emphasis on prevention and recovery.

The approach to delivering service provision is a layered approach with a continued emphasis on people being supported towards greater independence. It is summarised in the pyramid below.



Social Care works closely with GPs and inpatient facilities that treat people experiencing severe mental illness such as when they are being discharged from hospital and perhaps need residential care. Social care will always try to enable the person to go home and perhaps facilitate this by commissioning appropriate support packages such as formal carers to call in and support the person.

6.2. Leicestershire Partnership Trust

The Leicestershire Partnership NHS Trust (LPT) has three clinical directorates. The Adult Mental Health and Learning Disability Services directorate provides a range of both inpatient adult mental health services, and community mental health services.

6.2.1. Inpatient Adult Mental Health

Inpatient adult mental health services include a number of wards providing different levels of care and support depending on individual need. There are separate male and female wards which cover recovery focussed general psychiatric assessment and acute care; psychiatric intensive care and low secure care. These are based at the Bradgate Mental

Health Unit on the Glenfield Hospital site.

6.2.2. Community Mental Health services

Community Mental Health Team (CMHT) – the East Leicestershire and Rutland CMHTs receives referrals through a person's GP or other healthcare professional. Teams include Consultant Psychiatrists, Psychiatric Nurses, Occupational Therapists, Social Workers, and Psychologists providing a range of interventions and treatments.

Forensic Mental Health Team – single team covering Leicester, Leicestershire, Rutland (LLR). Provides specialist community (and inpatient) service for those individuals who pose a risk of harm to others in the context of their mental disorder. The multidisciplinary team includes Consultant Psychiatrists, Psychiatric Nurses, Occupational Therapists, Social Workers, and Psychologists. Access to the service is by referral from a Consultant Psychiatrist to the Referral Panel.

Crisis Resolution and Home Treatment Team – provides rapid assessment and care for people experiencing a crisis in their mental health that might otherwise result in a hospital admission. Intensive home treatment is provided for a short period before care is passed to the GP or other secondary care. Referral is primarily through a GP.

Perinatal mental health care – provides assessment, treatment and support for women experiencing severe mental illness during pregnancy and following birth of their child. This may be pre-existing conditions that recur in pregnancy, or conditions with their onset during pregnancy/following birth. The service includes a perinatal psychiatric liaison consultation service to primary care, maternity and mental health services. The service is accessed through GP, midwife, obstetrician, mental health worker, or health visitor.

PIER team (Psychosis Intervention and Early Recovery) – provides treatment and support for people (from 14 years of age) who are experiencing their first episode of psychosis. The service supports individuals and their families to recover, and manage ongoing difficulties, and minimise the chances of relapse/recurrence. The team includes mental health workers and support workers. Service covers LLR. Referral to the service is through GP or other healthcare professional.

Liaison Psychiatry Service – provides assessment and treatment for people who experience mental health problems in the context of their physical illness. This will usually take place on University Hospitals Leicester (UHL) hospital wards. Access is by referral only from GP, secondary care providers, clinicians from acute specialities.

Leicestershire Recovery College – based on a national model the Recovery College provides

a range of recovery focused educational courses for people with lived mental health experience, their families and friends and LPT staff. Courses cover a range of mental health and wellbeing subjects. The aim is for people to recognise their own resourcefulness and skills and become experts in their own self-care. A course prospectus is available and courses are free of charge. People can attend courses by enrolling as a student with a 'satellite' hub available at Rutland Adult Learning Service, Oakham Enterprise Park, Oakham.

Crisis House (Turning Point) - the Crisis House provides short term intensive support for adults who need extra support when experiencing a mental health crisis. The service, aims to avoid unnecessary hospital admissions. The house provides six beds and 24 hour care and support, including a structured recovery focused programme of activities. In addition to the Crisis House, the service provides a 24 hour crisis helpline and open access drop-in session at Turning Point in Rutland.

Employment Support (Aspiro) – provides employment support for people using specialist mental health support services

6.3. PAVE Team (Pro-Active Vulnerability Engagement)

PAVE is a partnership between police, mental health and substance misuse practitioners providing targeted support for people who intensively use health and police services. The aim is to reduce the number of people with mental ill health being held inappropriately in police cells. The multi-disciplinary team includes police officers, mental health and substance misuse practitioners and recovery workers. Clinical support is available as required from a Consultant Psychiatrist.

6.4. Rutland Community Wellbeing Service (RCWS)

RCWS offers information, support and signposting to self-help tools and onwards referral to a variety of community support. They provide a wide range of assistance to help people to overcome some of the factors which may have a negative impact on emotional wellbeing, such as poor housing, debt, economic disadvantage, serious illness, bullying, abuse, bereavement or isolation. This includes help to access specialist military/veteran support.

6.5. Mental Health Matters

This service provides community based advice, information and support to adults who are experiencing emotional and mental health problems, and their carers. They offer brief interventions and support for low-level and moderate mental health problems. This includes support for those recovering from clinical treatment of severe mental illness through group support and one to one interventions. The service offers both drop-in and appointment

based access within Rutland.

6.6. Let's Talk-Wellbeing (IAPT service)

This service provides psychological assessment and treatment for mild to moderate common mental health problems. Specialised skilled and accredited practitioners provide psychological therapies (talking therapies) for people experiencing common difficulties including depression, anxiety, panic, phobias, obsessive compulsive disorder (OCD), trauma and stress.

6.7. Adult Social Care & Health Services

Social care employs specialist qualified social workers and other support staff to engage with people suffering from the effects of serious mental illness in the community. Social care does not provide treatment but helps with the provision of after care and regular visits to ensure the person is being correctly supported to help them maintain good mental health after treatment. This approach helps prevent relapse of symptoms and possible return to hospital. In 2017/18 12 service users under the age of 65 with a mental health problem received a social care package. This is similar to previous years. In addition there were 28 Rutland service users under age 65 who were S117 entitled in 2018. This is an aftercare entitlement following being placed on a Section 3 of the Mental Health Act and aims to meet social care needs that will alleviate mental illness.

Health and social care services for people with more serious mental health problems are provided by staff based in the Rutland Community Mental Health Team. Services are provided on a multidisciplinary basis with input from social care staff where required. Following assessment a range of services from hospital and medical services to community services are available dependent on need. The aim is to enable people to remain as independent as possible in the community.

Social Care provides specialist staff called Approved Mental Health Professionals (AMHP's) who, alongside section 12 doctors, assess people who are in crisis. If the person is assessed to be a risk to themselves or others they can be detained under section of the mental health act. This service is provided 24 hours a day every day of the year.

6.8. Turning Point

Turning Point provide integrated drug and alcohol services across Rutland with a number of different treatment pathways and support interventions. These include: Recovery worker support and peer mentors, substitute prescribing, community detox, harm reduction and needle exchange. Support is provided one to one and in groups and the service works

closely with housing, employment and wellbeing services to ensure other needs are met. The service can advise and support friends and families of people with drug and alcohol problems and has a dedicated young people's service.

6.9. Leicestershire Action for Mental Health Project

Leicestershire Action for Mental Health Project works across Leicester, Leicestershire, and Rutland. It provides independent mental health advocacy for people who are seeking to be, or who are already, involved with mental health services. There is also a specialised service for carers of people with mental health problems. <http://www.lampadvocacy.co.uk/>

6.10. The Carers Centre

The Carers Centre Leicestershire & Rutland provides advocacy and support for carers <http://claspthecarerscentre.org.uk/>

6.11. Once, We Were Soldiers

Provides support for former serving members of the British Armed Forces including those with mental health needs. <https://owwsoldiers.co.uk/>

6.12. Domestic Abuse

There are a range of support services available for those who experience domestic abuse (DA) or sexual violence (SV). These services also include some limited assistance for perpetrators of DA. Many of the services are provided on an LLR basis by UAVA, which is a consortium of providers who offer support for any persons over 13 years. These services include:

- Confidential, free, hidden helpline number 8am to 8pm Monday to Saturday
- A dedicated professional support line
- Independent Domestic Violence Advisors providing short term, intensive support and advocacy which focuses on risk and managing risks.
- Independent Sexual Violence Advisors service for those 13+ who have experienced rape or sexual assault
- Outreach workers – providing emotional and practical support and counselling, and group work
- Counselling services to assist with a victims recovery
- Freedom and recovery programmes, including for children under 13 who have experienced or witnessed domestic abuse, are provided in Rutland.

7. Unmet needs/Gaps

7.1. IAPT

There is a lack of qualified staff completing training programmes, particularly Psychological Wellbeing Practitioners, meaning the service carries staff vacancies, and as a result long waiting lists.

7.2. Community Mental Health Teams

Caseloads within Community Mental Health Teams are an issue and this increases the pressure on pathways and systems.

7.3. Acute beds

Whilst the number of available beds across Leicester, Leicestershire and Rutland compares closely with the national average, there is a capacity issue related to the length of stay of patients. As a result of these capacity issues there are a number of people that are placed out of area. This is an area of concern as the Government has set an ambition for local areas to eliminate inappropriate out-of-area placements by 2020/21.

7.4. Liaison Psychiatry

Current capacity pressures in liaison psychiatry services impacts adversely on other service provision.

7.5. Support for deaf/hearing impaired people

Communication barriers impact of deaf people being able to access the support they need. Service users have identified a number of issues with current service provision for people who are deaf or who have hearing impairment. These include a gap in appropriate talking therapies for deaf people with mental health problems, and/or lack of resources and isolation for deaf people impacting on their mental health. There is a lack of social workers who are able to communicate using British Sign Language, staff in a range of services not trained in Deaf Awareness.

8. Recommendations

8.1. Wider Determinants of Mental Health, prevention of mental ill health

- Encourage GPs/primary care, and the health and care services, more generally to be aware of the services that are available and actively signpost or refer into services, including utilising social prescribing approaches where appropriate.

- Consider targeted interventions to tackle other potential causes of poor mental health e.g. loneliness, social isolation, and other wider determinants of poor mental health.
- Promote good mental health using approaches such as the Five Ways to Wellbeing.
- Commissioners and service providers should be aware of the occupations at higher risk of suicide, including labourers and those working in the agricultural sector.

8.2. Services

- CCGs/primary care to increase the numbers of people with common mental health problems who are detected and treated using IAPT services.
- Capitalise on the growing understanding of the links between poor mental health and wellbeing and physical health, thereby increase uptake of IAPT services.
- Provide targeted support for patients with mental health problems to address lifestyle factors including smoking, substance misuse and alcohol misuse, and inactivity.
- Specifically address the psychological support and intervention needs of deaf people and the needs of individuals whose first language is not English.
- Mental Health recovery services should incorporate more involvement of people with lived experience in design and delivery of recovery services. Increase opportunities for peer support, and self-care.

GLOSSARY OF TERMS

APMS	Adult Psychiatry Morbidity Survey
BME	Black and Minority Ethnic Groups
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CMD	Common Mental Health Disorders
ELR CCG	East Leicestershire and Rutland Clinical Commissioning Group
ESA	Employment Support Allowance
GAD	Generalised Anxiety Disorder
IAPT	Improving Access to Psychological Therapies
JSNA	Joint Strategic Needs Assessment
LGBTQ+	Lesbian, Gay, Bisexual, Transgender Queer or Questioning or Others
LLR	Leicester, Leicestershire and Rutland
LLR SAPG	Leicester, Leicestershire and Rutland Suicide Audit and Prevention Group
LPT	Leicestershire Partnership NHS Trust
LSOA	Lower Super Output Area
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
OCD	Obsessive Compulsive Disorder
PAVE	Pro-Active Vulnerability Engagement
PHE	Public Health England
PTSD	Post-Traumatic Stress Disorder
QOF	Quality Outcomes Framework
STP	Sustainability and Transformation Plan
UHL	University Hospitals Leicester

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RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2018

PHYSICAL HEALTH OF ADULTS - AGED 18 TO 64 YEARS

DECEMBER 2018

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Whilst every effort has been made to ensure the accuracy of the information contained within this report, Leicestershire County Council cannot be held responsible for any errors or omission relating to the data contained within the report.

FOREWORD

The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Rutland, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs.

The JSNA has reviewed the population health needs for the people of Rutland in respect of a person's adult years. This has involved looking at the determinants of health, the health needs of this population in Rutland, the impact of services, the policy and guidance supporting adults, and the existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

The JSNA offers an opportunity for the Local Authority, CCG and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCG and NHS England must be able to explain why.

EXECUTIVE SUMMARY

- Nationally the prevalence of smoking has been declining each year since 2012. In Rutland between 2012 and 2015, the smoking prevalence has remained significantly better (lower) than the national percentage. In 2016, 12.3% of adults in Rutland were current smokers, similar to the England proportion of 15.5%.
- In Rutland, in 2016/17, 60.2% of adults were classified as overweight or obese, this is similar to the England value of 61.3%. The percentage has increased (declined) from 2015/16, where the prevalence of excess weight in adults in Rutland was 58.0%.
- Rutland has a significantly higher prevalence of coronary heart disease, stroke and diabetes as recorded on GP registers in 2016/17. It must be noted that a higher prevalence could point to effective case finding in the practice population, allowing GPs and members of the primary care team to monitor, manage and treat the condition to reduce morbidity and mortality.
- In 2017/18, the proportion of the eligible population who received an NHS Health Check in Rutland was 7.0%, this is significantly worse than the England value of 8.3%. The percentage of the eligible population in Rutland who were invited for and who received an NHS Health Check was 32.4%. This is significantly worse than the England value of 47.9%.
- Over the last six years, cervical cancer screening coverage in Rutland has witnessed a significant downward trend, despite continuing to perform significantly better (higher) than nationally. This downward trend is witnessed nationally.
- In 2014-16, a higher proportion of deaths from cardiovascular disease are considered preventable in Rutland compared to nationally.
- Since 2010-12, the directly-standardised rate of oral cancer registrations in Rutland has remained similar to the national rate but has increased year on year, with 11 registrations in 2010-12 to 25 registrations in 2013-15.
- In 2016/17 in Rutland the directly standardised rate of alcohol-related admissions to hospital was 444 per 100,000 population (177 adults). This is significantly better than the England value of 636 per 100,000 population.
- The rate of killed and seriously injured casualties on Rutland's roads has increased year on year from 2011-13 to 2014-16. In 2014-16, 80 people were killed or seriously injured on Rutland's roads. This equates to a rate of 70.1 per 100,000 population and is significantly worse than the England rate of 39.7 per 100,000 population.

