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Rutland County Council

Catmose, Oakham, Rutland, LE15 6HP
Telephone 01572 722577 Email: governance@rutland.gov.uk

Ladies and Gentlemen,

A meeting of the **RUTLAND HEALTH AND WELLBEING BOARD** will be held via Zoom - https://us06web.zoom.us/j/86076102160 on **Tuesday, 11th October, 2022** commencing at **2.00 pm** when it is hoped you will be able to attend.

Yours faithfully

Mark Andrews
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) WELCOME AND APOLOGIES RECEIVED

2) CHAIR'S STATEMENT

To receive a brief update from the Chair on the Integrated Care Partnership and any other matters arising.

3) RECORD OF MEETING

To confirm the record of the meeting of the Rutland Health and Wellbeing Board held on the 12th July 2022.
(Pages 7 - 16)

4) ACTIONS ARISING

To review and update the actions arising from the previous meeting.

No.	Ref.	Action	Person
1.	10	The Chair to notify Board members of the date for the first meeting of the Health and Wellbeing Partnership.	**Councillor S Harvey**

2.	11	The amendments to the update reports would be discussed at the next meeting of the Integrated Delivery Group and the agreed way forward reported back to the Chair and the Strategic Director of Children and Families.	**Sandra Taylor & Debra Mitchell**
3.	15	All members of the Board were requested to complete the consultation on the proposed Rutland Pharmaceutical Needs Assessment. • LEICESTERSHIRE COUNTY & RUTLAND NHS PRIMARY CARE TRUST (lsr-online.org) • PNA Consultation 2022 (leics.gov.uk)	**ALL**
4.	16a	A report on primary care access, diagnostics and outpatients and elective care services was requested to be presented at the next meeting.	**Sarah Prema AGENDA**

5) 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.

6) 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 73.

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.

7) QUESTIONS WITH NOTICE FROM MEMBERS

To consider any questions from Members received under Procedure Rule 75.

8) NOTICES OF MOTION FROM MEMBERS

To consider any Notices of Motion from Members submitted under Procedure Rule 77.

STANDING AGENDA ITEMS

9) JOINT STRATEGIC NEEDS ASSESSMENT: UPDATES & TIMELINE **20 MIN**

a) HEALTH INEQUALITIES IN RUTLAND

To receive Report No. 159/2022 from Mike Sandys, Director of Public Health for Leicestershire & Rutland, LCC
(Pages 17 - 110)

b) END OF LIFE NEEDS ASSESSMENT

To receive Report No. 160/2022 from Mike Sandys, Director of Public Health for Leicestershire & Rutland, LCC
(Pages 111 - 128)

10) LEICESTER, LEICESTERSHIRE & RUTLAND (LLR) INTEGRATED CARE SYSTEM: UPDATE **10 MIN**

To receive Report No. 162/2022 from Sarah Prema, Chief Strategy Officer, LLR ICB
(Pages 129 - 134)

11) JOINT HEALTH AND WELLBEING STRATEGY **10 MIN**

To receive Report No. 164/2022 from Councillor S Harvey, Portfolio Holder for Health, Wellbeing and Adult Care and presented by Katherine Willison, Health and Integration Lead, RCC.
(Pages 135 - 182)

12) BETTER CARE FUND **10 MIN**

To receive Report No. 163/2022 from Councillor S Harvey, Portfolio Holder for Health, Wellbeing and Adult Care and presented by Katherine Willison, Health and Integration Lead, RCC.
(Pages 183 - 212)

13) UPDATE FROM THE SUB-GROUPS **10 MIN**

a) CHILDREN AND YOUNG PEOPLE PARTNERSHIP

To receive an update from Councillor David Wilby, Chair of the Rutland Children and Young People Partnership

b) INTEGRATED DELIVERY GROUP

To receive an update from Debra Mitchell, Deputy Chief Operating Officer, LLR ICB

ADDITIONAL AGENDA ITEMS

14) HEALTH UPDATE — 35 MIN

a) PRIMARY CARE UPDATE

To receive an update from Dr James Burden, Clinical Place Leader, Rutland Primary Care Network to cover:

- Changing Landscape to Primary Care Workforce
- Enhanced Access Plans
- Update on the Outcomes of the Recommendations from the Primary Care Access Task and Finish Group

(Pages 213 - 252)

b) DIAGNOSTICS, OUTPATIENTS AND ELECTIVE CARE SERVICES

To receive an update from Helen Mather, Elective and Cancer Commissioning Lead, LLR ICB.
(Pages 253 - 254)

c) RUTLAND MEMORIAL HOSPITAL: UPGRADES

To receive Report no. 161/2022 from Mark Powell, Deputy Chief Executive, Leicestershire Partnership NHS Trust.
(Pages 255 - 258)

15) WINTER VACCINATION PROGRAMME — 10 MIN

To receive an update from Dr James Burden, Clinical Place Leader, Rutland Health Primary Care Network.
(Pages 259 - 266)

16) COST OF LIVING CRISIS — 10 MIN

To receive updates from Emma Jane Perkins, Head of Community Care Services and Duncan Furey, Chief Executive Officer, Citizens Advice Rutland.

17) REVIEW OF FORWARD PLAN AND ANNUAL WORK PLAN — 5 MIN

To consider the current Forward Plan and identify any relevant items for inclusion in the Rutland Health and Wellbeing Board Annual Work Plan, or to request further information.

The Forward Plan is available on the website using the following link:

https://rutlandcounty.moderngov.co.uk/mgListPlans.aspx?RPId=133&RD=0
(Pages 267 - 268)

18) ANY URGENT BUSINESS

19) DATE OF NEXT MEETING

The next meeting of the Rutland Health and Wellbeing Board will be on Tuesday, 24th January 2023 at 2.00 p.m.

FOR INFORMATION ONLY

20) PHARMACEUTICAL NEEDS ASSESSMENT REPORT

To note the report from Mike Sandys, Director of Public Health.
(Pages 269 - 340)

21) JSNA DEMOGRAPHICS - CENSUS 2021 INITIAL RESULTS

To note the report from Andy Brown, Business Intelligence Team Leader, Public Health
(Pages 341 - 348)

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DISTRIBUTION
MEMBERS OF THE RUTLAND HEALTH AND WELLBEING BOARD:

Name		Title
1.	Samantha Harvey (Councillor) CHAIR	Portfolio Holder for Health, Wellbeing and Adult Care
2.	David Wilby (Councillor)	Portfolio Holder for Education and Children's Services
3.	Dawn Godfrey	Strategic Director of Children and Families (DCS), RCC
4.	Debra Mitchell	Deputy Chief Operating Officer, LLR ICB
5.	Duncan Furey	Chief Executive Officer, Citizens Advice Rutland
6.	Fiona Myers	Interim Director of Mental Health Services, Leicestershire Partnership NHS Trust
7.	Ian Crowe	Armed Forces Representative
8.	James Burden (Dr)	Clinical Place Leader, Rutland Health Primary Care Network
9.	Janet Underwood (Dr)	Chair, Healthwatch Rutland
10.	John Morley	Strategic Director for Adults and Health (DASS), RCC
11.	Lindsey Booth (Insp)	NPA Commander Melton & Rutland, Leicestershire Police
12.	Louise Platt	Executive Director of Care and Business Partnerships, Longhurst Group
13.	Mark Powell	Deputy Chief Executive, Leicestershire Partnership

		NHS Trust
14.	Mike Sandys	Director of Public Health for Leicestershire & Rutland, LCC
15.	Sarah Prema	Chief Strategy Officer, LLR ICB
16.	Simon Barton	Deputy Chief Executive, UHL NHS Trust
17.	Steve Corton	Ageing Well Team Support, NHS England - Midlands

OFFICERS ATTENDING

Name		**Title**
18.	Adrian Allen	Head of Service Design & Delivery, Public Health
19.	Jane Narey	Scrutiny Officer, RCC
20.	Katherine Willison	Health and Wellbeing Integration Lead, RCC

FOR INFORMATION

Name		**Title**
21.	Angela Hillery	Chief Executive, Leicestershire Partnership NHS Trust

Rutland County Council

Catmose Oakham Rutland LE15 6HP
Telephone 01572 722577 Email: goverance@rutland.gov.uk

Minutes of the **MEETING of the RUTLAND HEALTH AND WELLBEING BOARD** held in the Council Chamber, Catmose, Oakham LE15 6HP on Tuesday, 12th July, 2022 at 2.00 pm

PRESENT

1.	Councillor Sam Harvey (Chair)	Portfolio Holder for Health, Wellbeing and Adult Care
2.	David Wilby (Councillor)	Portfolio Holder for Education and Children's Services
3.	Dawn Godfrey	Strategic Director of Children and Families (DCS), RCC
4.	Debra Mitchell	Deputy Director Integration & Transformation, ICS
5.	Ian Crowe	Armed Forces Representative
6.	Janet Underwood (Dr)	Chair, Healthwatch Rutland
7.	John Morley	Strategic Director for Adults and Health (DASS), RCC
8.	Mike Sandys	Director of Public Health for Leicestershire & Rutland, LCC
9.	Sarah Prema (rep. Andy Williams)	Executive Director of Strategy and Planning, ICS

APOLOGIES:

10.	Andy Williams	Joint Chief Executive, ICS
11.	James Burden (Dr)	Clinical Director, Rutland Health Primary Care Network
12.	Lindsey Booth (Insp)	NPA Commander Melton & Rutland, Leicestershire Police
13.	Louise Platt	Executive Director of Care and Business Partnerships, Longhurst Group
14.	Mark Powell	Deputy Chief Executive, Leicestershire Partnership NHS Trust
15.	Mel Thwaites	Associate Director: Children and Families, ICS

ABSENT:

16.	Duncan Furey	Chief Executive Officer, Citizens Advice Rutland
17.	Fiona Myers	Interim Director of Mental Health Services, Leicestershire Partnership NHS Trust
18.	Steve Corton	Ageing Well Team Support, NHS England - Midlands

OFFICERS PRESENT:

19.	Jane Narey	Scrutiny Officer, RCC

20.	Sandra Taylor	Health and Wellbeing Integration Lead, RCC
21.	Vivienne Robbins	Consultant in Public Health, RCC
22.	Andy Brown	Business Intelligence Team Leader
23.	Hannah Blackledge	Public Health Intelligence Lead
24.	Angela Culleton	Interim Head of Safe and Active Public Realm, RCC

IN ATTENDANCE:

25.	Councillor P Browne	County Councillor

1 WELCOME AND APOLOGIES RECEIVED

The Chair welcomed everyone to the meeting. Apologies were noted from Lindsey Booth (Inspector), Mark Powell, James Burden (Dr), Andy Williams, Louise Platt, Melanie Thwaites

2 CHAIR'S STATEMENT

The Chair read out her written statement and confirmed that a copy would be attached to the minutes.

3 ELECTION OF A VICE CHAIR

- The Chair nominated Dr James Burden in his absence for the role of Vice Chair.
- There were no other nominations.

RESOLVED
That the Board:

a) **APPROVED** Dr James Burden as the Vice Chair for the Rutland Health and Wellbeing Board for the municipal year 2022/2023 on the provision that he accepted the nomination.

4 RECORD OF MEETING

The minutes of the Rutland Health and Wellbeing Board meeting held on the 5th April 2022 were approved as an accurate record.

5 ACTIONS ARISING

Action 1
The Chair requested that by the next Health and Wellbeing Board meeting in July 2022, the Place Led Delivery Plan was updated for the first year and that the sub-groups had identified their work-streams, named their work-streams and taken ownership of their work-streams.
The Chair confirmed that this action would be picked up the relevant agenda item.

6 DECLARATIONS OF INTEREST

There were no declarations of interest.

7 PETITIONS, DEPUTATIONS AND QUESTIONS

The Clerk confirmed that a deputation had been received from Mrs Jennifer Fenelon on behalf of the Rutland Health & Social Care Policy Consortium. The deputation had been approved by the Chief Executive and the Monitoring Officer and had been added to the website and circulated to committee members in advance of the meeting.

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Mrs Fenelon joined the meeting at 2.18 p.m.

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- Mrs Fenelon addressed the Board with the details of her deputation.
- To move from a broad strategy to a defined implementation plan, a process needed to be identified so that the correct conclusions could be identified.
- A dedicated resource e.g. officer time to focus on co-production and understanding the gaps within the proposal would be beneficial.
- The Chair re-iterated that the Board continued to work in close collaboration with stakeholders such as Rutland Healthwatch as part of the Integrated Delivery Board to ensure that the voice of residents was heard in such matters as community healthcare and integrated services.

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Mrs Fenelon left the meeting at 2.28 p.m.

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8 QUESTIONS WITH NOTICE FROM MEMBERS

There were no questions from members.

9 NOTICES OF MOTION FROM MEMBERS

There were no notices of motion from members.

10 LEICESTER, LEICESTERSHIRE & RUTLAND (LLR) INTEGRATED CARE SYSTEM: UPDATE

A presentation was received from Andy Williams, Chief Executive, Integrated Care System (ICS) and was presented by Sarah Prema, Executive Director of Strategy and Planning, ICS. During the discussion, the following points were noted:

- The Clinical Care Group ceased to exist on the 30th June 2022.
- The Integrated Care Board (ICB) came in to effect on the 1st July 2022.
- As from the 1st April 2023, the ICB will take on the delegated authority for direct commissioning (pharmacy, optometry and dental services) and for other specialised commissioning services.
- The Health and Wellbeing Partnership (HWP) held their first workshop, which was well received.
- Terms of Reference would need to be approved at the inaugural meeting of the HWP before a discussion could be held regarding extending the membership to include representatives from Children's Services as well as Adult Services.
- Extended workshops could be held in addition to the formal meetings of the HWP.

- The Board thanked Sarah and her colleagues for all their hard work in the creation of the new service and it was noted that the Chair would notify Board members of the date for the first meeting of the HWP.

ACTION: Councillor S Harvey

11 JOINT HEALTH AND WELLBEING STRATEGY: PLACE LED DELIVERY PLAN

Report No. 131/2022 was presented by Sandra Taylor, Health and Wellbeing Integration Lead, RCC. During the discussion, the following points were noted:

- The Social Prescribing Platform and the Shared Care Record had been created to improve collaboration.
- The Primary Care Network (PCN) was recruiting additional pharmacists, who could diagnose and prescribe so increasing the support to the service.
- The JHWS Update Reports shown in Appendix A were reviewed to ensure that they gave the Board sufficient information and that outcomes fed into the delivery plan.
- It was noted that a dual RAG rating system was needed. The first would be to measure the current progress of the item. The second would be to measure where the item was against the delivery plan indicators.
- A simpler more public facing document was requested as the current format was felt to be complicated and incredibly detailed when just the headlines were needed.
- It was proposed that an update should be given at the next meeting on the changing landscape of primary care, the diagnostic provision and the care services close to home.
- The amendments to the update reports would be discussed at the next meeting of the Integrated Delivery Group and the agreed way forward reported back to the Chair and the Strategic Director of Children and Families.

ACTION: Sandra Taylor and Debra Mitchell

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The Chair paused the meeting at 3.20 p.m.
The Chair re-started the meeting at 3.25 p.m.

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- The Draft Health and Wellbeing Communications and Engagement Plan shown in Appendix D was discussed.
- A working group that included Healthwatch Rutland had been created to produce a collaborative communication and engagement plan.
- A period of engagement, with members of the public, stakeholders and the workforce, was required to enrich the plan as the public needed to be at the forefront of all communication.
- Resources were limited but dedicated resources could be allocated to maximise the potential of the communications and engagement plan.

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Sandra Taylor left the meeting at 3.41 p.m.

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- A weekly newsletter was proposed that would update the public on what had been achieved and what was being done.

- All communication needed to be co-ordinated and sent via a one-stop-shop for all information regarding the JHWS.

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Sandra Taylor re- joined the meeting at 3.44 p.m.
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RESOLVED
That the Board:

a) **NOTED** the further development of the JHWS Delivery Plan coinciding with the July transition to the Integrated Care System, and the summary of progress to date.
b) **ENDORSED** the direction of travel of the associated Communications and Engagement plan and **APPROVED**:

- public engagement to enhance and refine that plan; and
- as the plan was not cost neutral, the development of an options appraisal addressing what could be achieved under the plan with different levels of resourcing.

12 BETTER CARE FUND

Report No. 130/2022 was presented by Sandra Taylor, Health and Wellbeing Integration Lead, RCC. During the discussion, the following points were noted:

- The policy and planning guidance for this year's Better Care Fund (BCF) was expected imminently.
- Only minor amendments were being made to the current plan.
- A BCF two-year program was being proposed for 2023-2025 with planning guidance expected this financial year.
- Funding has been raised by a small inflationary increase but costs continued to rise.

RESOLVED
That the Board:

a) **NOTED** the Rutland 2021-22 Better Care Fund end of year return, whose submission to the BCF national team on 27 May was signed off by the HWB Chair.
b) **NOTED** the update on the 2022-23 programming period.
c) **AGREED** to delegate the decision regarding the BCF planning for 2023-2025 to the Chair of the Health and Wellbeing Board and the Strategic Director of Adult Services.

13 UPDATE FROM THE SUB-GROUPS:

a) <u>CHILDREN AND YOUNG PEOPLE PARTNERSHIP</u>

An update was received from Councillor D Wilby and the Strategic Director of Children and Families. During the discussion, the following points were noted:

- Virtual meetings of the partnership had helped with the attendance at meetings.

- The recommissioning of the 0-19 Healthy Child Programme had been successful and recruitment to the new posts was ongoing.
- Grant funding for the Reducing Parental Conflict Programme had been received for a further 2 years.
- A Programme Manager was now in place to support the Family Hub and would be funded for 1-year. No funding was available for the delivery of the Family Hub but an update would be given at the next meeting.
- Increased secondary mainstream plus provision for children with SEND would begin at Uppingham Community College in September 2022.

b) INTEGRATED DELIVERY GROUP

An update was received from Debra Mitchell, Deputy Director Integration & Transformation, ICS. During the discussion, the following points were noted:

- The Group had improved the way partners worked together and this integration work would continue.
- The Strategic Health Development Group had been established regarding the health work as part of the JHWS.
- It was proposed that the JHWS update reports (as detailed in Appendix A of Report No. 131/2022) would be included as part of the updates from the Children and Young People Partnership and the Integrated Delivery Group at future HWB meetings and not be listed as a separate agenda item.
- Quarterly performance data from the ICS was presented to the Strategic Overview and Scrutiny Committee and it was proposed that an annual performance data report should also be presented to the Health and Wellbeing Board to identify future actions.

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Councillor P Browne left the meeting at 4.19 p.m.

---oOo---

14 JOINT STRATEGIC NEEDS ASSESSMENT: SCOPE AND PLAN

Report No. 132/2022 was presented by Andy Brown, Business Intelligence Team Leader and Hannah Blackledge Public Health Intelligence Lead. During the discussion, the following points were noted:

- The Joint Strategic Needs Assessment (JSNA) underpins local planning for health services and was last published in 2018.
- It was proposed to develop dashboards for the key information for Rutland on a regularly refreshed basis, with more in-depth reports and summaries of key topic areas for the Board, as required.
- Preparing for Population Growth: census data would need to include proposed housing figures. Population growth in Rutland would be a key issue.
- Equitable Access to Services: would need to ensure that work was not duplicated across the partnership.
- It was noted that Rutland does have areas of deprivation even though they would not register as such against the standard deprivation measurements.
- Proposed that the JSNA would become a rolling 3-year programme rather than a final document that was out of date as soon as it was published.

- A deep-dive exercise was suggested on the impact of Covid on very young children. Reports were being received from education sector about the effect on very young children's social interaction skills and development. Higher numbers of children in Rutland were being diagnosed with autism and social, emotional and mental health needs.
- Neonatal and still birth figures and oral health figures were also suggested for deep-dive exercises.
- A timeframe for the JSNA was requested for October and that an annual workshop should be arranged (date to be confirmed) to monitor the progress of the Place Led Plan and to ensure that the JSNA linked to the JHWS, as previously discussed at the Board meeting on the 22nd February 2022.

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Hannah Blackledge joined the meeting at 4.25 p.m.
---oOo---

RESOLVED
That the Board:

a) **NOTED** and commented on the suggested approach to the JSNA development.
b) **SUGGESTED** priority areas for the JSNA.
c) **NOTED** the latest Census 2021 timescale update and that data releases would be useful for elements of the chapters.
d) **NOTED** the supporting analytical work which had been progressed on the Pharmaceutical Needs Assessment, Health Inequalities and End of Life.

---oOo---
Viv Robbins left the meeting at 4.37 p.m.
---oOo---

15 RUTLAND PHARMACEUTICAL NEEDS ASSESSMENT

Report No. 135/2022 was presented by Andy Brown, Business Intelligence Team Leader. During the discussion, the following points were noted:

- The Rutland Pharmaceutical Needs Assessment was out for consultation until the 21st August 2022:
    - LEICESTERSHIRE COUNTY & RUTLAND NHS PRIMARY CARE TRUST (lsr-online.org)
    - PNA Consultation 2022 (leics.gov.uk)

- The final document would be produced after the consultation and would be presented to the Board at the next meeting on the 11th October 2022.
- There was a national shortage of pharmacists.
- A programme was in progress to train pharmacists to diagnose and prescribe.
- Pharmacies had successfully extended their offer over recent years and were meeting the needs of the Rutland population.
- All feedback and comments were welcome.
- All members of the Board were requested to complete the consultation.

ACTION: All

RESOLVED
That the Board:

a) **NOTED** the work undertaken to produce the draft Pharmaceutical Needs Assessment (PNA) 2022, which had been developed in line with the findings of the public and pharmacy surveys.
b) **COMMENTED** on the draft PNA which was out for consultation, to inform the final document.
c) **NOTED** that a further draft would be circulated to the Board prior to 1 October 2022 detailing the outcome of the consultation and seeking approval of the final PNA.

---oOo---
Andy Brown and Hannah Blackledge left the meeting at 4.49 p.m.
---oOo---

16 RUTLAND MEMORIAL HOSPITAL

a) HEALTH PLAN UPDATE

A presentation was received from Sarah Prema, Executive Director of Strategy and Planning, ICS. During the discussion, the following points were noted:

- Work was well underway for the next steps for local healthcare in Rutland.

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Angie Culleton joined the meeting at 4.51 p.m.
---oOo---

- It was noted that a report on primary care access, diagnostics and outpatients and elective care services was requested to be presented at the next meeting.

AGENDA

- A strategic assessment of Rutland Memorial Hospital would be undertaken but it would continue to be part of the healthcare plan.

b) THE LEVELLING UP FUND

Report No. 127/2022 was presented by Angie Culleton, Interim Head of Safe and Active Public Realm. During the discussion, the following points were noted:

- The report outlined the proposed joint bid for funding with Melton Borough Council.
- The joint funding bid was for £15 million and this was approved by Cabinet on the 14th June 2022.
- It was proposed that part of the funding would create a Health Innovation Centre. This would be a DigiTech/MediTech and clinical innovation centre operating as a managed workspace facility (c£6 million).
- Development options of the DigiTech Centre were being scoped at The Kings Centre and at Rutland Memorial Hospital (RMH).
- Deadline for the submission bid was the 6th July 2022.

RESOLVED
That the Board:

a) **NOTED** the submission of a joint application by Rutland County Council and Melton Borough Council for Round 2 of Levelling Up Funding, in line with the Councils Constitution Financial Procedure Rules.
b) **NOTED** that the joint application was submitted on the basis that a detailed discussion regarding funding including any ongoing financial implications would be required should the Council be successful in securing the bid. Any discussions would result in a Full Council decision to accept or reject funding offered.

17 REDUCING HEALTH INEQUALITIES - CORE20PLUS5

Report No. 133/2022 was presented by Sarah Prema, Executive Director of Strategy and Planning, ICS. During the discussion, the following points were noted:

- Funding would be available for the plus population to support the reduction of health inequalities.
- The Board would need to agree which Rutland population cohort, who experienced health inequalities, would require the initial focus to be on.

RESOLVED
That the Board:

a) **NOTED** the report.
b) **DELEGATED** the further work to agree an initial focus on a Rutland population cohort(s) who already experience health inequities – a plus cohort of the Core20Plus5 approach - to the Chair of the Health and Wellbeing Board, the Director of Public Health and the Clinical Director for Rutland Primary Care Network.

18 REVIEW OF FORWARD PLAN AND ANNUAL WORK PLAN

The work plan was discussed an updated accordingly.

19 ANY URGENT BUSINESS

The Chair informed attendees that this would be Sandra Taylor's last meeting as she would be going on secondment to the ICS. Members thanked Sandra for all her hard work and support and wished her well in her new seconded role.

20 DATE OF NEXT MEETING

Tuesday, 11th October 2022 at 2.00 p.m.

SUMMARY OF ACTIONS

No.	Ref.	Action	Person
1.	10	The Chair to notify Board members of the date for the first meeting of the Health and Wellbeing Partnership.	**Councillor S Harvey**

2.	11	The amendments to the update reports would be discussed at the next meeting of the Integrated Delivery Group and the agreed way forward reported back to the Chair and the Strategic Director of Children and Families.	**Sandra Taylor & Debra Mitchell**
3.	15	All members of the Board were requested to complete the consultation on the proposed Rutland Pharmaceutical Needs Assessment. • LEICESTERSHIRE COUNTY & RUTLAND NHS PRIMARY CARE TRUST (lsr-online.org) • PNA Consultation 2022 (leics.gov.uk)	**ALL**
4.	16a	A report on primary care access, diagnostics and outpatients and elective care services was requested to be presented at the next meeting.	**Sarah Prema AGENDA**

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Chairman closed the meeting at 5.04 pm**.**

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Report No: 159/2022
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

11 October 2022

HEALTH INEQUALITIES IN RUTLAND

Report of the Director of Public Health

Strategic Aim:	Healthy and well	
Exempt Information	No	
Cabinet Member(s) Responsible:	Cllr S Harvey, Portfolio Holder for Health, Wellbeing and Adult Care	
Contact Officer(s):	Mike Sandys, Director of Public Health	Telephone: 0116 3054239 Email: mike.sandys@leics.gov.uk
	Mitch Harper, Public Health Strategic Lead (Rutland)	Telephone: 0116 3050913 Email: mitchell.harper@leics.gov.uk
Ward Councillors		

DECISION RECOMMENDATIONS

That the Committee:

1. Notes the report findings and approves publication of the needs assessment on the Rutland Joint Strategic Needs Assessment (JSNA) website.

2. Approves development of a Health and Wellbeing Board development session on health inequalities with a deep dive on needs assessment findings (Appendix A) and further discussion on the report recommendations set out in Appendix C.

1 PURPOSE OF THE REPORT

1.1 This report shares the findings from a Rutland Health Inequalities Needs Assessment, developed by the Local Authority Public Health team with partners. The requirement for a health inequality needs assessment forms part of the Rutland Health & Wellbeing Strategy delivery plan. The purpose is to increase the collective understanding of health inequalities across Rutland and propose recommendations for equitable action.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The Joint Strategic Needs Assessment (JSNA) is a process which assesses the current and future health and wellbeing needs of the population and underpins local planning for health and care services, in particular the development of the Joint Health and Wellbeing Strategy. It involves working with local partners to ensure a broad approach to issues affecting health, including key social and economic determinants of health, where appropriate. Since 2013, the statutory responsibility for the development of the JSNA lies with the local Health and Wellbeing Board.

2.2 The 'Update on Joint Strategic Needs Assessment (JSNA)' paper from the July 12th, 2022, Health and Wellbeing Board outlined a plan for upcoming analysis, including requirements for 'Health Inequalities in Rutland'.

2.3 The needs assessment aims to explore healthy inequalities and deprivation across Rutland, including variation across small areas and population groups. Focus is on the four overlapping dimensions of health inequalities: socioeconomic groups and deprivation; geography; inclusion health and vulnerable groups; and protected characteristics in the Equality Duty.

2.4 Data looks at lower super output areas within Rutland, defined as areas having populations between 1,000 – 3,000. Mapping is provided for these areas in appendix B. Parts of the report include Census data. As the majority of Census 2021 data is yet to be released, some inclusions are from Census 2011. Once all data from Census 2021 has been released (likely throughout 2023), a minor update will be included for the areas referencing Census 2011.

2.5 There are several supporting documents to this report within the appendices. Appendix A presents the full Rutland Health Inequalities Needs Assessment, with an accompanying executive summary. Appendix B includes supporting mapping not included in the main report. Appendix C outlines an initial set of recommendations to consider for tackling health inequalities across Rutland, mapping against the Rutland Health and Wellbeing Strategy priorities.

3 SUMMARY FINDINGS FROM EACH SECTION IF THE NEEDS ASSESSMENT

3.1 A brief summary of the needs assessment findings for each of the four dimensions of health inequalities is below from point 3.2 – 3.5. As an example, **life expectancy from birth was 3.9 years lower for males in the most deprived areas of Rutland**, compared to least deprived in 2020/21. **For females it was 4.9 years lower**. However, on average, life expectancy in Rutland was still higher than the England average for males and females.

3.2 **Section 1 (socio-economic and deprivation)** – Rutland performs better than regional and national comparators for most economic deprivation indicators. However, there is still considerable variation within Rutland. For example, in 2020/21, children living in relative low-income families before housing costs ranged from 3% in an area of Ketton, to 15% in Cottesmore, 14% in Whissendine and 13% in Exton. Fuel poverty, benefit support and indices of deprivation are also explored.

The section also explores service demand, including Rutland Foodbank. The number of meals provided by Rutland Foodbank has significantly increased from 5,686 in 2015/16 to 42,525 in 2020/21. This may have continued to increase with the cost of living pressures.

3.3 **Section 2 (rurality and access)** – As expected, Rutland has a high proportion of its population living in areas classified as 'rural villages & dispersed households'. Looking at access to primary care, Whissendine and Braunston & Belton are most distant when looking solely at time taken to travel by car or public transport. The most accessible acute hospitals by time taken to drive alone are outside LLR (Peterborough City Hospital, Kettering Hospital and Grantham & District Hospital).

Digital exclusion is explored in this section too, showing digital skills are worse for people with mental health, learning, memory, physical or sensory impairments nationally. The Digital Exclusion Risk Index suggests Langham 002A, Ketton 004A and Martinsthorpe 005C have the highest risk for digital exclusion, based on deprivation, demography and connectivity.

3.4 **Section 3 (inclusion health and vulnerable groups)** – Carers, homelessness, prison population and Gypsy, Roma & Traveller communities are explored here, all of which typically experience poorer health outcomes than the general population, related to life expectancy, physical and mental health. 85 Rutland households (4.5 per 1,000) were owed a homelessness prevention or relief duty in 2020/21, lower than the England average (11.3 per 1,000). Estimated population sizes are provided in the needs assessment for Rutland.

Although not an inclusion health group, inequality within the armed forces community is also explored given the large proportion of Serving Personnel and Veterans. National and local insight suggests there are signs of some inequality within the armed forces community, particularly for female veterans' mental health and social relationships.

3.5 **Section 4 (protected characteristics in the Equality Duty)** – Rutland has a significantly higher proportion of people aged 65+ (25.1%) and 80+ (7.1%) than England. The 80+ population is projected to increase by 80% in 2040, from 2,819 residents in 2020 to 5,074 in 2040. For aged 65+, estimates indicate Rutland performs significantly worse on dementia diagnosis and excess winter deaths.

Evidence shows poorer health outcomes across all disabilities and lower levels of healthy behaviours. For example, 50% of Rutland residents with a disability or long term health condition reported being inactive (less than 30 minutes a week), compared to 17.1% without a disability or long term health condition. Sight loss is estimated to be more prevalent in Rutland (4.2%) than the England average (3.2%).

Other protected characteristics are also explored, although the level of data currently available may be limited.

4 REPORT RECOMMENDATIONS

4.1 Recommendations to address health inequalities within Rutland are set out in appendix C, showing alignment with the Rutland Health & Wellbeing Strategy and current position. The recommendations are initially set based on the findings in the needs assessment. They do however need further consideration and engagement to determine the suitability. The proposed recommendation for the Board to consider a development session on health inequalities would explore the specific report recommendations in greater detail.

5 CONSULTATION

5.1 A range of stakeholders across Rutland have been consulted throughout development of the report. A steering group was formed to ensure stakeholders could regularly input and feedback on the scope and progress.

5.2 Outcomes from recent consultations were utilised to identify priorities for the report, including engagement during the development of the Rutland Health & Wellbeing Strategy 2022-27.

6 ALTERNATIVE OPTIONS

6.1 JSNA development is a statutory requirement. As 'reducing health inequalities' is a cross-cutting priority in the Rutland Health & Wellbeing Strategy, a needs assessment is the most evidence-based approach to developing insight.

7 FINANCIAL IMPLICATIONS

7.1 Completion of the needs assessment was within existing capacity within the Rutland Public Health team and partners' support. Whilst the report findings do not carry any financial implications, recommendations to be considered for addressing health inequalities may need resource to deliver. The report recommendation for a development session will allow for more detail to be developed before any recommendations are taken forward.

8 LEGAL AND GOVERNANCE CONSIDERATIONS

8.1 The JSNA is a statutory document and must meet the requirements for production of such documents. It must be approved by the Health and Wellbeing Board.

9 DATA PROTECTION IMPLICATIONS

9.1 All data presented is anonymised and only available at population level to avoid any data confidentiality issues.

10 EQUALITY IMPACT ASSESSMENT

10.1 An Equality Impact Assessment (EqIA) has not been completed; however the report aims to highlight inequality across the protected characteristics and vulnerable groups. This led to recommendations to improve health outcomes for these populations and provide more inclusivity

11 COMMUNITY SAFETY IMPLICATIONS

11.1 Not applicable.

12 HEALTH AND WELLBEING IMPLICATIONS

12.1 The report enhances our awareness of health inequalities in Rutland, leading to more informed decision making on improving health and wellbeing for all. Recommendations will aim to improve health and wellbeing outcomes for those most in need.

13 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

13.1 The report aimed to enhance collective understanding of health inequalities within Rutland. The scope was large and the needs assessment in appendix A covers a

lot of detail, resulting in the recommendation for a development session. The Board is asked to note the report findings and approve the requirement for a development session, allowing for a deeper dive on findings and further develop recommendations to address inequality outlined initially in Appendix C.

14 BACKGROUND PAPERS

14.1 There are no additional background papers to the report

15 APPENDICES

15.1 Appendix A – Rutland Health Inequalities Needs Assessment

15.2 Appendix B – Supporting mapping

15.3 Appendix C – Rutland Health Inequalities Needs Assessment recommendations

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RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT

HEALTH INEQUALITIES NEEDS ASSESSMENT

October 2022

Strategic Business Intelligence Team

Leicestershire County Council

Rutland County Council

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

Public Health Intelligence

Strategic Business Intelligence Team
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Contents

Executive Summary

Rutland generally performs better than national averages on most health outcomes. However, inequality and deprivation can often be masked for rural areas when looking at a whole population. This report aims to identify some of this inequality and deprivation across small geographical areas in Rutland, inclusion health groups and vulnerabilities. Recommendations will be provided on equitable solutions, providing support proportionate to need.

Notes:

1. Some data presented include caveats or limitations, which are explained in the main report.
2. An updated version will be produced in 2023, including yet to be released Census 2021 data.
3. Lower Super Output Area (LSOA) is an area with a population typically between 1,000 - 3,000 residents. Maps of each Rutland LSOA is within the appendix.

Section 1 – economic need and deprivation (pages 13-25)

- In 2020/21, **life expectancy was 3.9 years lower for males in the most deprived areas of Rutland,** compared to least deprived. **For females it was 4.9 years lower**. On average, life expectancy was still higher than the England average for males and females.
- Whilst data is the latest available, the cost-of-living increases heading into winter 2022 are likely to result in underestimates. Additional pressures are likely to impact most households at varying levels. **The most impacted will likely be the areas of greatest economic disadvantage before additional pressures.**
- Rutland has an estimated 17.6% of **children living in poverty** after housing costs (2019/20).
- In 2020/21, Cottesmore 001A (14.9%), Whissendine 002D (13.8%) and Exton 001B (13.4) have the highest proportion of **under 16's in relative low-income families across Rutland before housing costs**; however, all were below the East Midlands average (16.1%).
- In May 2022, Oakham North East 003B (10.6%) and Uppingham 005F (10.6%) had the greatest proportion of **residents on Universal Credit in Rutland**, greater than the East Midlands average (10.0%).
- Estimates from 2020 show the LSOAs in Rutland with the highest proportion of **households in fuel poverty** are Ketton 004A (18%), Cottesmore 001A (16.2%), Lyddington 005B (15.9%) and Normanton 001D (15.8%), greater than the East Midlands average (14.2%). Studies predict half of UK households to be in fuel poverty by January 2023.
- The 2019 **'Barriers to Housing & Services'** Indices of deprivation domain (the physical and financial accessibility of housing and local services) shows **6 out of 23 LSOAs in the most disadvantaged 10% nationally** (Exton 001B, Greetham 001C, Martinsthorpe 005C, Ketton 004B, Lyddington 005B and Braunston & Belton 005A).
- **Urban areas of Rutland are more engaged with income support services** (Citizens Advice, Foodbank). They have higher population sizes, however the report shows **some rural areas have greater proportions of need.**
- **Rutland Foodbank use has been steadily increasing since 2017, with significant increases throughout the COVID-19 pandemic.** In 2015/16, 652 adults and children were provided with meals, rising to 2,025 in 2020/21. Note: some residents provided with meals could be repeats and doesn't equate to unique individuals.

- **Rutland distributed a higher proportion of meals per population in 2021/22** (4.5%) compared to East Midlands (2.6%) and England (3.2%). This is based on Trussell Trust foodbanks and doesn't account for independent use. Cross border use may also skew data.

Section 1 recommendations

1. Support available within the community to provide targeted provision to the most rural areas of Rutland identified with higher economic need and more distant from support.

Section 2 – Rurality and access

- 2020 population estimates show a significantly **higher proportion of adults aged 65 years and over living in rural villages and dispersed households** (37%) than the England average (10%). Similarly, there was a **higher proportion of adults aged 80 and over** within Rutland (32%) than the England average (12%).