- In Rutland, the rate of total prescribed Long Acting Reversible Contraception (LARC) excluding injections has remained significantly higher than the national rate between 2014 and 2016. Throughout this time, the rate of GP prescribed LARC excluding injections has remained significantly higher than the national rate whereas the rate of Sexual and Reproductive Health (SRH) Services prescribed LARC excluding injections has remained significantly lower than the national rate. This is likely to be due to the rural nature of the county.

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1. Introduction

This chapter presents a comprehensive overview of the physical health of adults in Rutland. The majority of indicators presented are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. We appreciate that this document uses technical language. This is due to the nature of the JSNA, which is intended for use by commissioning organisations such as local authorities and the NHS in developing their commissioning plans. One example is the use of statistical significance. A statistical significant result ensures the result is not likely to be caused by chance, for a given statistical significance level. Using these statistical tests improves the reliability of our evidence base which will help strengthen our commissioning based decisions.

2. Who is at risk?

There are many factors that influence the health of a person during their adult years.

2.1. Smoking

Smoking is the major cause of preventable ill health and premature mortality in England. Tobacco use is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

Nationally the prevalence of smoking has been declining each year since 2012. In Rutland between 2012 and 2015, the smoking prevalence has remained significantly better (lower) than the national percentage. In 2016, 12.3% of adults in Rutland were current smokers, similar to the England proportion of 15.5%.¹ For the same time period, 26.2% of adults aged 18-64 years who were in routine and manual occupations were current smokers. This is similar to the England proportion of 26.5%.¹

Deaths attributable to smoking have been following a downward trend both nationally and locally. In Rutland the trend in mortality attributable to smoking has remained significantly better (lower) than national over time. The latest data shows during 2014-16, 151 deaths in Rutland were attributable to smoking. This is a directly standardised rate of 184.4 per 100,000. This rate is better than the England value of 272.0 per 100,000 population.¹

2.1.1. Smoking cessation

Since 2012, Rutland has had a higher (but not significantly) percentage of ex-smokers

compared to nationally. The latest data shows over a third (36.3%) of adults in Rutland were ex-smokers in 2016. The England proportion was 26.2%.¹

In 2016/17, there were 118 people in Rutland using stop smoking services and 69 people quit smoking as a result of attending stop smoking services. This equates to a rate of 1,747 per 100,000 smokers aged 16 and above which falls in the second lowest quintile nationally.

¹ In the same time period, of those who self-reported quitting smoking at 4 weeks, 39 had confirmation by carbon monoxide validation. This equates to a rate of 988 per 100,000 smokers aged 16 and above which falls in the lowest quintile nationally.¹

2.2. Diet

In 2016/17, 62.0% of Rutland's adult population met the recommended consumption of five portions of fruit and vegetables a day, this is better than the England proportion of 57.4%. This percentage has declined from 63.8% in the previous year.⁷ Please note, this data is taken from the Active Lives survey and is self-reported so is likely to be susceptible to response bias.

Fast food is often high in calories from sugars and fat, and is therefore an unhealthy food choice which if eaten often is likely to lead to obesity. In 2014, there were 24 fast food outlets in Rutland – a density of 63.1 fast food outlets per 100,000 population. This is a statistically similar density to the England value of 88.2.²

2.3. Physical Activity

The percentage of physically active adults in Rutland has remained similar to the national average for the last two years. In 2016/17, 68.1% of adults in Rutland reported that they were physically active, that is, they engaged in at least 150 minutes of moderate intensity physical activity per week. This is similar to the England value of 66.0%.⁷ However, in 2016/17, a fifth (20.5%) of adults in Rutland reported that they were physically inactive, that is, they engaged in less than 30 minutes of physical activity per week. This is similar to the England value of 22.2%.⁷

2.4. Physical disabilities

In Rutland, in 2012, the estimated prevalence of physical disability was 12.0% of the population aged 16-64; this is in the highest quintile nationally. The England proportion rests at 11.1%.³

In 2017, 1,761 residents aged 16-64 years in Rutland were predicted to have a moderate physical disability and 540 residents aged 16-64 years in Rutland were predicted to have a

serious physical disability.⁴ Please note, these estimates are based on prevalence data for moderate and serious disability by age and sex included in the Health Survey for England, 2001.

2.5. Learning disabilities

A learning disability is a reduced intellectual ability and difficulty with everyday activities, for example household tasks, socialising or managing money, which affects someone for their whole life. The prevalence of people with learning disabilities as identified on GP registers in Rutland has remained significantly lower than the national average for the past three financial years. The latest data shows in 2016/17, 135 people in Rutland had been identified on GP registers as having a learning disability. This is a prevalence of 0.4% and is significantly lower than the England of 0.5%.⁵

The proportion of eligible adults with a learning disability having a GP health check in Rutland has remained similar to the national average over the past three years. In 2016/17, 82 eligible adults with a learning disability in Rutland had a GP health check (60.7%). This is statistically similar to the England proportion of 48.9%.⁵

In Rutland, in 2015/16, there were 15 supported working age adults with learning disability in paid employment (16.7%). This is better than the England value of 5.8%.⁵ This percentage has increased from 2014/15, where there 10 (12.5%) supported working age adults with learning disability in paid employment.

The trend in adults with learning disabilities living in stable and appropriate accommodation has shown no significant change over time. The latest data shows in 2016/17, there were 44 adults with learning disabilities living in stable and appropriate accommodation (71.0%). This is similar to the England proportion of 76.2%.⁷

2.6. Workplace health

The Labour Force Survey examined sickness absence in the previous working week. Since 2009-11, the percentage of Rutland employees who had at least one day off work due to sickness in the previous week has remained similar to the national average. The latest data shows during 2014-16, 2.6% of Rutland employees had at least one day off work due to sickness in the previous week. This is similar to the England proportion of 2.1%.⁷

The same survey above examines the percentage of working days lost due to sickness absence. Since 2009-11, the percentage of working days lost work due to sickness absence in the previous week has remained similar to the national average. The latest data from 2014-16 shows 1.3% working days were lost due to sickness absence. This is similar to the

England value of 1.2%.⁷

2.7. Pollution

2.7.1. Air pollution

Poor air quality impacts on a population's health and has a significant contributory role in all-cause mortality, particularly in cardiopulmonary mortality. In 2016, the fraction of adult all-cause mortality attributable to anthropogenic particulate air pollution (measured as fine particulate matter, PM2.5) in Rutland was 5.4%. The England value was 5.3%.⁷

Fine particulate matter, also known as PM2.5, has a metric of micrograms per cubic metre ($\mu\text{g}/\text{m}^3$). In 2016, Rutland had an average of $9.6\mu\text{g}/\text{m}^3$ of fine particulate matter. The England value was $9.3\mu\text{g}/\text{m}^3$.²

2.7.2. Noise pollution

Exposure to noise can cause a variety of physical and mental health effects. Noise can cause annoyance and stress, as well as sleep disturbance. Long-term exposure to high levels of noise can cause heart attacks. The following indicators examines noise measured in A-weighted decibels (dB(A)).

In 2011, 0.8% of the Rutland population was exposed to road, rail and air transport noise of 65dB(A) or more, during the daytime. The England value was 5.2%.⁷ Meanwhile, for the same time period, 1.2% of the Rutland population was exposed to road, rail and air transport noise of 65dB(A) or more, during the night-time. The England value was 8.0%. This increase in the percentage of the population exposed to noise in the night-time is likely to reflect the presence of the A1.⁷

3. Level of need in Rutland

In 2016, Rutland's population of 20-64 year olds was estimated to be a total of 20,630 (9,741 females and 10,889 males). This is projected to decrease by 11.8% to around 18,200 by 2039.⁶

Further information regarding Rutland's population can be seen in the JSNA Population chapter.

3.1. Obesity

Obesity can lead to several serious health conditions, such as type 2 diabetes, coronary heart disease, some types of cancer and stroke. In addition to these physical long term

conditions, obesity can also affect a person's quality of life and cause psychological problems. In Rutland, in 2016/17, 60.2% of adults were classified as overweight or obese, this is similar to the England value of 61.3%. Performance has declined from 2015/16, where the prevalence of excess weight in adults in Rutland was 58.0%.⁷

3.2. Long term conditions

Many long term conditions are avoidable. Preventable mortality is defined as "deaths are considered preventable if, in the light of the understanding of the determinants of health at the time of death, all or most deaths from the underlying cause (subject to age limits if appropriate) could potentially be avoided by public health interventions in the broadest sense."⁷

3.2.1. GP Recorded Prevalence

The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. The QOF examines the prevalence of certain long term conditions by dividing the counts of patients recorded on the disease register by the practice population, excluding exceptions. It must be noted that a higher prevalence could point to effective case finding in the practice population, allowing GPs and members of the primary care team to monitor, manage and treat the condition to reduce morbidity and mortality.

3.2.1.1. Coronary Heart Disease

The most common cause of premature death in England is coronary heart disease. Proper management of the condition can reduce the risk of death from the disease, and improve the quality of life of the patients.

The prevalence of coronary heart disease as recorded on GP registers in Rutland has remained stable for the past five years at 3.7%. The prevalence has remained significantly higher than the national prevalence throughout this time.⁸

3.2.1.2. Stroke

Another common cause of premature death in England is following a stroke. Proper management of the condition can reduce the risk of death from the disease, and improve the quality of life of the patients.

The percentage of patients with stroke or transient ischaemic attack (TIA), as recorded on practice disease registers (proportion of total list size) has remained significantly higher than the national percentage for the last five years. The latest data shows the prevalence of

stroke or transient ischaemic attack as recorded on GP registers is 2.3% for Rutland in 2016/17. This is significantly higher than the England proportion of 1.7%.⁸ Please note the significantly higher prevalence of stroke or transient ischaemic attack (TIA) in Rutland over time is likely to be affected by Rutland's proportionally older population compared to nationally. In 2016, almost a quarter (24.2%) of Rutland's population was over 65 years compared to less than a fifth (17.9%) nationally.⁷

3.2.1.3. Diabetes

Diabetes mellitus is a common endocrine disease. It is widely known that if you are overweight or obese, you are at greater risk of developing type II diabetes. People with diabetes can lead healthy lives with correct management and monitoring of their condition by primary care staff.

The trend of the percentage of patients aged 17 years and over with diabetes mellitus, as recorded on practice disease registers has been significantly increasing both nationally and locally. In 2016/17, 1,980 adults in Rutland had been identified on GP disease registers as having diabetes. This is a prevalence of 6.6%. The value for England was 6.7%.⁸

3.3. NHS Health Checks

In order to help prevent heart disease, stroke, diabetes and kidney disease, everyone between the ages of 40 and 74 who has not been diagnosed with any of those conditions is invited to have an NHS Health Check every five years. The Health Check assesses the risk of a person developing any of these diseases and identifies interventions to be put in place to reduce their risk.

Work is currently being completed across Rutland to improve the overall quality and data accuracy of Health Checks. This includes implementing a clinical template onto the GP practice system to support consistent high quality Health Check delivery and utilising data software to audit the quality and eligibility of Health Checks.

The latest data shows in 2017/18, the proportion of the eligible population invited for an NHS Health Check in Rutland was 21.6%, this is better than the England value of 17.3%. The proportion of the eligible population who received an NHS Health Check in Rutland was 7.0%, this is significantly worse than the England value of 8.3%. The percentage of the eligible population in Rutland who were invited for and who received an NHS Health Check was 32.4%. This is significantly worse than the England value of 47.9%.⁸

3.4. Cancer Screening

In Rutland, the breast cancer screening coverage has remained significantly higher than the national average since 2010. 80.1% of eligible women were screened adequately for breast cancer within the previous 3 years on 31 March 2017. This is better than the England proportion of 75.4%.

Over the last six years, cervical cancer screening coverage in Rutland has witnessed a significant downward trend, despite continuing to perform significantly better (higher) than nationally. This downward trend is witnessed nationally. The latest data shows in Rutland, 77.9% of eligible women were screened adequately for cervical cancer within the previous 3 and a half to 5 and a half years on 31 March 2017. This is better than the England proportion of 72.0%.⁷

Over the last three years, Rutland has continued to have a significantly higher bowel cancer screening coverage compared to nationally. Throughout this time, the coverage has increased each year both nationally and locally. The latest data shows in Rutland, 67.6% of eligible people were screened adequately for bowel cancer within the previous 2 and a half years on 31 March 2017. This is better than the England proportion of 58.8%.⁷

3.5. Mortality

3.5.1. Cardiovascular Disease

One of the major causes of death in under 75s in England is cardiovascular disease. Whilst huge improvements have been made in recent decades regarding treatment and lifestyle, action needs to continue to reduce the rate of premature mortality from cardiovascular disease.

As age increases, the percentage of deaths from circulatory disease also increases at a national level. However in Rutland in 2016, the highest percentage of deaths from circulatory disease (30.1%) was seen in the 75-84 age group whereas in the 85 year and over age group, less than a quarter of deaths (23.8%) were due to circulatory disease in Rutland. In both these age groups, over time there has been a significant decline in the percentage of deaths due to circulatory disease in Rutland. Across all age bands, the percentage of deaths from circulatory disease was similar to the national average.⁹

Mortality rates from cardiovascular disease in those aged under 75 years have remained significantly better than the national average for the last three time periods. In 2014-16, deaths from all cardiovascular disease for those aged less than 75 was 53.5 per 100,000 population aged less than 75 years, significantly better than the national rate of 73.5 per

100,000 population aged less than 75 years.⁷ In the same time period, deaths from cardiovascular disease considered preventable for those aged less than 75 was 37.4 per 100,000 population aged less than 75 years, similar to the national rate of 46.7 per 100,000 population aged less than 75 years.⁷ This infers a higher proportion of deaths from cardiovascular disease are considered preventable in Rutland compared to nationally.

3.5.2. Respiratory disease

Another of the major causes of death in under 75s in England is respiratory disease. Smoking is a major contributor to incidences of chronic obstructive pulmonary disease – one of the biggest respiratory diseases.

In 2016 in Rutland, 11.8% of all deaths were due to respiratory disease, this was similar to the national percentage of 13.7%. As age increases, the percentage of deaths from respiratory disease also increases at both a national and local level. In 2016 in Rutland, in the under 65s age group, the data for deaths from respiratory disease was suppressed. This percentage is 8.6% in the 65-74 age group, 11.7% in 75-84 age group and 13.9% in the 85 years and over age group. All age bands perform similar to the national percentage.⁹

Mortality rates from respiratory disease in those aged under 75 years have remained significantly better than the national average since 2001-03 (when the indicators were first recorded). However, the mortality rate from respiratory disease considered preventable for the latest two years (2013-15 and 2014-16) are similar to the national average. In 2014-16, respiratory deaths for those aged less than 75 were 19.9 per 100,000 population aged less than 75 years and those considered preventable were 12.5 per 100,000 population aged less than 75 years.⁷ The difference in rate infers that over half of the cases of deaths from respiratory disease are considered preventable in Rutland and in England.