Access to Primary Care (p.28-29)

- For time taken to drive and time taken by public transport, rural villages & dispersed households are further from primary care for drive time. **Most distant by driving time are Whissendine 002D and Braunston & Belton 005A.**

Access to hospitals (p.30-31)

- **The most accessible acute hospitals by time taken to drive are outside LLR** (1. Peterborough City Hospital, 2. Kettering General Hospital, 3. Grantham & District Hospital).

Digital exclusion and health literacy (p.33-36)

- The modelled estimated prevalence of **low health literacy in the Rutland population aged 16-64 is 30.5%,** lower than the national average of 40.6%, but still significant.
- The Digital Exclusion Risk Index suggests **Langham 002A, Ketton 004A and Martinsthorpe 005C have the highest risk for digital exclusion**, based on deprivation, demography and connectivity.
- Pockets of dispersed households and villages with speed less than 10mbps – **around Little Casterton, Greetham, Stretton, Brooke and Ridlington**.
- Although data isn't available locally, research indicates those with an **impairment are 28% less likely to have the digital skills needed for daily life.**
- **Digital skills lower** for those with **mental health, learning, memory, physical and sensory impairments** nationally.
- **Lower proportion of aged 75+ using the internet** than other age groups (54% v approx. 90%).

Rural farming communities (p.37-38)

- **Loneliness and isolation are common in rural farming communities**, contributing to mental health problems, negative impact on relationships and lack of healthcare/community access.
- Limited local insight on the health and wellbeing of rural farming communities.

Section 2 recommendations

2. Targeted engagement with Whissendine 002D and Braunston & Belton 005A to develop understanding of potential barriers to accessing primary care and whether they are at

greater disadvantage than other areas. Both areas are most distant from GP practices by time to travel and barriers may be hidden in GP/PCN wide engagement.

3. Ensure services are prioritising cross border working with neighbouring ICS to maximise opportunity for people to access support closest to home. For example, working with cross boundary ICS on access to acute hospital services.
4. Provide targeted digital skills programmes for population groups most in need, alongside universal provision. Identified in the report are people with mental health, learning, memory, physical and sensory impairments.
5. Engage with local farming organisations and communities to develop local understanding and consider the farming report recommendations on relieving loneliness.

Section 3 – Inclusion health and vulnerable groups

Armed forces community (p.39-42)

- As of 2017, **Rutland had a veteran population of an estimated 4,000**, which is the largest proportion of 16+ residents (14%) across all Great Britain counties. **Local estimates indicate this will be much higher, possibly up to 12,000.**
- National and local insight suggests there are signs of some inequality within the armed forces community, **particularly for female veterans' mental health and social relationships.**

Carers (p.43-44)

- COVID-19 significantly impacted Carers, with an **estimated 26% of the national population providing care during the pandemic.** Applying this estimate to Rutland, approximately 11,000 people *may* have been providing care, although this is thought to have decreased.
- **Carers reported poorer outcomes in mental health, social isolation, long term conditions, disability, finances, physical activity and illness** than the general population.

Homelessness (p.44-45)

- **85 Rutland households (4.5 per 1,000) were owed a homelessness prevention or relief duty in 2020/21**, lower than the England average (11.3 per 1,000).
- Homelessness has a negative impact on both physical mental health and other aspects of life, often leading to **significantly shorter life expectancy (up to 30 years shorter).**
- Homelessness often has multiple causes. **Rutland residents predominantly identified breakdowns in relationships and domestic abuse as the main contributing factors.**
- **Single parents and single adults were often most at risk.**

Gypsy, Roma and Traveller communities (p.45-46)

- Gypsy, Roma and Traveller communities often have poorer health outcomes, and access to health services than the general population, with Traveller sites within Rutland.

Section 3 recommendations

6. Develop new insight for the armed forces community in Rutland, covering the impact of COVID-19, female veterans and mental health.
7. Respond to findings from the LLR Carers Strategy consultation before determining specific recommendations for Rutland.

8. Respond to findings from the commissioned Gypsy, Traveller and Travelling Showpeople Accommodation Assessment.

Section 4 – Protected characteristics

Age (p.48-50)

- As of 2021, **Rutland has a significantly higher proportion of the population aged 65 and over (25.1%),** compared to England (18.4%) and East Midlands (19.5%).
- **Rutland also has a greater proportion aged 80 and over (7.1%)** compared to East Midlands (5.0%) and England (5.0%).
- This is projected to **continue growing up to 2040**, with an **80% increase in people aged 80 and over** from a 2020 baseline (2,819 people in 2020 to 5,074 in 2040).
- Estimates for **dementia diagnosis** and **excess winter deaths in people aged 65 and over** are **significantly worse** than national averages.

Disability (p.51-53)

- **Health outcomes are poorer across all physical and learning disabilities than the general population**, including life expectancy, perceived wellbeing, obesity and physical inactivity.
- **The median age of death for people with Learning Disabilities for Leicester, Leicestershire and Rutland (LLR) was 59** and nationally the median age was 62.
- **50.2% of Rutland residents with a disability or long-term health condition reported being inactive** (less than 30 minutes a week), **higher than regional and national comparators**. 17.1% of residents without a disability or long-term condition reported being inactive.
- **Sight loss is estimated to be more prevalent in Rutland (4.2%) than the England average (3.2%).**

LGBTQ+ (p.54-55)

- **LGB adults** were more likely to have a longstanding **mental health illness, be a current smoker and drink harmful levels of alcohol**.

Section 4 recommendations

9. Ensure health and wellbeing implications of the population projections for older age groups are embedded into the Local Plan and other long-term strategies.
10. Consider deeper dives on dementia diagnosis and excess winter deaths.
11. The specific access barriers for people with learning disabilities and/or sensory impairments should be factored into all service plans.
12. Consider the LGBT national survey recommendations to improve access and personalised support for mental health, smoking cessation and substance misuse.

Introduction

Why do we need to focus on health inequalities in Rutland?

Overall Rutland in an affluent county that performs well in term of health outcomes. However, a whole population view can mask small pockets of inequality and poor health outcomes. Rutland is predominantly a rural place with low population density, meaning small communities can have very different experiences in health, wellbeing and how accessible services are. Rutland has an ageing population, projected to continue growing over the next two decades.

A recent report by the National Centre for Rural Health & Care and the All-Party Parliamentary Group (APPG) on Rural Health & Social Care aimed to understand inequality typical within rural areas and specific health and care needs[1]. They include poor accessibility of public transport, leading to greater levels of car dependency, resulting in disadvantage for those unable to drive. Car ownership is often seen as a measure of affluence, whereas for rural areas it is often a necessity.

The report also observes more expensive, less maintained and less energy efficient housing compared to urban areas. Poorer facilities for young people, fewer day centres, unreliable digital connectivity and economic uncertainty with limited employment opportunities locally were also observed in the report. These are typical characteristics of a rural area; however, each rural area is different and has its own unique demographics, conditions and character. With Rutland being predominantly rural, it is important to explore whether the factors outlined above exist locally.

A simplistic view of deprivation and inequality will focus on tools such as the Index of Multiple Deprivation (IMD). IMD is a widely used tool measuring deprivation across multiple factors including income, education, access to services and housing. For 2019, Rutland was ranked 303 out of 317 Local Authorities, where 1 is the most deprived[2]. Overall, this demonstrates Rutland has low levels of deprivation, which is a positive outcome for Rutland. However, this approach doesn't identify pockets of deprivation and hidden need in small areas of Rutland.

In 2016, a Social Mobility Index was developed by Government, comparing the chances that a child from a disadvantaged background will do well at school and get a good job across Local Authority areas[3]. The index acts only as a guide, however it shows Rutland to be the 18th lowest performing area for social mobility. When factoring in IMD to predict where Local Authorities are expected to be on the Social Mobility Index, Rutland comes out as the third lowest performing area.

These examples demonstrate the need to explore deprivation and inequality in Rutland at a greater depth than solely relying on tools such as IMD which work well for more urban areas. Economic deprivation is widely viewed as a significant contributor to poor health outcomes and lower life expectancy[4].

Rutland performs well for male and female life expectancy, although there are still indications of inequality within Rutland from the most to least deprived areas based on IMD. For 2020-21, life expectancy in Rutland was 81.3 years for males in the most deprived area, compared to 85.3 in the least[5]. For females, it was 81.9 years in the most deprived area and 86.8 years in the least. This shows a 4.0 year and 4.9 year gap in life expectancy for males and females respectively. It is worth noting the small population sizes of Rutland affects the reliability of this data and COVID-19 deaths in younger age groups.

The following report will aim to enhance the understanding of where inequality and hidden need exists within Rutland.

What is a Health Needs Assessment?

Briefly, a Health Needs Assessment (HNA) is a systematic approach to understanding the needs of a population. It is a holistic assessment considering all factors influencing and shaping health. A HNA can focus on a specific health-related topic or a population of relevance to the local place.

To develop a thorough understanding, a HNA needs to include quantitative and qualitative methods. Quantitative can include population-based data and use establish benchmarks for health indicators. Qualitative includes descriptive data, providing community and stakeholder insight.

Figure 1 shows health outcomes aren't simply related to a single factor. There are many contributing factors relating to health behaviours, socio-economic, clinical care and the built environment, often referred to as the determinants of health. When assessing the health needs of a population, it is therefore important to ensure all contributors are explored.

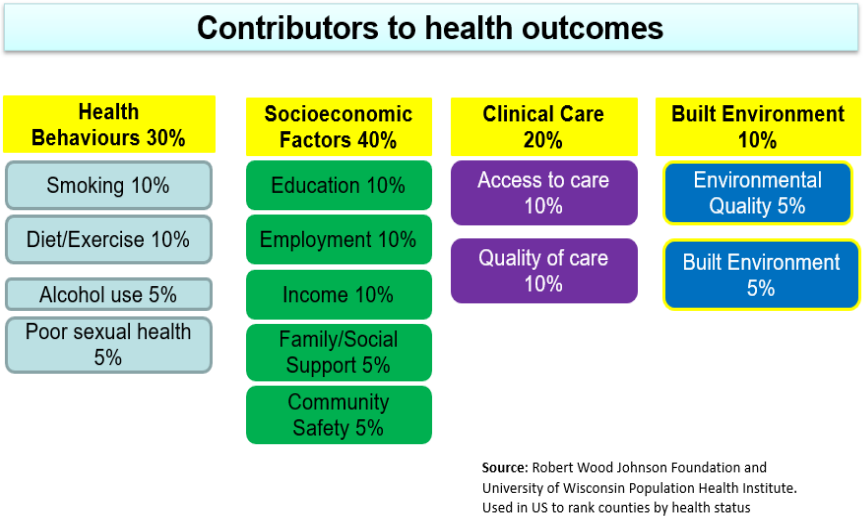


Figure 1 Contributors to health outcomes[6].

What are health inequalities?

Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to act and access treatment when ill health occurs[7].

Figure 2 below illustrates the differences between equality and equity using a bicycle example. At the top, under equality, you can see the same bicycle (same solution) has been provided to everyone. Equality ensures the same level of support for all; however, it doesn't address the specific needs of each individual and will therefore contribute to inequality. At the bottom, under equity, you can see different bicycles (different solutions) have been provided to each individual. This equitable approach addresses the specific needs of each individual to ensure they can cycle in the most efficient way, preventing the risk of inequality.

Figure 2 Equality v Equity.

Broadly, there are four dimensions of health inequality, each of which can lead to differences in health outcomes across populations. It is important to note the dimensions can also overlap in different ways for individuals potentially adding further complications and inequity, this is known as intersectionality.

Figure 3 demonstrates the four overlapping dimensions[8], which forms the basis for this report.

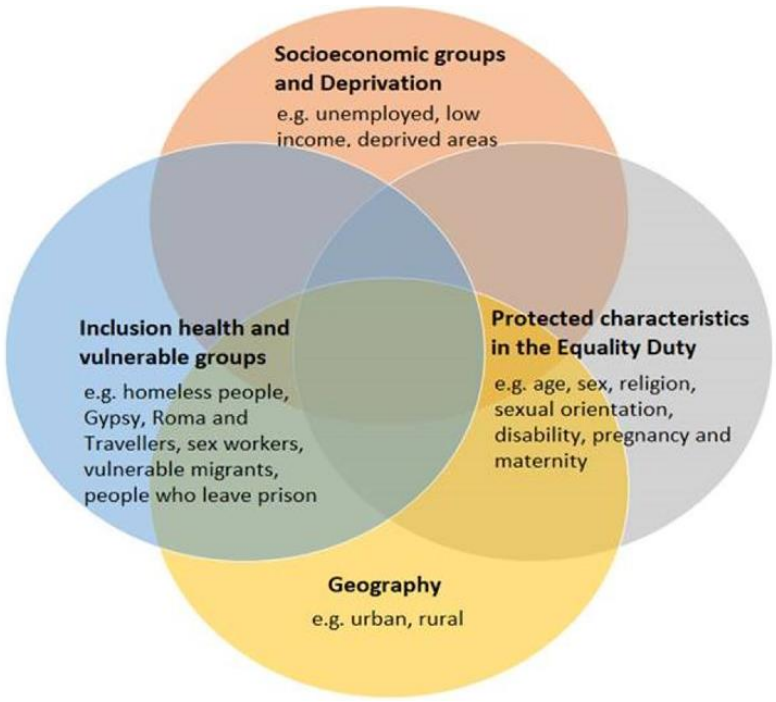


Figure 3 Overlapping dimensions of health inequality.

The impact of Covid-19 on health inequalities

Throughout the Covid-19 pandemic, health inequalities have been exposed and amplified, as presented within the Build Back Fairer: The Covid-19 Marmot review[9]. The review highlights inequalities in Covid-19 mortality rates follow a similar social gradient to that seen for all-cause

mortality and the causes of inequalities in Covid-19 are similar to the causes of inequality in health more generally, often relating to socio-economic factors.

Within this report, the impact of Covid-19 on inequalities will be explored, to identify how the pandemic has had an effect.

Strategic context for addressing inequalities

Nationally, the NHS Long Term Plan[10] outlines recommendations to address health inequalities across different service areas. There is also a renewed focus on prevention within the plan and the role it plays in relieving NHS pressures and cost savings on the public sector.

Core20PLUS5[11] is an NHS England and Improvement approach to support the reduction of health inequalities at national and system level – figure 4. The approach defines a target population cohort – the 'Core20PLUS' – and identifies 5 focus clinical areas required accelerated improvement. The 'core 20' element covers the most deprived 20% of the national population, as identified by the IMD. The 'Plus' covers Integrated Care System/ Health and Wellbeing Board determined population groups experiencing poorer than average health access, including inclusion health groups. The '5' sets out five clinical areas of focus - Maternity, Severe mental illness, Chronic respiratory disease, Early Cancer diagnosis and Hypertension case-finding.

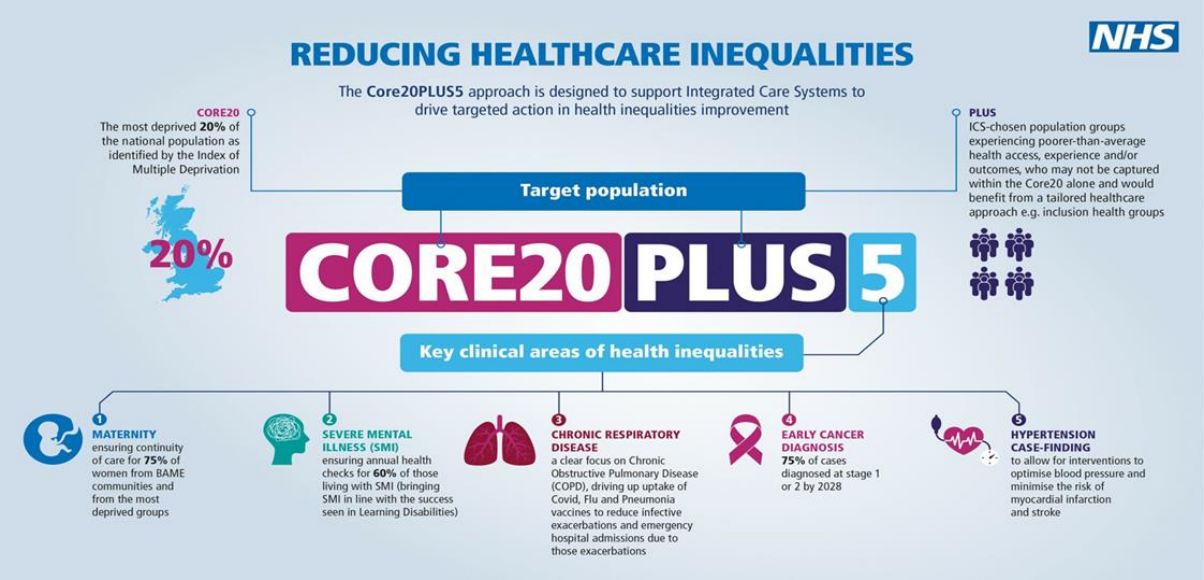


Figure 4 Core20PLUS5, NHS England and Improvement.

At local 'system' level, the Leicester, Leicestershire and Rutland (LLR) Integrated Care System (ICS) has developed an 'LLR Health Inequalities Framework'. The framework sets out the principles for addressing local health inequalities.

At local 'Place' level, Rutland has recently launched a new Joint Health and Wellbeing Strategy: The Rutland Place based Plan 2022 – 27[12]. The Strategy has six priorities, with additional cross cutting themes, including 'reducing inequalities'. The theme has an aim 'to ensure all people in Rutland have the help and support they need, we will focus on those living in the most deprived areas and households of Rutland and some specific groups as a priority'. Additionally, there will be a focus on embedding a proportionate universalism approach, 'meaning there will be a universal offer to all, but with equitable variation in service provision in response to differences in need within and

between groups of people'. To deliver on both priorities, it's vital we have the insight to enable an informed approach.

What Rutland residents say

The resident voice is crucial to ensure priority is given to the issues of most importance. Recently, there has been several consultation and engagement developments in Rutland, aiming to understand what matters most to residents. Insight from residents, alongside the evidence base will inform the focus of the report.

Three recent engagement and consultations have been assessed for directing focus – Healthwatch Rutland's 'What Matters to You' report[13], outcomes from the Joint Health & Wellbeing Strategy consultation and 'The Future Rutland Conversation'[14].

References to health, wellbeing and inequality within all three engagements led to clear commonalities on what is most important to Rutland residents. Frequently, residents raised access to services as the most prominent issue. This includes bringing health and care closer to home and transport difficulties within and across the Rutland border. There are likely to be some residents who experience greater levels of access issues than others. Variation will depend on various factors and can be linked back to figure 3 on the overlapping dimensions of health inequality.

Other areas raised as most important to residents include: complexity of accessibility of secondary care across the Rutland border; ensuring healthcare is made available in different ways, meeting the resident's needs (face-to-face, online or telephone); and having better information and education on maintaining their own health and wellbeing.

Aims and objectives

Summarising the above introduction, this report has the following aims and objectives:

- Identify and highlight 'hidden need' in Rutland.
- Explore inequalities relating to health outcomes and access to services across population groups and geography.
- Provide recommendations for partners to address Rutland health inequalities and hidden need, to further inform the implementation of the Rutland Joint Health & Wellbeing Strategy 2022-27.

Section 1 - Socio-economic and deprivation

The first section focuses on socio-economic inequality and deprivation, with a particular focus on understanding small areas within Rutland. Throughout this report, there will be reference to Lower Super Output Areas (LSOA). LSOAs are small areas with populations typically between 1,000 and 3,000 residents (or between 400 and 1,200 households). LSOAs are well aligned to Ward boundaries. Depending on the size, a Ward can include more than one LSOA. As LSOAs are more homogenous in terms of population size, findings are more reliable than Wards where population size can vary more. There are 23 LSOA's within Rutland. Appendix 1 provides a more detailed map of each LSOA.

The first part of this section will present indicators commonly used nationally to assess levels of deprivation in an area – the indices of deprivation. The second part will explore hidden and rural deprivation, looking at small areas of Rutland across multiple economic factors.

Indices of deprivation

Since the 1970's, national government have calculated local measures of deprivation in England. The current official measure of relative deprivation is the Index of Multiple Deprivation (IMD). The IMD is part of a suite of outputs, called the Indices of Deprivation (IoD). The IoD measures relative deprivation in LSOA's, covering seven distinct domains (Income; Employment; Health Deprivation & Disability; Education, skills training; Crime; Barriers to Housing & Services; and Living Environment).

The Ministry of Housing, Communities and Local Government (as it was known at the time), stated that "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]. Considering the rurality of Rutland, this is particularly pertinent in understanding local deprivation. The Indices of Deprivation aim to identify clusters and level of deprivation in small areas, rather than define every household within the LSOA.

There has been criticism of using the IMD to identify deprivation in rural areas, as it can be seen as a better tool for urban areas[16]. However, the IMD is widely used and therefore should be included. The below covers IMD and the individual domains of most relevance to a rural area. IMD shouldn't be used in isolation to determine resource allocation or targeting areas. It does however act as a valuable guide to help determine areas requiring further exploration. For the Rutland example, an LSOA appearing affluent from IMD doesn't mean there isn't need within the rural area.

For IMD, all LSOA's of Rutland perform well compared to all LSOA's across the country, as shown in figure 5 below. Only one area in Rutland is within the most deprived 50% of the country – Greetham – which is shown to be in the 5th most deprived decile and similar to the England average. All other LSOAs within Rutland are above the national average, albeit at different levels.

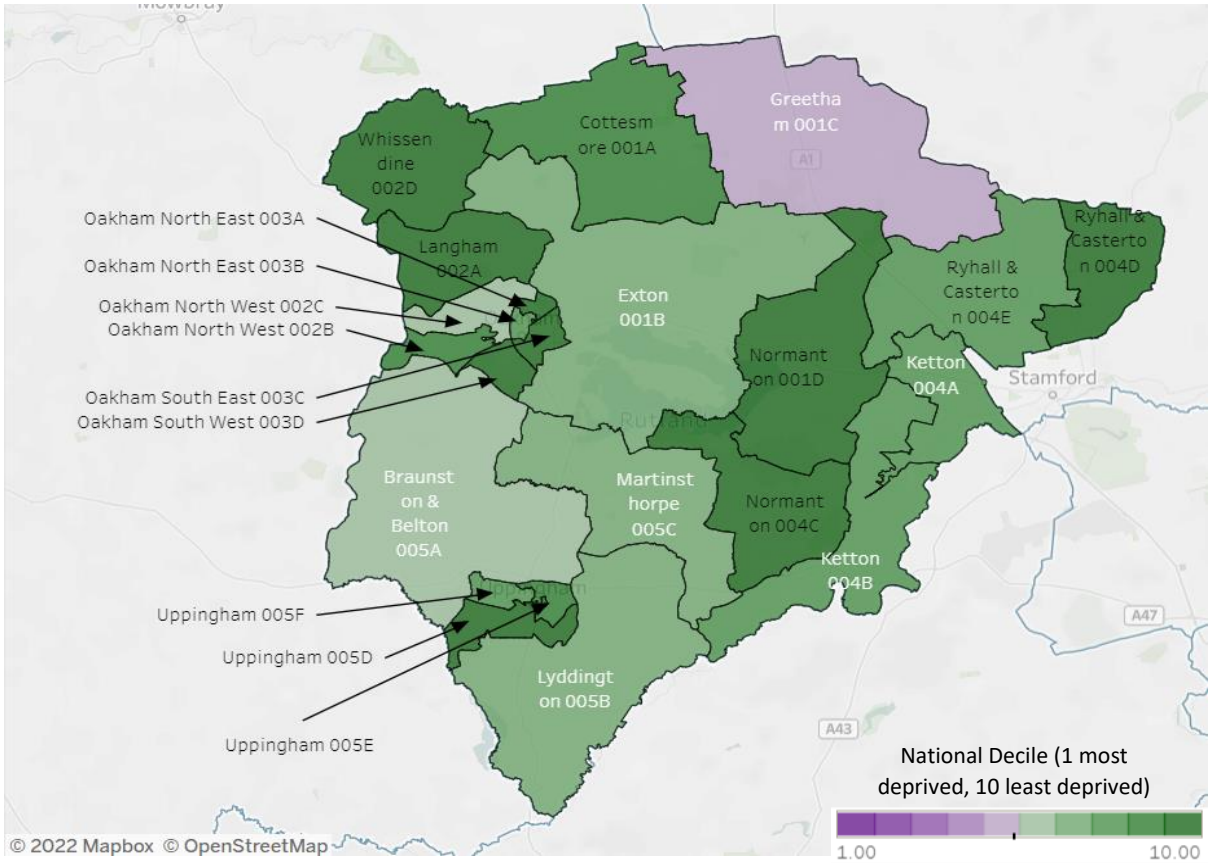


Figure 5 Index of Multiple Deprivation (IMD) in Rutland.

The 'Barriers to Housing & Services' IoD domain measures the physical and financial accessibility of housing and local services[17]. The indicators fall into two sub-domains: 'geographical barriers, which relate to the physical proximity of local services, and 'wider barriers', which includes issues relating to access to housing, such as affordability.

Figure 6 below maps Rutland LSOA's using the Barriers to Housing & Services domain. The map shows 6 out of the 23 Rutland LSOA's being in the most disadvantaged 10% nationally. 7 out of 23 are in the most disadvantaged 20% nationally. In fact, two Rutland LSOA's are in the most disadvantaged 1% nationally – Greetham 001C and Braunston & Belton 005A. Rutland has the greatest proportion of LSOA's within the most deprived 10% nationally (26.1%) compared to all Local Authorities across Leicester, Leicestershire and Rutland, including lower tier authorities Melton (20.0%), Harborough (17.0%) and Hinckley & Bosworth (6.1%). All others have 0%.

Breaking the domain down into the 'Geographical' sub-domain, figure 7 clearly shows geographical distance is the key contributor. The sub domain measures physical distance to community infrastructure, education and GP Practices. Seven out of the 23 LSOAs are in the most disadvantaged 10% nationally, with 10 in the most disadvantaged 20%. Three Rutland LSOA's are in the most disadvantaged 1% - Greetham 001C; Braunston & Belton 005A; and Martinsthorpe 005C. Rutland's large spatial scale and low population density can contribute towards poor access to local services. The sub-domain is limited to physical distance to services only, without covering other factors of accessibility such as access to cars and public transport options. This will be explored further in section 2.

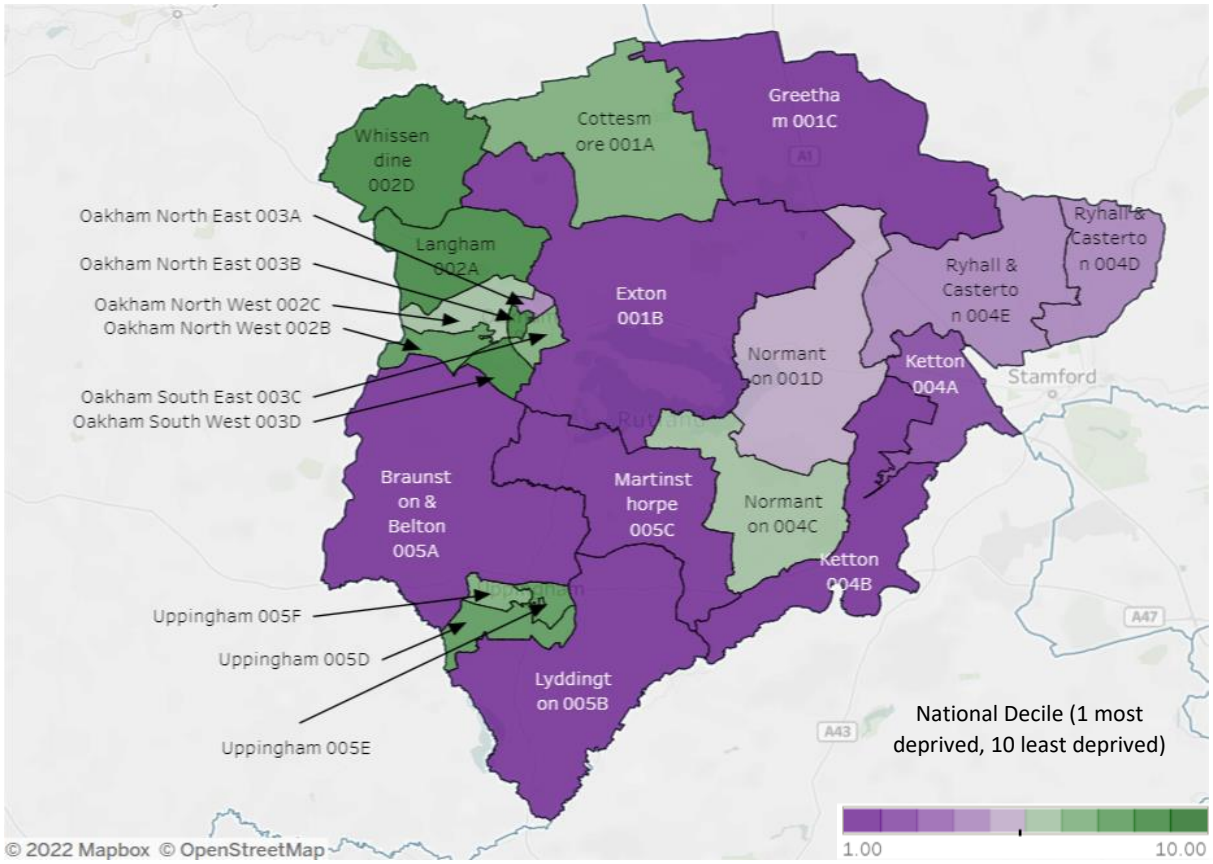


Figure 6 Barriers to Housing & Services[18]

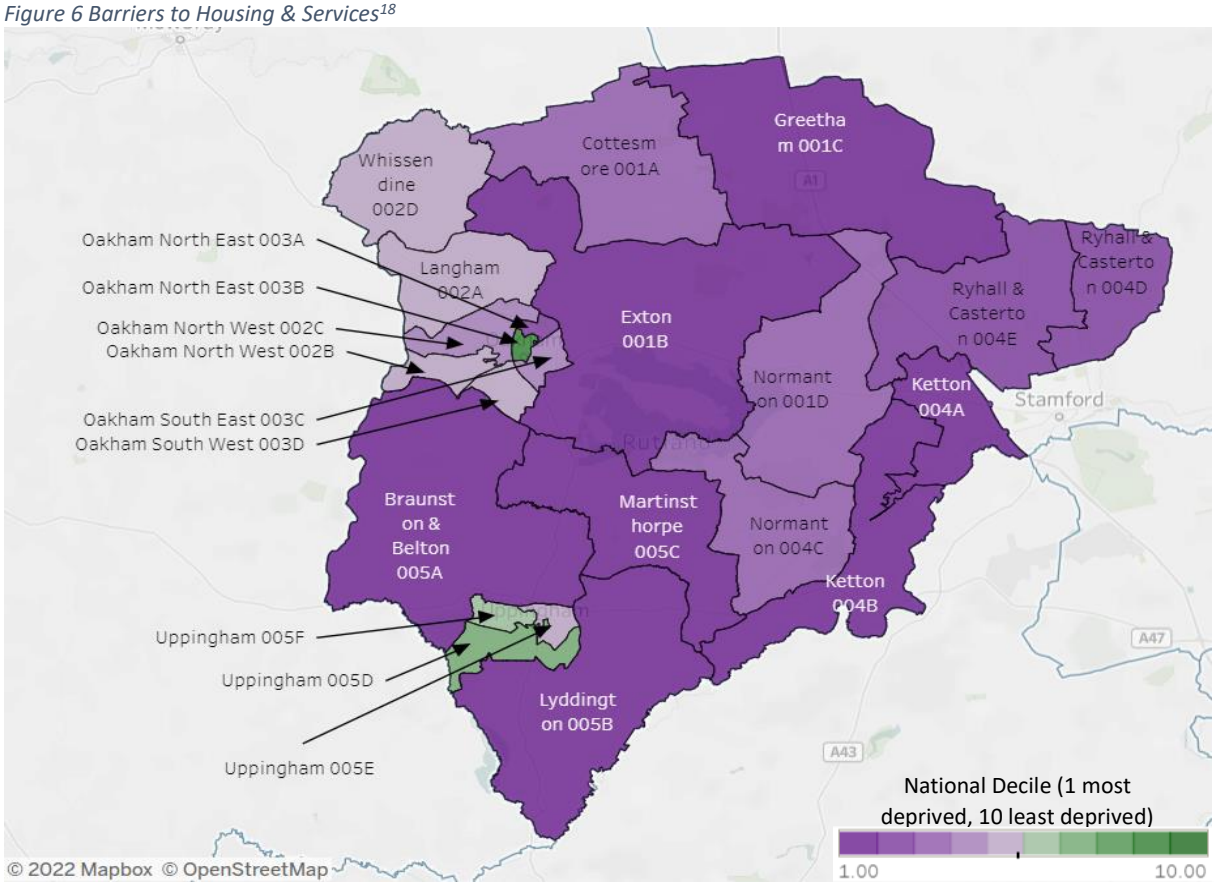


Figure 7 Geographical Barriers Sub-domain.

The ‘Living Environment’ domain is also of importance for rural areas, measuring the quality of the local environment. The ‘indoors’ living environment measures the quality of housing; while the ‘outdoors’ living environment contains measures of air quality and road traffic accidents.

There are two LSOA’s within the most disadvantaged 20% nationally for the ‘Living Environment’ domain – Lyddington 005B and Braunston & Belton 005A. Figure 8 shows one of the sub-domains – Indoors Living Environment – has one LSOA in the most deprived 10% nationally – Braunston & Belton 005A. Two more LSOA’s are within the most 20% disadvantaged nationally – Lyddington 005B and Martinsthorpe 005C. The ‘Outdoors Living Environment’ has no LSOA’s within the most disadvantaged 20% nationally.

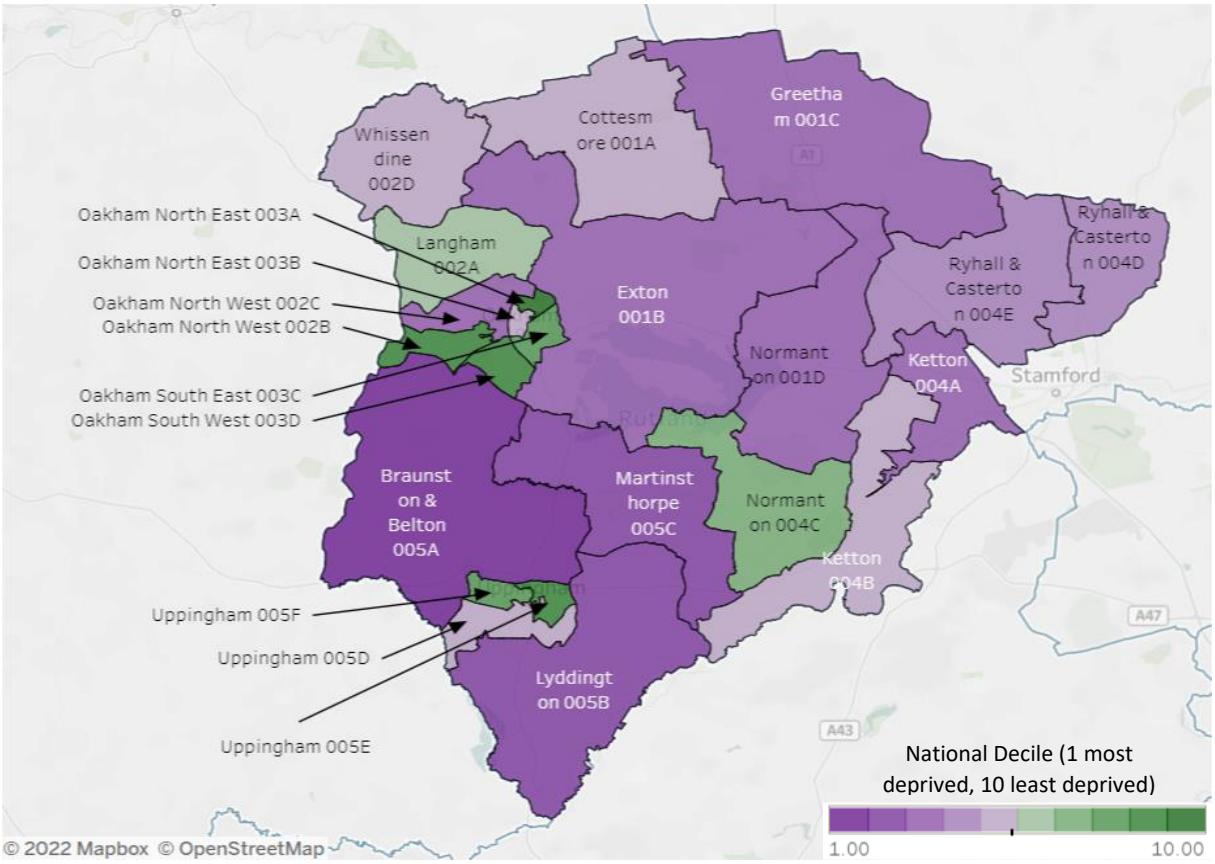


Figure 8 Indoors Sub-domain.

Rutland performs well nationally on the Income Deprivation domain of IoD, with all but one LSOA within the least 50% deprived. The one – Oakham North West 002C – is within the least 60% deprived. However, when we look at the national rank of LSOAs for Income Deprivation, some in Rutland have decreased considerably from 2015 to 2019. Whilst still performing similar or better than the England average, it’s worth exploring and being aware of the considerable decreases in rank for the following areas. By focusing on rank rather than score, we can partially control for any national or international affairs.

The change in decile from 2015 to 2019 in IMD, income deprivation[19], income deprivation affecting children and income deprivation affecting older people are shown in appendix 2. The IoD Technical Report outlines similar indicators used for 2015 and 2019 and therefore trends over the period can be used. All LSOAs have some level of increase or decrease over the period and there were three LSOAs where rank changed by more than 1 decile, all within the income deprivation affecting

children indicator. Two of the LSOAs improved by 2 deciles (Exton 001B and Normanton 001D) and one worsened by two deciles (Oakham South West 003D).

The figures and narrative above highlight there is disadvantage within Rutland when you focus on specific domains relevant to a rural place and small areas within. However, there isn't enough detail using IoD to inform action. Therefore, the following section will build on these findings, exploring inequality and hidden need in more detail.

Hidden economic deprivation in Rutland

This section will look at need and demand for support services across different economic indicators. Taking this approach will help to show where the greatest need is across Rutland and where there is high need but low demand for support services. High need and low demand could indicate either individuals aren't currently willing to come forward for help, there are barriers for residents to access, or residents aren't aware of what is available for them.

Child Poverty

The impact of poverty on health is clear. Poor health associated with poverty can limit potential and development across different areas of life, leading to poor health and life chances in adulthood[20].

Relative poverty is defined as 'households with income below 60% of the median (middle) household income. This can be seen as a measure of inequality between low- and middle-income households.' Child poverty is lower in Rutland; however, there is variation between small areas of the county. Absolute poverty is defined as 'households with income below 60% of (inflation-adjusted) median income in 2011/12. This is often used to look at how living standards of low-income households are changing over time.'

Figure 9 below shows LSOAs in Rutland by relative child poverty[21]. As the chart shows, Rutland has a lower proportion of children under 16 in relative low-income families (8.5%) than the East Midlands (16%) and England average (18.5%). According to research by Loughborough University[22], once housing costs have been factored in, the proportion of Rutland children living in poverty was an estimated 17.6% in 2019/20. This is lower than many areas, however it indicates there are still significant levels of child poverty in Rutland.

Small area data on relative poverty is only available *before* housing costs, which the following assessment will focus on. Five out of the 23 LSOAs had relative poverty at 12% or more in 2020/21, greater than the 8.5% Rutland average. There are 5 LSOAs below 4% relative poverty. The variation suggests targeted support and engagement in the most deprived areas would help to support those most in need. Looking at rurality, it's also worth noting 4 of the top 5 LSOAs in Rutland are the most rural, classified as 'rural villages & dispersed'.

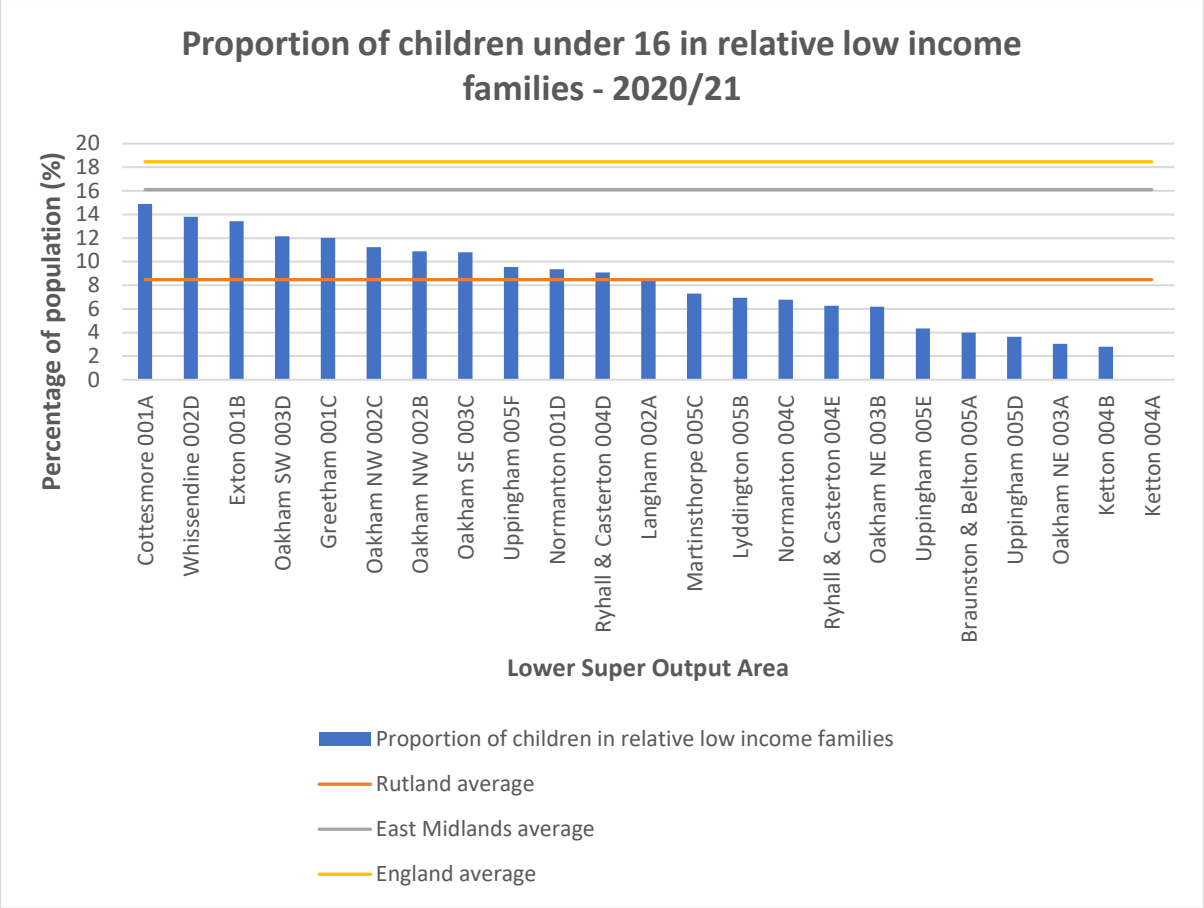


Figure 9 Proportion of children under 16 in relative low-income families - 2020/21.

Benefit support

Unemployment benefits and Universal Credit claimants shows a steady increase from 2018 for Rutland (see below figure 10[23]), with a large spike at the start of the COVID-19 pandemic. The spike has been decreasing in recent months at a considerable rate, however it's worth continuing to monitor the trend as it's still above pre COVID-19 levels.

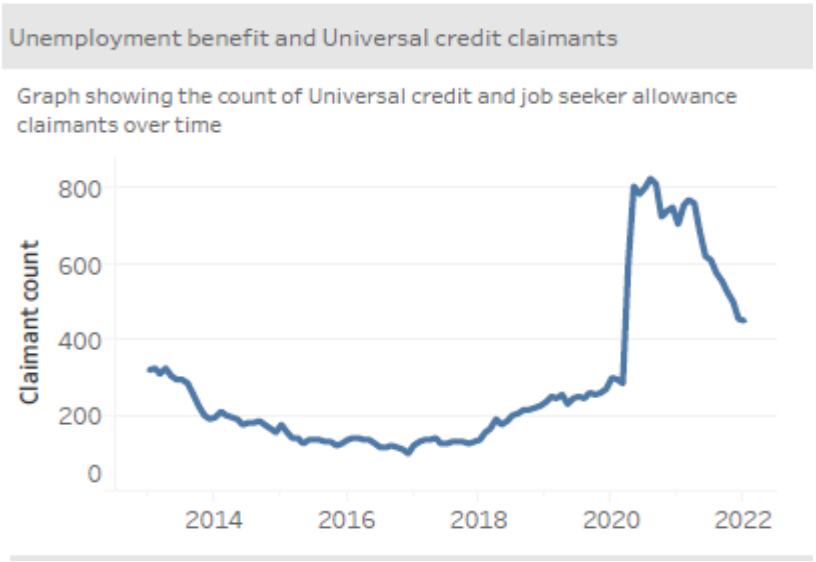


Figure 10 Unemployment benefits and Universal credit claimants.

At a smaller geography level, two Rutland LSOAs had a greater proportion of adult residents receiving Universal Credit than the East Midlands average – Oakham North East 003B and Uppingham 005F[24]. Both had above 10%, compared to ten LSOAs below 4% and the Rutland average of 5.3%, shown in figure 11. This could be interpreted in two ways. One way is saying there is greater need for wider support in the areas with highest proportions. The second is those areas with lower proportions may not be accessing the benefit support they may be eligible for, and therefore need targeted work to ensure they're accessing what they're entitled to. We will continue to explore this below.

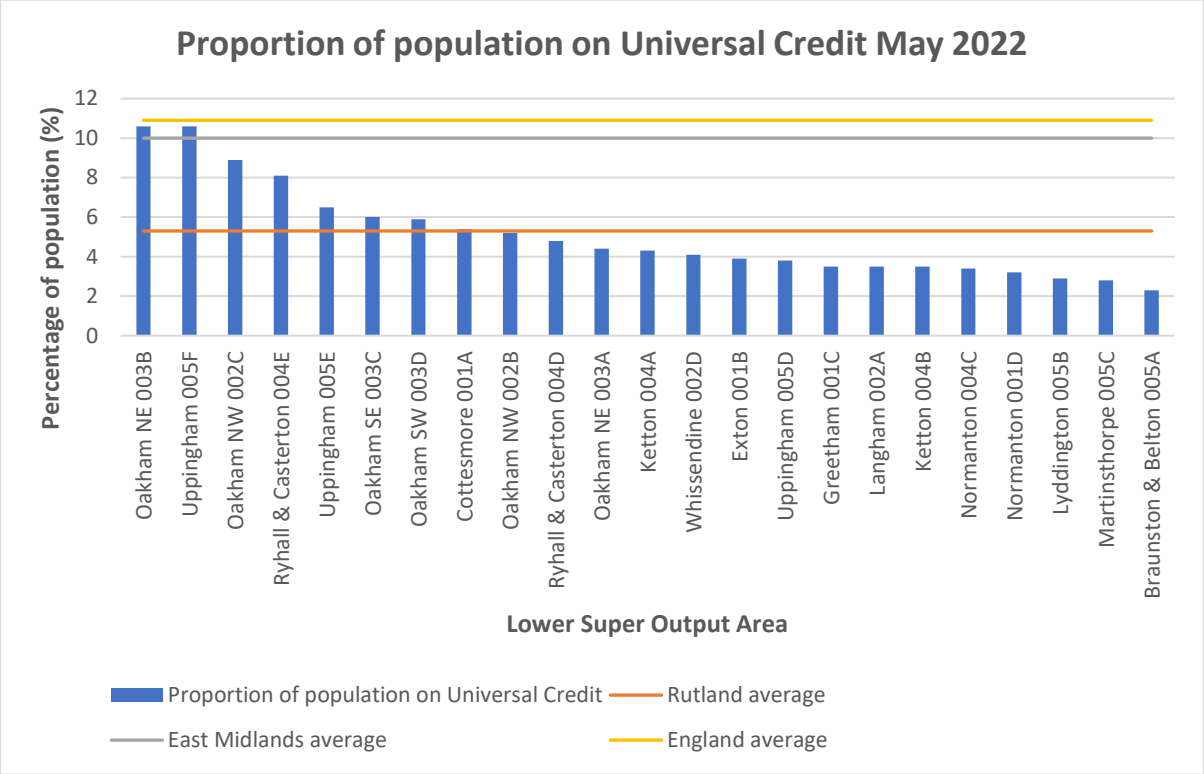


Figure 11 Proportion of population on Universal Credit May 2022.

Fuel poverty

Fuel poverty is assessed using the 'Low Income Low Energy Efficiency' indicator, which considers a household to be fuel poor if there is poor energy efficiency and disposable income falls below the poverty line (after housing and energy costs). Assessing fuel poverty at LSOA level should be treated with caution and estimates should be looked at for general trends and identify areas of particular high or low fuel poverty.

Figure 12 below shows estimated fuel poverty for Rutland LSOAs, by proportion of households in 2020[25]. There are five LSOAs in Rutland with a higher proportion of households estimated to be in fuel poverty than the East Midlands average of 14% - Ketton 004A, Cottesmore 001A, Lyddington 005B, Normanton 001D and Oakham North West 002C. Additionally, the significant energy price increases in 2022 could impact those areas already experiencing higher levels of fuel poverty. The cost of living in rural areas is substantially higher than in towns and cities, partly because of distance to services and the costs of heating homes which are often off-grid and less well insulated.

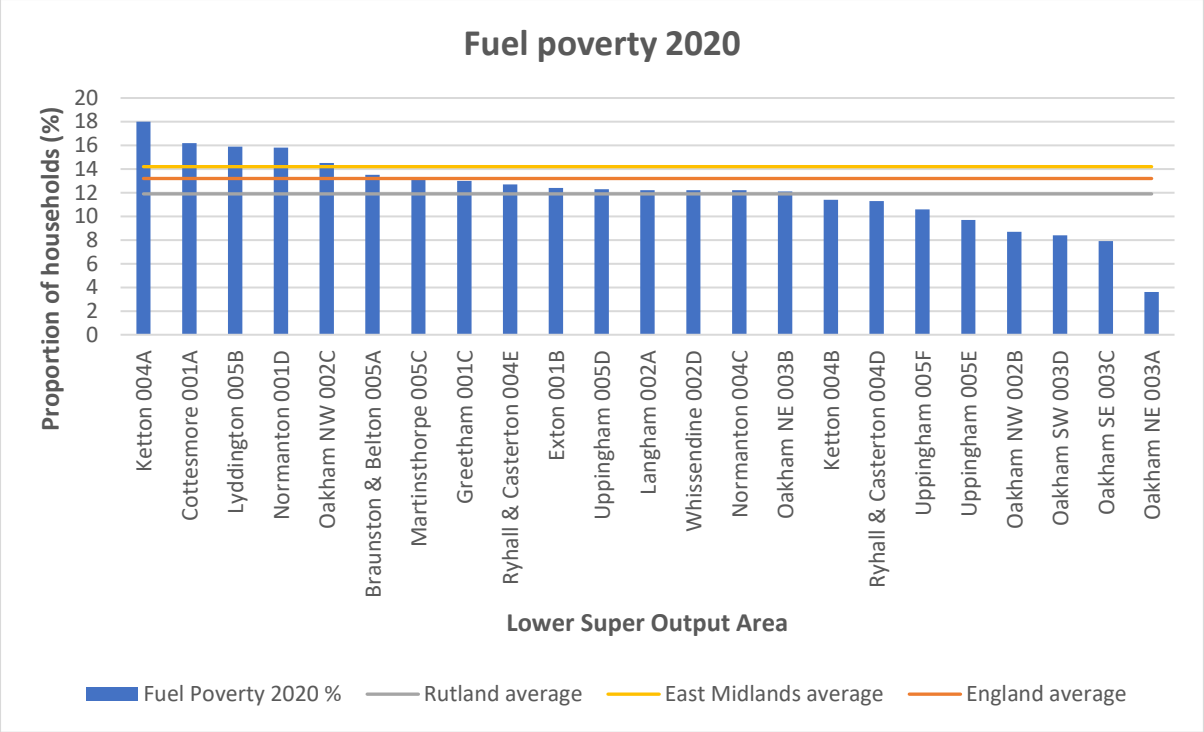


Figure 12 Fuel Poverty 2020.

A study in August 2022[26] has predicted over half of UK households will be in fuel poverty by January 2023. Whilst it is difficult to predict levels of fuel poverty due to many changing factors, it is highly likely there will be significant pressures on households for the 2022/23 winter and moving into 2023.

Focusing solely on energy efficiency, 40% of Rutland households have an EPC band C or above, ranked 144 out of 335 Local Authorities nationally with 1 being the lowest[27]. Local areas range considerably within Rutland. Data isn't available at LSOA, however it is at Middle Super Output Area (MSOA). MSOAs combine all LSOAs with the same number. For example, Rutland 001 (MSOA) will consist of Cottesmore 001A, Exton 001B, Greetham 001C etc. Maps can be found in appendix 3.

For households eligible for an EPC rating, Rutland 002 (Oakham West, Langham and Whissedine) has a considerably higher proportion of households with EPC band C or above (62%) compared to the Rutland average (40%). Rutland 004 (Ketton, Ryhall and Luffenham) has 27% of eligible households with EPC band C or above, Rutland 001 (Market Overton, Cottesmore and Empingham) 28% and Rutland 005 (Uppingham, Lyddington and Braunston) 35% are all considerably less and suggest a need for targeted support when energy efficiency measures and projects are being implemented. Rutland 003 (Oakham East) has 40%.

Cold homes have been widely linked to respiratory and cardiovascular problems. Resistance to respiratory infections is lowered by cool temperatures and can increase the risk of respiratory illness[28]. Older adults are especially susceptible to the impacts of cold homes and this could be a contributing factor to the significantly higher rate of excess winter deaths in Rutland compared to the East Midlands average and England, explored later. Estimates suggest 10% of excess winter deaths are directly attributable to fuel poverty and 21.5% attributable to cold homes[29].

Areas showing greatest need

It is acknowledged above that Rutland as a place is often performing better than regional or national averages on economic indicators. However, there are small areas within Rutland that perform better

than others. The above assessment helps understand which small areas within Rutland should be supported most through a proportionate universalism approach.

Out of all 23 Rutland LSOAs, Cottesmore 001A has the highest proportion of low-income families, 2nd highest estimated proportion of fuel poverty and 8th highest proportion of residents on Universal Credit. Whilst not a direct causation, it's worth noting the LSOA has Kendrew Barracks within its boundary alongside the Cottesmore Academy which has 100% of pupils as service children. It's worth exploring further whether there is a direct link. Inequality within the armed forces community will be explored later. Linked to health outcomes, Cottesmore ward performs worse than other Rutland wards for a few indicators linked to young people. Cottesmore had a significantly higher crude rate of emergency hospital admissions in under 5-year-olds (455.9 per 1,000) compared to England (162.1 per 1,000) between 2017/18 and 2019/20[30]. It's important to note ward populations aren't directly comparable with the LSOA populations.

Oakham North West 002C is another LSOA consistently high in the rankings above. It has the 6th highest proportion of low-income families within Rutland, 5th highest estimated proportion of fuel poverty (also above the East Midlands average) and 3rd highest proportion of the population on Universal Credit. For health outcomes, Oakham North West ward had significantly worse values than England for emergency hospital admissions for hip fractures in persons aged 65 years and over between 2015/16 and 2019/20. Life expectancy for females was significantly lower than England between 2015-2019, at 81.1 years compared to 83.2 years nationally. Mortality from all causes and circulatory disease between 2015-2019 was also significantly higher than England.

Greetham 001C – shown earlier as the only Rutland LSOA below the national average IMD ranking – has the 5th highest proportion of low-income families within Rutland, 8th highest estimated proportion of fuel poverty and 16th highest proportion of the population on Universal Credit. For health outcomes, Greetham ward had significantly higher emergency hospital admissions for COPD compared to England between 2015/16 and 2019/20 and hospital stays for self-harm.

Economic support services demand

Alongside economic need, it is also important to focus on how engaged residents are with support services, for example citizens advice or the foodbank. If there is an average level of need, but low demand for support, this could indicate a need for prioritisation to ensure residents are aware of and don't experience barriers to support. This is where the rurality of Rutland needs to be considered as the more rural areas will likely experience poorer accessibility to support.

For both Citizens Advice Rutland and Rutland Foodbank, wards of the more urban Oakham and Uppingham had highest levels of engagement, shown in figure 13 below. Some of these wards have higher populations and often have better access with closer proximity to support and greater awareness of what is available. Oakham North West ward was highest for both services, aligned to the high level of economic need in the previous section. The other two areas highlighted in the previous section – Greetham and Cottesmore – both have lower levels of engagement. Note the ward and LSOA population sizes aren't directly comparable but do cross over considerably.

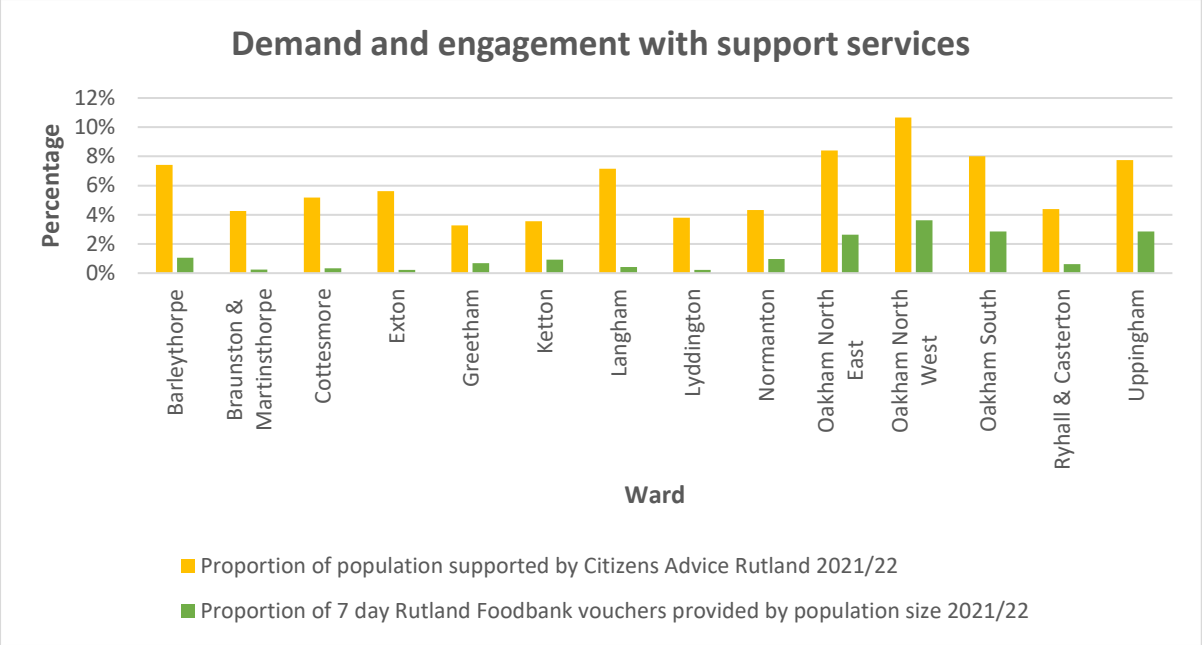


Figure 13 Demand and engagement with support services.

Rutland Foodbank

Rutland Foodbank insight[31] provides a valuable extra layer to understanding economic deprivation locally. Rutland Foodbank activity has been steadily increasing since 2016, prior to the COVID-19 pandemic, with a slight decrease from 2020/21 to 2021/22. In 2015-16, 652 adults and children were provided with food via the foodbank. To note, this doesn't refer exactly to 652 unique residents. For example, if a resident was referred 3 times, they would account for 3 of the 652. By 2020-21, this increased by 211% to 2,025 adults and children. For children alone, the increase from 2015-16 to 2020-21 was 283% from 232 to 888.

Figure 14 below shows the year-by-year trend for number of residents fed and the number of meals provided. The total number of meals provided was 5,686 in 2015-16 increasing to 42,525 in 2020-21. 76% of residents provided with food via the foodbank were due to income related issues. The Trussell Trust[32] shows Rutland distributed a higher proportion of meals per total population in 2021/22 (4.5%) compared to East Midlands (2.6%) and England (3.2%). This doesn't account for independent foodbank use. A higher proportion of meals distributed doesn't necessarily mean more people are using the foodbank, as the numbers include families using the foodbank more than once. Frequent use could however indicate greater dependence on the foodbank over time.

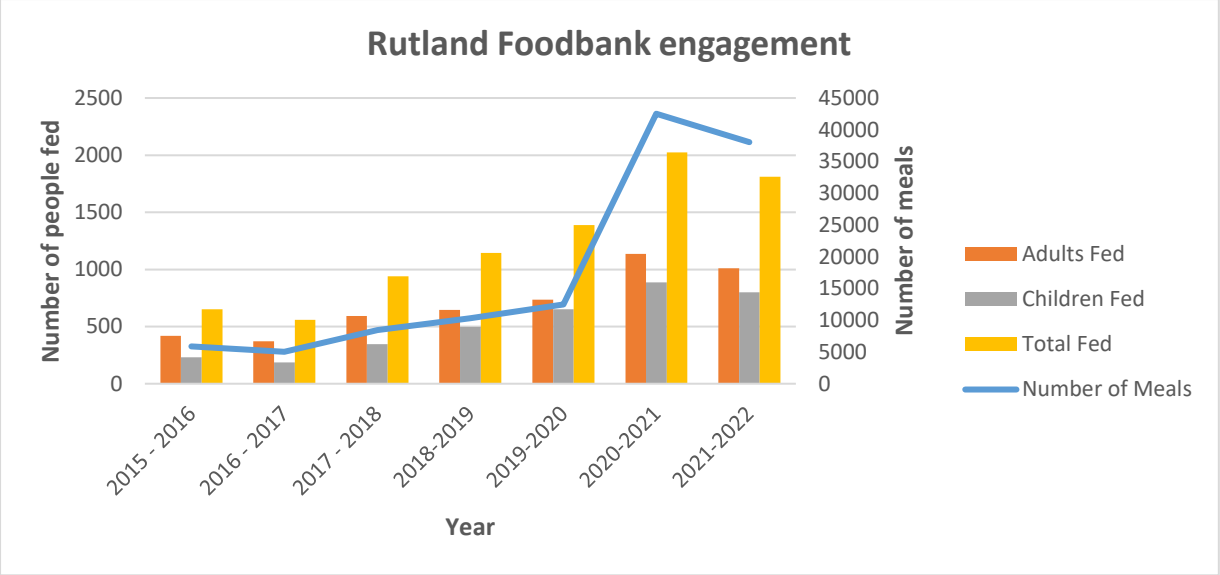


Figure 14 Rutland Foodbank engagement.

A closer look at the household dynamics of those supported though the Rutland foodbank indicates single adults and single parents are most supported, shown in figure 15 below. 42% of vouchers distributed in 2020-21 were to single adults and 30% to single parents. 14% were distributed to families, 7% couples and 6% other. Most adults (76%) supported were of working age (25 – 64 yrs), followed by 20% of young adults (16-24 yrs) and 4% aged 65 or higher.

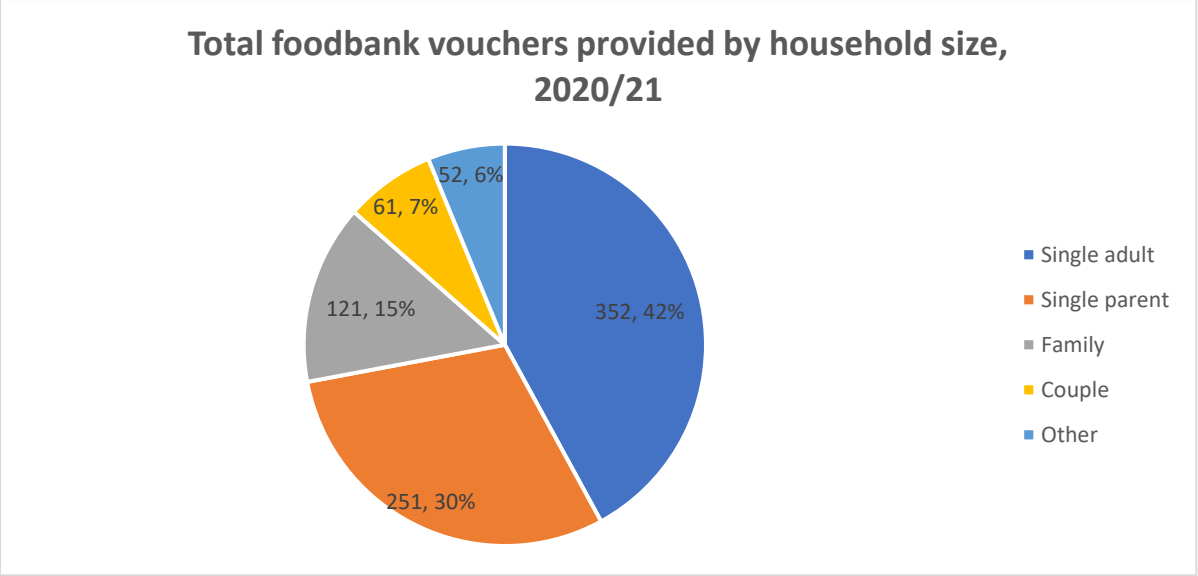


Figure 15 Total foodbank vouchers provided by household size, 2020/21.

Figure 16 below shows the distribution of Foodbank vouchers by Rutland wards. The majority have been distributed within Oakham and Uppingham wards. Whilst this is partially expected for Oakham due to the foodbank being located there and higher ward populations, Rutland Foodbank started delivering vouchers and food to homes in 2020 during the pandemic and this has continued.

Insight from the previous section above shows some of the more rural areas of Rutland have similar levels of economic deprivation. Therefore, these findings could indication there is need to target support on the most rural areas of Rutland. For example, Exton has the highest proportion of children in low-income families but one of the lowest levels of vouchers provided via the foodbank.

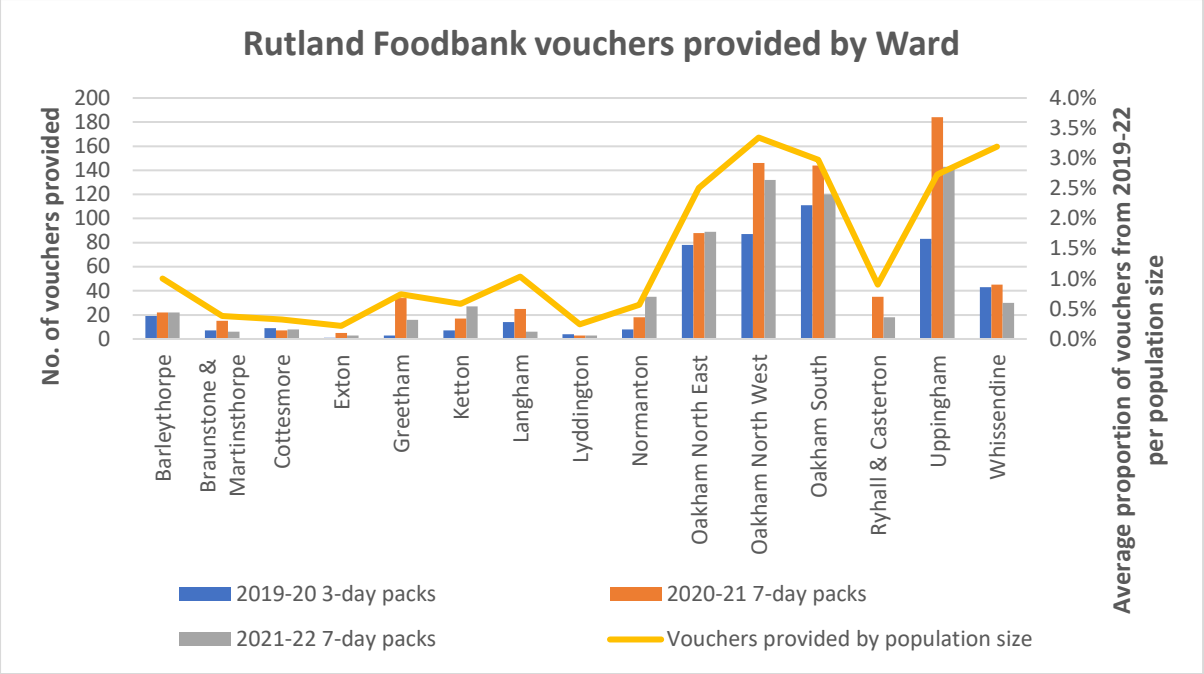


Figure 16 Rutland Foodbank vouchers provided by Ward.

Foodbank use is a critical support in the short term, especially with the significant challenges on cost of living at present for families. There is however a need to ensure medium- and long-term solutions are considered at the same time, addressing the root causes of economic hardship.

Acorn Classification

The Acorn Classification was developed by CACI to understand local neighbourhoods based on social factors and population behaviour[33]. Acorn is widely used to help the public sector understand the needs for targeted resource in local communities. The Acorn category 'Financially Stretched' will be explored, as it factors in broader social and living factors related to economic need.

The 'Financially Stretched' category combines the following factors:

- Housing is often terraced or semi-detached, a mix of lower value owner occupied housing and homes rented from the council or housing associations, including social housing developments specifically for the elderly.
- There tends to be fewer traditional married couples than usual and more single parents, single, separated and divorced people than average.
- Incomes tend to be well below average. Although some have reasonably well-paid jobs more people are in lower paid administrative, clerical, semi-skilled and manual jobs.
- People are less likely to engage with financial services. Fewer people are likely to have a credit card, investments, a pension scheme, or much savings. Some are likely to have been refused credit. Some will be having difficulties with debt.
- Overall, while many people in this category are just getting by with modest lifestyles a significant minority are experiencing some degree of financial pressure.

The estimated England average population within the 'financially stretched' category is 22.4%. In Rutland, 7 of the 23 LSOAs are above the England average, shown in table 1 below. The majority of these are within the more urban Uppingham and Oakham areas, with 005D Uppingham having an

estimated 62.8% in the financially stretch category. Outside of the more urban Oakham and Uppingham, 004E Ryhall & Casterton also has an estimated 26.7%.

Table 1 Rutland population by Acorn category.

Lower Super Output Area	Population within Acorn category 'financially stretched'	Total LSOA population	Estimated percentage of population
005D Uppingham	1,208	1,923	62.8%
005F Uppingham	603	1,511	39.9%
003B Oakham North East	603	1,639	36.8%
002B Oakham North West	464	1,573	29.5%
004E Ryhall & Casterton	372	1,391	26.7%
002C Oakham North West	910	3,713	24.5%
003C Oakham South East	618	2,624	23.6%

Demographic variation

A closer look at demographics suggests possible economic inequality by age and sex. Figure 17 below shows a significantly higher number of females on Universal Credit in May 2022 (1,060) than males (674)[24]. This accounts for 61% and 39% of the total respectively. Compared to Great Britain, as of January 2022 females accounted for 55% of people on Universal Credit. The difference between females and males in Rutland is greatest between ages 16 – 44. 19% of females aged 25-34 are on Universal Credit, compared to 7% of males aged 25-34. Looking at how this relates with service support, Citizens Advice Rutland has a similar split with 62% of residents being female and 38% male.

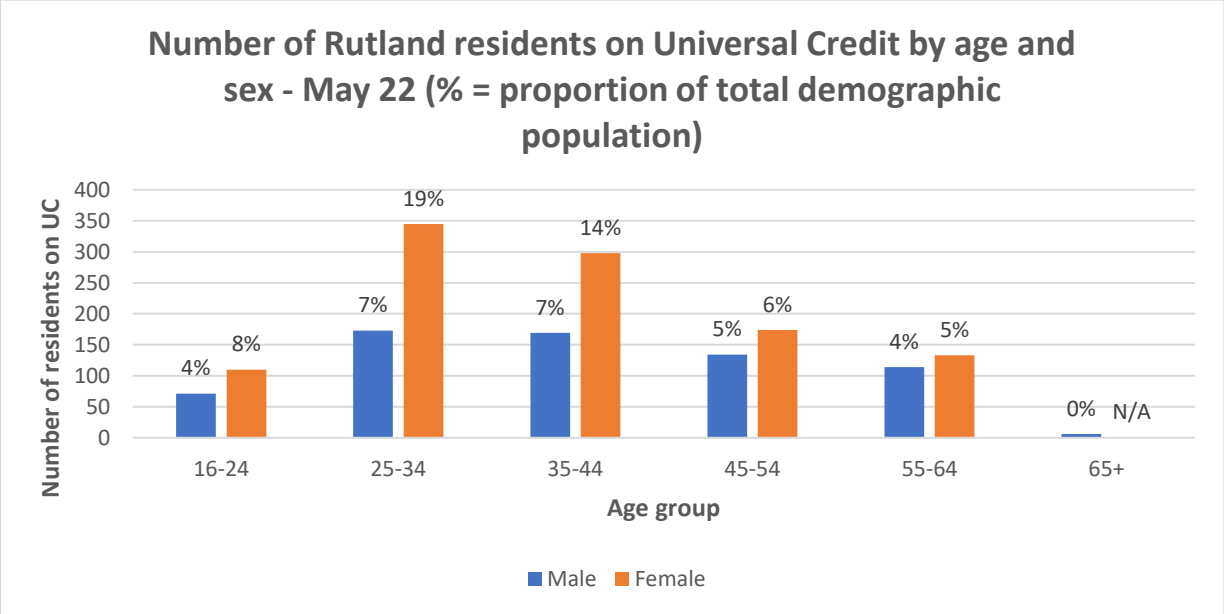


Figure 17 Number of Rutland residents on Universal Credit by age and sex.

Section 1 recommendations

1. Support available within the community to provide targeted provision to the most rural areas of Rutland identified with higher economic need and more distant from support.

Section 2 – Rurality and access

Rural areas often have distinctive health, care and wellbeing needs. Universal services and support can often leave rural communities excluded, with poorer access than urban communities. The APPG on Rural Health & Social Care[1] identified five common characteristics of rural health and care needs based on evidence from witnesses. It is important to note that although these are common characteristics, rural places are all different in their own way. The five characteristics identified are:

1. **Ageing population:** rural areas commonly have a disproportionate number of older people leading to higher levels of demand.
2. **Mental health:** geographical isolation and loneliness can heighten mental health issues in rural areas and there is also limited data available on rural mental health.
3. **Distance from services:** people in rural areas need to travel further to access treatment (often costing more) and often have less access to specialist provision and emergency services.
4. **Housing:** issues in rural communities such as the cost of housing, prevalence of older properties, fuel poverty, older populations and living alone can increase vulnerability to poor health and chronic illness.
5. **Cultural and attitudinal differences**, combined with remoteness from specialist provision, often lead to rural patients seeking medical help late; rural poverty and deprivation is linked to lack of confidence and aspiration.

The following section will explore some of these characteristics for Rutland.

Rurality of Rutland

Rutland is predominantly rural, as shown in figure 18 looking at the commonly used rural/urban classification from 2011 Census[34]. Rutland also has an ageing population, projected to keep increasing. From the 2021 Census[35], 25.1% of Rutland residents are aged 65 and over, compared to 19.5% for the East Midlands and 18.4% for England. 7.1% of Rutland residents are aged 80 and over, compared to 5.0% for both East Midlands and England.

The mid 2020 population estimates[36] show a significantly higher proportion of Rutland residents aged 65 and over were estimated to live in rural villages & dispersed households (37%) than Leicestershire (14%) and England (10%). There are similar findings for Rutland residents aged 80 and over, with 32% living in rural villages & dispersed households compared to 12% for Leicestershire and 10% for England. Figure 19 show these findings.