3.5.3. All Cancers

In Rutland, just under a third (30.1%) of all deaths were due to cancer in 2016. This is similar to the national percentage of 28.0%. In 2016 in the 65-74 age group in Rutland, just over half of deaths (53.4%) were due to cancer, this is similar to the national picture (44.1%). This is followed by 35.0% of deaths in those aged 75-84 years and a third (33.3%) of deaths in the under 65s in the county. Deaths from cancer in the 85 years and over age group accounted for 17.2% of all deaths in 2016.⁹ Of these deaths with an underlying cause of cancer, 50.0% occurred in the person's usual place of residence. This is similar to the England value of 44.4%.⁹

Mortality rates from cancer in those aged under 75 years have remained significantly better than the national average since 2001-03 (when the indicators were first recorded).

Nationally, the rate of all premature deaths from cancer has decreased year on year since 2001-03, whereas the rate in Rutland has decreased year on year since 2011-13.⁷

The under 75 mortality rate from cancers considered preventable in Rutland have increased to perform similar to the national average for the two most recent time periods (2013-15 and 2014-16). In 2014-16, the rate of cancer deaths for those aged less than 75 was 100.0 per 100,000 population aged less than 75 years and the rate for those cancer deaths considered preventable was 65.2 per 100,000 population aged less than 75 years.⁷ The difference in rate infers over half the cases of deaths from cancer are considered preventable in Rutland, this percentage is smaller nationally.

3.5.4. Lung cancer

The third most common cancer in England is lung cancer and is difficult to treat with a low five-year survival rate compared to other cancers. It accounts for 1 in 5 cancer deaths. There is a link between smoking and lung cancer and therefore, lung cancer registration is a measure of smoking-related harm.

Since 2001-03, the age-standardised rate of lung cancer registrations has remained significantly lower (better) than the national average. During 2013-15, the age-standardised rate of lung cancer registrations was 39.7 per 100,000 population (52 registrations). This is significantly better than the England average value of 78.9 per 100,000 population.¹

Since 2001-03, the mortality rate from lung cancer has remained significantly lower (better) than the national average. The latest data shows during 2014-16, the age-standardised rate of deaths from lung cancer was 32.6 per 100,000 population (44 deaths). This is significantly better than the England average value of 57.7 per 100,000 population.⁷

3.5.5. Oral cancer

There is a link between smoking and oral cancer and therefore, oral cancer registration is a measure of smoking-related harm.

Since 2010-12, the directly-standardised rate of oral cancer registrations in Rutland has remained similar to the national rate but has increased year on year, with 11 registrations in 2010-12 to 25 registrations in 2013-15. The latest data shows during 2013-15, the directly-standardised rate of oral cancer registrations was 19.7 per 100,000 population (25 registrations). This is similar to the England average value of 14.5 per 100,000 population.¹

3.5.6. Breast cancer

Over the last four time periods, the directly standardised rate of mortality from breast

cancer in females less than 75 years of age has remained similar to the national average. The latest data shows during 2014-16, the directly standardised rate of mortality from breast cancer in females less than 75 years of age was 31.7 per 100,000 population (18 deaths). This is statistically similar to the England average value of 20.9 per 100,000 population.⁷

3.5.7. Bowel cancer

Bowel cancer is the second most common cause of deaths from cancer in the UK, and the third most common cancer. Since 2011-13, the age-standardised rate of mortality from colorectal cancer in persons less than 75 years of age in Rutland has remained similar to the national rate. The latest data shows during 2014-16, the directly standardised rate of mortality from colorectal cancer in people less than 75 years of age was 14.0 per 100,000 population (16 deaths). This is statistically similar to the England average value of 11.9 per 100,000 population.¹⁰

3.5.8. Human papillomavirus

The human papillomavirus, or HPV, is a type of virus that infects the skin and the cells lining body cavities. Infection with human papillomavirus (HPV) increases the risk of some cancers. Most people will be infected with HPV at some point in their lives and it usually doesn't cause any problems at all. In 2016/17, 88.8% of 12-13 year old females in Rutland received the primary dose of the human papillomavirus vaccination, this is similar to the benchmark of between 80%-90%. Rutland has shown an increase when compared to the previous year, where the coverage was 86.6%. The national coverage increased slightly compared to the previous year at 87.0%. In 2016/17, 75.8% of 13-14 year old females in Rutland received the second dose of the human papillomavirus vaccination, this is significantly worse than the benchmark of 80%. Rutland has shown a decrease since the previous year where the coverage was 85.2%. This was similar to the benchmark (80%-90%).⁷

3.6. Substance misuse – alcohol

3.6.1. Hospital admissions

Excess drinking of alcohol can lead to a wide range of conditions which can lead to hospital admission or death.

The directly standardised rate of alcohol-related admissions in England has remained reasonably stable since 2008/09. In Rutland, the rate performed similar to the national average in 2014/15, but since then, the rate has declined year on year. In 2016/17 in Rutland the directly standardised rate of alcohol-related admissions to hospital was 444 per

100,000 population (177 adults). This is significantly better than the England value of 636 per 100,000 population.¹¹

Both nationally and locally, the rate of alcohol-related admissions to hospital is higher in males than females. For the same time period, the rate for males in Rutland was 527 per 100,000 population (106 males) which is better than the England rate of 818 per 100,000 population. Meanwhile, the rate for females in Rutland was 375 per 100,000 population (71 females) which is statistically similar to the England rate of 473 per 100,000 population.¹¹

Rates of hospital admissions are available for different conditions. In 2016/17 in Rutland the directly standardised rate of admissions to hospital for alcohol-related unintentional injuries was 115.6 per 100,000 population (45 people). This is statistically similar to the England average value of 141.6 per 100,000 population.¹¹ For the same time period, the rate of admissions to hospital for alcohol-related cardiovascular disease conditions was 793 per 100,000 population (357 people). This is better than the England value of 1,127 per 100,000 population.¹¹ Meanwhile, the rate of admissions to hospital for alcohol-related cancer was 40.22 per 100,000 population (50 people). This is statistically similar to the England value of 38.0s per 100,000 population.¹¹

Alcohol misuse is common amongst people with a mental health problem. In 2016/17 in Rutland the directly standardised rate of admissions to hospital for mental and behavioural disorders due to the use of alcohol was 149 per 100,000 population (61 people). This is better than the England value of 367 per 100,000 population.¹¹

3.6.2. Mortality

For 2014-16, the alcohol-specific mortality rate for Rutland was 9.8 per 100,000, this is similar to the England average value of 10.4 per 100,000 population.¹¹ This represents 12 deaths in the county due to alcohol between 2014-16.

In 2015, the estimated directly standardised rate of years lost due to alcohol-related conditions was 553 per 100,000 population (197 years lost for people dying from alcohol-related conditions before reaching 75 years old). This is statistically similar to the England rate of 622 per 100,000 population.¹¹

Liver disease is influenced by alcohol consumption and obesity, as such, it is considered to be preventable. For 2014-16, the mortality rate from chronic liver disease for Rutland was 11.8 per 100,000 (15 people). This is similar to the England average value of 12.0 per 100,000 population.¹¹

3.6.3. Other impacts

One in seven deaths in reported road traffic accidents in Great Britain are due to drivers being over the drink drive limit.

During 2013-15, there were 7 alcohol related road traffic accidents in Rutland. This equates to a crude rate of 26.6 per 1,000 population, and is similar to the England rate of 26.0 per 1,000 population.¹¹

Alcohol misuse can cause conditions with disabilities. In 2016, 10 claimants of benefits in Rutland were claiming incapacity benefit, severe disablement allowance or employment and support allowance with alcohol misuse as the main disabling condition. This equates to a rate of 46.1 per 100,000 population. This is better than the England rate of 132.8 per 100,000 population.¹¹

3.6.4. Treatment

The number of people in specialist alcohol misuse services has decline in Rutland from 30 to 21 to 9 people between 2014/15 to 2016/17. The latest data shows no-one was waiting more than three weeks for alcohol treatment.¹¹

In 2016/17, the percentage of individuals in concurrent contact with mental health services and substance misuse services for alcohol misuse in Leicestershire and Rutland was 21.5%, similar to the England average of 22.7%.¹²

In 2011/12 in Rutland the rate of parents of children aged 0-15 in alcohol treatment was 106.1 per 100,000 population (7 parents). This is statistically similar to the England value of 147.2 per 100,000 population.¹³

3.7. Substance misuse - drugs

3.7.1. Mortality

The rate of adult drug-related deaths for Rutland is not available due to the numbers being too small to calculate a rate.

3.7.2. Treatment

Structured drug treatment services are vital in order to support people with drug misuse problems. Structured treatment can improve the person's life and that of their family, as well as prevent the spread of blood-borne viruses.

For the past three years in Leicestershire and Rutland, the percentage of those entering substance misuse treatment services and also receiving mental health support services for a reason other than their substance misuse has remained significantly lower than the national average. The latest data shows in Leicestershire and Rutland, 15.2% of those entering substance misuse treatment services were also receiving mental health support services for a reason other than their substance misuse. This is significantly lower than England's average of 24.3%.¹⁶

In 2014/15, in Rutland, the rate of adults in treatment as specialist drug misuse services was 0.7 per 1,000 population (20 adults). This is significantly lower than the England value of 4.8 per 1,000 population.¹⁴

In 2016, the number of adult opiate users in Leicestershire and Rutland combined that successfully completed drug treatment was 77 (6.6%). This is similar to the England value of 6.7%.⁷ The estimated proportion of opiate users not in treatment for Rutland in 2014/15 was 78.2% (43 users). This is statistically similar to the England value of 40.8%.¹⁵

Whereas in 2016, the number of adult non-opiate users in Leicestershire and Rutland combined that successfully completed drug treatment was 81 (35.7%). This is similar to the England average value of 37.1%.⁷ In 2016/17, 1 person in Rutland waited more than three weeks for drug treatment.¹⁶

People who inject drugs are at risk of contracting hepatitis C. Approximately a third of people with hepatitis C will go on to develop liver cirrhosis, and will have a greater risk of developing liver cancer. In 2016/17, 85.7% of eligible people who inject drugs and were in drug misuse treatment received a hepatitis C test (6 people). This proportion is similar to the England value of 83.3%.¹⁷

Substance misuse treatment services also provide hepatitis B testing and vaccination, however the data is suppressed for Rutland.

3.8. Avoidable Injury

3.8.1. Road traffic accidents

Road traffic accidents are preventable and can be minimised via improved education, awareness, road infrastructure and vehicle safety. The rate of killed and seriously injured casualties on Rutland's roads has increased year on year from 2011-13 to 2014-16. In 2011-13, 58 people were killed or seriously injured on Rutland's roads and the rate performed was similar to the national average. During 2014-16, this rose to 80 people killed or seriously

injured on Rutland's roads. This equates to a rate of 70.1 per 100,000 population and is significantly worse than the England rate of 39.7 per 100,000 population.⁷

Drink driving is responsible for approximately one in seven deaths in road traffic accidents in Great Britain. Between 2010-12 and 2013-15, the rate of road traffic accidents in Rutland which were alcohol related has declined each year. This equates to a decrease from 18 road traffic accidents in 2010-12 to 7 road traffic accidents in 2013-15. The latest data shows a local rate of 26.6 per 1,000 road traffic accidents. This is similar to the England rate of 26.0 per 1,000 road traffic accidents.⁷

3.9. Sexual health

3.9.1. HIV

HIV testing coverage is defined as the proportion of 'eligible new attendees' in whom a HIV test was accepted. In 2017, Rutland performed significantly better than the national average for being tested for HIV at a specialist sexual health clinic. The last time Rutland performed significantly better than England was 2010. In 2017, 80.6% of patients attending a specialist sexual health service accepted a test for HIV compared to 65.7% nationally. When splitting by sex, males (86.8%) and females (74.3%) in Rutland perform significantly better than England in 2017, compared to 2016 when both sexes performed similar to the national average. Meanwhile, HIV testing coverage in Rutland for men who have sex with men (MSM) has remained similar to England for the last nine years. In 2017, the coverage for men who have sex with men was 89.5% which was similar to the England value of 89.0%.¹⁸

HIV testing uptake is defined as the number of 'eligible new episodes' where a HIV test was accepted as a proportion of those where a HIV test was offered. An individual can have multiple episodes of HIV test offer and uptake within a year. For the past three years Rutland has performed significantly better than the national percentage of HIV testing uptake. The uptake has increased year on year since 2014, with the gap between Rutland and England widening year on year. In 2017, HIV testing uptake in Rutland is 91.0% compared to 77.0% nationally. HIV testing uptake in women in Rutland has remained significantly higher than the national average for the past six years. In men, a significant increasing trend has been seen with the uptake performing significantly worse in 2014 to now performing significantly better than national uptake in 2017. This followed a year on year increase throughout this time. In Rutland, HIV testing uptake in MSM has consistently performed similar to the national percentage since recording began in 2009.¹⁸

The count of new HIV diagnosis are very low in Rutland, in 2016 there were 2 new cases of HIV in the county. The new HIV diagnosis rate for Rutland in 2016 is 6.1 per 100,000

population aged 15 and over, this is similar to the national rate of 10.3 per 100,000 population aged 15.¹⁸

The prevalence of diagnosed HIV infection in Rutland has remained significantly better (lower) than the benchmark target of benchmarked target of 2 – 5 per 1,000 population aged 15-59 years since 2011. In 2016, the rate was 0.67 per 1,000 population aged 15-59 years which equated to 14 people living with HIV in Rutland.¹⁸

3.9.2. All STIs

The all new STI diagnosis rate indicator examines the rate of new STI diagnoses among people accessing sexual health services who are residents in Rutland. The rate of all new STI diagnoses in Rutland has remained significantly lower than national average since 2012 and throughout this time, has shown no significant change in trend. The latest data shows the all new STI diagnosis rate for people in Rutland in 2017 was 483 per 100,000 population (188 people). This is significantly lower than the England rate of 743 per 100,000 population.¹⁸

Nationally, the latest data in 2017 shows genital warts followed by gonorrhoea is the most prevalent STI, however in Rutland, genital warts is the most prevalent, followed by an identical rate of herpes and gonorrhoea.¹⁸

3.9.3. Genital warts

The rate of first episode of genital warts diagnoses in Rutland has shown a significant decline over the past five years. Nationally a declining trend has also been seen. Locally the rate has decreased from 92.4 per 100,000 population in 2016 to 64.2 per 100,000 population in 2017, this equates to a decrease from 36 to 25 diagnoses. The latest data in 2017 is the first year Rutland has performed significantly better than the national rate, previously Rutland have always performed similar to England.¹⁸

3.9.4. Genital herpes

The rate of genital herpes diagnoses in Rutland has shown no significant change over the past five years, whereas nationally the rate has declined. The count of genital herpes diagnoses in the county are low and range from 9 to 16 diagnoses per year between 2012 to 2017. Between 2016 and 2017, the counts of diagnoses decreased from 16 in 2016 to 9 in 2017 and the rate has improved from performing similar to the national average to significantly better than the national average throughout this time. The latest rate for Rutland in 2017 is 23.1 per 100,000 population, this is less than half the rate of the national rate of 56.7 per 100,000 population.¹⁸

3.9.5. **Gonorrhoea**

The rate of gonorrhoea diagnoses in Rutland has remained significantly better than the national average since records began in 2012. The local trend has shown no significant change throughout this time. The latest data shows in 2017, 23.1 per 100,000 population in Rutland had a diagnosis of gonorrhoea, this is significantly better than national rate of 78.8 per 100,000 population. This equates to 9 diagnoses in the county.¹⁸

3.9.6. **Syphilis**

Nationally the rate of syphilis diagnoses has increased year on year from 5.5 per 100,000 population in 2012 to 12.5 per 100,000 population in 2017. Throughout this time, Rutland has seen no significant change in rate and consistently performed similar to the national average. The latest data shows in 2017, the rate of 7.7 per 100,000 population were diagnosed with syphilis in Rutland compared to a rate of 20.5 per 100,000 population in 2016, this is a decrease of 5 diagnoses from 8 to 3.¹⁸

3.9.7. **Chlamydia**

Rutland continues to perform significantly worse than the national percentage for proportion of the population aged 15-24 screened for chlamydia. The percentage has decreased from 18.6% in 2016 to 16.2% in 2017. This equates a decrease of 109 screenings in Rutland in 2017. Nationally the percentage screened has also decreased from 21.0% in 2016 and 19.3% in 2017. Rutland continues to perform significantly worse than the benchmark for chlamydia detection rate in 2017, but has seen a year on year increase since 2015. In Rutland the chlamydia detection rate increased (got better) from a rate of 1,461 per 100,000 population aged 15-24 years in 2016 to 1,614 per 100,000 population aged 15-24 years in 2017. It is worth noting that the national rate of 1,882 per 100,000 is now rated significantly worse against the benchmark goal of 1,900 per 100,000 population aged 15-24 years.¹⁸

In 2017, the chlamydia diagnostic rate in Rutland is 141 per 100,000 population aged 25+, this is similar to the national rate of 189 per 100,000 population aged 25+. For the past three years Rutland performed lower than the national rate.¹⁸

3.9.8. **Pelvic inflammatory disease**

Pelvic inflammatory disease (PID) is the infection and inflammation of the upper female genital tract. It can lead to ectopic pregnancy, tubal factor infertility and chronic pelvic pain. Sexually transmitted infections are considered to be major causes of PID and ectopic pregnancy. PID can usually be treated in primary care, but may occasionally require a

hospital admission.

The PID admissions in Rutland has remained similar to the national average since recording in 2008/09. Nationally, the rate has remained stable throughout this time. The latest data shows in 2016/17 there were 7 admissions to hospital for pelvic inflammatory disease. This is a rate of 124.6 per 100,000 female population aged 15-44 years, similar to the England rate of 242.4 per 100,000 population.¹⁸

3.9.9. LARC prescriptions

Long acting reversible methods of contraception (LARC) such as contraceptive injections, implants, the intra-uterine system and intra-uterine device, are more effective than methods that rely on daily compliance such as the pill and are more cost effective than condoms.

Contraceptive injections have been included from the following analysis as:

1. injections rely on timely repeat visits/administration within the year and consequently have a higher failure rate than the other LARC methods
2. injections are easily given thus do not require the resources and training that other LARC methods require
3. injections are outside local authority contracts

In Rutland, the rate of total prescribed LARC excluding injections has remained significantly higher than the national rate between 2014 and 2016. Throughout this time, the rate has declined year on year, a pattern which is reflected nationally. The latest data shows the total prescribed LARC excluding injections was a rate of 61.0 per 1,000 female population aged 15-44 years in 2016. This is significantly higher than the England rate of 46.4 per 1,000 population.¹⁸

The prescribing rates of LARC excluding injections in Rutland is significantly higher than nationally in GPs and significantly lower than nationally in Sexual and Reproductive Health (SRH) services. This is likely to be due to the rural nature of the county.

In Rutland, the rate of GP prescribed LARC excluding injections has remained significantly higher than the national rate since 2011. Over the last 6 years, locally the rate has increased significantly, whereas the national rate has remained stable. The latest data shows the GP prescribed LARC excluding injections was a rate of 52.8 per 1,000 female population aged 15-44 years in 2016. This is significantly higher and almost double the England rate of 46.4 per 1,000 population

In Rutland, the rate of SRH services prescribed LARC excluding injections has remained significantly lower than the national rate between 2014 and 2016. Throughout this time, the rate has increased year on year, whereas the national rate has stabilised. The latest data shows the SRH prescribed LARC excluding injections was a rate of 8.2 per 1,000 female population aged 15-44 years in 2016. This is significantly lower and less than half the England rate of 17.6 per 1,000 population.

3.9.10. Abortions

Since 2012, Rutland has continued to have a significantly lower rate of abortions than England. Despite witnessing no significant change in trend since 2012, the total abortion rate has increased year on year in Rutland over the last four years. The rate of abortions for all ages in Rutland has increased from 9.0 per 1,000 females in 2013 to 11.1 per 1,000 females in 2016, this equates to an increase of 10 abortions.¹⁸

For women aged under 25 years 15.0% of the abortions in Rutland in 2016 were after a birth, this is similar to the England value of 27.4%.¹⁸

Meanwhile, the rate of abortions for women over the age of 25 years was 11.9 per 1,000 population. This is statistically similar to the England rate of 14.5 per 1,000 population.¹⁸

Since 2014, the counts of over 25s abortion rate has increased in Rutland from 27 in 2014 to 43 in 2016. Throughout this time, the national rate has increased, although in Rutland the rate has increased faster than nationally. In 2016, the over 25s abortion rate in Rutland was 11.9 per 1,000 females, statistically similar than the national rate of 14.5 per 1,000 females.¹⁸

Since 2013, Rutland has remained statistically similar to England for the percentage of abortions under 10 weeks. The count of under 10 weeks abortions has steadily increased in Rutland from 34 abortions in 2012 to 46 abortions in 2016, peaking at 52 abortions in 2015. Between 2015 and 2016, the percentage of abortions under 10 weeks decreased from 85.2% to 73.0%. In 2016, 91.3% of these abortions under 10 weeks were medical. This is a higher proportion than the England value of 71.3%.¹⁸

3.10. Mortality

3.10.1. Premature mortality

Premature mortality is a high-level indicator of the overall health of a population, being correlated with many other measures of population health. Premature mortality examines all deaths under the age of 75. Both nationally and locally the rate for persons has

decreased year on year from 2010-12. During 2014-16 there were 277 deaths in Rutland for persons under 75 years of age. This equates to a directly standardised rate of 238 per 100,000 population and is better than the England rate of 334 per 100,000 population.¹⁹

The rate of premature mortality in Rutland has remained significantly lower than the national average over time for both males and females. The rate was 212 per 100,000 for females and 263 for males. These rates are better than the England rates of 266 per 100,000 and 405 per 100,000 respectively.¹⁹

3.10.2. Preventable mortality

Preventable deaths are those that are considered that could have been potentially avoided by public health interventions. The rate of mortality from causes considered preventable in Rutland has remained significantly lower than the national average over time, for both persons and males. In the last two time periods for females (in 2013-15 and 2014-16), the rate of mortality from causes considered preventable has increased to perform similar to the national rate. This reflects an increase in 15 and 17 deaths compared to the counts of deaths in Rutland in 2012-14.⁷

3.10.3. Mortality from communicable diseases

Communicable, or infectious diseases, are caused by microorganisms such as bacteria, viruses, parasites and fungi that can be spread, directly or indirectly, from one person to another. Some are transmitted through bites from insects while others are caused by ingesting contaminated food or water. Examples of communicable diseases include influenza, tuberculosis (TB) and cholera.

Since 2001-03, the directly standardised rate for mortality from communicable diseases has continued to perform similar to the national average (when data is available). The latest data shows in 2014-16, in Rutland, there were 10 deaths from certain infectious and parasitic diseases, including influenza. This equates to a directly standardised rate of 7.0 per 100,000 population and is statistically similar to the England rate of 10.7 per 100,000 population.⁷

4. How does this impact?

Overall, Rutland performs better than the national average on a number of health and wellbeing measures. However there are still a number of health challenges facing the Rutland population. For instance, 60.2% of adults in Rutland were overweight or obese in 2016/17. Obesity increases the likelihood of developing heart disease, type 2 diabetes, some types of cancer (such as breast and bowel cancers) and stroke as well as a number of

other illnesses. Therefore, it is likely that there will be an increase in numbers of people with these medical conditions in the next few years as a consequence of adults being obese. Linked to this, 20% of adults in Rutland are inactive. If this remains the case this is likely to contribute to levels of obesity and chronic medical conditions in the future.

Workplace health is of great importance to the physical health of working age adults. Days lost to sickness in Rutland are similar to the national average. Each year in the UK, 140 billion days are lost to sickness, costing businesses an estimated £29 billion.²⁰ Supporting working age adults in maintaining and improving their physical and mental wellbeing is important for business productivity and profitability as well as the obvious benefits to individuals' wellbeing.

Many long term conditions are avoidable. Many cases of heart disease, lung disease, type 2 diabetes and many other medical conditions can be avoided, or the impact of them reduced through prevention and early intervention, through local authority and NHS and other health services and support.

5. Policy and Guidance

Upper tier authorities have a statutory duty for Public Health under the Health & Social Care Act 2012 which requires that they take steps to improve the health and wellbeing of their population.

The primary statutory duties of adult social care in respect of vulnerable adults are set out in The Care Act 2014. People have a right to a free needs assessment from the council regardless of finances or presenting needs are too low to qualify for help. All councils must use new national eligibility criteria to decide whether someone can get help from them.

If people get social care support, they now have a right to request a personal budget. This is a summary of how much the council thinks qualifying peoples care should cost enabling people to commission their own care. If the needs assessment shows they don't qualify for help from the council, they must advise people how the care system works and how to pay for their own care. Carers too have a legal right to a care assessment from the local council and can also get support services if they qualify for them.

If people find it difficult to communicate or to understand the issues being discussed, the council must provide an advocate to help when discussing their care. They will represent people's interests if they don't have a friend or relative who can help.

The council is the lead agency in preventing abuse to vulnerable adults and now has powers under section 42 of the Care Act to cause enquiry. This means the council can ask providers

of health and domiciliary services to investigate concerns and present the findings to the council for scrutiny. The council works closely with the Police and other statutory agencies at these times always keeping in contact with and supporting the alleged victim.

The Rutland Sexual Health Strategy 2016-2019 (available at: <https://www.rutland.gov.uk/pdf/Rutland%20Sexual%20Health%20Strategy%20v0.3.pdf>) outlines the vision and strategic approach for sexual health services.

The aim of the strategy is for the Rutland population to have informed, positive relationships that result in reduced rates of unplanned pregnancy and sexually transmitted infections (STIs) including HIV. There is a regular review of sexual health data to inform planning. The priorities in the strategy are:

- A co-ordinated approach to sexual health commissioning and partnership work
- Develop a highly skilled local workforce
- Coordinated, consistent sexual health communications
- Support schools to deliver high quality relationships and sex education (RSE)
- Increase links between sexual violence prevention and sexual health services.
- Increase access to sexual health improvement and HIV prevention to at-risk groups
- Strengthen the role of primary care (GPs)
- Utilise new technologies to support sexual health delivery

6. Current Services

6.1. Rutland Community Wellbeing (RCWS) Service

Rutland Community Wellbeing (RCWS) Service offers information, support and signposting to help residents of Rutland with a range of health and wellbeing needs. This includes self-help tools, and onwards referral to a variety of community support, through an interactive website, (<https://www.rutlandwellbeing.org.uk/>) single telephone number and drop-in services. They provide a wide range of assistance to help people to overcome some of the factors which may have a negative impact on their health and wellbeing, such as poor housing and debt. This includes help to access specialist military/veteran support. RCWS also provides support to help people around a range of lifestyle issues such as help to stop smoking, basic dietary and weight management advice and referral.

6.2. Turning Point

Turning Point provide integrated drug and alcohol services across Rutland with a number of different treatment pathways and support interventions. These include: Recovery worker support and peer mentors, substitute prescribing, community detox, harm reduction and needle exchange. Support is provided one to one and in groups and the service works closely with housing, employment and wellbeing services to ensure other needs are met. The service can advise and support friends and families of people with drug and alcohol problems and has a dedicated young peoples' service. <http://wellbeing.turning-point.co.uk/leicestershire/hubs/rutland-hub/> GP's also provide brief interventions for alcohol.

6.3. Rutland County Council's Adult Social Care (ASC)

Rutland County Council's Adult Social Care (ASC) has a number of specialist teams covering all aspects of adult social care from both a commissioning perspective and a provider perspective.

The teams are divided into three service areas- Prevention and Safeguarding, Long-term Support, and Hospital Discharge, with a range of professional and support staff; including social workers, occupational therapists, physiotherapists, nurses and care managers. Teams work on an outcome-focused ethos with the person at the centre involving and empowering them to take decisions over their own lives at often very difficult times for them and their families. The Hospital Discharge team is an integrated team and includes health professionals as well as local authority employed staff. They work closely with other agencies, GPs and third sector partners to ensure the best possible outcome for the person and their families.

The provider services within ASC include supported living projects for people with learning disabilities and day centres for people with learning disabilities. They ensure people live as independently as possible while getting the appropriate support that enables them to do so. Such services also give much needed respite to dedicated carers and families.