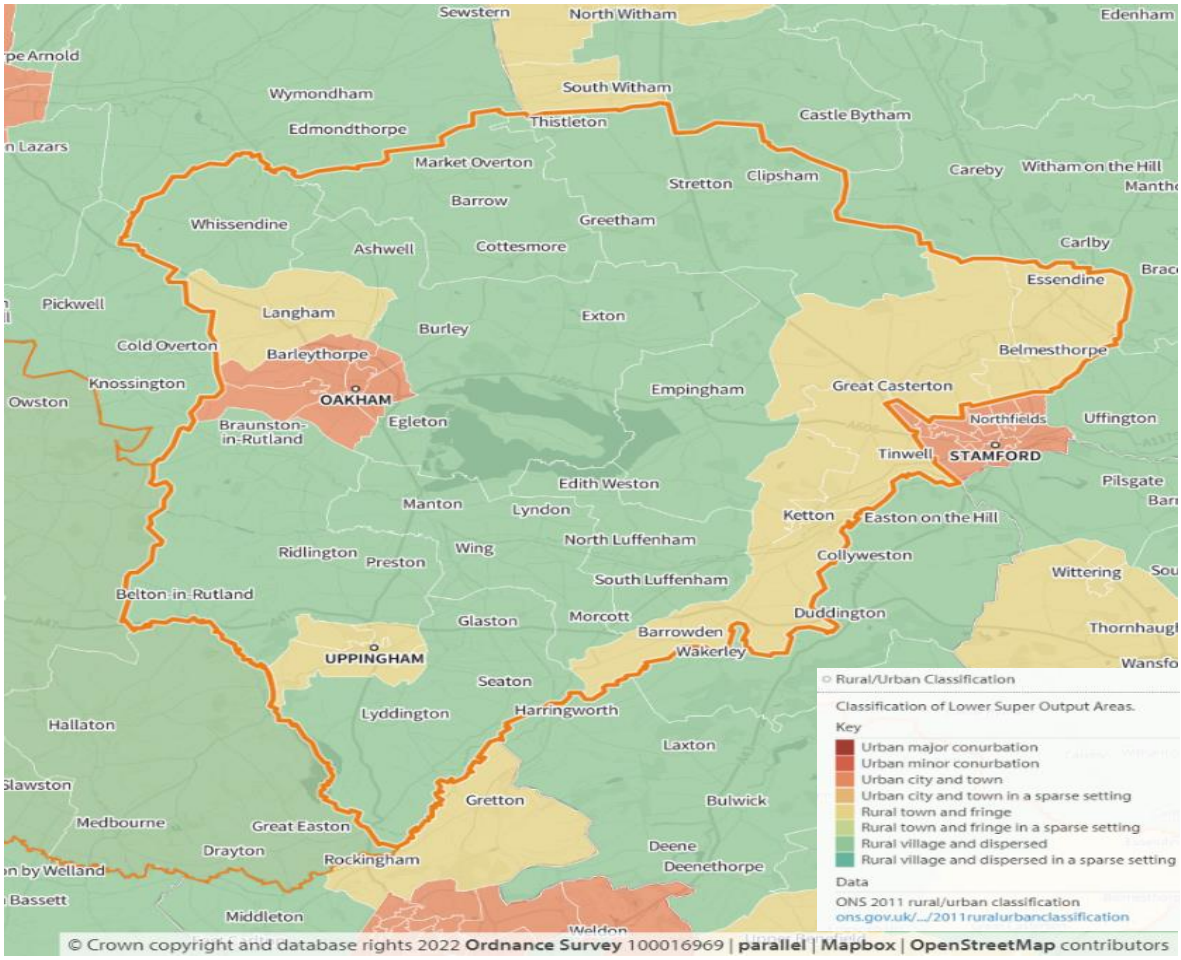


Figure 18 Rural/Urban Classification.

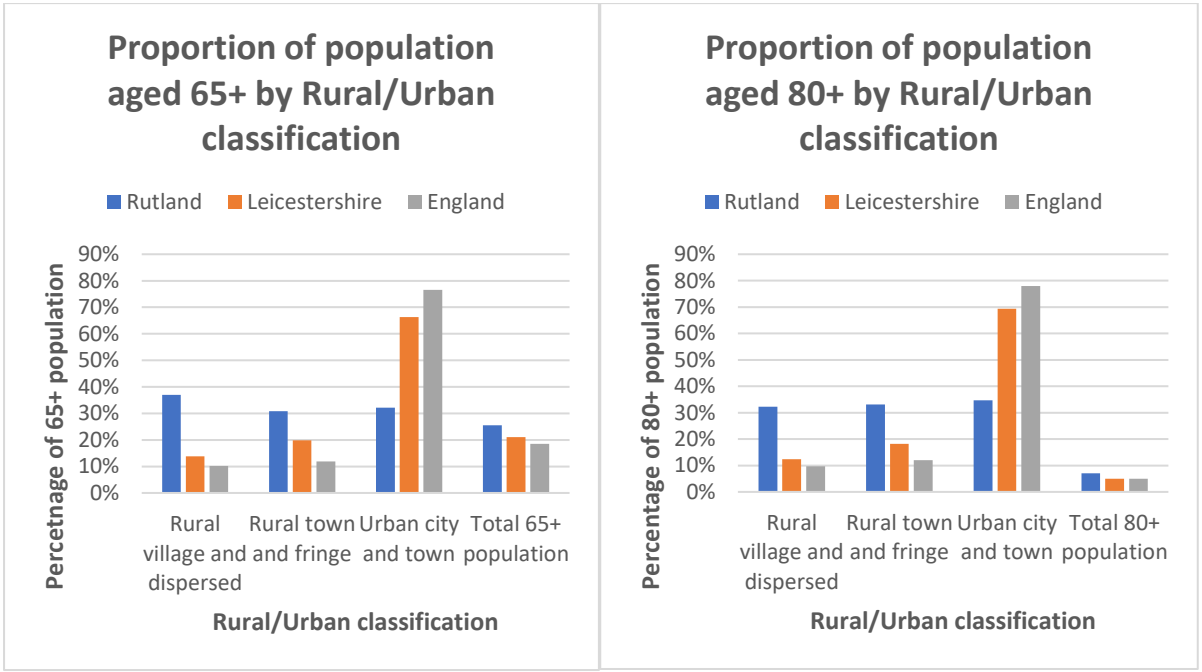


Figure 19 Proportion of population aged 65+ and 80+.

The following section will explore access to health services across small areas of Rutland. Although rurality may not always be a cause of poor health outcomes, a lack of accessibility to community and healthcare could lead to social isolation, poor mental health and difficulty managing long term conditions. Geography and location are key factors in determining how accessible services are, however there are other things to consider too, including car ownership, public transport, income, mobility, digital and health literacy. Where insight is available, the wider factors will also be explored to provide a rounded assessment of the impact of rurality of accessiblity locally.

Access to Primary Care

Figure 20 below shows access to GP Practices for residents living in Rutland **broken down by time taken to drive**. Mapping is provided in appendix 4. Access includes the four GP Practices located within Rutland (Empingham Medical Centre, Oakham Medical Practice, Uppingham Surgery and Market Overton & Somerby Surgeries) and the branch practice Barrowden Surgery (part of the Uppingham Surgery group), making up the Rutland Primary Care Network.

To ensure that the accessibility across boundary is accounted for, a 2km buffer is added. The buffer allows a further two GP Practices to be included in the mapping for Rutland residents, Glenside Country Practice in Castle Bytham and Lakeside Healthcare in Stamford. Three additional branch surgeries, are also included, although it's worth noting limited hours and service. These are Gretton Surgery in Corby (Uppingham Group), Coltersworth Medical Practice in Grantham and St Mary's Medical Centre in Stamford.

Looking at the time it takes to drive to the nearest GP surgery, **just under half of the Rutland population (49.8%) can access a GP within 5 minutes of driving**. This is largely due to the two most populous areas of Rutland (Oakham and Uppingham) having a GP Practice central to each respective town. The vast **majority (96.7%) of the population can access a GP within a 15-minute drive**, with 3.3% (or 1,355 residents) over 15, but within 20 minutes. The map in appendix 4 shows the majority of residents over 15 minutes are in the 005A Belton and Braunston LSOA on the border of Rutland towards the West.

Figure 20 below shows approximately **82.5% of the Rutland population living in 'rural villages and dispersed' can access a GP within a 10 minute drive, compared to 100% in 'rural town and fringe' and 'urban city and town' LSOAs.** The other 17.5% predominantly covers the LSOAs of 002D Whissendine and 005A Braunston & Belton.

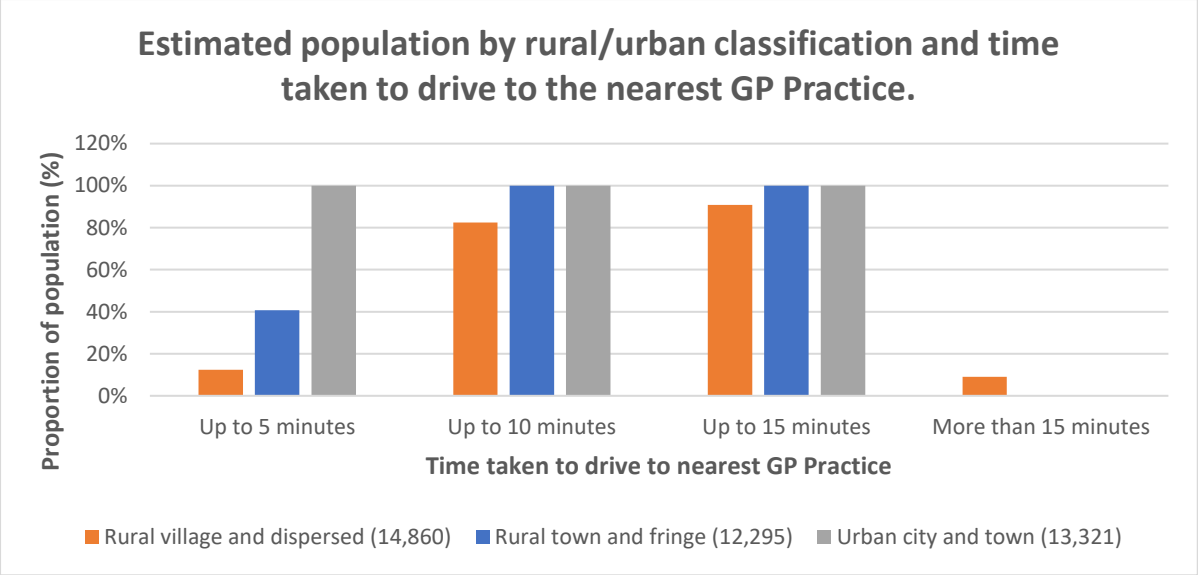


Figure 20 Access to GP Practices by time taken to drive.

For **public transport** (shown in figure 21), **59.2% of Rutland residents living in 'rural villages and dispersed' can access a GP within 30 minutes** by public transport, compared to **85.9% in 'rural town and fringe' and 100% in 'urban city and town'**. The areas are mapped in appendix 4, which shows the areas above 30 minutes are the most rural and furthest distance from the larger towns of Oakham, Uppingham and Stamford across border, such as Whissendine, Greetham and Braunston.

For **walking**, 12.4% of Rutland residents living in 'rural villages and dispersed' can access a GP within 30 minutes by walking, compared to 40.7% in 'rural town and fringe' and 89.2% in 'urban city and town'.

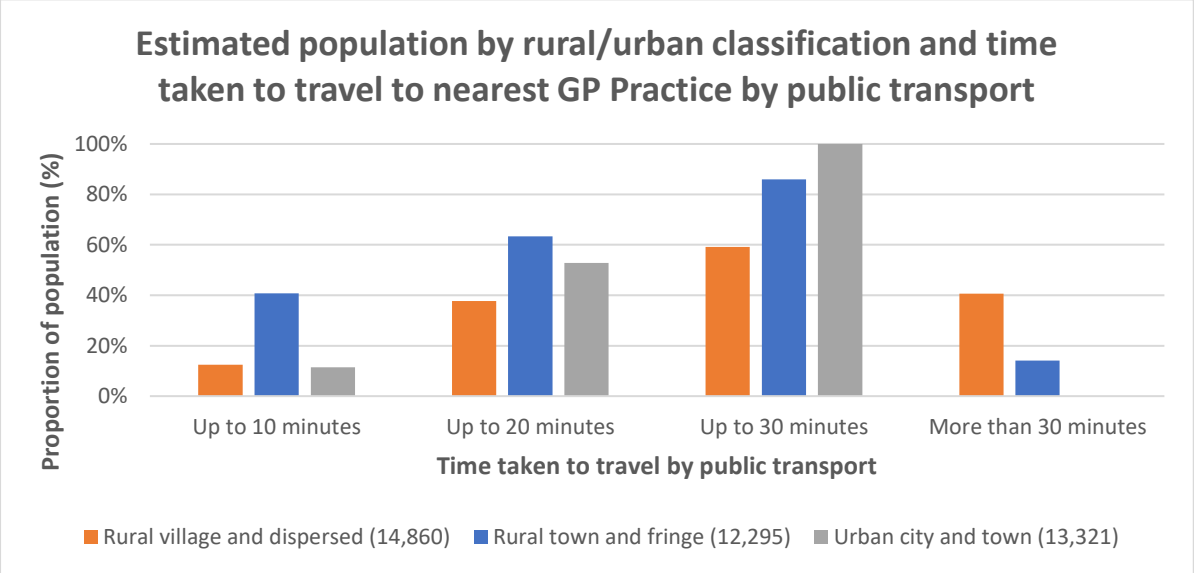


Figure 21 Access to GP Practices by time taken via public transport.

The findings for rural/urban classification may have been expected, however the scale may not have been appreciated. Although presented for GP Practices, it is likely a similar picture for other healthcare services and other aspects of health and wellbeing, such as employment, social opportunities and public spaces. Findings support consideration of further community outreach work and rural transport, engaging those living in the most rural communities of Rutland.

Access to hospitals

Access to acute hospitals can be challenging for Rutland residents, with the closest being across border. 57% of Rutland residents can access any acute hospital within 30 minutes and 100% within 45 minutes driving. There is however Rutland Memorial Hospital, a community hospital located in Oakham. Community Hospitals don't however provide all services you'd expect at a larger acute hospital. For comparison, 99% of Leicestershire residents can access within 30 minutes and 100% for Leicester. Similar rural areas Herefordshire and Shropshire have 90% and 82% of residents within a 30-minute drive respectively. Figure 22 below shows the majority of Rutland residents over a 30 minute drive from acute hospitals are within the west of the county.

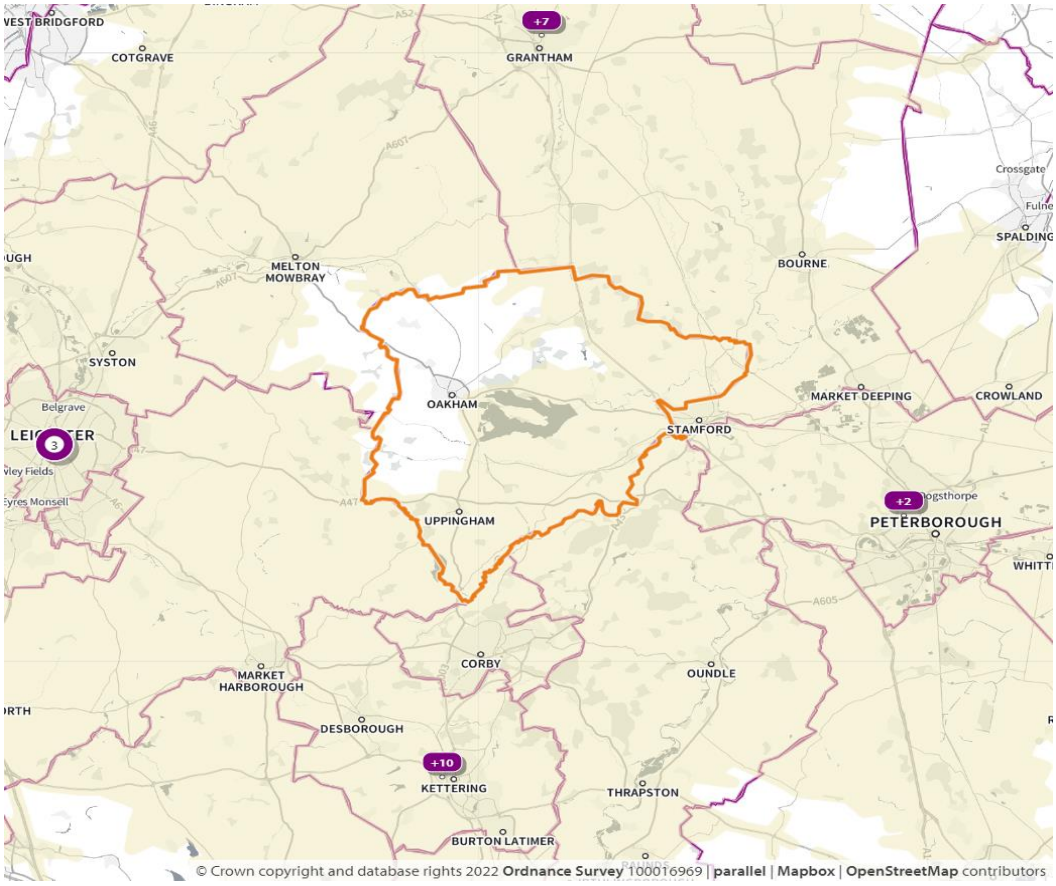


Figure 22 Proportion of Rutland residents within a 30-minute drive of acute hospitals.

Less than 30 minutes

More than 30 minutes

Whilst there are acute hospitals located within the Leicester, Leicestershire and Rutland ICS, they may not be the most accessible options for Rutland residents, based on geography alone. Figure 23 below shows for driving, Peterborough City Hospital (Cambridgeshire & Peterborough ICS) has the greatest proportion of Rutland residents within 30 minutes (25%) and 45 minutes (97%) by drive time. Then follows Kettering General Hospital (Northamptonshire ICS) and Grantham & District Hospital (Lincolnshire ICS). These findings emphasise the need for efficient cross border working with different ICS.

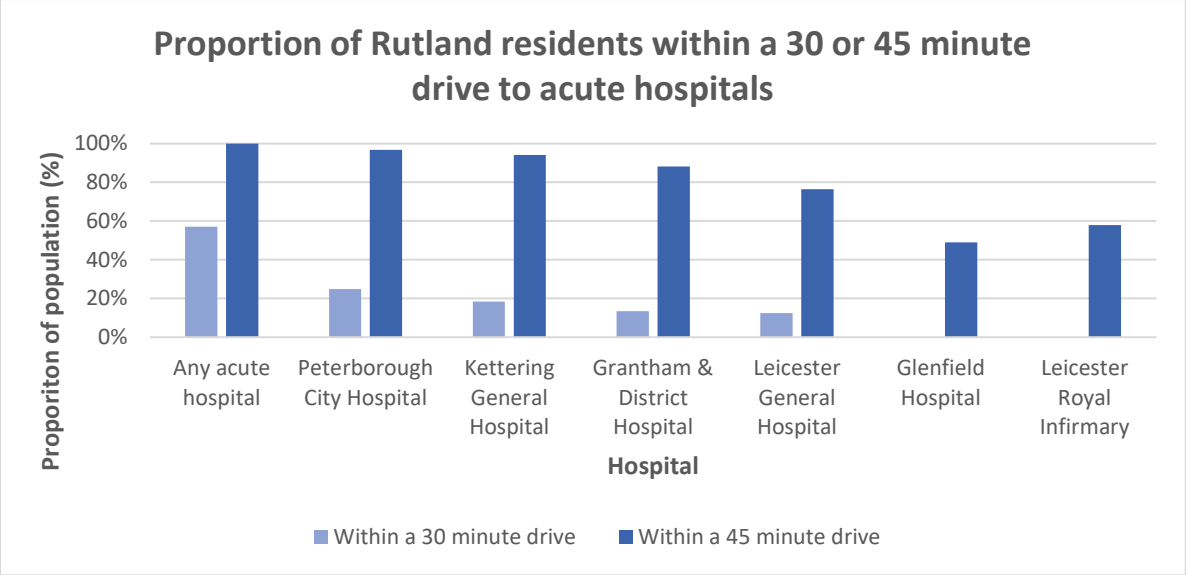


Figure 23 Proportion of Rutland residents within a 30- or 45-minute drive to acute hospitals.

For **public transport**, 33% of Rutland residents are within 60 minutes to any acute hospital. The 33% predominantly cover the Oakham area towards Leicester based hospitals. 64% are within 90 minutes by public transport. Rural comparisons to Shropshire and Herefordshire have almost double (60% and 64%) within 60 minutes by public transport. This demonstrates the importance of supported transport to acute hospitals and ensuring the public are notified of the support available to reduce barriers in access.

Community hospitals are more accessible for Rutland residents based on distance alone, with 73% of residents within a 15 minute drive to Rutland and 100% within 30 minutes. Additionally, it's worth noting 18.8% of the population is within a 15 minute drive to Stamford & Rutland Hospital across border, potentially offering easier access for residents living in the east of the county. Appendix 5 shows distance for all community hospitals in the area.

For public transport, 62% of the Rutland population are within 30 minutes of any community hospital, mainly covering the larger towns. 52% are within 30 minutes of Rutland Memorial Hospital and 10% within 30 minutes of Stamford & Rutland Hospital.

Current transport availability and limitations

Although a few years old, the Rutland County Council 2016 travel survey[37] found 67.5% of responders travel to hospital by car with 18.5% as a car passenger. 3.3% of responders travel by bus, 2.6% train and 3.4% community transport. 29% said they had difficulties or found it inconvenient getting to hospital appointments. Of those experiencing problems, findings indicate those aged 60 or over had greatest difficulty. The main five issues highlighted related to parking, lack of lift availability, congestion, reliability of public transport and timing of bus/train services.

For a rural place like Rutland, car ownership is viewed as a necessity, rather than luxury. The proportion of households without access to a car or van is lower in Rutland (12.4%) than the East Midlands average of 22.1% and CIPFA nearest neighbours 17.2%[38]. The Chartered Institute of Public Finance and Accountancy (CIPFA) nearest neighbours measures local authority neighbours based on characteristics, rather than closest borders. This offers a better comparison of similar areas.

Looking at rurality, households without cars are generally higher in Oakham and Uppingham compared to the more rural villages and dispersed households. This suggests the rural villages and dispersed households are more dependent on car usage, likely due to more limited public transport and active travel opportunities and further distances from community amenities.

Nationally, a transport survey by the Department for Transport in 2020[39] shows areas classified as rural villages & dispersed households having less trips per person per year across all transport modes (728) compared to rural town & fringe (801) and urban city & towns (772). Additionally, rural villages & dispersed households made less trips by walking and public transport, with more made by car. Whilst the rural villages & dispersed households of Rutland have more cars than rural towns, those who don't have access to cars are likely to be at greater risk of social isolation and have more difficulty accessing services. Rural villages had on average higher miles per person per year (even though they made less trips overall), which will increase the cost of travel for these households.

Figure 24 below shows the number of households without cars in LSOAs, including the rural/urban classification. Data is from the 2011 Census and will be updated once released for 2021 Census. For rural villages & dispersed households, Braunston & Belton 005A and Normanton 001D had the greatest proportion of households without cars, 9.6% and 9.4% respectively[38]. Across all rural villages & dispersed household LSOAs, there are a total of 392 households without access to cars.

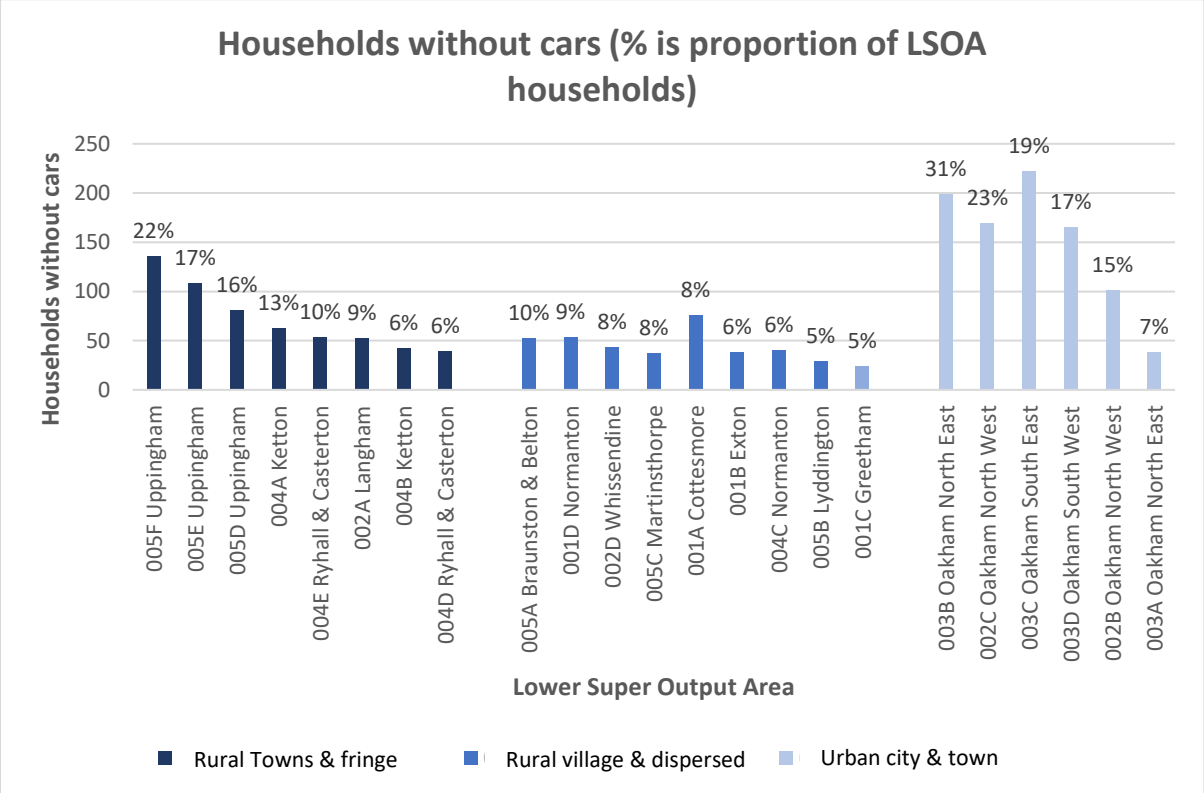


Figure 24 Households without cars (% is proportion of LSOA households).

Public transport is available, although buses do not operate late into the evening or on a Sunday. 1,800 residents (5%) do not have access to regular bus services and 25,000 (63%) currently have no access to demand responsive transport (DRT) [40]. A vision for improving the bus services in Rutland are set out in the Rutland County Council Bus Service Improvement Plan, aiming to make bus journeys more accessible and efficient.

There are a few other transport options for Rutland residents available, although the level of capacity varies depending on funding arrangements. The options are outlined in table 2 below and it's worth further exploration on how well these options are supported.

Table 2 Rutland transport options.

Transport offer	Description
Demand Responsive Transport	To help provide transport to residents unserved by scheduled services, RCC currently has an agreement within Lincolnshire County Council, to deliver a demand responsive transport service to the east of the county called CallConnect that runs only in response to pre-booked requests.
Community transport within Rutland is provided by Voluntary Action Rutland (VAR).	Through the service volunteers use their own cars to transport people who are either unable to use public transport, or for journeys where public transport is not available or is difficult. VAR also has three wheelchair-accessible vehicles (an MPV and 2 minibuses).
Hopper service	Rutland County Council currently delivers an in house, free of charge 'Hopper' service in Oakham town centre, delivered using in house minibuses.
Non-emergency patient transport	Eligible residents can access free of charge nonemergency patient transport or assistance with transport costs via the NHS. Transport is provided both to hospitals, and to hospital services delivered in the community. NEPT is provided solely based on medical needs; social need is not taken into account.

Digital exclusion and health literacy

Digital innovation in healthcare has accelerated recently, with the COVID-19 pandemic fast-tracking the growth. Digital solutions are positive, offering more flexibility for staff and patients alongside more cost-effective services. However, the rapid growth in the area has led to a digital divide. People may be digitally excluded for multiple reasons, including not having access to the required infrastructure/devices, a lack of skills, connectivity issues, lack of confidence or lack of motivation.

The rurality of Rutland can affect broadband availability and digital confidence and skills tend to be lower in older populations.

Factors influencing the digital divide include age, rurality, socioeconomic status and disability. An ONS survey in 2020[41] found on average 67% of people aged 65 and over used the internet daily compared to nearly 100% in all ages up to 54 years. A smaller proportion of people with a disability also used the internet daily, with 84% compared to 91% of those without a disability.

It can be difficult to assess who is digitally excluded due to a lack of a national dataset. However, a **Digital Exclusion Risk Index (DERI)** has been developed by the Salford City Council for adoption across Greater Manchester[42]. The Co-operative Councils Innovation Network used this model, expanding it to cover Great Britain and contains public sector information licensed under the Open Government Licence v3.0. The DERI provides a score between 0 (low risk of digital exclusion) and 10 (high risk) for all LSOA's based on the following three component scores:

1. **Deprivation** – includes IMD, skills and welfare recipients
2. **Demography** – includes information on disabled people and older residents
3. **Digital connectivity** – primarily focuses on broadband access

Developers are clear that the DERI can be used to provide context about levels of digital exclusion risk in an area, identify which areas require further investigation and help for prioritisation. It shouldn't be used to set score targets, monitor change over time or lead to investment without further investigation. Limitations include: data quality, with various sources used; data recency, some dating back to census 2011; and geography, presenting LSOA data as one homogenous area, likely with variation within.

Figure 25 below maps Rutland LSOAs by DERI score (A Leicester, Leicestershire and Rutland map can be found in appendix 6). There are areas of Rutland at greater risk of digital exclusion. Langham 002A has the highest score for Rutland at 6.5, followed by Ketton 004A (6.1), Martinsthorpe 005C (5.6), Oakham South East 003C (5.5) and Uppingham 005F (5.5). Only two LSOAs across LLR scored higher than Langham 002A.

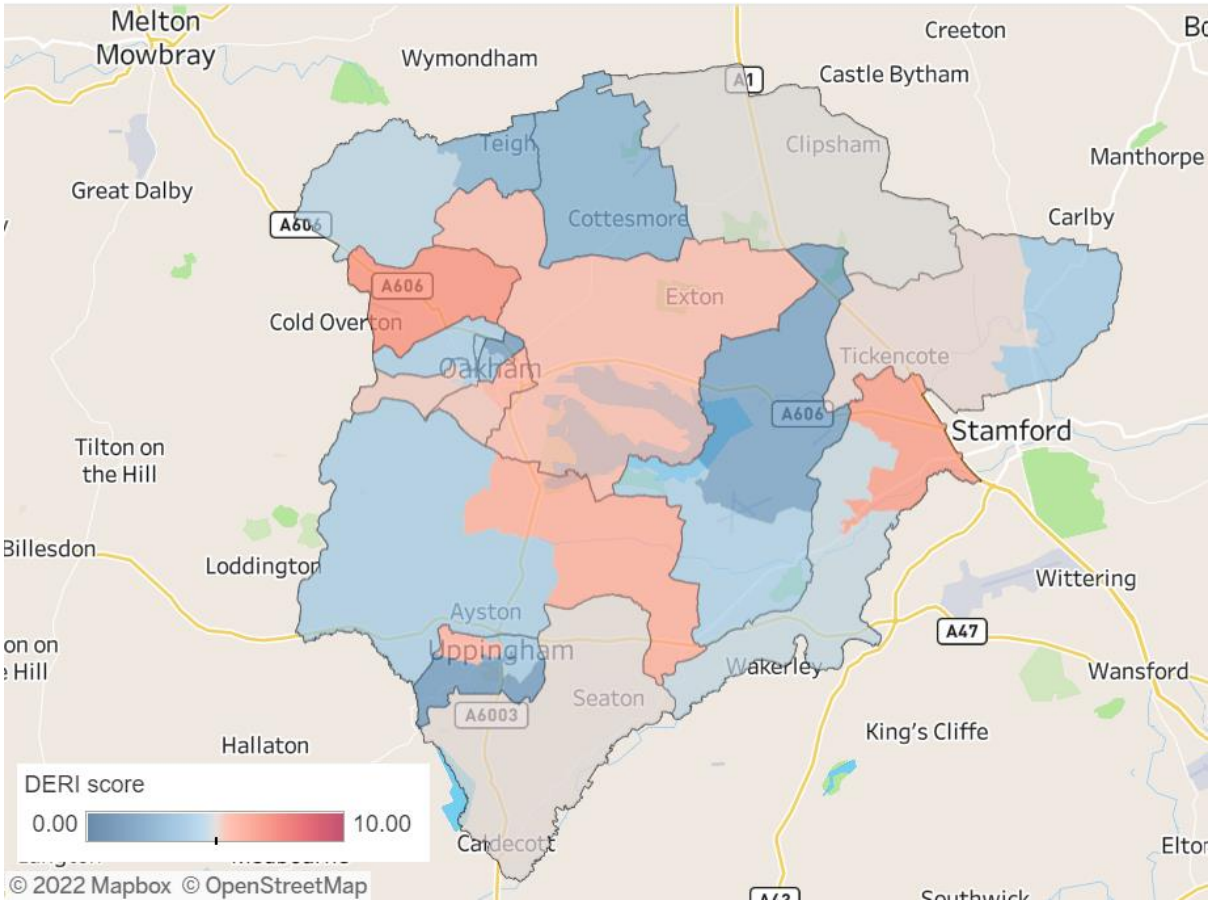


Figure 25 Digital Exclusion Risk Index mapping.

The DERI provides an initial guide to areas of potential risk. To inform effective recommendations, it's also important to look at each of the three components separately alongside the total index, as this will identify specific support recommendations. Table 3 below identifies the 5 highest scored LSOAs for each of the three risks - deprivation, demography, digital connectivity.

Table 3 Digital Exclusion Risk Index by domain.

Deprivation		Demography		Digital Connectivity	
LSOA	**Score**	**LSOA**	**Score**	**LSOA**	**Score**
002C Oakham North West	7.8	003C Oakham South East	8.1	002A Langham	9.1

005F Uppingham	7.6	005C Martinsthorpe	8.1	004C Normanton	8.5
001C Greetham	6.4	004A Ketton	7.1	004E Ryhall & Casterton	6.8
003B Oakham North East	5.6	002B Oakham North West	6.5	005B Lyddington	6.3
004A Ketton	5.5	003D Oakham South West	6.3	001B Exton	6.1

Health literacy refers to people having the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use and navigate health and social care information and services[43]. Limited health literacy is linked with poorer health outcomes and are more likely to access emergency services. People with limited financial and social resource are more likely to have limited health literacy. It is thought that improving health literacy is an effective method to reducing inequalities in populations.

Aa modelled estimate predicted 30.5% of the 16–64-year-olds population in Rutland to have low health literacy, although this was based on 2011 Census and 2016 population projections[44]. Whilst this is lower than the national average (40.6%), it is still a significant proportion. Taking action to improve population health literacy can help to increase health knowledge, build resilience, encourage positive lifestyle change and reduce the burden on health and social care services.

Broadband availability

Broadband availability continues to improve nationally, however, there are still areas and communities where poor access can impact how residents can access digital health appointments and find out about wellbeing support available. Considering the additional barriers rural communities have accessing face to face appointments than urban communities, it could be argued there is greater need for prioritising rural broadband development to improve accessibility.

Figure 26 below shows the Rutland and Melton constituency has poorer average broadband speed than the East Midlands and UK average[45]. There is also a rural/urban divide with rural areas of Rutland and Melton considerably lower than urban areas. For Superfast broadband, as of January 2022, 93% of Rutland households had access compared to the UK average of 96%. More urban areas of Rutland had 97% coverage compared to 90% for more rural areas. 21% had gigabit capability in Rutland in January 2022, compared to 66% UK average.

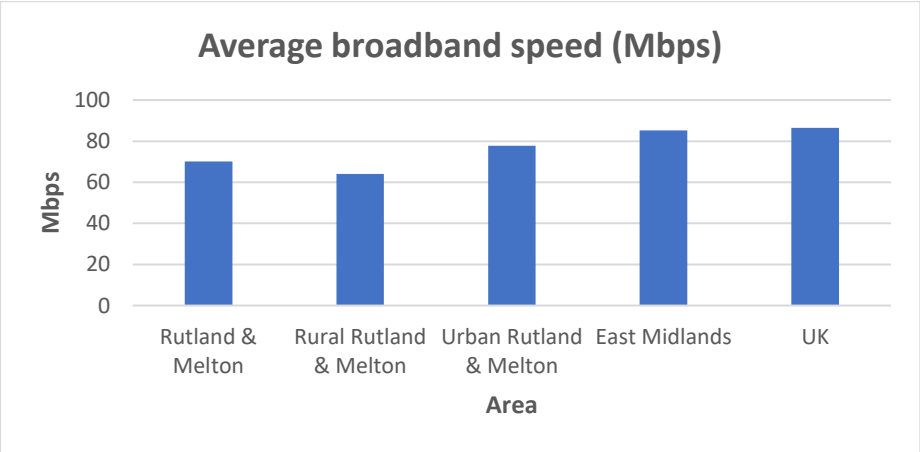


Figure 26 Average broadband speeds.

Within Rutland there are pockets of low coverage/speed in the worst 10% of areas in the UK. Oakham East has an average speed 42.8 Mbps, within the worst 10% of the UK. Ketton, Ryhall & Luffenham has 84.5% superfast availability, within the worst 10% of the UK. There are pockets of dispersed households or villages where speed is less than 10Mbps, including around Little Casterton, Greetham, Stretton, Brooke and Ridlington. The pockets are visually mapped in appendix 6.

Nationally, data suggests poorer internet access in households where one adult aged 65 or over lives alone[46], possibly linked to rural areas, with populations often older. In 2020, 80% of households with one adult aged 65 or over had internet access, compared to 95% with one adult living alone aged 16-64 and 100% for households with 2 adults aged 16-64 or households with children.

There are various reasons why residents access health information or appointments digitally. In 2020, 81% nationally used the internet to find information about goods or services, dropping to 64% for those aged 65 or over. 60% looked for health-related information, dropping to 40% for those aged 65 or over. COVID-19 has likely had an impact on this data, with more digital innovation being used for appointments. Whilst this may increase the proportion of people using this option, it may further exclude residents who aren't actively using the internet for such activity. It's therefore important to consider different approaches for age groups, as a single universal approach may not support everyone equally.