The reablement team specialise in helping people back to being independent such as after a hospital stay. The REACH team will support and encourage people in their own homes facilitating them to stay there as long as possible.

Rutland Council commissions services to assist it with its statutory duties. This includes advocacy services for example for those who lack capacity and equipment services for occupational therapy and home adaptations. Further services include assistive technology and specialist long term care.

In addition Rutland Council also commission external providers to deliver services to prevent physical ill health and promote independence of those with existing conditions. These include residential and home care, community based support services including day services and sensory impairment support.

6.4. Leicester-Shire and Rutland Sport (LRS)

Leicester-Shire and Rutland Sport (LRS) is a partnership of the local authorities of Leicestershire, Leicester and Rutland (LLR) working together with amongst others, schools, National Governing Bodies of Sport, clubs, coaches and volunteers. The Physical Activity Sport Strategy 2017-21²¹ sets out areas for action:

- Getting more people to take part in physical activity and sport.
- Improving our citizen's physical and mental well-being.
- Developing our paid and unpaid workforce.
- Creating a strong voice for physical activity and sport.
- Building a physical activity and sport environment that is safe, fair and customer focused

<https://www.activerutland.org.uk/> provides details of all the activity and sports available within the county, including those aimed at specific groups such as older people, young people with disabilities and those recovering from injury.

6.5. The Exercise Referral Scheme

The Exercise Referral Scheme is a programme for adults (16+) with health conditions, who could benefit from increased physical activity. It is a partnership between Public Health, Leicester-Shire and Rutland Sport, local authorities, GP practices and other healthcare professionals. It offers an opportunity for these individuals to exercise in a safe, supervised and structured environment.

Rutland operates a Passport to Leisure scheme which allows specific groups the opportunity to access daytime services and facilities at the local sports centre at a discounted rate, this includes low income families, students and individuals with a disability or impairment.

6.6. Workplace Health

Workplace Health - Active Rutland are starting development of a programme of support to several employers around workplace wellbeing and assisting people to improve their health

whilst at work.

6.7. Integrated Sexual Health Service (ISHS)

Rutland County Council in collaboration with Leicestershire County and Leicester City Councils, has recently recommissioned a new model of integrated sexual health service (ISHS) to provide open access services across the three local authority areas. The new service will commence 1 January 2019. In addition GP's provide a range of contraception services and pharmacies provide free Emergency Hormonal Contraception for under 25's

6.8. NHS Health Check

The NHS Health Check is a health check-up for adults in England aged 40-74. It's designed to spot early signs of stroke, kidney disease, heart disease, type2 diabetes or dementia. People aged 40-74 without a pre-existing condition, are invited for a free NHS Health Check every five years. A review of the NHS Health Check strategy is in progress to improve the proportion of those receiving and taking up the offer of an NHS Health check, improve quality of the Health Check and increase targeting to improve identification of those at highest risk of developing cardiovascular disease.

7. Unmet needs/Gaps

Coronary heart disease, strokes and transient ischaemic attacks are seen at higher levels than the national average. This may be due to a higher proportion of Rutland's population being over 65 years old compared with the national average, or increased detection and diagnosis of these conditions in primary care compared with other areas. However the prevalence of these conditions are higher in Rutland, and so a heightened focus on prevention of these illnesses through weight management, physical activity, reductions in smoking and alcohol are likely to be beneficial.

As outlined in section 5 above, there are a wide range of health, care and wellbeing services in Rutland. However, better coordination and improved communication across services would help to ensure needs are met, more equitable access to services, with service users experiencing services seamlessly and thereby improving quality.

8. Recommendations

- Use a tiered approach to prevention and addressing people's needs: ensuring universal services promote wellbeing and self-help, but with targeting of resources that is proportionate to need.
- Services across Rutland should focus on improving coordination and communication

to ensure needs are met, a high quality experience, and ease of access for Rutland residents.

- Focus on getting adults active and keeping them active for longer to prevent or reduce the impact of a range of health conditions particularly focused on those aged 45-65 years to improve healthy life expectancy.
- Undertake a military health needs assessment to include serving personnel and their families that are resident in Rutland, including a detailed section on sexual health to ensure the needs of this population are appropriately met.
- Develop workplace wellbeing programmes with active engagement with local employers.
- Review Long Acting Reversible Contraception (LARC) provision in Rutland to maintain and improve LARC prescribing rates as there has been a year on year reduction.
- Work with NHS England, commissioners of human papillomavirus (HPV) vaccination programme, to improve uptake of second dose. Although this vaccination is given in the teenage years, a lower than expected update of the second dose will have an impact on the health of the future adult population.
- Continued partnership working through the Road Safety Partnership to consider ways to reduce the number of people killed or severely injured on Rutland's roads.

GLOSSARY OF TERMS

ASC	Adult Social Care
BME	Black and Minority Ethnic Group
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
HPV	Human Papillomavirus
ISHS	Integrated Sexual Health Service
JSNA	Joint Strategic Needs Assessment
LARC	Long Acting Reversible Contraception
LLR	Leicestershire, Leicester and Rutland
LRS	Leicester-Shire and Rutland Sport
MSM	Men who have Sex with Men
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PHE	Public Health England
PID	Pelvic Inflammatory Disease
QOF	Quality and Outcomes Framework
SRH	Sexual and Reproductive Health
TIA	Transient Ischaemic Attack
TB	Tuberculosis

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RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT 2018

AGEING WELL – 65 YEARS AND OVER

DECEMBER 2018

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Whilst every effort has been made to ensure the accuracy of the information contained within this report, Leicestershire County Council cannot be held responsible for any errors or omission relating to the data contained within the report.

FOREWORD

The purpose of the Joint Strategic Needs Assessment (JSNA) is to:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To determine what actions the local authority, the local NHS and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a Joint Strategic Needs Assessment (JSNA) for Rutland, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs.

The JSNA has reviewed the population health needs for the people of Rutland in respect of a person's later life. This has involved looking at the determinants of health, the health needs of this population in Rutland, the impact of services, the policy and guidance supporting the older population, the existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

The JSNA offers an opportunity for the Local Authority, CCG and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCG and NHS England must be able to explain why.

EXECUTIVE SUMMARY

- The rate of emergency hospital admissions for injuries due to falls in persons aged 80 and above has declined year on year for the last four years, at a faster rate than nationally. In 2016/16, the rate of emergency hospital admissions due to falls for adults aged 80 and over was 4,329 per 100,000 population, better than the England average value of 5,363 per 100,000 population.
- The rate of emergency hospital admissions for hip fractures in persons aged 65 and above and in persons aged 80 and above (separately) has increased each year between 2014/15 to 2016/17. In both age bands the national rate has declined slightly year on year.
- The ratio of excess winter deaths for all ages and in persons aged 85 and above in Rutland (over 3 years) has remained similar to the national ratio since August 2001 – July 2004.
- In 2016/17, there were 26 new certifications of visual impairment in Rutland. This relates to completions of Certificate of Visual Impairment by a consultant ophthalmologist and initiates the process of registration with a local authority. The rate in Rutland is 67.3 per 100,000 population, significantly worse (higher) than the England rate of 42.4 per 100,000 population.
- The prevalence of dementia as recorded on GP registers in Rutland has increased significantly over the last seven years, following the national trend. Through this time, the prevalence in Rutland has remained significantly higher than the national prevalence. In 2016/17, 1.0% of the practice population in Rutland were recorded on GP registers with dementia, significantly higher than the national percentage of 0.8%. This equates to 362 patients in Rutland with this diagnosis. Although prevalence of dementia is higher it is estimated that there are more people living with undiagnosed dementia in Rutland and in 2018, 56.5% of those patients estimated to have dementia had been diagnosed. This is significantly worse (lower) than the national average of 67.5% and means people are not able to access suitable support.
- In Rutland, the directly age standardised rate of emergency inpatient hospital admissions for people with a mention of dementia for Rutland's over 65 population has remained significantly lower than the national rate during the last five years.
- In 2016 in Rutland, 84.5% of all deaths of people with a recorded mention of dementia were in their usual place of residence (DiUPR). This is significantly higher than the national percentage of 67.9%. Almost three-quarters (70.4%) of all deaths of people with a recorded mention of dementia in Rutland in 2016 were in a care home, followed by in hospital

(15.5%) and in the home (14.1%). This pattern of place of death is reflected nationally. The latest data shows Rutland has a significantly lower proportion of deaths occurring in hospital and a significantly higher proportion of deaths of people with a recorded mention of dementia in care homes compared to nationally.

- In Rutland, 10.1% of all deaths in 2015 were in those aged under 65. This is significantly lower than the national percentage of 14.8% and has decreased year on year from 13.2% in 2012. Of all deaths in Rutland, 46.6% were from those aged 85 and above. This proportion, which has increased over time, is now significantly higher than the national percentage of 40.4%, indicative of a growing proportion of people living to over 85.
- Two-thirds (66.1%) of all deaths from those aged 85 and above in Rutland were in the usual place of residence, this is significantly higher than the national percentage of 54.1%. The percentage of deaths in usual place of residence in this age group has increased significantly over time.

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1. Introduction

This chapter presents a comprehensive overview of the ageing population in Rutland. The majority of indicators presented are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. We appreciate that this document uses technical language. This is due to the nature of the JSNA, which is intended for use by commissioning organisations such as local authorities and the NHS in developing their commissioning plans. One example is the use of statistical significance. A statistical significant result ensures the result is not likely to be caused by chance, for a given statistical significance level. Using these statistical tests improves the reliability of our evidence base which will help strengthen our commissioning based decisions.

2. Who is at risk?

There are many factors that influence the health of a person during their older adult years.

2.1. Income deprivation

A person is classed as income deprived if they receive income support, income based job seekers allowance, pension credit or child tax credit. In Rutland, in 2015, 7.9% of people aged 60 years and over were classed as income-deprived households. This is in the lowest quintile nationally and less than half the England average value of 16.2%.¹

2.2. Community and residential care

Since 2013/14 the number of permanent admissions to nursing and residential care homes has fallen significantly: during 2016/17 11 older adults were admitted. This equates to 0.2% of the over 65 population per year in the three years from 2014-15, although with variation year on year with variation in cohorts.

Data from 2013/14 has been examined to allow comparison to the national average. In 2013/14 in Rutland, the rate of older adults who were supported throughout the year by receiving community and residential care was 10,709 per 100,000 population (915 older adults). This is higher than the England average value of 9,781 per 100,000 population.

In 2013/14 in Rutland, the rate of older adults who were permanently admitted to nursing and residential care homes was 527 per 100,000 population (45 older adults). This is

statistically similar to the England average value of 651 per 100,000 population.

2.3. Minimising unnecessary time in hospital

Delayed Transfers of Care (DToC) are the additional days that a person may stay in hospital, once medically fit for discharge, because they are unable to move on to their onward destination, e.g. because there is a lack of capacity in non-acute hospital for convalescence, or a package of care is not yet in place for them. Where DToCs can be avoided, as well as freeing up hospital capacity, this reduces the risk to individuals of hospital-contracted infections and of deconditioning due to prolonged inactivity, which can then impede recovery and independence.

DToC rates in Rutland have been reducing over time, and now match those of some of the best performing parts of the country: Rutland was ranked 19th out of 152 Health and Wellbeing Board areas in England in 2017-18 for its DToC rate, at 5.5 delays per day per 100,000 adult population. This was the lowest rate in the East Midlands, where rates ranged between 5.5 and 24.2.

2.4. Regaining the ability to manage at home after a hospital stay

Reablement helps people to learn new ways to accomplish day to day tasks that they can no longer manage as well as they used to, prolonging their ability to manage independently.

In Rutland, in 2016-17, 3.1% of people aged 65 years and over who were discharged from hospital were offered reablement services, which was similar to the England average. This is an improvement on previous patterns: in 2013-14 the rate was 2.8%, 0.5% below the then England average of 3.3%. The 2016-17 rate equals the rate of reablement being offered in Leicester and is 0.7% higher than that in Leicestershire.

Rutland has achieved very high rates of success with reablement services. In 2016-17 and 2017-18, more than 95% of individuals who received reablement services were still at home 91 days after being discharged from hospital. The 2016-17 rate of 97.2% was the best in the country.

2.5. Living alone

According to the 2011 census, 6.25% of households in Rutland were occupied by a single person aged 65 and over living alone (2,142 households). This is higher than the England value of 5.24%.²

2.6. Quality of life

The health related quality of life index for people 65 years and over in Rutland in 2016/17 was 0.761. This is similar to the England value of 0.735.⁹

2.7. Carers

Family carers play a key role in supporting the health and wellbeing of those they care for. The Care Act 2014 requires that carers are supported in their role by social services. The number of carers supported by Rutland County Council during 2017/18 increased by 25%, from 143 to 194 (503 per 100,000 population). In 2016/17, 62.1% reported that they were satisfied with the support they had received, relative to an English average of just 39%, and 79.5% said that they found it easy to find information about services, relative to an English average of 70.6%.

In 2017, the total number of people aged 65 and over providing unpaid care to a partner, family member or other person in Rutland was estimated to be 1,385. This is expected to increase by 33.9% to 1,855 carers by 2035.³

It can be difficult for carers to maintain their own connection to what is important to them while fulfilling their caring role. According to the Personal Social Services Carers survey, the latest data from 2016/17 shows carer reported quality of life in 2016/17 was rated as 7.9 in Rutland, similar to the English average of 7.7. In the same survey less than a third (31.1%) of adult carers who use support services in Rutland and felt they have as much social contact as they would like. This is lower than the national percentage of 35.5%.⁹

3. Level of need in Rutland

In 2016, 4.6% of the population was aged 0-4 (1,766 people), 18.0% was aged 5-19 (6,859 people), 53.4% was working age (20,320 people aged 20-64) and 23.9% was older than 65, this includes 3.3% of the total population that was aged 85 and over (1,249 people). Compared to nationally, Rutland has a higher proportion of the population aged over 65 and 85 respectively.⁴

Nationally the over 65 population is predicted to grow by 53.5% and the over 85 population by 127.1% between 2016 and 2039. In Rutland, the over 65 population is predicted to grow at a slower rate than nationally, by 48.9% from 9,400 to 14,000 people, whilst the 85 and over population is predicted to grow at a faster rate than nationally, by 142.9%. The largest change in population is the age band 90 years and over, an increase of 1,200.⁵

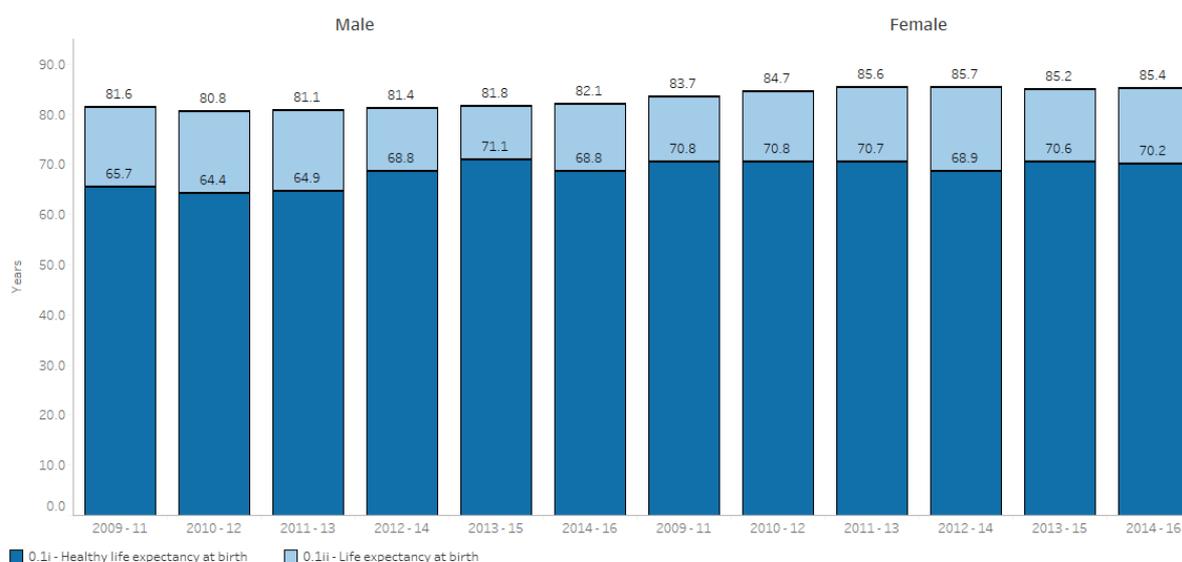
3.1. Gap in healthy life expectancy at birth and life expectancy at birth

Nationally, life expectancy at birth has remained constant for males over the last two time periods and in females over the last three periods, at 79.5 and 83.1 years respectively. In Rutland, life expectancy at birth for males has shown a year on year increase from 80.8 years in 2010-12 to 82.1 years in 2014-16, whereas life expectancy for females has fluctuated, residing at 85.4 years in 2014-16.⁹

Nationally, healthy life expectancy at birth has fallen for males and females compared to the previous time period, from 63.4 years to 63.3 years in males and from 64.1 years to 63.9 years in females. In Rutland, healthy life expectancy at birth in males has decreased from 71.1 years in 2013-15 to 68.8 years in 2014-16. In females, healthy life expectancy at birth has also decreased compared to the previous time period from 70.6 years in 2013-15 to 70.2 years in 2014-16.⁹

The gap in life expectancy at birth and healthy life expectancy at birth infers the number of years a person is likely to live in poor health. As shown by the graph, females, on average, live more years in poor health than males. The latest data from 2014-16 shows in Rutland males spend 13.4 years in poor health compared to 15.2 years in females. This is lower than the national average of 16.2 and 19.3 years respectively.⁹

Figure 1: Gap in Healthy Life Expectancy at Birth and Life Expectancy at Birth in Rutland

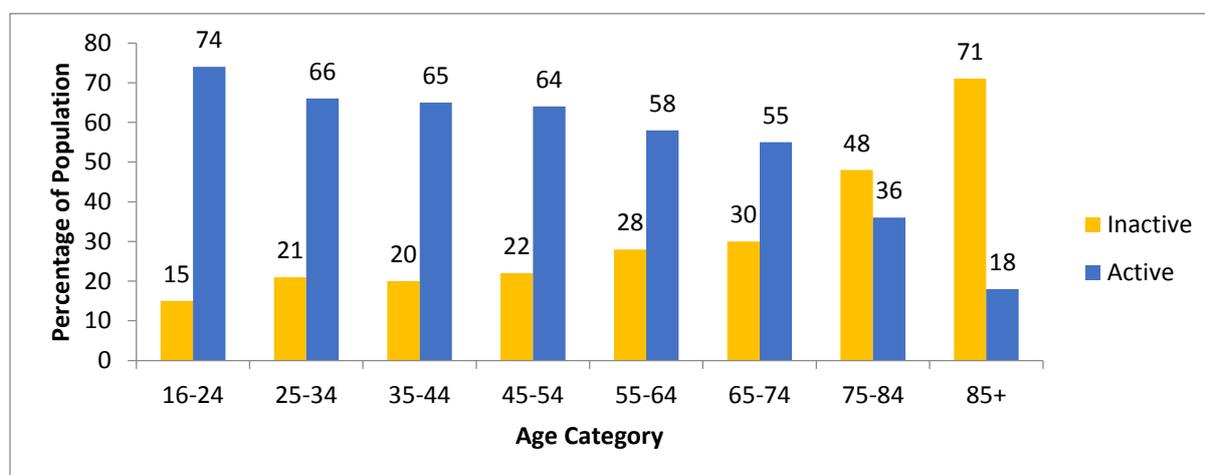


3.2. Physical activity

Nationally, as the population ages, the percentage of the population classified as physically

active (150+ moderate intensity equivalent minutes per week) decreases. The percentage of the population classified as physically inactive (<30 moderate intensity equivalent minutes per week) increases with each age-band from 30 years and above. Local activity data for Rutland is not available segmented by age.⁶

Figure 2: Percentage of the national population who are physically active and inactive, 2016/17



Data from 2015/16 showed the favourite sports in Rutland are swimming (12.5% of the adult Rutland population), gym sessions (11.8%), cycling (11.4%) and fitness classes (7.7%). Participation rates in all of these sports are greater than East Midlands and England values.

The Exercise Referral Scheme is a programme for adults (16+) with health conditions, who could benefit from increased physical activity. This prevention programme has become increasingly popular with numbers referred to the scheme increasing steadily over the last few years. See table below. Evaluation shows that participants are very positive about the scheme and a high proportion report continuing into mainstream activity programmes.

Table 1: Rutland Numbers of People accessing the Exercise Referral programme

2015	2016	2017	2018 Jan- Oct
315	350	479	465

There is considerable evidence of the benefits of physical activity in preventing ill health including reducing the likelihood of falls. Steady Steps and its predecessor FAME provide a 24-week programme tailored to those who have previously fallen or worry about falling and

it is designed to help improve balance and stability. The programme evaluates well, numbers referred have increased (see table below) and many individuals report having joined mainstream activities such as bowls, gym and other classes.

Table 2: Rutland participants in FAME/Steady Steps

2016	2017	2018
28	32	52

3.3. Loss of hearing

A person who is not able to hear as well as someone with normal hearing, hearing thresholds of 25 decibels (dB) or better in both ears, is said to have hearing loss. Unaddressed Hearing Loss can have a serious impact on health and wellbeing:

- People with hearing loss are more likely to experience emotional distress and loneliness.
- Hearing loss doubles the risk of developing depression.
- People with hearing loss are at least twice as likely to develop dementia.

Action on Hearing Loss have estimated the number of people with hearing loss of at least 25 dB in each Local Authority area in the UK, using mid-2014 ONS population estimates. In 2014, approximately 8,000 people in Rutland were estimated to be affected by hearing loss, over a fifth (21.0%) of the total population.⁷

3.4. Loss of sight

Over two million people in the UK live with sight loss. That's around one person in 30. It is predicted that by 2020 the number of people with sight loss will rise to over 2,250,000. And by 2050, the numbers of people with sight loss in the UK will double to nearly four million.⁸ This is because:

- the UK population is ageing and as we get older we are increasingly likely to experience sight loss
- there is a growing incidence in key underlying causes of sight loss, such as obesity and diabetes

Prevention of sight loss will help people maintain independent lives as far as possible and reduce needs for social care support, which would be necessary if sight was lost permanently. The counts of new completions of Certifications of Visual Impairment (all causes - preventable and non-preventable) by a consultant ophthalmologist as a rate of the resident population in the county have been examined. In Rutland the rate of sight loss certifications per 100,000 population has fluctuated to perform significantly worse (higher) and similar to the national average since 2010/11. The latest data shows in 2016/17 there were 26 new certifications in the county, which equates to a rate of 67.3 per 100,000 population. This is significantly worse (higher) than the national rate of 42.4 per 100,000 population.⁹ Whilst a higher level of sight certifications is deemed to be worse, completing the sight loss certification initiates the process of registration with a local authority and leads to access to services. This may well indicate that people with sight loss in Rutland are being proactively identified and therefore able to access the help and support they require. However sight loss can develop for a number of preventable reasons, for example related to diabetes or smoking, and therefore it is worth considering whether some of these sight loss certifications could be avoided through better diabetic control, or through improving smoking cessation rates.

Where the cause of sight loss is Age-related Macular Degeneration (AMD) or Glaucoma, the rate of new completions of Certifications of Visual Impairment due to these disorders have been examined separately. For the last six years, the rate of sight loss due to AMD in those aged 65 years and above has remained similar to the national average. The rate of sight loss due to glaucoma in those aged 40 years and above performs similar to the national average in 2016/17 with 6 new certifications.⁹

3.5. Mental health

3.5.1. Common mental health conditions

Common mental health conditions, also known as common mental disorders (CMDs) or neurotic disorders, encompass different types of depression and anxiety, including generalised anxiety disorder, phobias, OCD and panic disorder. While they do not affect cognition, they do cause emotional distress and can interfere with a person's day to day life. Many of these conditions are known to overlap; for example someone who is experiencing anxiety and depression may also have OCD symptoms. It is further recognised that not all CMDs are diagnosed. For this reason, data relies on estimates, with the understanding that those in service and receiving treatment do not account for all those with CMDs.

Table 3 shows the national prevalence of CMDs from the Adult Psychiatric Morbidity Survey (APMS) 2014¹⁰ applied to Rutland’s population across age bands¹¹. Despite the prevalence of CMDs decreasing as age increases, it must be recognised that a substantial proportion of the older population, one in ten females and one in twenty males over the age of 75 years, will continue to be affected by these disorders. With the population in Rutland predicted to age, this demand is also set to increase by 48% in males (from 290 individuals in 2017 to 430 in 2040) and 45% in females (from 597 individuals in 2017 to 867 in 2040) aged over 65 years.⁵

Table 3: Estimated prevalence of common mental health disorders in Rutland mid-2017 population based on APMS (2014)

Age	Males			Females		
	APMS Prevalence (%)	Rutland Pop	Rutland Est. Counts	APMS Prevalence (%)	Rutland Pop	Rutland Est. Counts
16-24	9.1	2,162	197	26.0	1,766	459
25-34	15.3	2,315	354	19.1	1,642	314
35-44	15.1	2,355	356	20.6	2,042	421
45-54	13.2	2,851	376	22.7	2,867	651
55-64	14.9	2,575	384	19.1	2,628	502
65-74	7.3	2,583	189	12.9	2,719	351
75+	5.3	1,919	102	10.0	2,463	246
All	12.2	16,760	2,045	19.1	16,127	3,080

3.5.2. Dementia

With the introduction of the new General Medical Services (GMS) contract in April 2004, a quality framework of indicators (QOF) was developed for general practice, the QOF. An integral part of the QOF is the collection of prevalence data to allow practices to identify those patients that require specific management. Prevalence data within the QOF are collected in the form of practice registers. Please note, while many patients are likely to suffer from multi-morbidity, i.e. are diagnosed with more than one of the clinical conditions included in the QOF clinical domain, robust analysis of multi-morbidity is not possible. Identifying these patients may rely on finding those that are on more than one chronic disease (or long term condition) register.

The recorded dementia QOF prevalence examines the number of people with dementia recorded on GP practice registers as a proportion of the people (all ages) registered at each

GP practice. In Rutland the dementia QOF prevalence has significantly increased over time from 0.6% in 2011/12 to 1.0% in 2016/17. Throughout this time, the prevalence in Rutland has remained significantly higher than the national average. The latest data reflects 362 patients have been diagnosed with dementia in Rutland.¹²

Increasing the number of people living with dementia who have a formal diagnosis enables patients, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes. In 2018 in Rutland, 56.5% of those patients estimated to have dementia had been diagnosed; this is significantly worse (lower) than the national average of 67.5% and significantly lower than the national benchmark of 66.7%.⁹

Examining the trend in the directly age standardised rate of emergency inpatient hospital admissions for people with a mention of dementia in any of the diagnosis code positions (aged 65 years and above) per 100,000 population is useful to understand the variation in the provision of care of people with dementia. Over the last five years in Rutland the rate has remained significantly better (lower) than the national average and has declined compared to the previous year. The latest data shows there were 214 emergency admissions with a mention of dementia in the population aged 65 years and above in Rutland in 2016/17.¹³

In 2016 in Rutland, 84.5% of all deaths of people with a recorded mention of dementia were in their usual place of residence (DiUPR). This is significantly higher than the national percentage of 67.9%. Almost three-quarters (70.4%) of all deaths of people with a recorded mention of dementia in Rutland in 2016 were in a care home, followed by in hospital (15.5%) and in the home (14.1%). This pattern of place of death is reflected nationally. The latest data shows Rutland has a significantly lower proportion of deaths occurring in hospital and a significantly higher proportion of deaths of people with a recorded mention of dementia in care homes compared to nationally.¹²

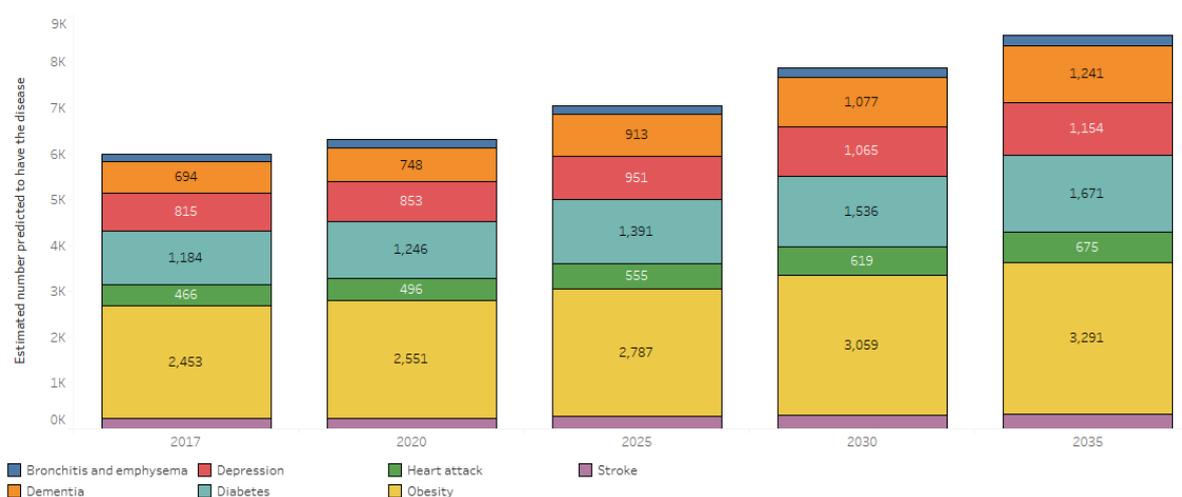
3.5.3. **Suicide**

In Rutland between 2011-15 there was one male death from suicide and injury of undetermined intent in the 65 and over age range. The crude mortality rate from suicide and injury of undetermined intent in males aged 65 and over was 5.1 per 100,000 population during 2011-15, this is statistically similar to the England rate of 12.6 per 100,000 population.¹⁴

3.6. Forecasted prevalence of long term conditions in people aged 65 years and above

The projected number of people over the age of 65 years with a long term condition between 2017 and 2035 in Rutland have been examined in the chart below. The numbers are based on the current prevalence rates applied to projected populations. Please note, the numbers refer to people on individual registers i.e. people with multi-morbidities will be counted on each register, therefore the totals will be greater than projected populations for the over 65s.