Skills and confidence

Although data isn't available locally, research by Lloyds indicates those with an impairment are 28% less likely to have the digital skills needed for daily life[47]. Additionally, the research found digital skills at foundation level for adults aged 18+ without an impairment were 87% compared to 68% with an impairment. Broken down, this covers 77% for Mental Health; 67% learning or memory; 61% physical; and 58% sensory.

Whilst the proportion of people using the internet nationally continues to increase, there are discrepancies when looking at age. In 2020, approximately 54% of people aged 75 and over used the internet in the previous 3 months, with approximately 84% of people aged 65-74[48]. All other age groups were above 90%. This shows digital inclusion is broader than connectivity alone and those aged 75 and over may not have the skills, confidence or willingness to use the internet.

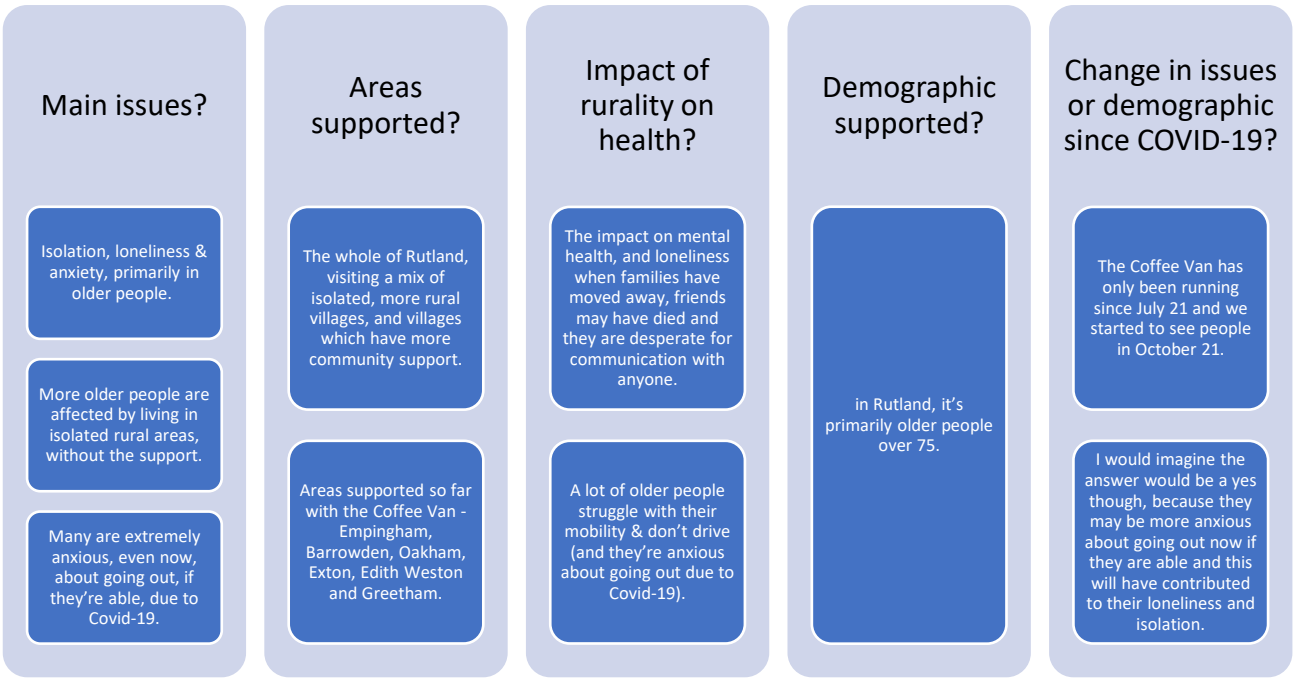
To mitigate against digital exclusion, The Leicester, Leicestershire and Rutland Integrated Care Board have funded local Voluntary and Community Sector organisations to deliver digital literacy programmes amongst groups of people for whom digital inclusion is often more of a challenge. They will be extending culturally competent programmes to more underserved groups. More complete data collection will be carried out, to identify who is accessing face-to-face, telephone, or video consultations, broken down by relevant protected characteristic and health inclusion groups.

Insight from community services

There is limited insight available differentiating the health of people living in rural areas compared to urban. The health of a rural population is typically better than urban populations, with higher life expectancy and lower risk of non-communicable disease. However, older, rural populations can lead to increase prevalence of poor health, even if the average is higher than urban areas.

When assessing the impact of rurality on health and wellbeing, it's important to ensure we understand the views of services and communities. The Rural Community Council, for example,

provide a range of services for rural areas, including the Rural Coffee Connect. Rural Coffee Connect shows up in different places across Rutland for people to enjoy a coffee, chat and build connections, aiming to tackle loneliness and isolation. In July 2022, the project lead provided insights into the issues, demographics and the impacts of rurality on health.



Rural farming communities

Farming is inherently isolated, with many farmers and farm workers living in rural areas with low access to amenities, poor internet access and a lack of social mobility and opportunities. While isolation is not always a negative thing, there are many occupational, physical and psychological risks associated with lone working, long working hours and a lack of social interaction.

In 2021, researchers engaged with farming practitioners, farmers and members of farming families to develop an understanding of loneliness and isolation in farming communities[49]. The research covers different types of farming. Although it was national research, findings help to identify specific needs of Rutland farming communities. It is recommended further engagement is done locally though to identify if there are similar issues to the evidence. A summary of the findings is presented below.

Loneliness is experienced to different degrees within farming. Some research participants stated they had never experienced loneliness, some experienced it previously and some are experiencing it now. Participants could therefore provide a range of perspectives on how the farming community can be supported and support themselves in preventing and coping with loneliness. The main suggestions were:

- **Regular social contact and getting of the farm** – farmers stressed the importance for mental health. Whilst farming-related social activity is beneficial, non-farming activity can be preferable.
- **Socialising and talking with other farmers** – opportunity to share problems and anxieties with those who understand and can relate.
- **Building good relations with the local community** – there was greater sense of social connection where farmers were involved in community activity (e.g., parish council)
- **Self-help strategies** – Some farmers found their own ways of coping with negative feelings. Organisations could support farmers to find self-help opportunities.
- **Farming-specific support** – stressed importance of farm-specific mental health support, with professionals who understand the farming context.
- **Information and training for healthcare workers** – developing an understanding of the issues and challenges faced by the farming communities for GP's and healthcare workers.

Section 2 recommendations

2. Targeted engagement with Whissendine 002D and Braunston & Belton 005A to develop understanding of potential barriers to accessing primary care and whether they are at greater disadvantage than other areas.
3. Ensure services are prioritising cross border working with neighbouring ICS to maximise opportunity for people to access support closest to home. For example, working with cross boundary ICS on access to acute hospital services.

4. Provide targeted digital skills programmes for population groups most in need, alongside universal provision. Identified in the report are people with mental health, learning, memory, physical and sensory impairments.
5. Engage with local farming organisations and communities to develop local understanding and consider the farming report recommendations on relieving loneliness.

Section 3 - Inclusion Health and vulnerable groups

Section 3 will highlight inequality across communities, inclusion health groups and vulnerable groups in Rutland. Certain communities may need support to be provided in a different way to reduce the likelihood of inequality, such as the Armed Forces. Inclusion health is a 'catch-all' term used to describe people who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases).

Armed Forces community

The armed forces community is a population with specific health and wellbeing needs based on its demographics, occupation and conditions in which they live. In general, the armed forces population have good health compared to the general population[50]. However, there are signs of disadvantage within the wider armed forces community if universal support doesn't consider specific needs. The specific circumstances in which armed forces families live can lead to difficulties for spouse employment, children's interaction within schools and armed forces transition into civilian life to name a few.

Rutland has a large armed forces community, currently across two sites – Kendrew Barracks and St Georges Barracks. St Georges is due to close by 2024, with most personnel based at Kendrew. As of 1st April 2021, 1,580 personnel were based in Rutland, of which 1,490 are Military and 90 Civilians[51]. Broken down by percentage of local authority population, as of 2015, Rutland had the third highest population share at around 3.7%, only behind Wiltshire and Portsmouth[52].

For Veterans, there is an estimated 4,000 veterans living in Rutland as of 2017, which is approximately 14% of the 16 years + population[53]. This is the largest proportion of total residents across every county in Great Britain. Local estimates say veteran numbers could be higher, up to 12,000. Once released, Census 2021 data will provide a clearer indication on the number of veterans in Rutland.

The NHS Long Term Plan outlines a commitment to 'expand support for all veterans and their families as they transition out of the armed forces, regardless of when people left the services' Additionally, the Armed Forces Covenant is a pledge that 'together we acknowledge and understand that those who serve or who have served in the armed forces, and their families, should be treated with fairness and respect in the communities, economy and society they serve with their lives'[54].

On behalf of the Armed Forces Covenant locally, Connected Together CIC carried out a survey to understand the population needs for across Rutland, South Kesteven and Harborough[55]. The survey suggested the main reasons for leaving the armed forces were - 48% end of service, 18% retirement, 17% due to impact on family life, 7% medical discharge.

The following will look at specific needs of the armed forces population relating to inequality may within the community, whether that be personnel, veterans, reservists or families.

Medical discharge

Most medical discharges from the Army between 2015 – 2020 were due to Musculoskeletal (MSK) disorders (58%), followed by mental and behavioural disorders (25%)[56]. Although not a direct comparison, the percentage of people reporting a long term MSK problem in Rutland was 21% in 2020[57]. At the same point, 51% of the national medical discharges were due to MSK disorders. When factoring in both principal and contributory cause of discharge MSK disorders increase up to 65%. These findings suggest there is a significantly higher proportion of Army personnel requiring MSK support as they transition to civilian life.

Overall, the Army had the highest rate of medical discharge across the three services. Females had significantly higher rates of medical discharge than males in all the years from 2015 – 2020, except 2017/18. The report suggests this could be due to their higher risk of MSK disorders and higher presentation of mental health disorders. Although the gap between medical discharges in untrained and trained personnel has been falling, the rate of medical discharge is still significantly higher in untrained.

Mental Health and Loneliness

From the Connected Together CIC survey[55], findings suggest veterans and the serving personnel had similar perceived loneliness, with 14% feeling lonely always or often for both populations. For the spouses of those serving, loneliness was considerably higher, with 29% feeling lonely always or often. Although not a direct comparison, the Active Lives Adult Survey[58] suggest 8% of the Leicester, Leicestershire and Rutland adult population feel lonely always or often as of 2020/21. This suggests the armed forces community experience greater loneliness, in particular spouses of those service.

Looking at age, the Connected Together CIC survey shows more younger veterans and spouses of service personnel reported feeling lonely always or often, with both decreasing as the age groups increase. There was limited variation in loneliness by age for the serving population.

Nationally, the Ministry of Defence[59] identified 10% of the Army population were seen in a military healthcare setting for a mental health related reason in 2020/21. This was a statistically significant decrease from 2019/20 with a rate of 12.4%. The Ministry of Defence suggest reductions in some routine and training activity due to COVID-19 could have reduced some of the military life stressors.

The same report found female Army personnel are at a significantly greater risk of a mental disorder (4.1%), compared to male personnel (1.9%). However, this could partially result from typically higher levels of healthcare engagement with females. For age, rates of mental disorders were highest in those aged 20 – 44 years. This differs from the general population where people aged 16 – 19 years had higher presentations to secondary mental health services.

Regarding medical discharges, it is stated above that the second highest cause is related to mental and behavioural disorders. Of the 25%, 8% relate to mood disorder (of which 7% depression) and 16% neurotic, stress related and somatoform (of which 10% Post-Traumatic Stress Disorder). Medical discharges have decreased over the 2015-2020 period, although the percentage caused by mental and behavioural disorders steadily increased from 21% in 2015 to 33% in 2020. A crude comparison to the general public shows a similar steady increase over the same time period looking at prevalence of depression. When considering both principal and contributory causes of discharge, mental and behavioural disorders were present in 43% of all discharges.

The Connected Together CIC survey also looked at access for support services. The most used service for all who took the survey within the last 12 months were mental health services (28%). Broken down, Mental health services were the 2nd highest type accessed in the last 12 months for serving personnel (23%) and Veterans (26%). For spouses, mental health services were highest at 31%. Other services with high access for the armed forces community can be attributed to poor mental health risk factors, including job centres, housing, social care, sexual health and domestic abuse.

Additionally, when asked how service history had affected their current life, serving personnel and veterans said mental health was highest. There was a strong reference to mental health affecting current life for spouses of serving, spouses of veterans, reservists and children. Nationally, this is reflected in the findings from the Ministry of Defence Continuous Attitudes Survey 2021[60]. The top five reasons factors influencing intentions to leave related to the impact on family and personal morale, both of which can impact negatively on mental health. Incidentally, mental health and healthcare provision were both within the top five reasons to stay in the armed forces. These findings demonstrate the importance of the transition period to civilian life, providing support as personnel leave due to impacts on their family and personal morale. A lack of support with accessing health, employment and income will likely lead to inequality for veterans in civilian life.

Access to support and services

Access to services and support can be more difficult for the Armed Forces community. Veterans can experience difficulties during transition from the Armed Forces to civilian life, whilst frequent movement across locations can present difficulty for families to know what is available in the community.

The Continuous Attitudes Survey found nationally, in 2021, 22% of Army personnel felt their family was disadvantaged in accessing NHS care, with 12% feeling advantaged compared to the general public. 37% felt disadvantaged accessing children's education compared to 17% feeling advantaged. Similar findings were found for family life, with 51% feeling disadvantaged and 11% advantaged compared to the general public. Housing and benefit access were more evenly balanced between feeling disadvantaged and advantaged. Whilst findings here are national based, the large feelings of disadvantage in certain aspects of life – children's education and family life – indicate an inequality for Army personnel which could also be present within Rutland.

Veteran inequality

Whilst the above sections allude to some level of inequality as Armed Forces personnel transition to civilian life – particularly when medically discharging – self-reported surveys indicate similar findings on different aspects of life, compared to non-veterans. That said, when we start to break down veterans into different characteristics, there are quite clear signs of inequality.

Starting with the whole veteran population, a Ministry of Defence survey in 2017 asked veterans about different aspects of life and compared findings to the non-veteran population[61]. Veterans said their health overall was a similar level to the non-veteran population and they were just as likely to have bought their own home.

There were also no differences in who had a qualification, although more non-veterans had a degree (30%) compared to veterans (21%). A greater proportion of veterans gained a qualification through work (60%) compared to non-veterans (43%). There were similar levels of employment, although type of employment differed. Veterans aged 16-34 were more likely to work as 'process, plant and machine operatives' than non-veterans and less likely to work in 'professional occupations'.

The survey found no differences between veterans and non-veterans' self-reported health conditions. However, when broken down by age, veterans aged 35-49 were significantly more likely than non-veterans to report problems with the following:

- Back or neck related conditions (34% and 23% respectively)
- Leg or feet related conditions (33% and 20% respectively)
- Arm or hand related conditions (22% and 13% respectively)

Looking at population characteristics, the findings suggest some additional inequality within the veteran population as follows:

- Male veterans of working age were significantly more likely than female veterans of the same age to report having diabetes (15% and 8% respectively) and difficulties with hearing (11% and 4%).
- Male veterans of retirement age were significantly more likely than female veterans of the same age to report having heart, blood pressure and/or circulatory problems (53% and 42% respectively).
- Female veterans of retirement age were significantly more likely than males to currently smoke (20% and 11% respectively).
- Veterans in some age groups were significantly more likely to have ever smoked than non-veterans (18-34 years, 50-64 years and 65-69 years).

Great Britain is projected to have a 7% decrease in the veteran population by 2028, based on baseline data from 2016[62]. However, female veterans are projected to increase by 3% over the same period, indicating a greater proportion of veterans will be female. A report in 2021 did a scoping review of available research and conducted interviews with subject matter experts to explore the needs of female veterans [63]. The review presents the relationships between pre-service experiences and service life on post-service outcomes.

The review found over half of female veterans may have experienced childhood adversity, which has been linked to leaving the Armed Forces prematurely. Subject Matter Experts echoed this finding, highlighting the potential impact of adverse childhood experiences and socioeconomic disadvantage in early life on health and wellbeing post service. 20% of those interviewed had been in Local Authority care during childhood and over 50% reported joining the Armed Forces to escape an abusive home environment. A summary of findings related to health are presented below.

Health conditions	Mental Health	Access to services	Finances, employment & housing	Social relationships
• Most of the gender differences reported in the physical health of veterans reflects gender differences seen in the general population. • However, female veterans are more likely to report headaches, fatigue, digestive issues, and less likely to report acute MI, non-melanoma skin cancer, alcoholic liver disease and substance misuse than male veterans.	• Research suggests ex-servicewomen are at a lower risk of self-harm/suicide than male veterans, but at a higher risk of common mental health disorders. • Compared to civilian women, female veterans are at increased risk of posttraumatic stress disorder (PTSD) and suicide/suicidal thoughts.	• UK research suggests that whilst female veterans are more likely to access formal medical support, they are less likely to access informal sources of support in comparison to male veterans. • SMEs suggests that a lack of uptake of informal support in women appears to be related to both the male-dominated nature of many veteran support organisations and a lack of awareness of female-only support networks.	• US research indicates that female veterans are at increased risk of homelessness compared to civilian women. • Female veterans in the UK are more likely to be unemployed, but less likely to claim unemployment benefits compared to male veterans. • UK research and SMEs suggest that barriers to employment for female veterans include poor mental health, finding suitable employment, inability to recognise and articulate transferable skills to civilian employers.	• Limited research suggests that female veterans are more likely to be divorced than men, with additional strain associated with dual-serving partnerships. • SMEs reported difficulties associated with readjusting to family life following discharge, and this was seen to be particularly challenging for single female veterans with children.

Carers

Providing unpaid care often impacts negatively on health and wellbeing, increasing the likelihood of poor health compared to non-carers[57]. COVID-19 has had a significant impact on the number of people providing care, according to the State of Caring 2021 report[64]. Being a Carer also impacts other aspects of life, such as relationships, finances and emotional wellbeing. During the pandemic, an estimated 26% of people were providing care. This estimate is thought to have decreased, however by how much is not yet clear. Applying this national estimate to the Rutland population, approximately 11,000 people *may* have been providing care at the peak of the pandemic. When released, Census 2021 data will help to identify a more reliable indication of how many people in Rutland are unpaid carers.

Data from the Rutland Primary Care Network (PCN) indicates the proportion on patients registered as 'Carers' on their records. Primary care awareness of carers helps to ensure they have the support they need. As of August 2022, Market Overton & Somerby Surgeries had 176 patients recorded as carers (3.5%), Empingham Medical Centre 352 patients (3.7%), Uppingham Surgery 183 patients (1.5%) and Oakham Medical Practice 462 patients (3.0%). Overall, the Rutland PCN has 1,173 patients registered as carers or 2.8%. This could indicate there are many carers primary care isn't aware of and needs further exploration.

A report by Carers UK[65] using data from the 2021 GP Patient Survey looked closer at the health of carers compared to non-carers. The key findings from the survey relating to inequality are presented below. 18% of the 850,000 respondents have some unpaid care responsibilities. Whilst this provides a good indication of carers needs in Rutland considering the large sample size, further work to understand if the findings are similar locally would be beneficial.

Long-term conditions, disability and illness	Mental Health	Social isolation
•**60% of carers stated they had a long-term condition**, disability or illness compared to **50% of those who weren't caring**. The most likely were arthritis, back or joint problems and high blood pressure. •**69% of those providing 50 hours or more** reported having a long-term condition compared to **58% providing less than 35 hours**. •**Older and retired carers were also most likely to report having a long-term condition**, 79% and 76% respectively.	**27% of carers not in work** declared they had a mental health condition compared to **12% of working carers and 5% of retired carers.** •**26% of carers under the age of 25** had a mental health condition, compared to **5% of carers over 65.** •**36% of lesbian, gay and bisexual carers** had a mental health condition compared to **13% of heterosexual carers.**	•**18% of carers reported feeling isolated** compared to 14% of those who weren't caring. •**Feeling isolated increased during COVID-19,** from 8% in 2019, 9% in 2020 and 18% in 2021. •**32% of carers aged under 25** reported feeling isolated over the last 12 months, **compared to 12% over 65.**

In 2011 3,799 Rutland residents stated they were providing unpaid care, approximately 10% of the population. From the 3,799, 671 were giving 50 or more hours of unpaid care per week. The percentage of people giving between 1 and 19 hours of unpaid care per week is higher in Rutland than it is regionally or nationally. With growth in Rutland projected to be significant in older age groups, the level of unpaid care is likely to increase.

Overall, Carers have significantly lower levels of physical activity (14%) than all adults (54%)[66]. 46% of Carers are inactive, compared to 33% of all adults, with the remaining fairly active. The greatest barriers were limited time, lack of motivation, affordability and not having anyone to go with. 76% of Carers do not feel that they can do as much physical activity as they'd like to do and is highest in Carers who are disabled, lonely or struggling financially.

Homelessness

Homelessness is widely researched as both a cause and result of health inequality[67]. Homelessness can have negative impacts on different aspects of life, including education, poor social and health outcomes. The causes of homelessness are often from a combination of events, such as substance misuse, relationship breakdown, debt, adverse childhood experiences and ill health. As a result, homelessness has a negative impact on both physical and mental health, often leading to significantly shorter life expectancy. The average age of death for the homeless population is 30 years younger than the general population[68].

Other risk factors of homelessness and vulnerabilities include leaving care, leaving the armed forces, leaving prison and domestic abuse. With the high proportion of armed forces personnel and veterans in Rutland, support at the point of transition to civilian life is crucial.

In 2020/21, Rutland had 85 households owed a duty under the Homelessness Reduction Act (to prevent or relieve homelessness), down from 98 in 2019/20. This is a rate of 4.9 per 1,000, which is significantly lower than the East Midlands (9.8 per 1,000) and England (11.3 per 1,000). For households with dependent children owed a duty under the Homelessness Reduction Act, Rutland was similar to East Midlands and England in 2020/21. Rutland had a rate of 9.2 per 1,000 compared to 11.9 for East Midlands and 11.6 for England.

Table 4 below looks at the causes, risk factors and demographics of households owed a prevention or relief duty[69]. Understanding the reasons for loss of a settled home can help to inform preventative action. However, it's important to note loss of a settled home is typically because of multiple causes. Table 4 shows the reasons reported by affected households.

Additionally, the table shows those most at risk are predominantly single parents or adults, with females highest for prevention duty and males for relief duty. There are also indications applicants aren't solely unemployed and those in full time or part time work are also affected.

Table 4 Homelessness Relief and Prevention breakdown.

Initial assessment indicator 2020/21	Top 3 responses
Reason for loss of last settled home for households owed a prevention duty	1. Family or friends no longer willing or able to accommodate (44.7%) 2. End of private rented tenancy (25.5%) 3. Non-violent relationship breakdown with partner (14.9%)
Reason for loss of last settled home for households owed a relief duty	1. Domestic abuse (28.9%) 2. Family or friends no longer willing or able to accommodate (23.7%) 3. Non-violent relationship breakdown with partner (15.8%)
Household type owed a prevention duty	1. Single parent with dependent children – female (27.7%)

	2. Single adult – female (23.4%) 3. 'Single adult – male' and 'Couple with dependent children' (both 17.0%)
Household type owed a relief duty	1. Single adult – male (50.0%) 2. Single parent with dependent children – female (28.9%) 3. Single adult – female (10.5%)
Support needs of households owed a prevention or relief duty	1. History of mental health problems (9.4%) 2. At risk of / has experienced domestic abuse (7.1%) 3. Physical ill health and disability (4.7%)
Age of main applicants	1. 35-44 years (30.6%) 2. 25-34 years (25.9%) 3. 18-24 years (23.5%)
Employment status of main applicant	1. Registered unemployed (28.2%) 2. Full-time work (21.2%) 3. Part-time work (15.3%)

Support available

Support currently available in Rutland for the main risk factors of homelessness and prevention services available is outlined below. This helps to identify any gaps in the current level of provision based on the needs outlined above. Please note this isn't an exhaustive list and more support may be available.

Risk Factors	Homelessness prevention	Homelessness relief
•**Domestic Abuse services** - UAVA, Living Without Abuse, Refuge, The Hope Project, Citizen's Advice Rutland. •**Substance Misuse services** - Turning Point, Family Action. •**Mental Health services** - many across organisations such as Mental Health Matters, CAMHS, MIND support, IAPT, Peppers. •**Income support services** - Citizens Advice Rutland.	•**Tailored support for people at risk of homelessness** - P3 Rutland Housing & Homelessness Floating Support Service. •**Information around services and housing advice** - Rutland County Council Housing Options. •**General advice on housing** - Citizens Advice Rutland.	•**Support for people who are homeless or threatened with homelessness** - Rutland County Council Housing Options. •**Tailored support for people in housing need** - P3 Rutland Housing & Homelessness Floating Support Service.

Gypsy, Roma, and Traveller communities

Evidence suggests Gypsy, Roma and Traveller communities have significantly poorer health than the general population across most outcomes, summarised by the Office for Health Improvement &

Disparities[70]. Gypsy and Traveller people have life expectancies 10-12 years shorter than the general population. 42% are affected by a long-term condition, as opposed to 18% of the general population. They are also nearly three times more likely to be anxious and twice as likely to be depressed. Gypsy, Roma and Traveller communities have disproportionately high levels of infant mortality, child mortality and still birth. Mothers are 20 times more likely to experience the death of a child.

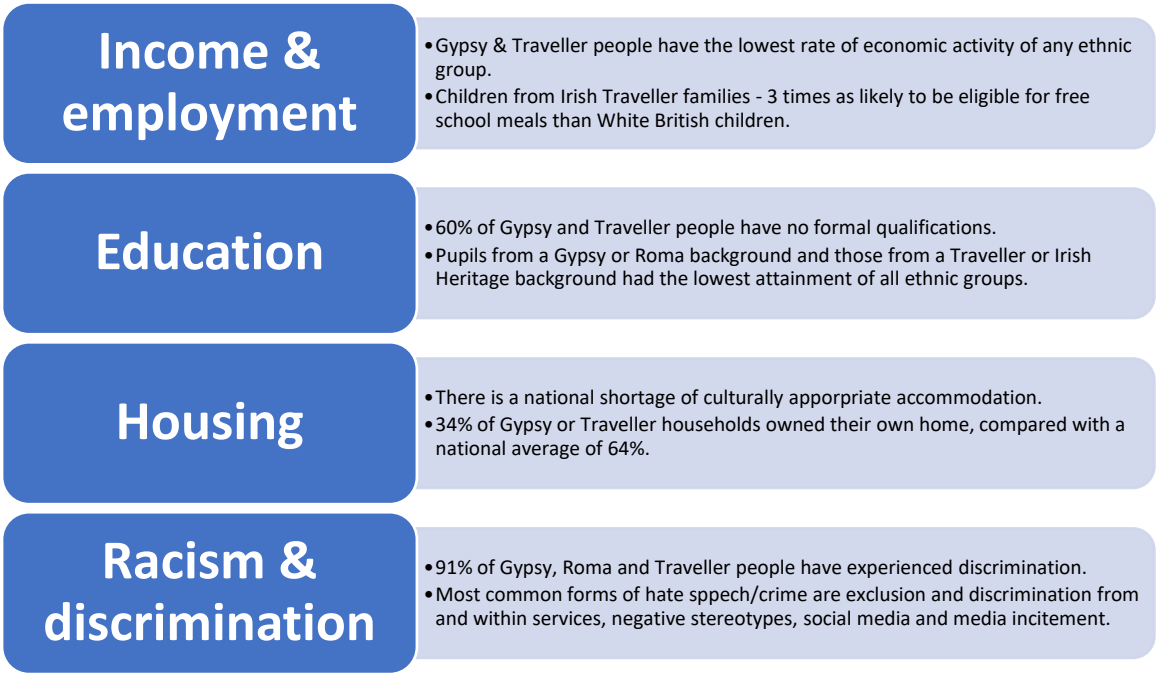
From the 2011 Census, there were 58 White Gypsy or Irish Traveller's in Rutland. There was no Roma category available at the 2011 Census. This represented 0.16% of the total Rutland population. There are 3 authorised sites for Gypsies and Travellers and 3 authorised sites for Travelling Showpeople in Rutland. There is one unauthorised encampment for New Travellers in Rutland. Rutland County Council has commissioned a Gypsy, Traveller and Travelling Showpeople Accommodation Assessment which is expected to start survey work on sites in September 2022.

Nationally, Gypsy or Irish Traveller households were made up of a higher proportion of lone parents with dependent children and a higher proportion of households with dependent children.

From the OHID report, they also looked at access to healthcare services, which Gypsy, Roma and Traveller people can have difficulty with. The national findings will be explored locally, with the Gypsy, Traveller and Travelling Showpeople Accommodation Assessment mentioned above. Access to healthcare was impact by the following reasons:

- **Being refused registration**
- **Discrimination and poor experiences**
- **Lack of cultural sensitivity**
- **Stigma**
- **Low literacy**
- **Language barriers**
- **Digital barriers**

The OHID report also summarises inequality across the wider determinants of health, which can be contributing factors to the poorer outcomes outlined above. A summary is provided below.



Prison population and prison leavers

Prisoners tend to be of poorer health than the general population and have complex health needs. Research suggests people in prison are more likely to have been taken into care or have experienced abuse as a child, been homeless or in temporary accommodation, or unemployed[71]. Natural causes are the main cause of death in prison, with the leading cause being disease of the circulatory system (43%) followed by cancer (32%). NHS England has overall responsibility for the commissioning of prison healthcare in the region.

There is one prison facility in Rutland, a Category C men's prison near Oakham (HMP Stocken), currently holding approximately 1,009 men with an operational capacity of 1,044 as of March 2021. NHS England and NHS Improvement commissioned a Health and Social Care Needs Assessment in 2021 to better understand the health needs of the resident population at HMP Stocken[72]. The following paragraphs cover a brief overview of findings.

HMP Stocken has a similar distribution of age to the national average, although higher in lower age groups. Approximately 36% of HMP Stocken population is aged 30-39 years, 33% aged 21-29 years and 20% aged 40-49 years. 39% of residents in 2021 have a disability on record, higher than comparators.

Most of the healthcare at HMP Stocken is delivered from the healthcare centre, consisting of a GP room; two mental health rooms; a shared room for physiotherapy and podiatry; an optician suite; a triage room; a bloods room, and two multi-use rooms. In the NHS England survey, residents' satisfaction with healthcare has improved, with 41% of patients reporting they thought healthcare was 'excellent' or 'good'.

On health outcomes, 6% of patients at HMP Stocken reported 2 or more long term physical health conditions, similar to comparator establishments. 76% of residents in 2021 were identified as having a mental health issue, including substance misuse, higher than the predicted 47%.

Limited data is available on prison leavers, however it's worth noting most residents at HMP Stocken are from Nottinghamshire, Derbyshire and Leicestershire. This could mean the number of prison leavers residing in Rutland is low, although this is only an assumption based on where they're from whilst at HMP Stocken.

Section 3 recommendations

6. Develop new insight for the armed forces community in Rutland, covering the impact of COVID-19, female veterans and mental health.
7. Respond to findings from the LLR Carers Strategy consultation before determining specific recommendations for Rutland.
8. Respond to findings from the commissioned Gypsy, Traveller and Travelling Showpeople Accommodation Assessment starting in September 2022 and consider the population as a 'Plus' group for Core20Plus5.

Section 4 - Protected Characteristics in the Equality Duty

Understanding the Rutland demographics in relation to the 9 protected characteristics outlined in the Equality Act 2010 will largely be presented within the Rutland Joint Strategic Needs Assessment.

However, it's worth a closer look at some of the protected characteristics in relation to inequalities, as they can be a contributing factor to poorer access or health outcomes. Most of the insight into protected characteristics comes from Census. Census 2021 data is yet to be released for most protected characteristics and will be updated once released, including those not covered below.

Protected characteristics

Age

Rutland has a significantly higher proportion of the population aged 65 and over at 25.1%, compared to England (18.4%) and East Midlands (19.5%)[73]. Rutland also has a greater proportion aged 80 and over at 7.1% compared to 5.0% for the East Midlands and 5.0% for England. All 5-year age groups aged 70 and over had significant increases in population size from the 2011 to 2022 Census, ranging from a 25% to 48% increase.

Older age groups are projected to increase at a faster rate than younger age groups based on 2011 Census and the 2020 population estimates[74]. Figure 27 below presents this, showing the greatest level of growth in those aged 80 and over, an 80% growth from 2020 to 2040 (2,819 people in 2020 to 5,074 in 2040). For those aged 90 and over, a 115% growth from 2020 to 2040 is estimated (527 people in 2020 to 1,135 in 2040) For working age adults, population size is projected to stay at a similar size to 2020.

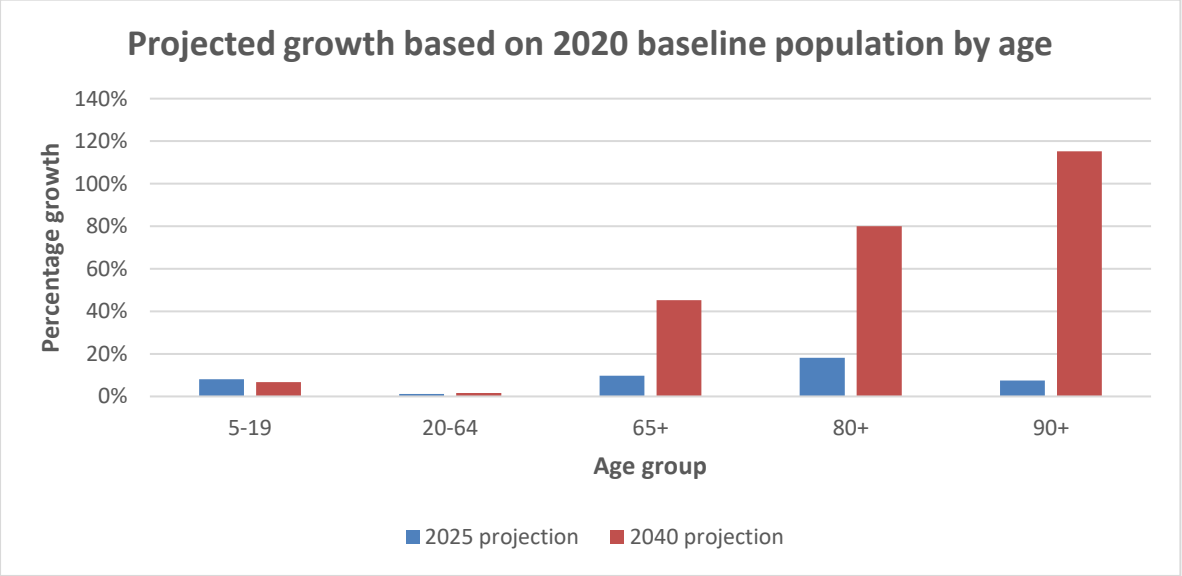


Figure 27 Projected growth based on 2020 baseline population by age.

Public Health England reviewed evidence of 36 studies focusing on the determinants and drivers of health inequalities experienced by older populations in rural areas[75]. Whilst every rural area has its own unique characteristics, there will be commonalities. The determinants and drivers were found to be:

- Mobility.
- Exclusion, marginalisation and lack of social connections felt by certain groups such as LGBT+ or those who are divorced or living alone.
- Being socially detached and lack of community support.
- Lack of access to health and other community-based services due to lack of transport and distance from services which again can contribute to feeling isolated.

- Equitable outcomes costing more in rural areas.
- Financial difficulties experienced by older people themselves in rural areas including fuel poverty and housing issues, different types of treatment provided in rural areas.
- Workforce challenges facing the NHS and social care in rural areas such as recruitment, retention and development.
- Lack of awareness of certain conditions or services.

Whilst the overall proportion of people aged 65 and over is higher in Rutland, there is variation when you focus on smaller geography[36]. It is estimated that approximately 36% of residents in the Oakham South ward are aged 65 and over, compared to approximately 12% in Barleythorpe. Only Barleythorpe and Greetham were below the England average, shown in figure 28 below.

As referenced earlier, being socially detached can be a driver of inequality in rural areas. In the aged 65 and over population of Rutland, there are two wards where the proportion of the age group is higher than the England average – Oakham North East and Uppingham. Oakham North East is considerably higher at approximately 39%, with Uppingham approximately 34%.

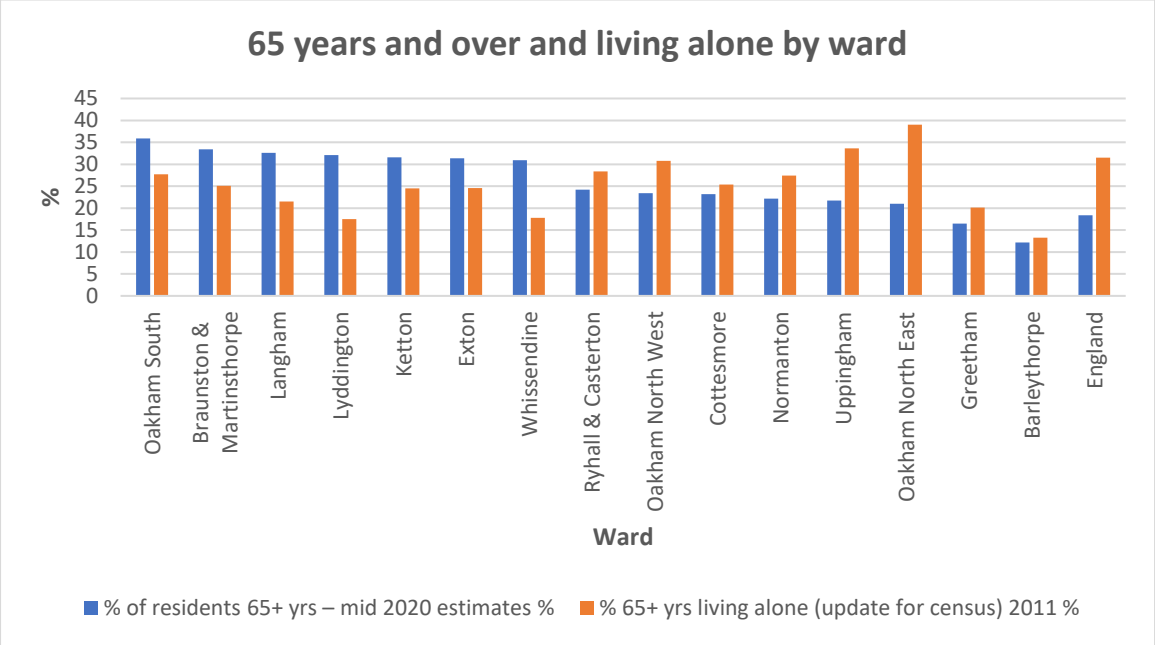


Figure 28 65 years and over and living alone by ward.

Looking at certain health indicators relating to age suggests some priority areas to consider where Rutland performs worse than other areas.

Firstly, the estimated dementia diagnosis rate for those aged 65 and over in Rutland, as of April 2022 is 50.0%, compared to 61.8% nationally and 61.9% for the Leicester, Leicestershire and Rutland ICS[76]. This relates to approximately 350 receiving diagnosis and approximately 350 more currently undiagnosed. Rutland is ranked 2nd worst for estimated dementia diagnosis out of 152 upper tier local authorities. It's important to note this doesn't guarantee levels of undiagnosed dementia, with the rate being an estimate based on population demographics in an area.

Another area where Rutland performs worse linked to age is the Excess Winter Deaths Index (EWD Index)[77]. The EWD Index is the excess of deaths ratio in people aged 85 and over. The excess winter deaths indicator looks at the ratio of excess deaths in the winter months in winter (*December to*

March) compared with non-winter months from the preceding *August to November* and the following *April to July* expressed as a percentage.

For 2019-20, Rutland had an EWD Index of 50.2%, significantly higher than England at 17.4% and the East Midlands at 18.4%. This means there was approximately an extra 1 in 2 deaths in winter compared to non-winter months. Looking specifically at those aged 85 and over, Rutland had an EWD Index of 61.5%, significantly higher than England at 20.8% and East Midlands at 23.1%.

Colder homes are typically associated with higher levels of excess winter deaths from cardiovascular disease. Poorly insulated homes and lack of access to mains gas can contribute to fuel poverty. Rutland has a high number of off-gas properties, particularly in the most rural areas.

Relating to **health behaviours**, many discrepancies exist between different age groups looking at data for England. The below chart summarises the findings, with comparisons showing the significant difference between age groups and the England average[77]. For adults, obesity and physical inactivity both increased with age, both risk factors for many preventable diseases. Smoking prevalence decreased with age.

Smoking prevalence in adults 2020/21	• Significantly worse - **aged 18-54** • Significantly better - **aged 65 and over** • **Trend** - decreasing with age
Adults classified as overweight or obese 2020/21	• Signficantly worse - **aged 45 and over** • Significantly better - **aged 18-34** • **Trend** - increasing with age
Physically inactive adults 2020/21	• Significantly worse - **aged 75 and over** • Significantly better - **aged 19-64** • **Trend** - increasing with age

Looked after children (LAC) are a vulnerable group and face a range of social and health inequalities. They have poorer educational outcomes; higher rates of special educational needs; higher rates of emotional and mental health problems; and when they leave care, they experience higher rates of homelessness and unemployment when compared to their peers who are not looked after[78]. Looked after children had an average attainment 8 score of 23.2 in 2021 compared to 54.5 for the England average and 22.6 for children in need.

In 2021, Rutland had a rate of 43 looked after children per 10,000 children under the age of 18. The CIPFA average was 61 per 10,000 and England average 74 per 10,000[79].

Disability

From the ONS Annual Population Survey 2020/21 for 16–64-year-olds, 200,000 individuals were asked various questions about their wellbeing and scored on a scale of 1-10. Disabled people consistency scored approximately 1 point worse on perceived happiness, feeling worthwhile, life satisfaction, and anxiety.

Disabled people were also more likely to report feeling loneliness 'often or always' (15.1%) than non-disabled people (3.6%). Disabled people feeling lonely was highest in younger ages, with 28.1% of 16–24-year-olds compared to 8.6% of 65 years and over. Additionally, in 2020/21 there was significantly higher prevalence of overweight adults and physically inactive adults with a disability (72.6%) than people without a disability (61.3%) nationally[77].

The Active Lives 2020/21 survey[58] shows significant difference in the levels of physical inactivity for disability. In Rutland, 50.2% of residents with a disability or long-term health condition reported being inactive (less than 30 minutes a week), compared to 17.1% of residents without a disability or long-term condition. The level of inactivity in residents with a disability or long-term health condition is higher than the England and East Midlands averages, shown in figure 29.

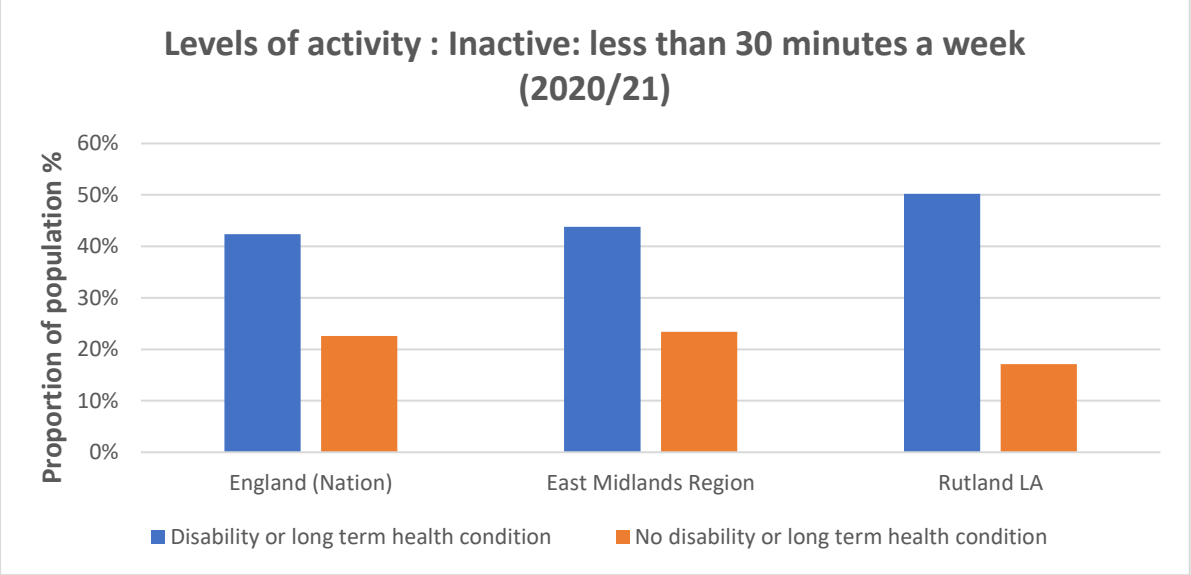


Figure 29 Inactivity by disability status.

For the academic year 2021/22, in Rutland **12.5% of pupils have a statutory plan of Special Educational Needs (SEN) or are receiving SEN support[80]**. This compares to an average of 15.9% across Rutland CIPFA nearest neighbours and 16.6% nationally. For 2020/21, 23.3% of children in need are on SEN support compared to 19.8% across CIPFA neighbours and 20.9% nationally.

For learning disabilities, modelled data estimates that in 2020 there were approximately 530 18–64-year-olds with a learning disability, making up 2.4% of the total Rutland 18–64-year-old population[81]. There was an estimated 210 people aged 65 and over with a learning disability, making up 2.2% of the total Rutland aged 65 and over population.

On average, the life expectancy of females with a learning disability is 26 years shorter than women in the general population. For men, life expectancy is 22 years shorter than men in the general population[82]. Life expectancy continues to decrease as the severity of the learning disability increases. The median age of death for people with Learning Disabilities for Leicester, Leicestershire and Rutland (LLR) was 59[83]. For comparison, over the same period national the median age was 62[84], shown in figure 30 below. There were 73 reported deaths across LLR, 16 of which were notified as *potentially* due to COVID-19. 46% of reported deaths were due to respiratory disease (including COVID-19), 20% cancer, 10% cardiovascular, 7% epilepsy, 5% dementia, 12% other.

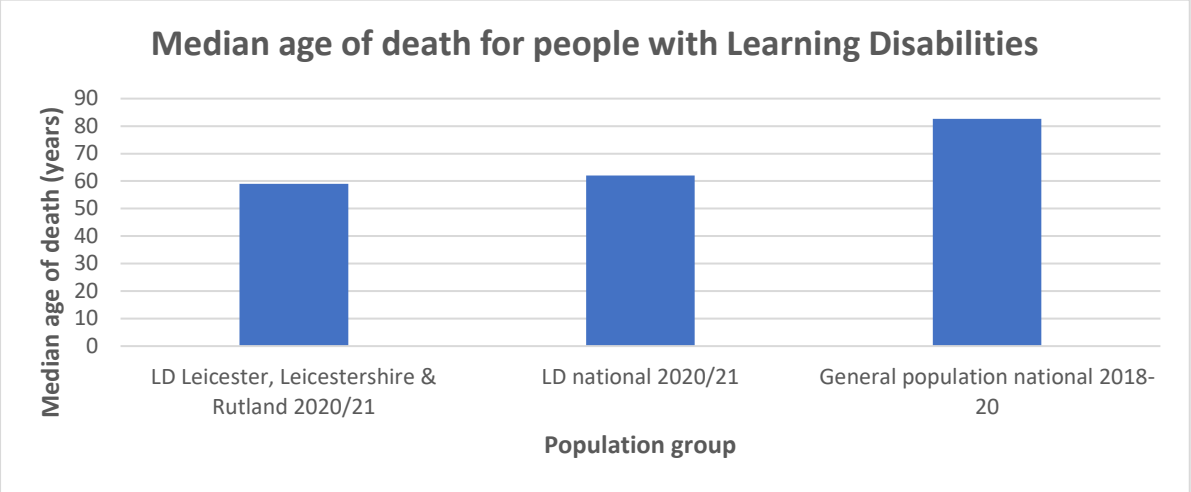


Figure 30 Median age of death for people with Learning Disabilities.

There are also barriers for people with learning disabilities when accessing healthcare services. These include:

- a lack of accessible transport links.
- patients not being identified as having a learning disability or limited staff understanding.
- failure to make a correct diagnosis.
- anxiety or a lack of confidence for people with a learning disability.
- lack of joint working from different care providers and involvement from carers.
- inadequate aftercare or follow-up care.

Impairments

According to the Royal National Institute of Blind People[85], **there are an estimated 1,730 people in Rutland living with sight loss, including around 1,490 with partial sight loss and 240 with blindness.** Note: these figures include people whose vision is better than the levels that qualify for registration, but that still has a significant impact on their daily life (for example, not being able to drive).

The **estimated prevalence of sight loss is higher in Rutland (4.2%) compared to England (3.2%).** 85% of Rutland residents with sight loss are aged 65 and over. By 2030, people in Rutland living with sight loss is expected to increase by 32% from 2021 to 2,290.

From an economic perspective, sight loss in Rutland is estimated to have a direct cost of £2,300,000 per year, mainly relating to hospital treatments, sight tests, prescription and social care. The indirect cost is £4,340,000 per year, covering unpaid care by family/friends, lower employment rate and devices/modifications.

There are an estimated 5,530 people in Rutland with a moderate or severe hearing impairment, 120 of which have a profound hearing impairment. An estimated 330 people have an element of dual sensory loss.

Sex

Variation in health outcomes and access to services is covered at different points of this report above. However, there are also variations when it comes to health behaviours. Figure 31 below demonstrates this with data based on England. Smoking prevalence and obesity were significantly higher in males, whilst females were higher in physical inactivity[77].

The reasoning for this variation will likely cover a range of factors. The findings do offer an opportunity to tailor programmes for males and females, ensuring those with the poorest outcomes are supported most in the solutions.

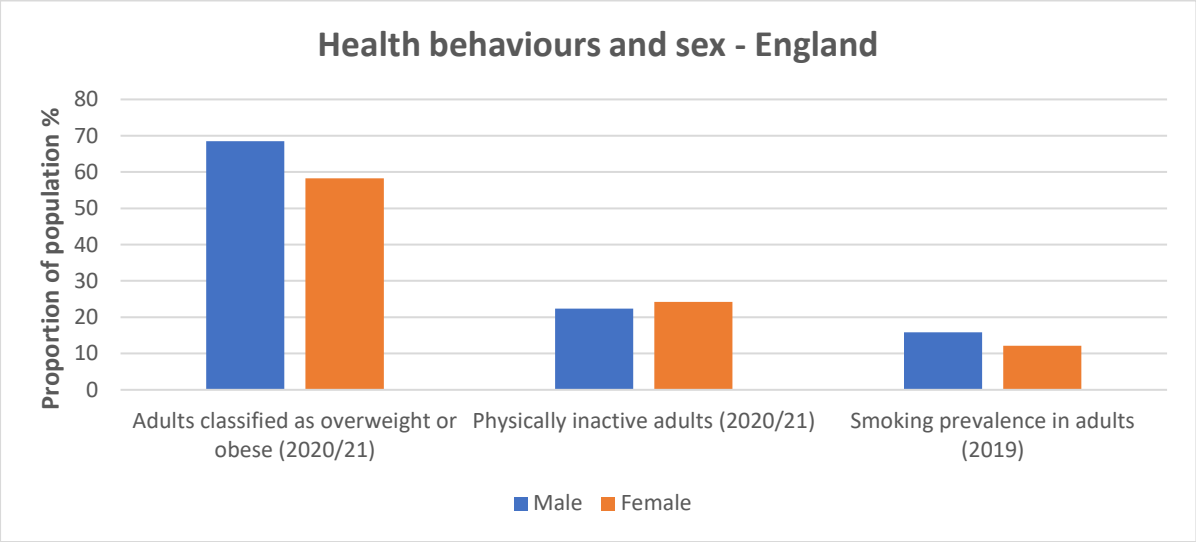


Figure 31 Health behaviours and sex - England.

Ethnicity

There are health inequalities in England between ethnic minority and white groups, and between different ethnic minority groups. People from ethnic minority groups are more likely to report being in poorer health and to report poorer experiences of using health services than their white counterparts[86]. Additionally, the COVID-19 pandemic has had a disproportionate impact on ethnic minority communities, who have experienced higher infection and mortality rates. Examples of difference in health outcomes between ethnic groups are summarised below:

- people from the Gypsy or Irish Traveller, Bangladeshi and Pakistani communities have the poorest health outcomes across a range of indicators.
- compared with the white population, disability-free life expectancy is estimated to be lower among several ethnic minority groups.
- rates of infant and maternal mortality, cardiovascular disease (CVD) and diabetes are higher among Black and South Asian groups.
- mortality from cancer, and dementia and Alzheimer's disease, is highest among white groups.

Locally, the Census shows the vast majority of Rutland was White in 2011 (97.1%), with 94.3% being White UK. 1.0% were Asian/Asian British, 1.0% Mixed/multiple ethnic groups, 0.7%

Black/African/Caribbean/Black British and 0.2% other ethnic group. When Census 2021 data is released for ethnicity, there will be a clearer picture locally. There is also variation between the wards of Rutland. Figure 32 below demonstrates this variation with the proportion of the population whose ethnicity is not 'White UK'. Greetham (12.5%) and Oakham North East (10.6%) are both above 10%, approximately twice as high as the Rutland average (5.7%).

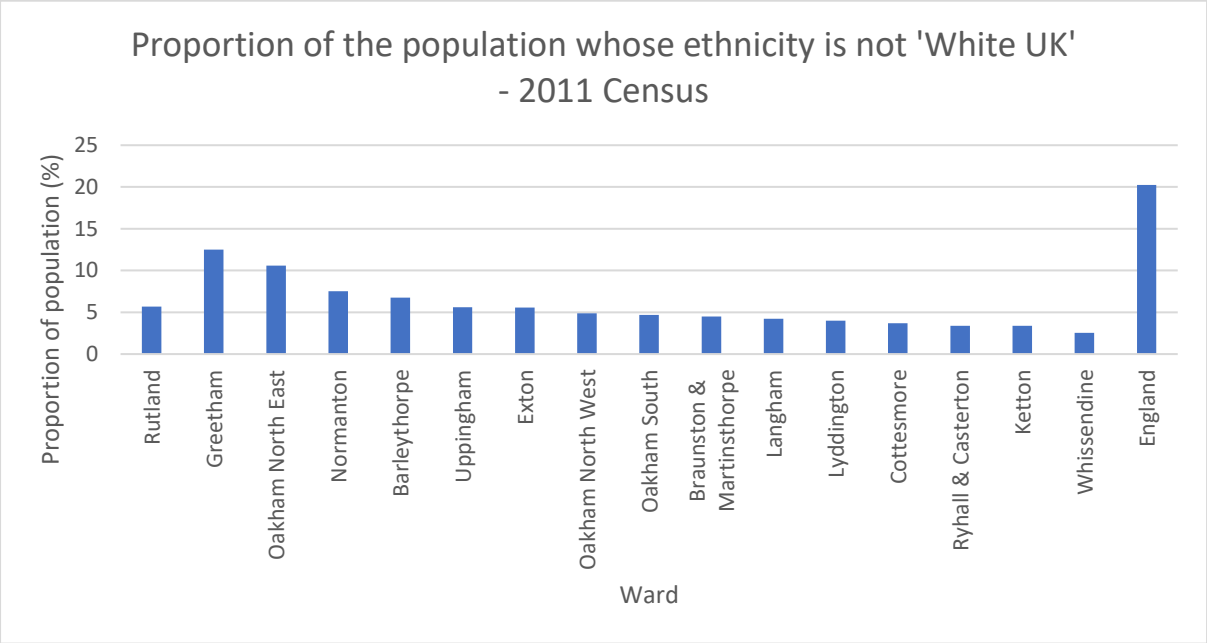


Figure 32 Proportion of the population whose ethnicity is not 'White UK'.

LGBTQ+

The LGBTQ+ population experience disproportionately worse health outcomes and have poorer access to health services. There is limited data and insight available on this, particularly locally. Most research to data has focused on people identifying as Lesbian, Gay and Bisexual (LGB).

An NHS Digital report compared statistics on health and health related behaviours between LGB and heterosexual adults between 2011 and 2018[87]. A summary of findings is outlined below, showing LGB adults to have poorer health and behaviours except for obesity:

- **LGB adults were more likely to report having a longstanding mental illness** (16%) compared to 6% of heterosexual (such as anxiety, depression or a learning disability).
- **LGB adults were more likely to be current smokers** (27%) compared to heterosexual adults (18%). The gap is greater for women than men.
- **A lower proportion of LGB adults were overweight or obese** (51%) compared to heterosexual adults (63%).
- **LGB adults were more likely to drink at harmful levels** (32%) compared to heterosexual adults (24%).

Whilst local data at Local Authority level isn't readily available, it is available at regional level. Between 2018 and 2019, the estimated proportion of people who identified as LGB in the East Midlands was 2.7%[88]. Applying this rate to the Rutland population aged 16 and over, a crude estimate would be 1,093 people identifying as LGB. Once Census 2021 data is available, there could be a better local understanding on the whole LGBTQ+ population locally.

The national LGBT Survey in 2018[89] included questions on experiences of accessing healthcare services. 40% of trans respondents who had accessed or tried to access public health services reported having faced negative experiences due to their gender identity. Trans men had the poorest experiences, followed by Trans women and non-binary. The following outlines the specific negative experiences accessing public healthcare services in order of frequency, with number 1 being the most frequent experience:

1. **Inappropriate questions** or curiosity.
2. My **specific needs were ignored** or not considered.
3. I avoided treatment or accessing services for **fear of discrimination or intolerant reaction**.
4. **Discrimination or intolerant reactions** from healthcare staff.
5. I was **inappropriately referred to specialist services.**
6. **Unwanted pressure or being forced** to undergo any medical or psychological test.
7. I had to **change GP due to negative experiences**.

Section 4 recommendations

9. Ensure health and wellbeing implications of the population projections are embedded into the Local Plan and other long-term strategies.
10. Consider deeper dives on dementia diagnosis and excess winter deaths.
11. The specific access barriers for people with learning disabilities and/or sensory impairments should be factored into all service plans.
12. Consider the LGBT national survey recommendations to improve access and personalised support for mental health, smoking cessation and substance misuse.

Conclusion

This report aimed to identify health inequalities across Rutland. As acknowledged throughout the report, data availability is limited across certain population groups. There are however conclusions that can be drawn from what is available. Rutland often performs better than national comparators for health inequalities and outcomes. The report does show however, health inequalities do exist within the county, with differences in outcomes across small geographical areas and population characteristics. For example, even though all small areas of Rutland have lower levels of children in low-income families compared to national comparators, there is a range across Rutland from 3% to around 15%.

The report aims to help organisations delivering services across Rutland understand where the greatest level of support should be provided. A proportionate universalism approach will help to ensure services are universal, whilst also providing a targeted approach to those most in need. Recommendations are initially set as considerations for a proportionate universalism approach, factoring in population groups and small areas of Rutland.

All data presented is the latest availability at point of release. The data will likely fluctuate given the unpredictable changes in cost of living throughout winter 2022 and 2023 likely impacted most households. However, the data presented does indicate which areas and populations have the greatest level of inequality and therefore increases to cost of living will impact these households most. Delays in release of Census 2021 data has also left gaps in our understanding for some of the report. An update will be provided in 2023 once all data has been released for Census 2021.

Glossary

All Party Parliamentary Group (APPG) – informal cross-party groups that have no official status within Parliament. They are run by and for Members of the Commons and Lords, though many choose to involve individuals and organisations from outside Parliament in their administration and activities.
Index of Multiple Deprivation (IMD) - the official measure of relative deprivation in England and is part of a suite of outputs that form the Indices of Deprivation.
Indices of Deprivation (IoD) - The IoD is based on 39 separate indicators, organised across seven distinct domains of deprivation.
Integrated Care System (ICS) - Integrated care systems are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.
Lower Super Output Area (LSOA) – LSOAs are small areas with populations typically between 1,000 and 3,000 residents (or between 400 and 1,200 households). LSOAs are well aligned to Ward boundaries, however depending on the size, a Ward can include more than one LSOA.
Proportionate Universalism - Proportionate universalism is the resourcing and delivering of universal services at a scale and intensity proportionate to the degree of need.

Acknowledgements

The needs assessment was developed by the Public Health Rutland team. Input from a stakeholder group during development has provided extra valuable depth and understanding to the report. Thanks to all partners who have provided feedback and insight, including Leicestershire County Council, Rutland County Council, NHS LLR, Rutland Primary Care Network, Healthwatch Rutland, Rutland Foodbank, Citizens Advice Rutland, Rural Community Council and Midlands & Lancashire Commissioning Support Unit.

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જો આપ આ માહિતી આપની ભાષામાં સમજવામાં થોડી મદદ ઇચ્છતાં હો તો 0116 305 6803 નંબર પર ફોન કરશો અને અમે આપને મદદ કરવા વ્યવસ્થા કરીશું.

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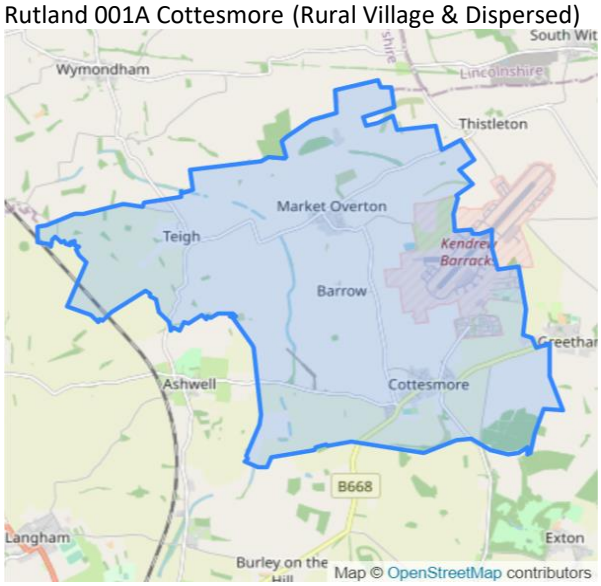
Rutland Health Inequalities – Supporting mapping

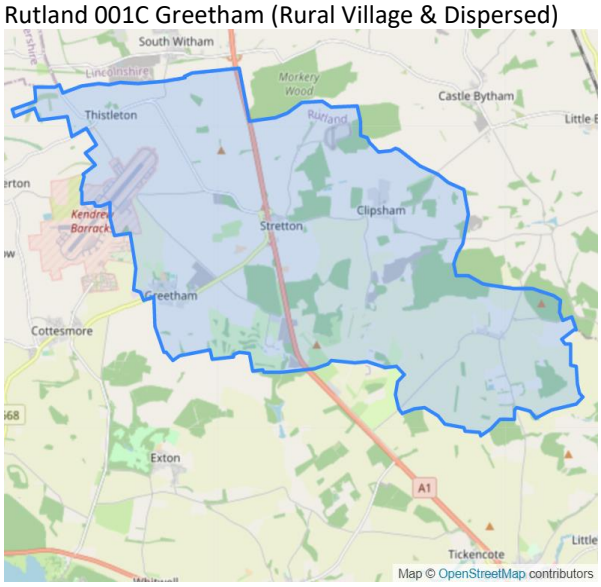
Appendix 1 – Lower Super Output Area (LSOA) maps[1]

Rutland 001A Cottesmore (Rural Village & Dispersed)

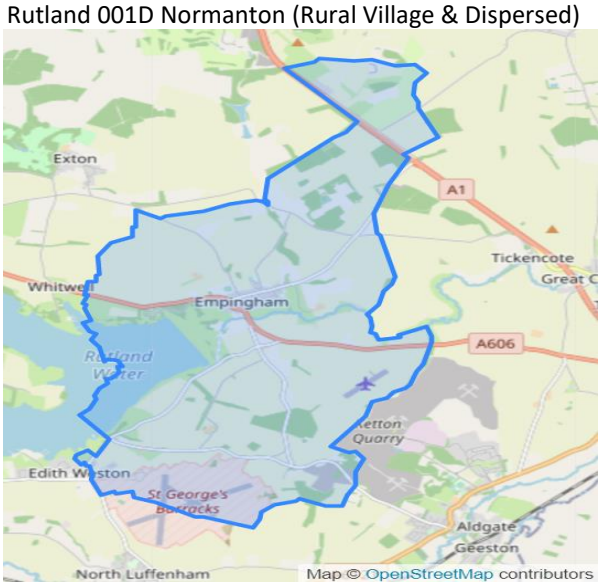


Rutland 001B Exton (Rural Village & Dispersed)

Rutland 001C Greetham (Rural Village & Dispersed)

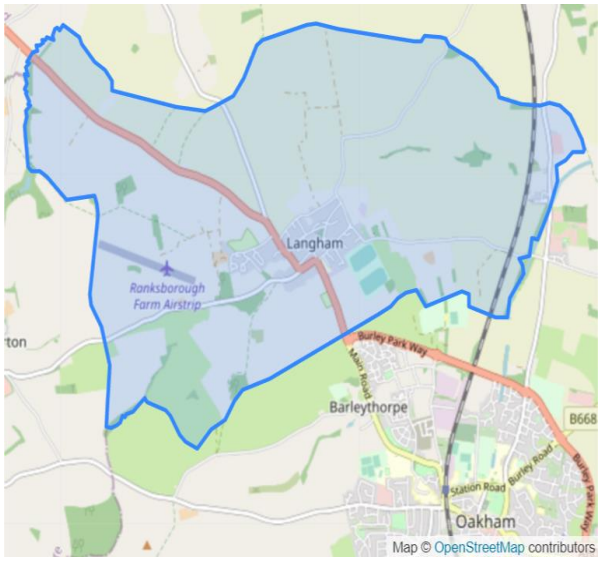


Rutland 001D Normanton (Rural Village & Dispersed)



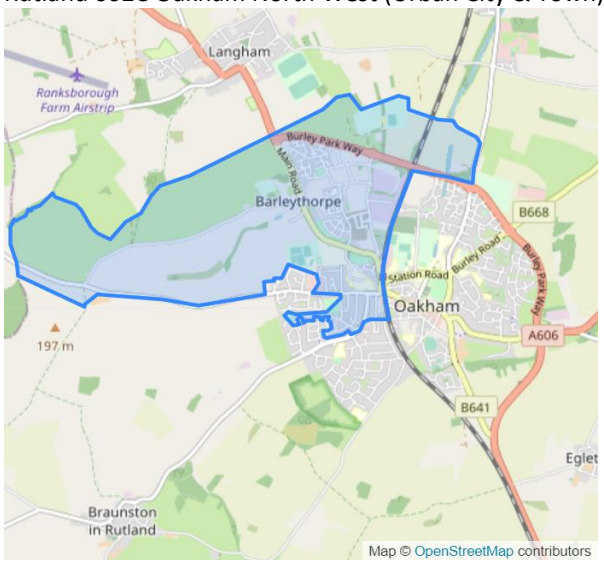
Rutland 002A Langham (Rural Town & Fringe)

Rutland 002B Oakham North West (Urban City & Town)



Rutland 002C Oakham North West (Urban City & Town)

Rutland 002D Whissendine (Rural Village & Dispersed)



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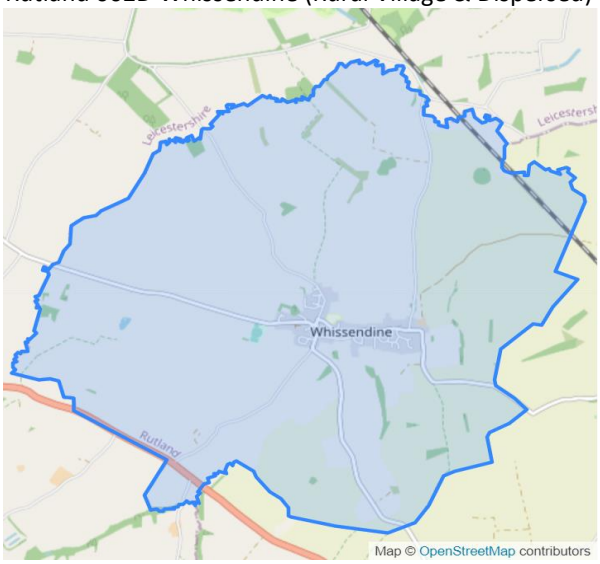
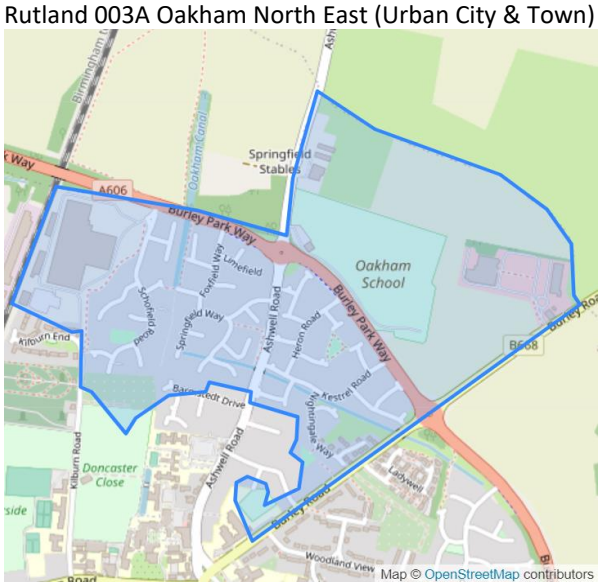


Rutland 003B Oakham North East (Urban City & Town)



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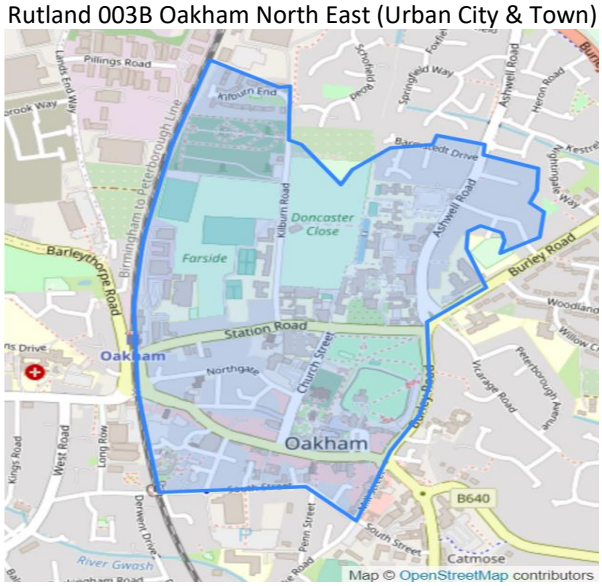
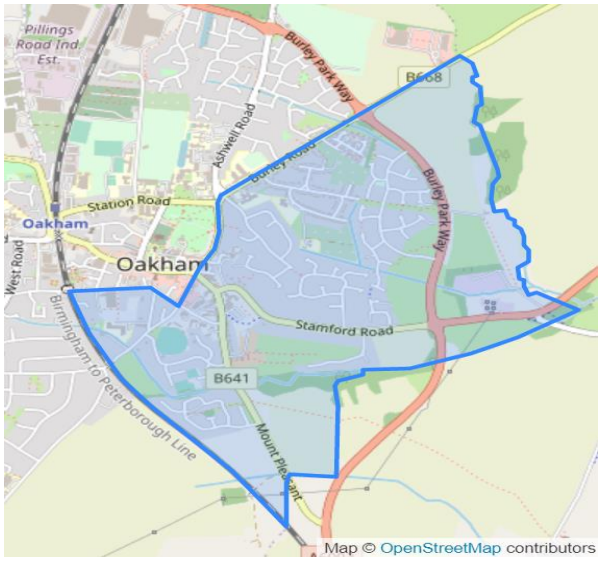
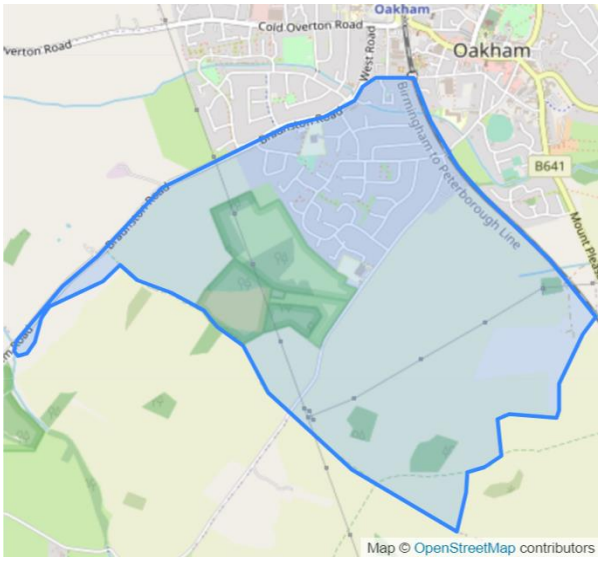
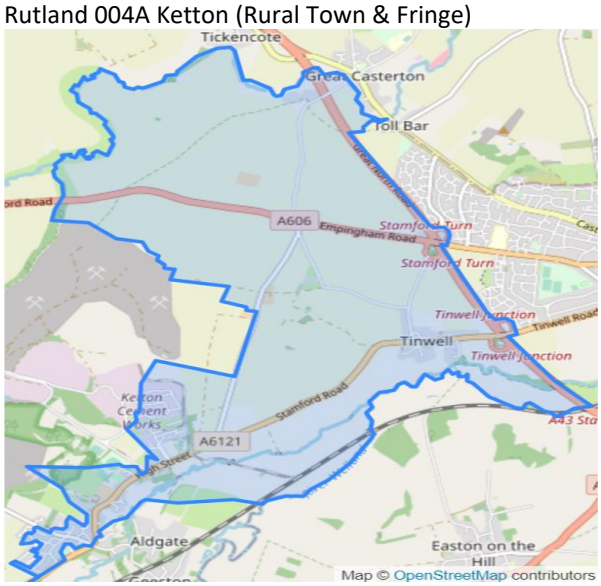


Rutland 003D Oakham South West (Urban City & Town)

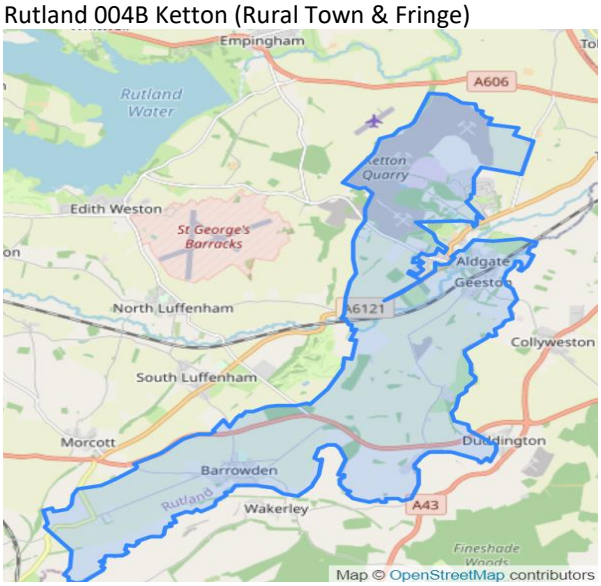




Rutland 004A Ketton (Rural Town & Fringe)

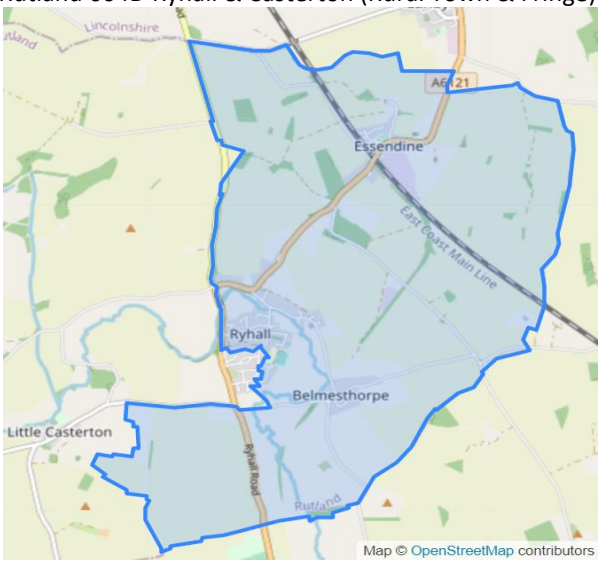


Rutland 004B Ketton (Rural Town & Fringe)