Figure 3: Forecasted prevalence of specified Long Term Conditions in people aged 65 years and above, Rutland



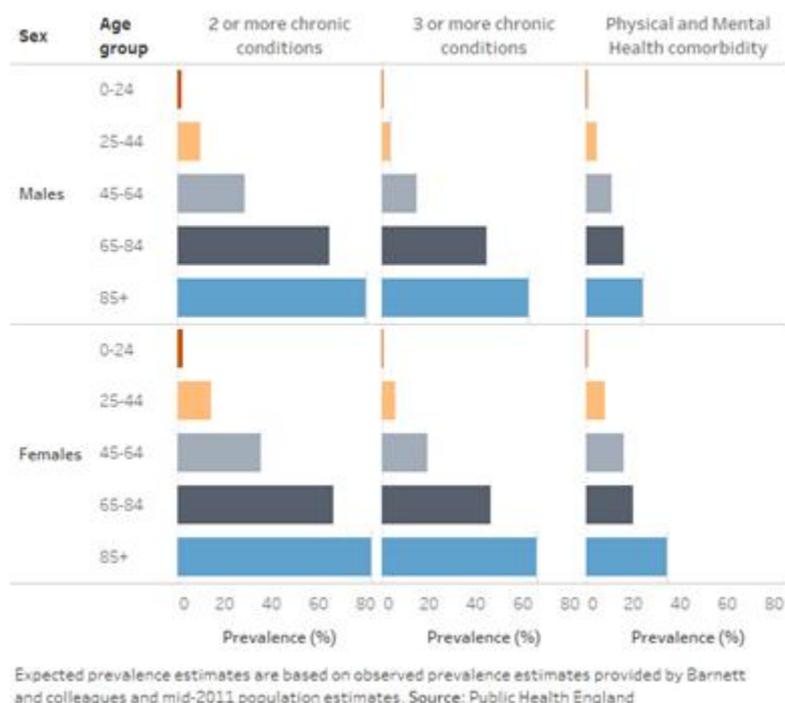
The projected increase in number of people with the following conditions between 2017 and 2035 in Rutland is: Dementia (78.8%), Stroke (47.5%), Heart attack (44.8%), Bronchitis and emphysema (42.9%), Depression (41.6%), Diabetes (41.1%), Obesity (34.2%).³

3.7. Prevalence estimates of multi-morbidity

Although multi-morbidity (presence of multiple chronic (long-term) conditions) has been researched extensively, there is currently no consensus on its precise definition. The number, type (physical or mental health) and selection criteria for conditions included in multi-morbidity indices vary from one author to another. The differences in definitions and measurement tools give rise to non-comparable information on the prevalence of multi-morbidity across various studies. Barnett et al.¹⁵ defined multi-morbidity as the presence of 2 or more chronic conditions from 40 specified conditions, and reported prevalence by sex, age group and area deprivation decile. The data reported here are based on 2 or more, 3 or more, and physical and mental health comorbidity only.

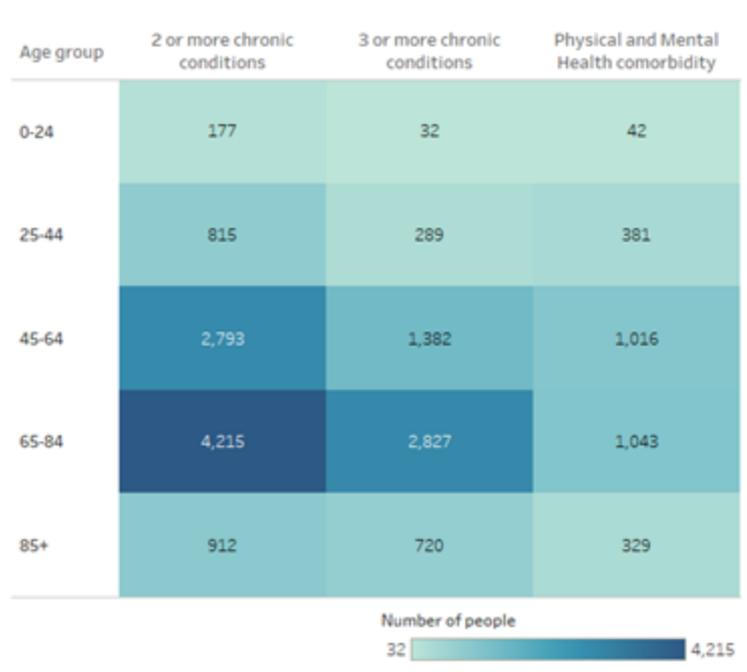
Prevalence estimates of multi-morbidity are only available at a regional level. Data for the East Midlands shows, regardless of gender, as we age the prevalence of multi-morbidity increases. In each age group, the prevalence of 2 or more chronic conditions was the highest, followed by 3 or more chronic conditions and the physical and mental health comorbidity.

Figure 4: Estimated prevalence of multi-morbidity in the East Midlands



In Rutland, the highest count of people (4,215) with multi-morbidity was in the 65-84 years age group with 2 or more conditions respectively. This was followed by the 65-84 years age group with 3 or more conditions (2,827) and 45-64 years age group with 2 or more conditions (2,793).¹⁶

Figure 5: Estimated counts of residents with multi-morbidity in Rutland



3.8. Hospital admissions

3.8.1. Emergency Admissions

Good management of long term conditions requires effective collaboration across the health and care system to support people in managing conditions and to promote swift recovery and reablement after acute illness. There should be shared responsibility across the system so that all parts of the health and care system improve the quality of care and reduce the frequency and necessity for emergency admissions.

Against a strong national trend of rising emergency admissions, the rate of emergency admissions has been maintained at a steady level in Rutland, with the 2017/18 rate only 0.5% higher than the rate in 2014-15. Non elective admissions rose by 9% in England over the same period according to national hospital activity data.¹⁷

In 2017/18, the crude rate of emergency admissions for patients aged 65 years and above in Rutland is 18,815 per 100,000 population aged 65 years and above. This equates to 1,822 emergency admissions in the population aged 65 years and above in Rutland. This is the 2nd lowest rate out of the 16 CIPFA nearest neighbours to Rutland.¹⁸

3.8.2. Falls

Nationally falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. they are a major precipitant of people moving from their own home to long-term nursing or residential care. The highest risk of falls are in those aged 65 years and above and it is estimated that about 30% people aged 65 years and above living at home and about 50% of people aged 80 years and above living at home or in residential care will experience an episode of fall at least once a year.

The local data for Rutland shows the rate of emergency admissions for falls increases with age, with the rate of admissions for those aged 80 years and above being six times higher than those aged 65 to 79 years. The rate of emergency admissions for falls for those aged 80 years and above has decreased year on year since 2012/13. The data from the most recent two years now perform significantly better (lower) than the national average, the previous three years performed similar to the national average.⁹

3.8.3. Fractured neck of femur

Only one in three people that suffer a hip fracture return to their former levels of independence. The condition is so debilitating that one in three sufferers end up moving into long-term care facilities.

The rate of emergency hospital admissions for hip fractures in persons aged 65 and above and in persons aged 80 and above (separately) has increased each year between 2014/15 to 2016/17. In both age bands the national rate has declined slightly year on year.

Emergency hospital admissions for hip fractures in persons aged 65 and above per 100,000 population has increased (worsened) from 532 per 100,000 population in 2015/16 to 558 per 100,000 population in 2016/17, representing an increase of 4 admissions. The latest rate performs similar to the national average. In 2016/17, the rate of emergency hospital admissions for hip fractures in males aged 65 and above per 100,000 population is significantly worse than the national average, whereas the rate in females is significantly better than the national average.⁹

Meanwhile in 2016/17, the rate of emergency hospital admissions due to fractured neck of femur for adults aged 80 and over was 1,432 per 100,000 population, this is similar to the England average value of 1,545 per 100,000 population. The counts of emergency hospital admissions for hip fractures in persons aged 80 and above has increased by 5 admissions compared to the previous year, from 31 in 2015/16 to 36 in 2016/17.⁹

3.9. Excess winter deaths

In common with other countries, more people die in the winter than in the summer in England and Wales. The Excess Winter Deaths (EWD) Index is defined as the ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths. Between August 2013 to July 2016 there were an estimated 38 excess winter deaths in Rutland. This represents a EWD Index of 10.9%, which means that 10.9% more deaths occurred in the winter months compared with the non-winter months.⁹ As it is common to observe large fluctuations in EWDs for which trends over time are often not smooth, we have presented a three-year moving average to smooth out any short-term fluctuations and make the trend over time clearer in the graphs presented.

Nationally, EWDs are generally higher in females and the elderly. In Rutland, for all but one data point in August 2006 to July 2009, the EWD Index for those aged 85 years and above has been consistently higher than those of all ages since recordings began. When examining by gender, on a national level, the EWD Index for females aged 85 and above has been higher than males (although not always significantly) for the last 12 time periods. In Rutland, the EWD Index for females aged 85 and above has been higher (although not significantly) than males in the same age group for the last three time periods.⁹

3.10. Mortality

The directly age standardised mortality rate (ASMR) is calculated to take into account the age structures of the population. Since 2004, the ASMR for all ages in Rutland has remained significantly lower than the national average. The latest data in 2015 shows when the ASMR is broken down into age groups, those under 65, between 65 and 74, between 75 and 84 and above 85 years all have a similar rate to the national average.¹²

In Rutland, 10.1% of all deaths in 2015 were in those aged under 65. This is significantly lower than the national percentage of 14.8% and has decreased year on year from 13.2% in 2012. Of all deaths in Rutland, 46.6% were from those aged 85 and above, this is significantly higher than the national percentage of 40.4%. The percentage of deaths in this age group has increased significantly over time, likely due to the ageing population.¹²

3.10.1. Place of death

Over a third (38.9%) of all deaths in Rutland in 2016 were in hospital, followed by: in the home (27.7%), in care homes (27.7%), hospices (3.2%) and other places (2.4%). This pattern

of place of death is reflected nationally. The latest data shows Rutland has a significantly lower proportion of deaths occurring in hospital and a significantly higher proportion of deaths in care homes compared to nationally. In Rutland the trend is significantly decreasing over time for in-hospital deaths and significantly increasing over time for deaths in care homes.¹²

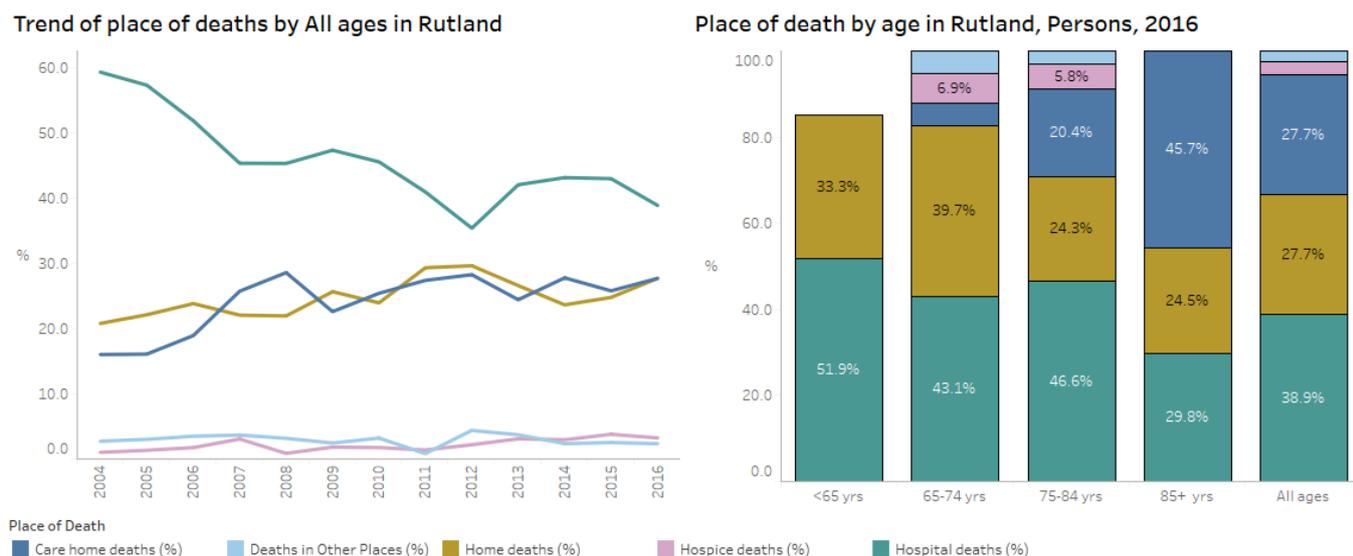
In Rutland, over half (51.9%) of deaths in the under 65 years age group occurred in hospital in 2016, this is the highest percentage out of all age groups. The lowest percentage of in-hospital deaths occurred in those aged over 85 years. In 2016, less than a third of deaths (29.8%) in this age group were in hospital, significantly lower than the national percentage of 43.8%. The trend of in-hospital deaths has been significantly decreasing across the 65-74 age band and 85 and above age band over time.¹²