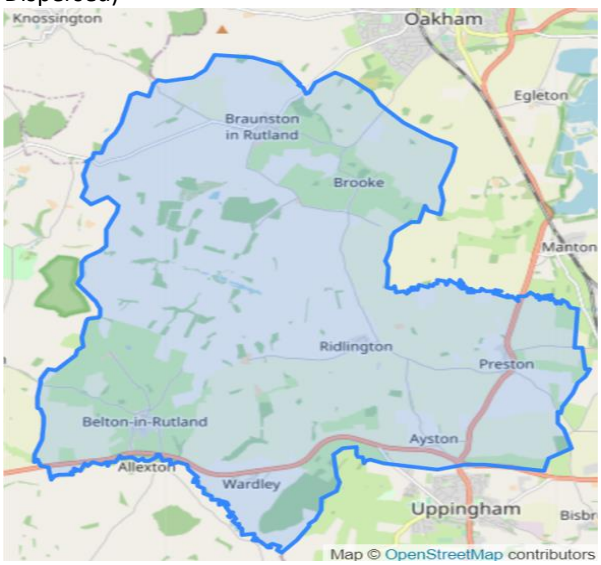
Rutland 004C Normanton (Rural Village & Dispersed)

Rutland 004D Ryhall & Casterton (Rural Town & Fringe)

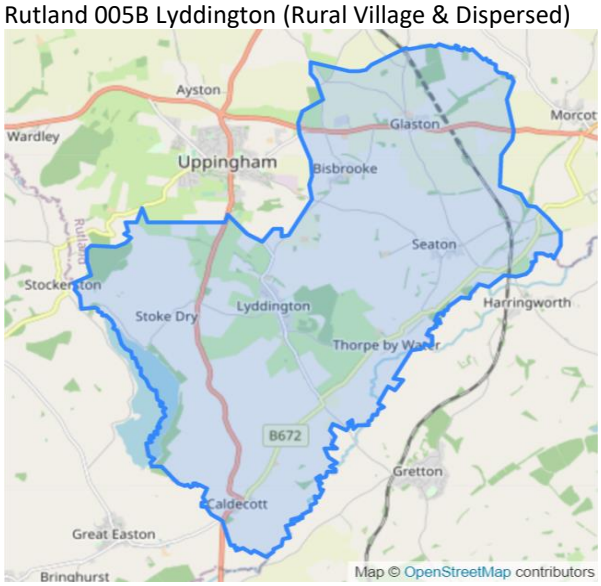


Rutland 004E Ryhall & Casterton (Rural Town & Fringe)

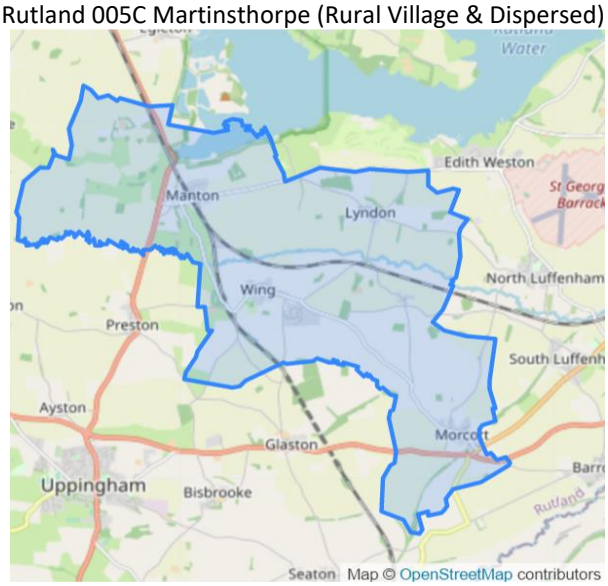
Rutland 005A Braunston & Belton (Rural Village & Dispersed)



Rutland 005B Lyddington (Rural Village & Dispersed)

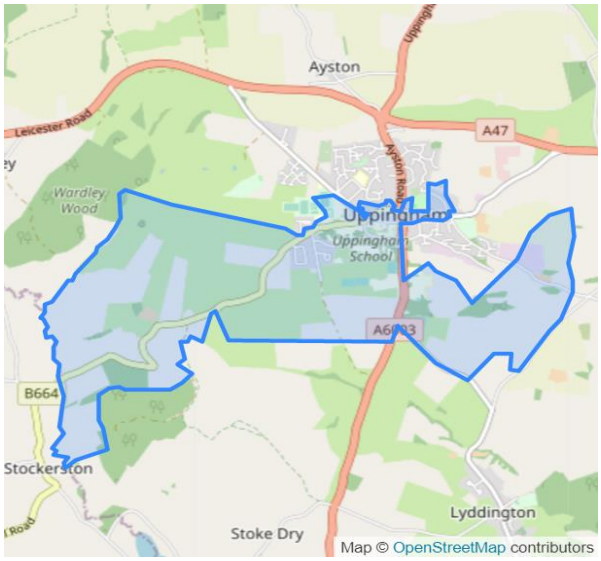


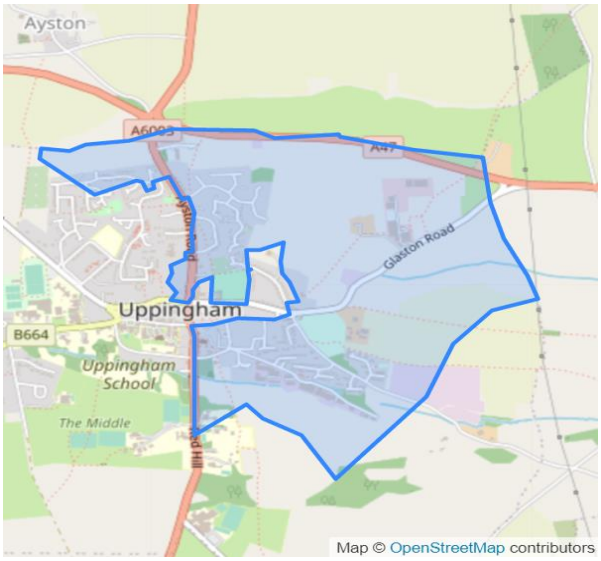
Rutland 005C Martinsthorpe (Rural Village & Dispersed)



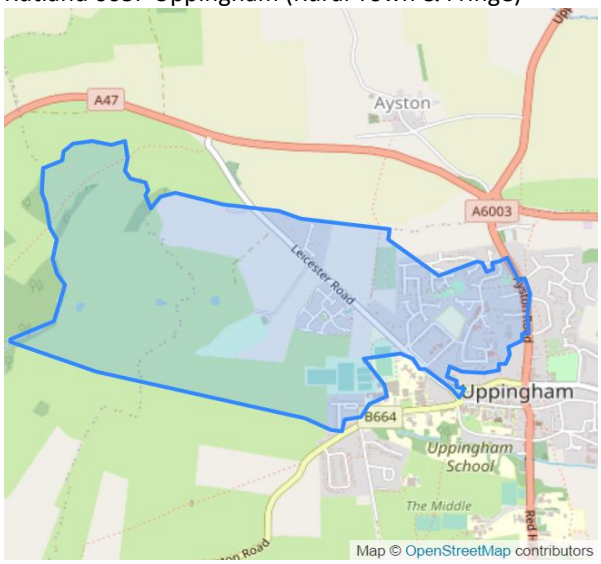
Rutland 005D Uppingham (Rural Town & Fringe)

Rutland 005E Uppingham (Rural Town & Fringe)

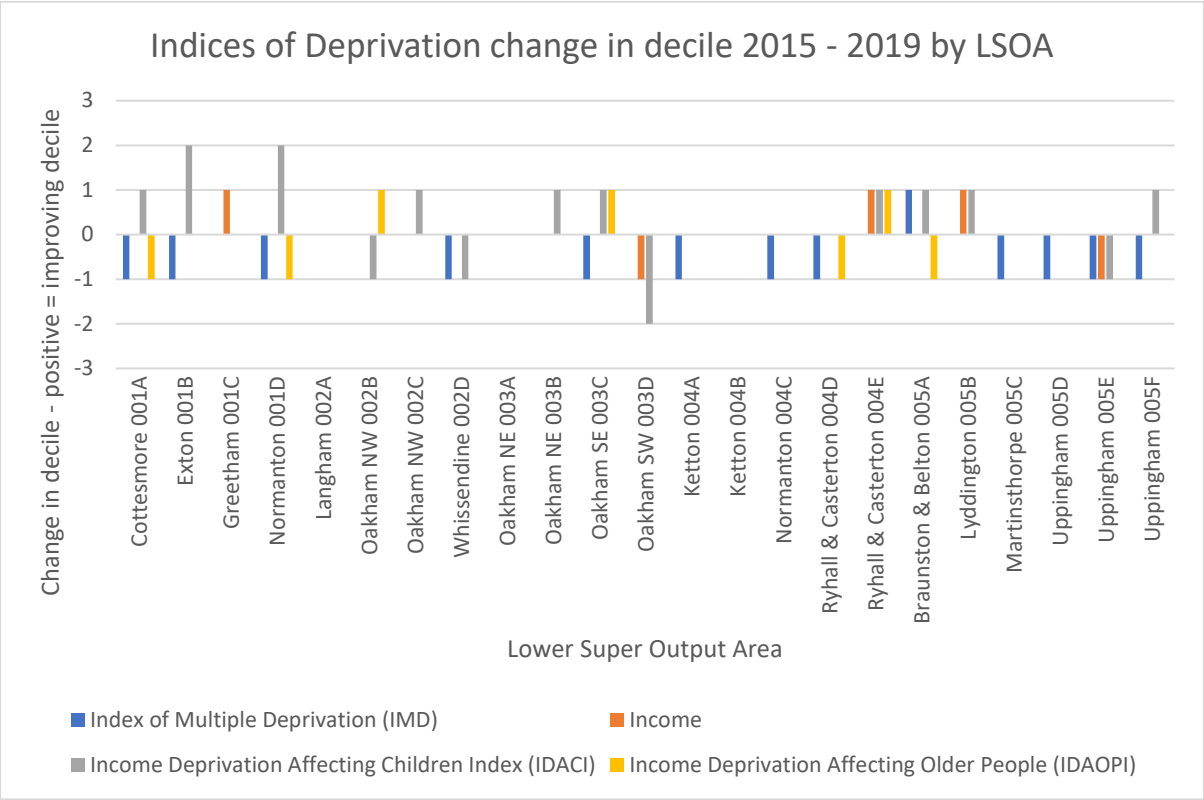




Rutland 005F Uppingham (Rural Town & Fringe)

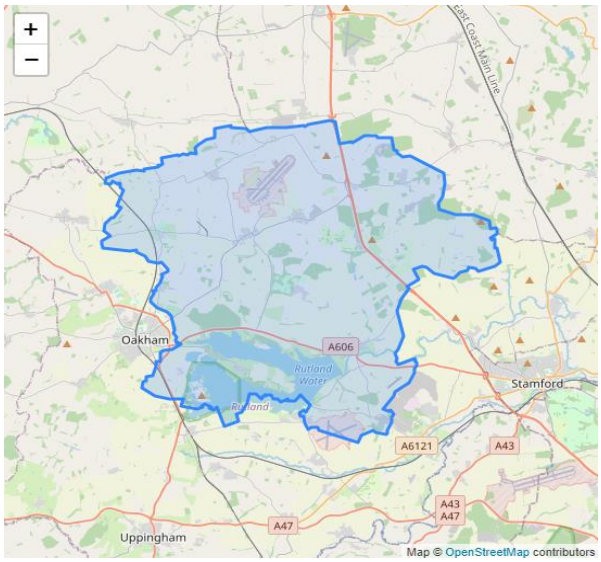


Appendix 2 – change in Indices of Deprivation[2]

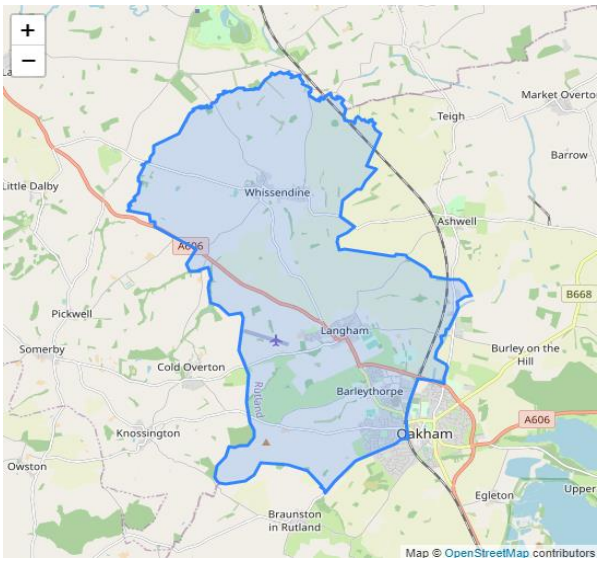


Appendix 3 – Middle Super Output Area (MSOA) maps[1]

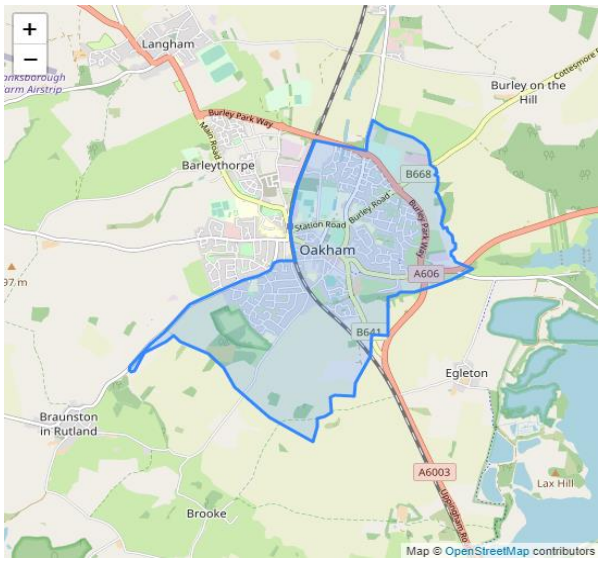
Rutland 001



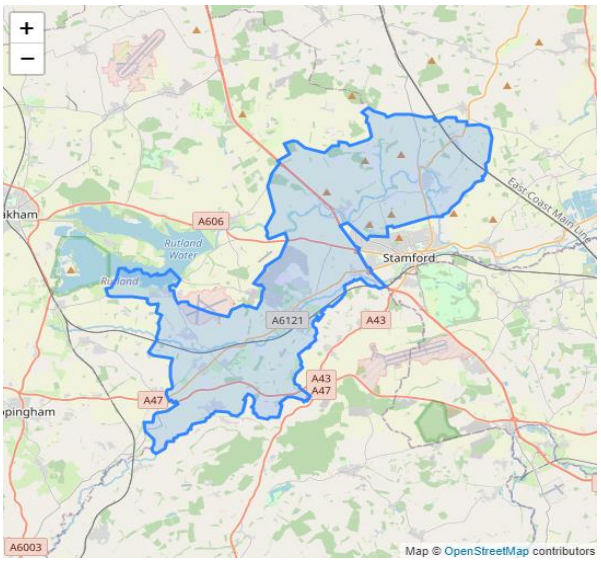
Rutland 002



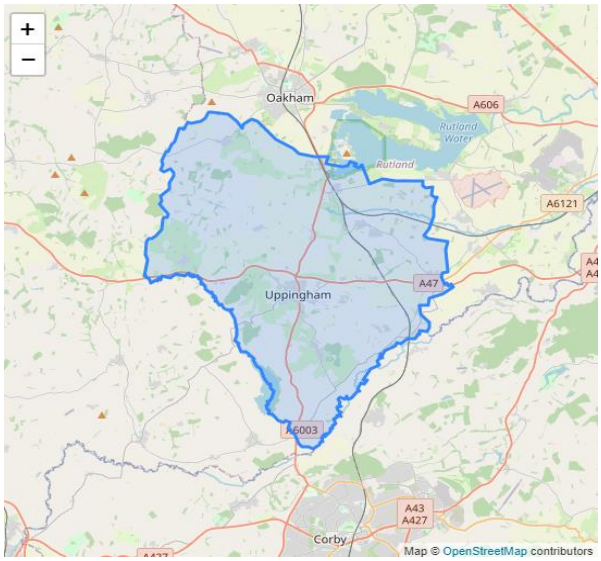
Rutland 003



Rutland 004



Rutland 005



Appendix 4 – Access to Primary Care mapping[3]

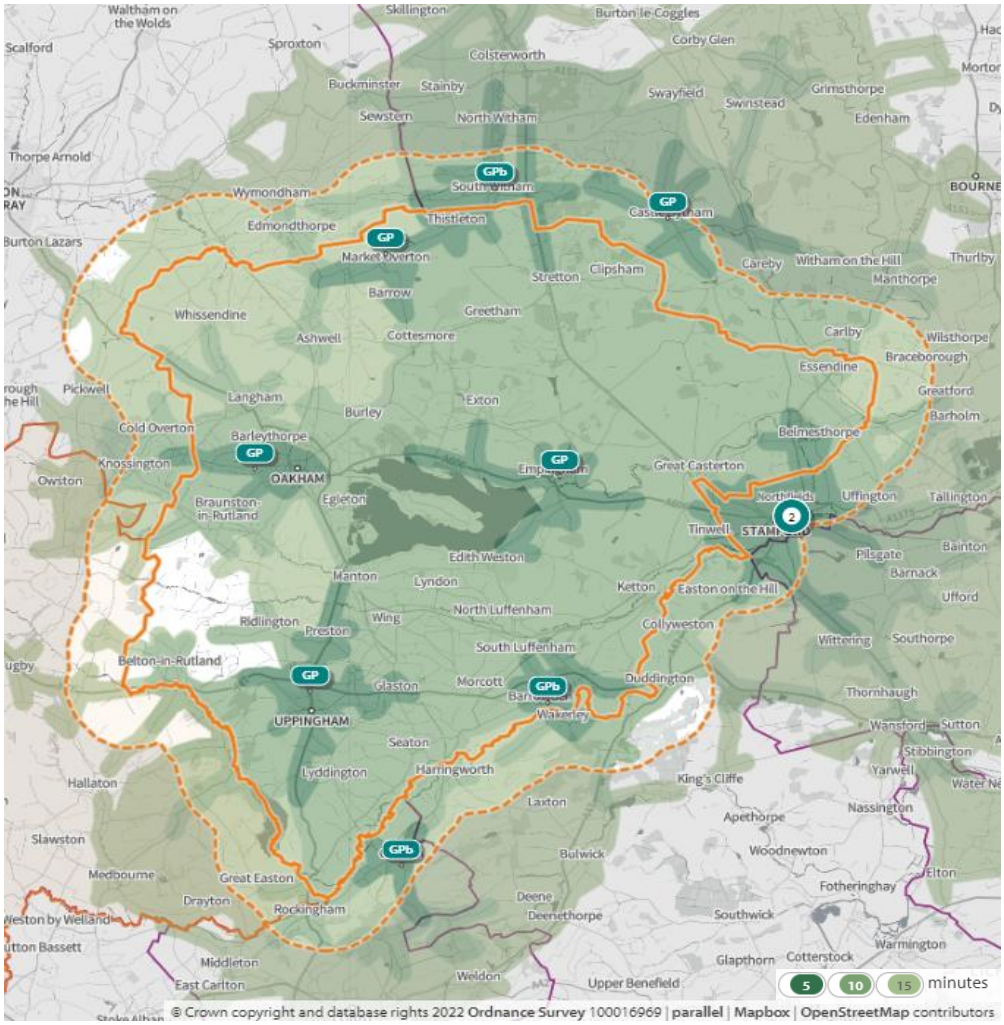


Figure 1 Access to GP Practices broken down by time taken to drive.

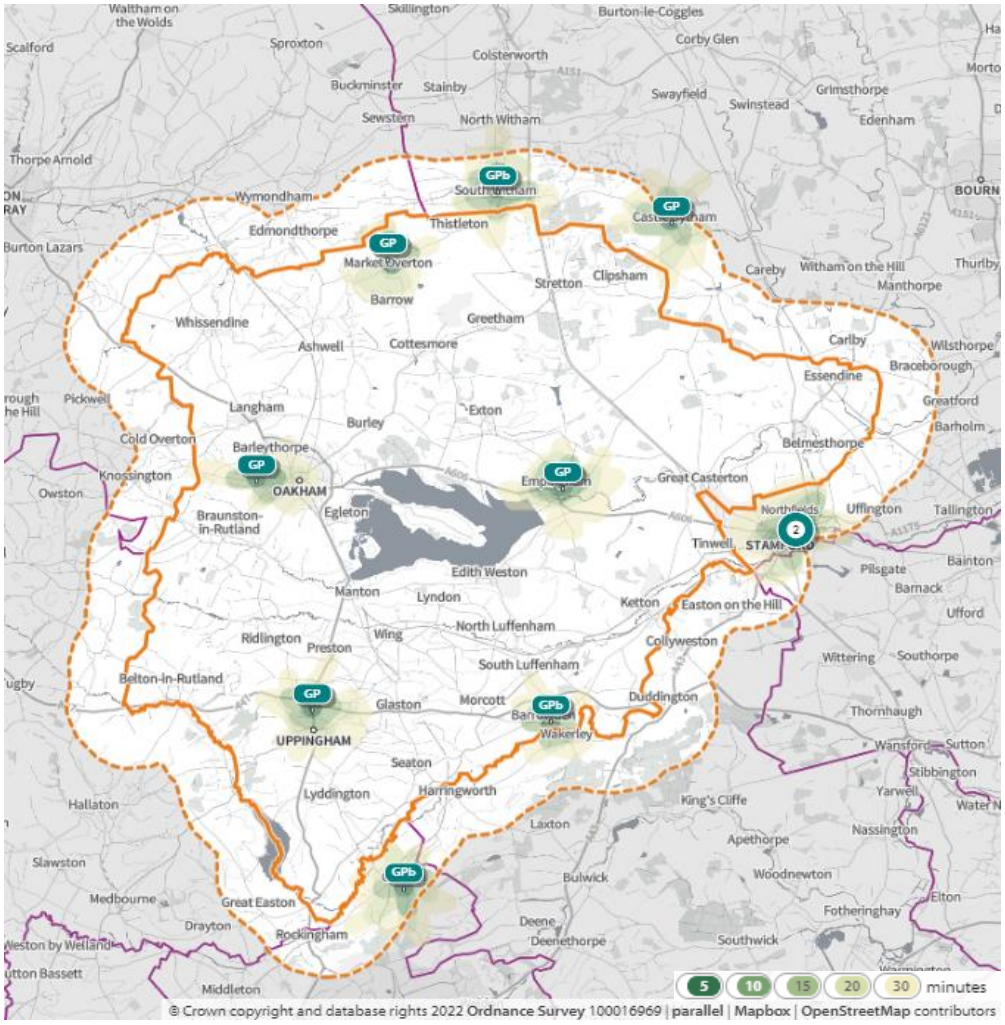


Figure 2 Access to GP Practices broken down by time taken to walk.

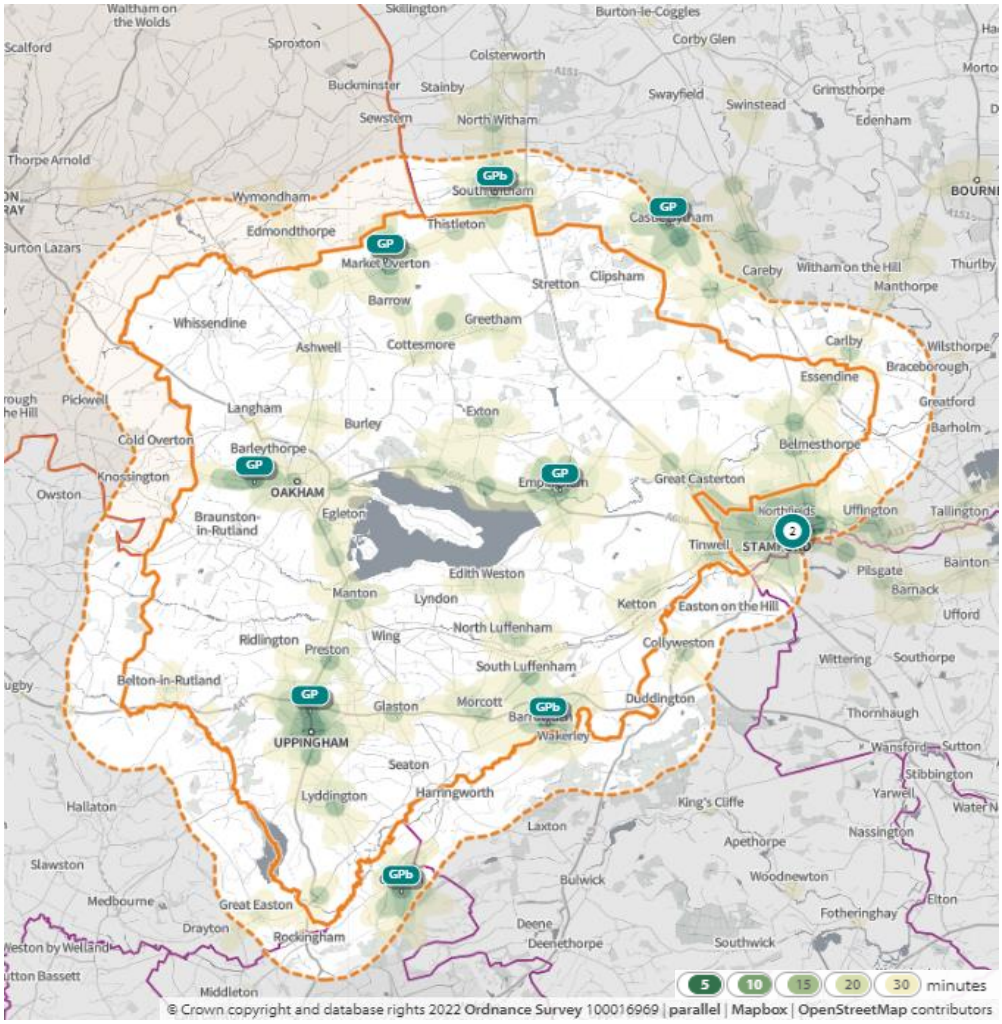


Figure 3 Access to GP Practices broken down by time taken via public transport.

Appendix 5 – Access to Secondary Care mapping

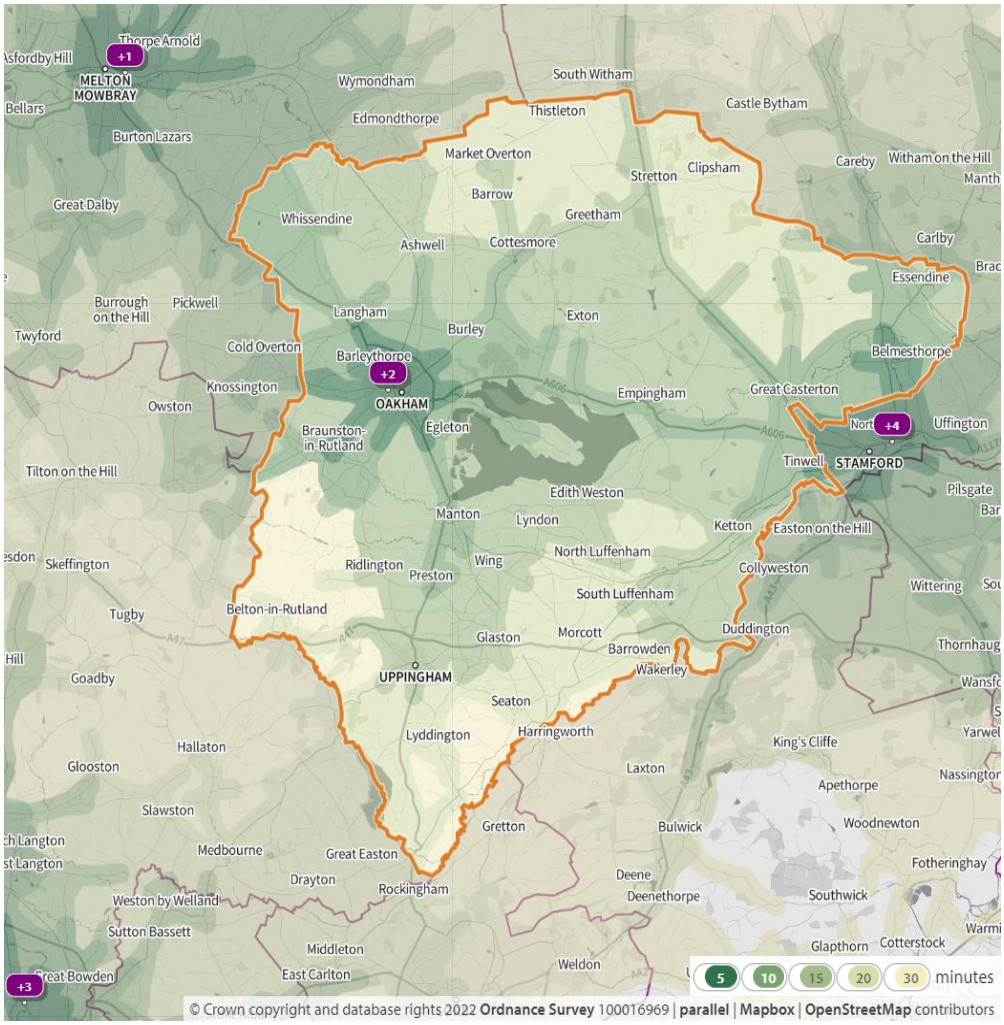


Figure 4 Access to Community Hospitals by time taken to drive.

Community hospital	**Number of Rutland residents within a 15 minute drive**	**Number of Rutland residents within a 30 minute drive**
Rutland Memorial Hospital (Leicester, Leicestershire & Rutland ICS)	29,538 (73.0%)	40,476 (100%)
Stamford & Rutland Hospital (Lincolnshire ICS)	7,590 (18.8%)	39,121 (96.7%)
St Lukes Hospital Wards (Leicester, Leicestershire & Rutland ICS)	0 (0%)	5,001 (12.4%)
Melton Mowbray Hospital (Leicester, Leicestershire & Rutland ICS)	2,680 (6.6%)	27,795 (68.7%)
Any community hospitals	35,385 (87.4%)	40,476 (100%)

Appendix 6 – Digital Exclusion mapping[4]

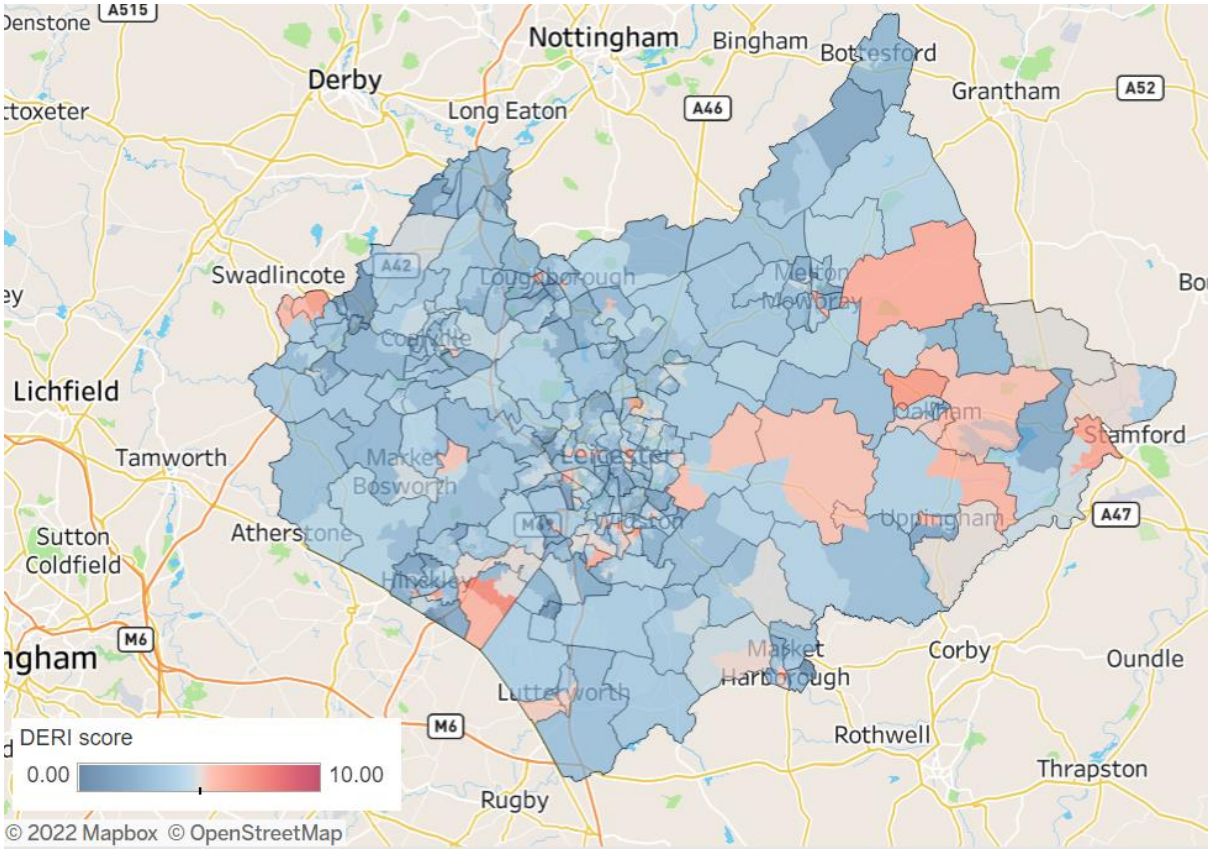


Figure 5 Digital Exclusion Risk Index LLR.

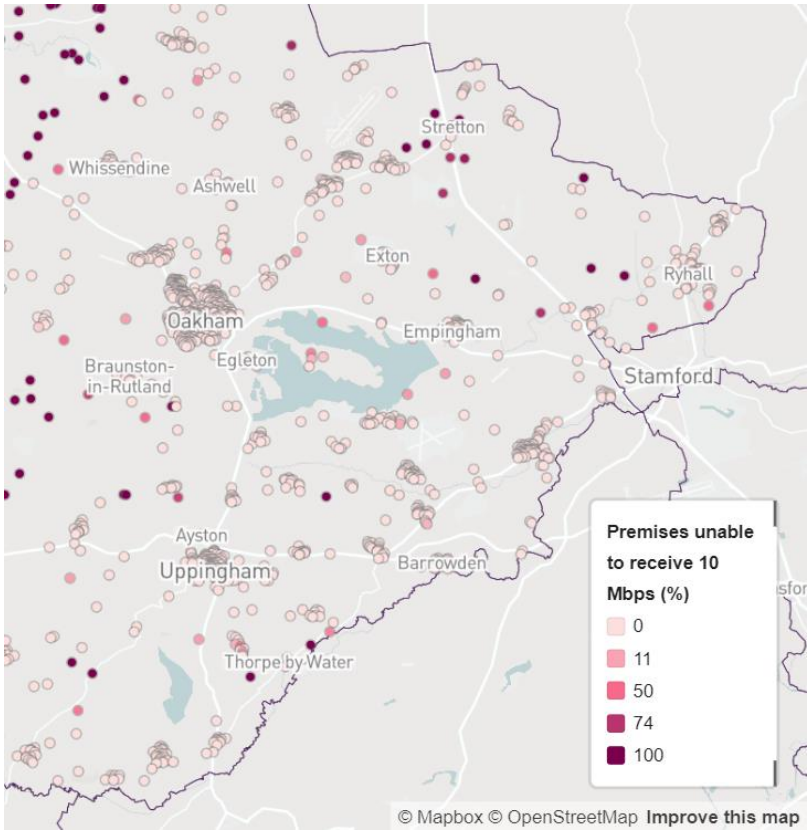


Figure 6 Postcodes unable to receive 10 Mbps as of Sept 2021.

[1] My Society, Map It UK, 2022
[2] English Indices of Deprivation, Ministry of Housing, Communities & Local Government, 2019
[3] Strategic Health Asset Planning and Evaluation, Place Atlas, 2022
[4] Greater Manchester Office of Data Analytics, Digital Exclusion Risk Index, 2021

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Appendix C - Recommendations from Rutland Health Inequalities Needs Assessment

The requirement for a health inequality needs assessment forms part of the Rutland Health & Wellbeing Strategy delivery plan. The report outlines a range of recommendations for local partners to consider addressing health inequalities across Rutland. It is important to recognise that seeing changes in health inequality outcomes are often long term. Therefore, any local action on inequalities will **measure** inputs, for example if some of the recommendations below were implemented, there would be clear milestones. Alongside this, health inequality outcomes will be **monitored** to track any long term change.

For clarity, recommendations aren't necessarily requiring additional resource. The recommendations intend to inform an approach to 'proportionate universalism', meaning there will be a universal offer to all, but equitable variation in provision in response to differences in need within and between groups of people. A proportionate universalism approach forms part of the Rutland Health & Wellbeing Strategy priorities and delivery plan.

Recommendations are set out in the table below, along with the current position and alignment with the Health & Wellbeing Strategy. Recommendations are initial thoughts at this stage based on the report findings and further detail will need to be developed on feasibility to determine whether they are taken forward. This forms the basis for the recommendation for a development session below. Some recommendations already have progress outlined within the 'current position' column and could instigate further collaborative work across partners, as tackling inequalities is the responsibility of us all.

Health and Wellbeing Board recommendations

- Note report findings and approve publication of the needs assessment on the Rutland Joint Strategic Needs Assessment (JSNA) website.
- Approve development of a Health and Wellbeing Board development session on health inequalities with a deep dive on needs assessment findings (Appendix A) and further discussion on the report recommendations set out in Appendix C.