As age increases, the percentage of deaths in care homes increases. Almost half (45.7%) of all deaths in the 85 and above age bands occurred in care homes, a significantly higher percentage to the national average (36.7%). The trend of care home deaths has been significantly increasing in the county across the 85 and above age band over time.¹²

Nationally the percentage of deaths at home decreases with age. In 2016 in Rutland, over a third (39.7%) of deaths in those aged 65-74 years died at home, similar to the national percentage of 30.3%. This was the highest percentage out of all age bands in Rutland residents. In those aged 85 and above, a quarter (24.5%) of all deaths were in the home. This is a significantly higher percentage compared to the national average (16.4%).¹²

In 2016, hospice deaths accounted for 3.2% of all deaths in Rutland. This is similar to the national percentage of 5.7%. In Rutland the trend is significantly increasing over time for deaths in hospices.¹²

Figure 6: Place of death in Rutland



3.10.1.1. Deaths in Usual Place of Residence

In Rutland, over half (52.4%) of all deaths were in usual place of residence (DiUPR) in 2015, this is significantly higher than the national percentage of 46.0%. The trend has increased significantly in Rutland over time and the percentage of DiUPR has continued to have a significantly higher percentage than nationally since 2006. Two-thirds (66.1%) of all deaths from those aged 85 and above in Rutland were in the usual place of residence, this is significantly higher than the national percentage of 54.1%. The percentage of DiUPR in this age group has increased significantly over time.¹²

When examining DiUPR by cause of death in 2015, this showed Dementia and Alzheimer’s disease had the highest percentage of DiUPR (87.3%), followed by Circulatory disease (49.0%), Cancer (48.0%) and Respiratory disease (32.5%). Trend analysis for Rutland shows that the percentage of deaths in usual place of residence for Cancer has shown a significant increase over time whereas Dementia and Alzheimer’s disease, Circulatory disease and Respiratory disease have all shown no significant change in the percentage of DiUPR.¹²

4. How does this impact?

The last few years have seen a steady increase in the prevalence of a range of long term conditions in Rutland, many of which are largely preventable and closely associated with lifestyle factors including increased levels of obesity, lack of exercise and smoking. Supporting people to stay healthy for longer is therefore a key area for action.

The number of complex cases is increasing, as more people are living with more than one long term condition. In light of the challenges of frailty and multimorbidity, the longer term challenge for the health and care system is a shift towards treating the person, not the individual conditions, and using this to move towards a holistic approach to Healthy Ageing. The 'system' should be about prevention, early identification and management of conditions, ideally within primary care, to prevent the onset of ill health.

Being housebound is a risk factor for loneliness, and that loneliness is itself a risk factor for depression, poor sleep, impaired thinking skills, higher use of health care with more GP visits, higher use of medication, and higher incidence of falls. Linked to prevention and social prescribing, tackling loneliness and supporting people in their own communities will help mitigate the increasing numbers of frail people.

Social prescribing is a way of linking patients in primary care with sources of support within the community. It provides GPs with a non-medical referral option that can operate alongside existing treatments to improve health and well-being. The earlier this support can be offered, the better, and preferably it should be available in that individual's own communities.

Informal carers, friends and family, often provide considerable support to people with multimorbidity. It is important to take an integrated approach to identifying and assessing carer health and wellbeing. Carers have worse health outcomes than people who are not carers and they might need support too. 70% of carers come into contact with health professionals with only around 10% being identified as carers.

5. Policy and Guidance

5.1. NICE (National Institute for Health and Care Excellence) Guidance

There is an extensive range of guidance relating to ageing well and health and care of older people. This includes NICE (National Institute for Health and Care Excellence) guidance ranging from mental wellbeing in the over 65's (PH16) to Older people with social care needs and multiple long-term conditions (NG22) to Falls in older people: assessing risk and prevention (CG161). NHS guidance includes Frail Older People – Safe Compassionate Care. This is a practical guide outlining responsibilities and approaches for commissioners, providers and nursing, medical and allied health professional leaders.

5.2. The Care Act 2014

A major piece of legislation that has shaped care in recent years stems from The Care Act 2014. This sets out the primary statutory duties of adult social care. People have a right to a free needs assessment from the council regardless of finances or presenting needs or are too low to qualify for help. All councils must use national eligibility criteria to decide whether someone can get help from them.

If people get social care support, they now have a right to request a personal budget enabling people to commission their own care. If the needs assessment shows they do not qualify for help from the council, they must advise people how the care system works and how to pay for their own care. Carers too have a legal right to a care assessment from the local council and can also get support services if they qualify for them.

If people find it difficult to communicate or to understand the issues being discussed, the council must provide an advocate to help when discussing their care. They will represent people's interests if they do not have a friend or relative who can help.

The council is the lead agency in preventing abuse to vulnerable adults and now has powers under section 42 of the Care Act to cause enquiry. This means the council can ask providers of health and domiciliary services to investigate concerns and present the findings to the council for scrutiny. The council works closely with the Police and other statutory agencies at these times, always keeping in contact with and supporting the alleged victim.

5.3. Realising Realistic Medicine

In 2017, the Chief Medical Officer published a report titled 'Realising Realistic Medicine'. Realistic medicine puts the person receiving health and social care services at the centre of decisions about their care. It recommends a holistic approach, along with aiming to treat the person as an individual rather than treating the conditions that they may have.¹⁹

5.4. The Better Care Fund (BCF)

The Better Care Fund (BCF) programme was set up in 2014, spanning both the NHS and local authorities, to join-up health and care services, in order that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. Rutland's Better Care Fund programme aims to shape more integrated, efficient and effective health and care services which work well for the people of Rutland. This is so that people receive the right care and support at the right time to maintain their health and

wellbeing, staying well for as long as possible, thus preventing, delaying or reducing their need for care. The programme is run jointly by Rutland County Council and East Leicestershire and Rutland Clinical Commissioning Group, and overseen by the Rutland Health and Wellbeing Board.

5.5. A connected society: a strategy for tackling loneliness

Most recently, in recognition of the impact loneliness can have on a person's wellbeing, the government published 'A connected society: a strategy for tackling loneliness' in October 2018. This strategy provides an assessment of the existing evidence and outlines actions to embed loneliness as a consideration across government policy, recognising the wide range of factors that can exacerbate feelings of loneliness and ways to support people's social wellbeing and resilience. It also aims to build a national conversation on loneliness, to raise awareness of its impacts and to help tackle stigma.

5.6. Carer's Strategy (2018 -2021)

Additionally, at a local level across Leicestershire, Leicester and Rutland (LLR) a number of cross agency strategies have been developed. This includes the recently adopted Carer's Strategy (2018 -2021) which seeks to improve services and support for carers through the work that is carried out by NHS, social care and voluntary sector organisations for unpaid carers who are caring for someone that lives in LLR. It outlines eight key priorities to support carers in their caring role and to maintain their own health and wellbeing. It covers all carers: adults, parent carers, young carers and life-long carers. The draft LLR Living Well with Dementia Strategy 2019-2022 is out for consultation. This outlines actions to create a health and social care system that works together so that every person with dementia, their carers and families have access to and receive compassionate care and support not only before diagnosis but after diagnosis and through to end of life.

6. Current Services

6.1. The Rutland Information Service

The Rutland Information Service website is designed to support people to access a wide range of information, advice and support enabling them to help themselves. It also offers a directory for signposting organisations who are working with the public, enabling the public to obtain more consistent referrals information, wherever they go to ask for support.

6.2. The Rutland Community Wellbeing Service

The Rutland Community Wellbeing Service (RCWS) offers support and signposting to help residents of Rutland with a range of health and wellbeing needs. This includes self-help tools, and onwards referral to a variety of community support, through an interactive website (<https://www.rutlandwellbeing.org.uk/>), single telephone number and drop-in services. They provide a wide range of assistance to help people to overcome some of the factors which may have a negative impact on their health and wellbeing, such as poor housing and debt. This includes help to access specialist military/veteran support. RCWS also provides support to help people around a range of lifestyle issues such as stopping smoking, and basic dietary and weight management advice and referral.

6.3. Active Rutland

Active Rutland provides details of all the physical activities and sports available within the county, including those aimed at specific groups such as older people, young people with disabilities and those recovering from injury.

The Exercise Referral Scheme is a programme for adults (16+) with health conditions, who could benefit from increased physical activity. It is a partnership between Public Health, Leicester-Shire and Rutland Sport, local authorities, GP practices and other healthcare professionals. It offers an opportunity for these individuals to exercise in a safe, supervised and structured environment.

Rutland operates a Passport to Leisure scheme which allows specific groups the opportunity to access daytime services and facilities at the local sports centre at a discounted rate, including low income families, students and individuals with a disability or impairment.

6.4. Rutland County Council's Adult Social Care Service

Rutland County Council's Adult Social Care (ASC) Service has a number of specialist teams

covering all aspects of adult social care from both a commissioning and a provider perspective.

The teams are divided into three multi-disciplinary service areas: Prevention and Safeguarding, Long-term Support, and Hospital Discharge and Reablement. All of the teams work on an outcome-focused ethos with the person at the centre, involving and empowering them to take decisions over their own lives at often very difficult times for them and their families. The Hospital Discharge team is a fully integrated team which includes health professionals from the community health provider (Leicestershire Partnership Trust) as well as local authority employed staff. The teams work closely with other professional agencies, GPs and appropriate third sector partners to ensure the best possible outcome for the person concerned and their families.

In addition, Adult Social Care have a reablement team which specialises in helping people back to being independent such as after a hospital stay. The service will support and encourage people in their own homes, facilitating them to stay there as long as possible.

Rutland is one of only two local authorities within the UK to directly employ an Admiral Nurse to support people following a diagnosis of dementia. Services are being restructured to increase provision and support available for dementia.

The local authority commissions services from other sources to assist it with its statutory duties. This includes advocacy services for those who lack capacity and equipment services for occupational therapy and home adaptations.

In addition to adult social care, the local authority commission a number of external providers to deliver residential and nursing care, homecare (domiciliary care), and wider support services, including specific older people's support from Age UK Leicester-Shire and Rutland, via Rutland Access Partnership (a VSCE consortium).

The Council funds a well-established Assistive Technology service provided by Spire Homes and complemented this from October 2017 with a Housing MOT service which offers users a more holistic assessment of their home environment, including for falls prevention, fire safety, energy efficiency and security. The scheme, delivered by Spire Homes, provides an integrated response to housing-related issues that could impact on wellbeing. In its first ten months, 193 visits were undertaken, advising clients, two thirds of whom were aged 75 or over. This contact generated 476 onward referrals to a wide variety of largely preventative services (2.2 referrals per service user visited). Where users have a disability and would benefit from more significant home adaptations costing under £10k e.g. stair-lift, level

access shower, the Housing MOT service can also recommend assessment for a Housing and Prevention grant for home adaptations. This streamlined grant funding approach delivers small-scale adaptations rapidly using DFG funding, increasing the preventative impact of this budget. In the first half of 2018-19, 17 DFG projects were completed including 15 level access showers, 11 stairlifts and 4 access improvements. Anticipated benefits are improved carer sustainability, prolonged independent living in the community and falls prevention.

6.5. Mental health services

Most common mental health problems are appropriately managed in primary care. Mental health services provide support to those 65 and over as well as those under 65. The Let's Talk-Wellbeing (IAPT service) service provides psychological assessment and treatment for mild to moderate common mental health problems. Specialised skilled and accredited practitioners provide psychological therapies (talking therapies) for people experiencing common difficulties including depression, anxiety, panic, phobias, obsessive compulsive disorder (OCD), trauma and stress.

For specialist input for severe mental illness and for those with dementia age 65 and over, referral can be made to 'old age psychiatry' services. Inpatient and community mental health services are provided by Leicestershire Partnership Trust. Further details can be found in the Adult Mental Health chapter of the JSNA.

7. Unmet needs/Gaps

In Rutland, carers who are supported by Rutland County Council are substantially more satisfied with the support they received than the English average. However the proportion of carers accessing support from the Council is about 14% of the estimated total number of people aged 65 and over that are providing unpaid care to a partner, family member or other person in Rutland. This means that there are a large number of older carers who could be accessing alternative sources of support, or who are not accessing or receiving any form or support. This could mean a lack of resilience in that carer's arrangements which could have a substantial impact on the person cared for if the carer became unwell or otherwise unable to continue in their carer role.

Those aged 75-84 and 85+ in Rutland are more likely to be inactive than active, whereas in all other age groups people are more likely to be active than not. It may be that there are people in these older age groups who would wish to, and are able to, be more physically active but who do not have access to appropriate physical activity and exercise opportunities.

In 2018 in Rutland, 56.5% of those patients estimated to have dementia have been diagnosed, which is significantly lower than the national average and the national benchmark. There is room to improve this figure. Doing so will mean that patients, carers, the multidisciplinary healthcare team, as well as healthcare commissioners, are able to plan, deliver and access individual and population level care and services. This in turn could improve the health and care outcomes, including quality of life, of patients with dementia.

8. Recommendations

- Support Rutland residents to remain well, active and connected, and therefore to stay healthy for longer.
- Encouraging and enabling individuals to take a greater role in their own care.
- Promote and develop a social prescribing model, to help address social isolation and loneliness, and to support mental and physical wellbeing.
- Health and care services to work together to develop a holistic approach to Healthy Ageing that treats the patient rather than the separate conditions, reviewing commissioned pathways where relevant and appropriate.
- Health and care services to consider how the system may need to adapt in its processing and use of data to focus on the patient, particularly those with multimorbidities, rather than on separate medical conditions.
- Develop the dementia pathway to increase the proportion of those with living with dementia who have a formal diagnosis, enabling them to access services and support.
- Consider ways to proactively identify carers aged 65 and older, and those caring for people aged 65 and over, in order to provide appropriate support to increase carer resilience.

GLOSSARY OF TERMS

ASC	Adult Social Care
AMD	Age-related Macular Degeneration
CCG	Clinical Commissioning Group
CMDs	Common Mental Health Disorders
DiUPR	Deaths in Usual Place of Residence
DToC	Delayed Transfer of Care
EWD	Excess Winter Deaths
GMS	General Medical Services
JSNA	Joint Strategic Needs Assessment
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
QOF	Quality Outcomes Framework
PHE	Public Health England
RCWS	Rutland Community Wellbeing Service

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