Report Recommendations

Section 1 – Socio-economic and deprivation

Recommendations	Health & Wellbeing Strategy alignment	Current position
1. Support available within the community to provide targeted provision to the most rural areas of Rutland identified with higher economic need and more distant from support.	Cross-cutting theme 7.2 on reducing health inequalities. Delivery plan action 7.2.2 service delivery builds in adjustments	• Integrated Neighbourhood Team meetings are in place for Rutland. Health inequalities insight has been presented to the group and ongoing support will be provided to target areas most in need.

	ensuring that it reaches more of the population in scope, including rurality.	• As a part of the PCN Investment and Impact Fund, Rutland PCN is required by 31 March 2023 to make use of GP Patient Survey results for practices to identify patient groups experiencing inequalities in their experience of access to general practice and develop and implement a plan to improve access for these patient groups. This work has started in Rutland.

Section 2 – Rurality and access

Recommendations	Health & Wellbeing Strategy alignment	Current position
2. Targeted engagement with Whissendine 002D and Braunston & Belton 005A to develop understanding of potential barriers to accessing primary care and whether they are at greater disadvantage than other areas. Both areas are most distant from GP practices by time to travel and barriers may be hidden in GP/PCN wide engagement.	Priority 4 on equitable access to services. Section 4.1 on understanding the access issues.	• Primary care access surveys have been completed via the Primary Care Task and Finish Group. • Rutland PCN need to implement the Enhanced Access Service from 1st October 2022.
3. Ensure services are prioritising cross border working with neighbouring ICS to maximise opportunity for people to access support closest to home. For example, working with cross boundary ICS on access to acute hospital services.	Priority 4 on equitable access to services. Section 4.5 on enhancing cross boundary working across health and care with key neighbouring areas.	• For new developments and Local Plan, an agreed approach is in place with neighbouring Local Planning Authorities on health infrastructure requirements aligned to proposed growth in each area. Ongoing reviews of population health data informs the approach.
4. Provide targeted digital skills programmes for population groups most in need, alongside universal provision. Identified in the report are people with mental health, learning, memory, physical and sensory impairments.	Priority 4 on equitable access to services. Section 4.4 on improving access to services and opportunities for people less able to travel, including through technology.	• Age UK Digital Skills programme set up, focusing on skills, access and confidence. Digital section of the report shared to focus targeting areas of highest need. • Care Coordinators are actively identifying selected cohorts and proactively contacting patients, identifying those who are experiencing digital exclusion to offer interventions.

5. Engage with local farming organisations and communities to develop local understanding and consider the farming report recommendations on relieving loneliness.	Cross cutting theme 7.1 on supporting good mental health.	• Further work needed to consider any specific needs of the community, particularly around access to services.

Section 3 – Inclusion Health and Vulnerable groups

Recommendations	Health & Wellbeing Strategy alignment	Current position
6. Develop new insight for the armed forces community in Rutland, covering the impact of COVID-19, female veterans and mental health.	Multiple links to armed forces, including priorities on improving access to services and reducing inequalities.	• LLR Armed Forces Health Needs Assessment in development. Additional Place insight may be needed for Rutland depending on outcomes. • All four Rutland PCN practices have veteran accreditation.
7. Respond to findings from the LLR Carers Strategy consultation before determining specific recommendations for Rutland.	Priority 3 on living well with long term conditions and healthy ageing. Section 3.3 support, advice, and community involvement for carers.	• LLR Carers Strategy consultation has now closed and awaiting results. LLR Carers Strategy due to go to RCC Cabinet in October 22, with a specific Rutland delivery plan. • Recommendations from the findings could be incorporated into the Rutland Health & Wellbeing Strategy if taken forward, alongside Comms & Engagement Plan.
8. Respond to findings from the commissioned Gypsy, Traveller and Travelling Showpeople Accommodation Assessment.		• Assessment is planned to start in September. • Recommendations from the findings could be incorporated into the Rutland Health & Wellbeing Strategy if taken forward, alongside Comms & Engagement Plan.

Section 4 – Protected Characteristics

Recommendations	Health & Wellbeing Strategy alignment	Current position
9. Ensure health and wellbeing implications of the population projections for older	Priority 5 on preparing for our growing and changing population.	• Population projections are incorporated within the Local Plan Strategic Housing Market Assessment and Public Health are providing insight into the health and wellbeing implications.

age groups are embedded into the Local Plan and other long term strategies.	Section 5.3 Health and equity in all policies, in particular developing a healthy built environment aligned for projected growth.	
10. Consider deeper dives on dementia diagnosis and excess winter deaths.	Priority 3 living well with long term conditions and healthy ageing. Section 3.4 increase the diagnosis rate for dementia.	• Healthwatch Rutland beginning joint engagement across LLR to inform the next iteration of the Dementia Strategy for 2023. • Rutland PCN has a proactive framework for identifying and managing frailty targeting support for Housebound and/or frail patients in collaboration with RISE team, including screening for dementia.
11. The specific access barriers for people with learning disabilities and/or sensory impairments should be factored into all service plans.	Priority 3 living well with long term conditions and healthy ageing. Section 3.4 on learning disabilities.	• Work on learning disability access needs to align with the Comms and Engagement Plan. • Currently, there are actions in the delivery plan under the 'watch' category, including around active learning, meeting care needs for people with significant disabilities and further strengthening opportunities in Rutland for people with learning disabilities to have healthy, fulfilled lives and part of Rutland communities.
12. Consider the LGBT national survey recommendations to improve access and personalised support for mental health, smoking cessation and substance misuse.	Priority 7.2 on reducing health inequalities including protected characteristics.	• Further work needed to identify from the needs assessment the best approach going forward and whether it's an area of need relating to health inequalities.

Rutland County Council

Rutland County Council

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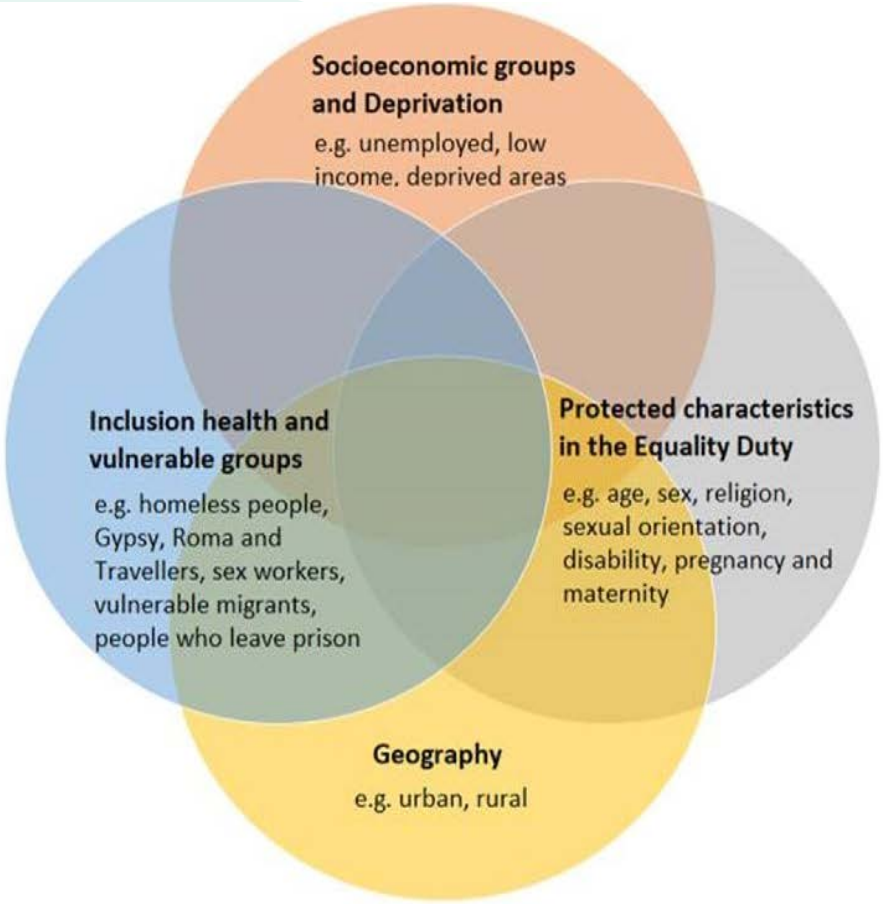
Rutland Health Inequalities Needs Assessment

Health & Wellbeing Board

October 2022

Introduction



Overlapping dimensions of health inequalities (HEAT)

Aims:

- **Explore inequalities relating to health outcomes and access to services** across population groups and geography.
- Provide recommendations to address Rutland health inequalities with a **proportionate universalism** approach (universal delivery with an element targeted to most in need).

Notes:

1. Some data presented include caveats or limitations, which are explained in the main report.
2. An updated version will be produced in 2023, including yet to be released Census 2021 data.
3. Lower Super Output Area (LSOA) is an area with a population typically between 1,000 and 3,000 residents. Maps of each Rutland LSOA is within the appendix.

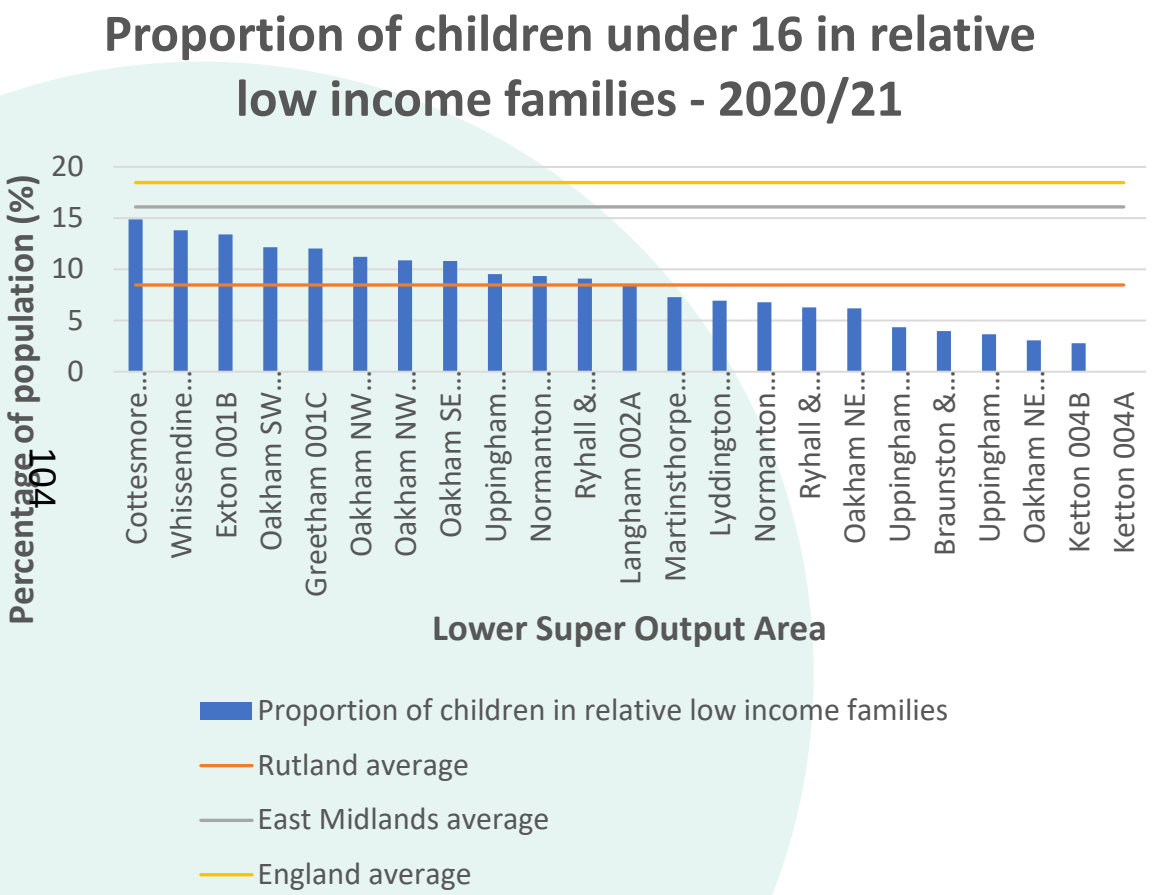
Life expectancy

2020/21		
	Male	Female
Life expectancy in Rutland	82.9	85.2
Life expectancy in England	78.7	82.7
Gap	**-4.2**	**-2.6**

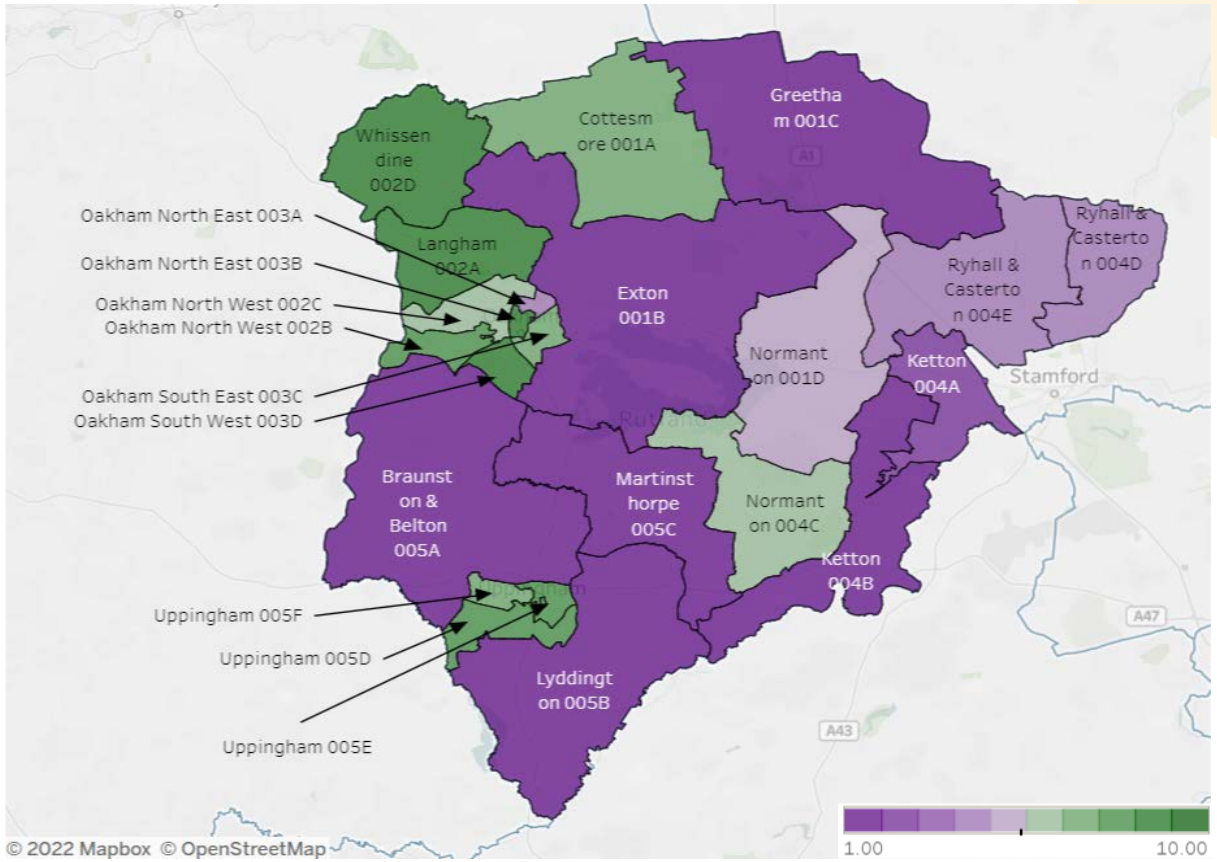
2020/21		
	Male	Female
Life expectancy most deprived quintile	81.3	81.9
Life expectancy least deprived quintile	85.3	86.8
Gap	**3.9**	**4.9**

- **Whilst life expectancy is higher in Rutland than the England average, there is variation between areas within Rutland.**
- 2020-21 data will have an element of influence from COVID-19 deaths in younger age groups.

Section 1 – socio-economic and deprivation



Barriers to Housing & Services domain - the physical and financial accessibility of housing and local services, covering physical proximity of local services, and issues relating to access to housing, such as affordability.



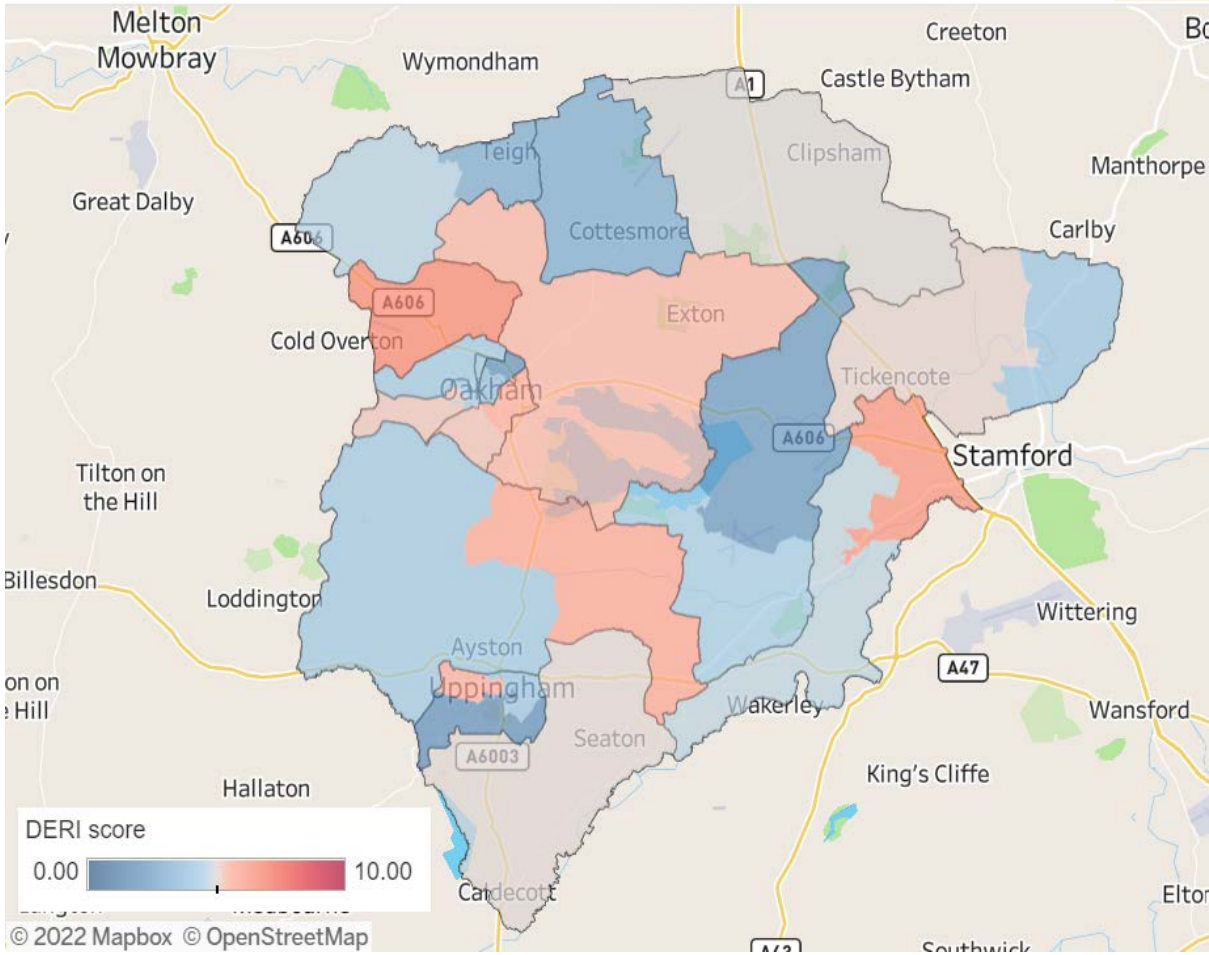
- Rutland performs better than regional and national comparators for most economic deprivation indicators. However, there is still considerable variation *within* Rutland.
- The section also explores service demand, including Rutland Foodbank. The number of meals provided by Rutland Foodbank has significantly increased from 5,686 in 2015/16 to 42,525 in 2020/21.

Section 2 – rurality and access

All Party Parliamentary Group on Rural Health & Social Care identified 5 common characteristics of rural health. These are explored within the report for Rutland, as all rural areas are different.

1. **Ageing population:** rural areas commonly have a disproportionate number of older people.
2. **Mental health:** geographical isolation and loneliness can heighten mental health issues in rural areas.
3. **Distance from services:** people in rural areas need to travel further to access treatment (often costing more).
4. **Housing:** issues in rural communities such as cost, older properties, fuel poverty, older populations and living alone.
5. **Cultural and attitudinal differences**, combined with remoteness from specialist provision.

Digital Exclusion Risk Index (DERI) - deprivation, demography and digital connectivity.

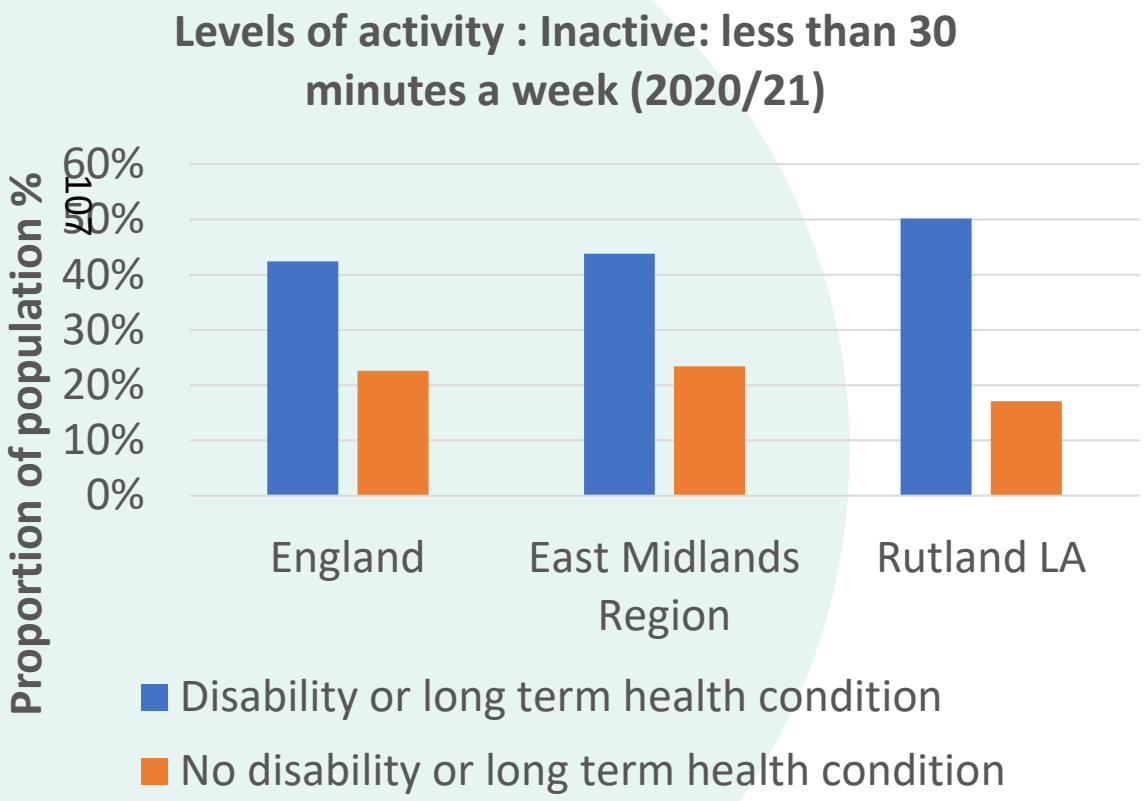


Section 3 – inclusion health groups, vulnerabilities and large population groups

Population (awaiting Census for clear position)	Inequality
Armed forces community	• Although not an inclusion health group, given the high proportion of personnel and veterans in Rutland, specific needs should be explored to prevent inequality. • National and local insight suggests signs of inequality within the armed forces community, **particularly for female veterans mental health and social relationships.**
Carers	• COVID-19 significantly impacted Carers, with an **estimated 26% of the national population providing care during the pandemic.** • Applying this estimate to Rutland, approximately 11,000 people *may* have been providing care, although this is thought to have decreased.
Homelessness	• **85 Rutland households (4.5 per 1,000) were owed a homelessness prevention or relief duty in 2020/21**, lower than the England average (11.3 per 1,000). • **Rutland residents predominantly identified breakdowns in relationships and domestic abuse as the main contributing factors.**
Gypsy, Roma and Traveller communities	• Gypsy, Roma and Traveller communities often have poorer health outcomes and access to health services than the general population. • RCC have commissioned a Gypsy, Traveller and Travelling Showpeople Accommodation Assessment starting in September 2022 to gain further insight.

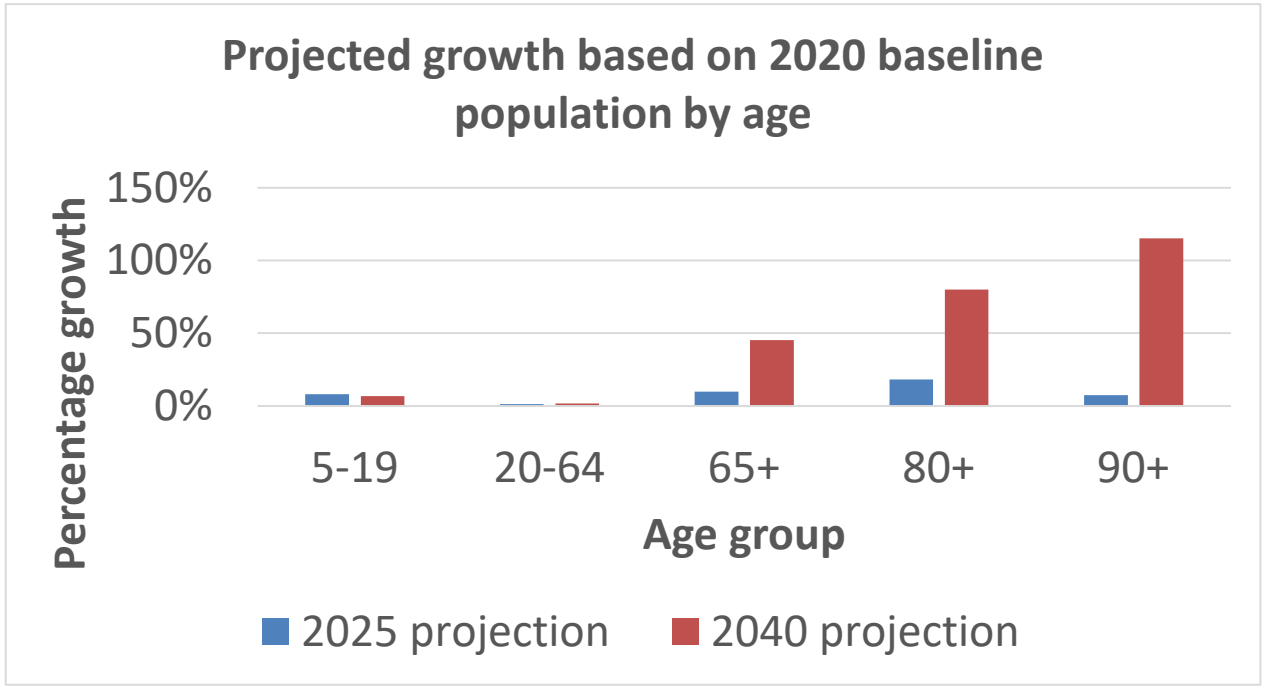
Section 4 – protected characteristics

Disability



Age

- **Rutland has a significantly higher proportion of people aged 65+ (25.1%) and 80+ (7.1%) than England.**
- The 80+ population is projected to increase by 80% in 2040, from 2,819 residents in 2020 to 5,074 in 2040.
- Rutland significantly worse for estimated dementia diagnosis and Excess Winter Deaths Index.



Other protected characteristics covered within the report.

Health and Wellbeing Board recommendations

1. Note report findings and approve publication of the needs assessment on the Rutland Joint Strategic Needs Assessment (JSNA) website.

2. Approve development of a Health and Wellbeing Board development session on health inequalities with a deep dive on needs assessment findings (Appendix A) and further discussion on the report recommendations set out in Appendix C.

Report recommendations

Section 1

- Support available within the community to provide targeted provision to the most rural areas of Rutland identified with higher economic need and more distant from support.

Section 2

- Targeted engagement with Whissendine 002D and Braunston & Belton 005A to develop understanding of potential barriers to accessing primary care and whether they are at greater disadvantage than other areas. Both areas are most distant from GP practices by time to travel and barriers may be hidden in GP/PCN wide engagement.
- Ensure services are prioritising cross border working with neighbouring ICS to maximise opportunity for people to access support closest to home. For example, working with cross boundary ICS on access to acute hospital services.
- Provide targeted digital skills programmes for population groups most in need, alongside universal provision. Identified in the report are people with mental health, learning, memory, physical and sensory impairments.
- Engage with local farming organisations and communities to develop local understanding and consider the farming report recommendations on relieving loneliness.

Report recommendations

Section 3

- Develop new insight for the armed forces community in Rutland, covering the impact of COVID-19, female veterans and mental health.
- Respond to findings from the LLR Carers Strategy consultation before determining specific recommendations for Rutland.
- Respond to findings from the commissioned Gypsy, Traveller and Travelling Showpeople Accommodation Assessment.

Section 4

- Ensure health and wellbeing implications of the population projections for older age groups are embedded into the Local Plan and other long-term strategies.
- Consider deeper dives on dementia diagnosis and excess winter deaths.
- The specific access barriers for people with learning disabilities and/or sensory impairments should be factored into all service plans.
- Consider the LGBT national survey recommendations to improve access and personalised support for mental health, smoking cessation and substance misuse.

Report No: 160/2022
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

11 October 2022

JOINT STRATEGIC NEEDS ASSESSMENT – END OF LIFE

Report of the Director of Public Health

Strategic Aim:	Healthy and well	
Exempt Information:	No	
Cabinet Member(s) responsible:	Councillor S Harvey, Portfolio Holder for Health, Wellbeing and Adult Care	
Contact Officer(s):	Andrew Turvey, Acting Consultant in Public Health	Telephone 01162658799 email andrew.turvey@leics.gov.uk
	Adrian Allen, Head of Service Design & Delivery for Public Health	Telephone 01163054222 email adrian.allen@leics.gov.uk
Ward Councillors	N/A	

DECISION RECOMMENDATIONS
That the Committee: 1. Endorses the recommendations arising from the JSNA End of Life chapter, which seek to address the unmet needs and gaps identified therein. 2. Notes that the JSNA End of Life chapter will be used to inform the refresh of the LLR End of Life Strategy which will be undertaken by the Integrated Care Board.

1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to provide the Health and Wellbeing Board with a summary of the recommendations that have arisen from the recently completed Joint Strategic Needs Assessment (JSNA) End of Life chapter.

2. BACKGROUND AND MAIN CONSIDERATIONS

2.1 The local authority and Integrated Care System (ICS - previously clinical commissioning groups) have an equal and joint statutory responsibility to prepare a 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.

2.2 JSNAs are a continuous process and are an integral part of ICS and local authority commissioning cycles. Health and Wellbeing Boards have a responsibility to decide

when to update or refresh JSNAs or undertake a fresh process to ensure that they are able to inform local commissioning plans over time.

2.3 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.

2.4 The JSNA will be used to help 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. The local authority, ICS and NHS England's plans for commissioning services will be expected to be informed by the JSNA.

2.5 The JSNA is a process which assesses the current and future health and wellbeing needs of the population and underpins local planning for health and care services, in particular the development of the Joint Health and Wellbeing Strategy. It will also contribute towards the ICS strategy development and involves working with local partners to ensure a broad approach to issues affecting health, including key social and economic determinants of health, where appropriate.

3. SUMMARY OF JSNA END OF LIFE CHAPTER FINDINGS

3.1 The JSNA End of Life chapter provides an overview of the data on End of Life care and support for those who are themselves at this stage of life, their loved ones, and for those who work in this area. Data was collected from multiple sources in addition to the public engagement described in section 5. These include data gathered by local organisations and services, locally commissioned reports, nationally collected data, and a literature search. The chapter also considers the relevant national and local policy and guidance context for this stage of life. The chapter reviews this range of national and local evidence under the guidance of a steering group and identifies any gaps or unmet need before making recommendations for future work or improvement.

3.2 Findings from the chapter include:

- Everybody is affected by death, but most occur in older age groups with 48.2% of deaths in Rutland in 2020 attributed to people aged 85+ years. Rutland has a growing population, with the greatest cumulative change projected to occur in the 65+ age band. There is therefore a significant need for robust end of life pathways and services, which is likely to grow in the coming years.

- For many, conversations about end of life preferences currently occur too late to be able to have a meaningful impact, particular for groups such as those with dementia. Advance Care Planning (ACP) at a sufficiently early stage provides people with the opportunity to plan their future care and support whilst they have the capacity to do so. It has been shown to increase the chance that a person's wishes will be understood and followed, contributing to improved quality of care. Despite this, uptake is low, with as few as 9.7% shown to have an ACP in place prior to their final hospital admission. Contributing to this is a low level of understanding of terms relating to end of life care, and poor awareness of the support services available. These issues are exacerbated by a system which is often fragmented, with complex referral pathways and little formal coordination.

- The loss of a loved one is a traumatic life event, and as such, bereaved individuals have increased emotional, social, and practical needs. Whilst people in Rutland have told us they are often happy with the support received from services once they have accessed them, they have described a difficulty in identifying what help is available particularly at such a challenging time.

- Informal carers provide as much as 75-90% of homebased care for those nearing the end of life and are integral in supporting many people to remain at their place of choice. Despite significant financial, physical, and emotional costs to themselves in undertaking this important role, carers informed us that they feel unsupported and often overlooked by services. They are also often burdened with attempting to navigate and coordinate complex health and social care systems on behalf of their loved one.

- Staff working across the health and social care sector must be supported to feel confident in working with patients approaching the end of life. This is increasingly of import, given we are faced with an ageing and increasingly co-morbid population which interacts with multiple health services and specialties.

4. SUMMARY OF JSNA END OF LIFE CHAPTER RECOMMENDATIONS

4.1 As a result of the JSNA findings, a set of recommendations have been developed with the aim of improving the help and support available for, and quality of life of, people approaching death and affected by it in Rutland.

The recommendations are:

- **Further exploration of the issue**

- Undertake a tailored piece of engagement to capture the views, preferences, and experiences of those who are themselves approaching the end of life.

- Produce a health equity audit to further explore inequalities in end of life care and how services can be tailored to better address the needs of disadvantaged groups.

- Further explore the reasons for deaths taking place at hospital / hospice / home / care home, to better understand if this is due to patient choice or factors such as a lack of community services meaning there is insufficient capacity to support people dying at home. To particularly consider those who live elsewhere but die in a care home.

- Explore how accurately advance care plans are being followed and enacted, particularly for patients attending hospitals outside of LLR which may have different systems to those used locally.

- **Facilitating conversations**

- Seek to modify social norms by utilising behaviour change theory and social marketing, to improve the acceptability of discussing death and end of life preferences.

- Consider how conversations relating to end of life preferences and planning can be initiated at times surrounding major life events, by incorporating a Making Every Contact Count plus (MECC+) approach.

- Seek to increase the number of people with an advance care plan.

- Encourage healthcare staff to initiate advance care planning discussions during early interactions, particularly for those with degenerative conditions such as dementia who will be less able to contribute meaningfully as their condition progresses.

- **Increasing public understanding**

- Undertake local campaigns aimed at enhancing the public's understanding of what is meant by end of life, the terms frequently used in relation to it, and the role of different services.

- Improve awareness of existing, locally available services.

- Build on work by Dying Matters to provide a central source of information and signposting advice to end of life and bereavement services.

- **Delivering services**

- Develop a more robust community out of hours offer so that support for those approaching the end of life and their carers is available throughout the week.

- Improve the coordination of services working together to deliver end of life care, to reduce the burden currently placed on patients and their loved ones.

- Promote continuity of care within services, particularly with primary and community services, to support the building of trusted relationships between patients and their health or social care provider.

- Work to introduce beds specifically for end of life care provision locally in Rutland, to ease travel burdens and facilitate respite care.

- Consider how to introduce a form of routine follow up with those who have undergone a recent bereavement.

- **Supporting carers and staff**

- Improve the advice and support available to informal carers, so that they feel better equipped with the skills and knowledge to support their loved one.

- Consider how regular check-ins with informal carers can take place.

- Support informal carers in taking respite care, so as to ensure their own wellbeing.

- Ensure training is available and accessible for staff who do not regularly deliver end of life care as a core part of their role.

5. CONSULTATION

5.1 To help ensure the JSNA End of Life chapter captured the views of local people, a survey was created to ensure that lived experiences were incorporated. This was targeted at those who have been bereaved in the past three years, those who are or have been informal carers for a loved one approaching the end of life, and staff working in end of life and palliative care services. A total of 51 people responded, 13 of whom had been recently bereaved, 7 had experience of being an informal carer to someone nearing the end of life, and 36 were paid staff working in end of life and palliative care services.

5.2 The results from this survey are presented in the JSNA End of Life chapter and were used to help shape the final recommendations.

6. ALTERNATIVE OPTIONS

6.1 The production of a JSNA is a statutory requirement. In July, the Health and Wellbeing Board noted the suggested approach to JSNA Development that identified End of Life as a key topic for consideration.

7. FINANCIAL IMPLICATIONS

7.1 The JSNA End of Life chapter has been completed within the existing capacity and resources of the Public Health Department and Leicestershire Business Intelligence team.

8. LEGAL AND GOVERNANCE CONSIDERATIONS

8.1 The JSNA is a statutory document and must meet the requirements for production of such documents. The End of Life chapter was produced with the support and input of a steering group consisting of local government partners, individuals who work in services that deliver end of life or palliative care, and members of related third sector organisations.

9. DATA PROTECTION IMPLICATIONS

9.1 A Data Protection Impact Assessments (DPIA) has not been completed for this JSNA chapter. The data collected through the consultation (Section 5) was processed in line with corporate requirements, following discussions with the Leicestershire County Council Information Governance team. All other data sources contributing to this chapter were secondary sources, with information anonymised if it was not presented in an aggregate format.

10. EQUALITY IMPACT ASSESSMENT

10.1 The JSNA chapter takes due regard to the equality and human rights of different population groups. The End of Life JSNA chapter will inform the future LLR End of Life strategy which will be subject to an EHRIA.

11. COMMUNITY SAFETY IMPLICATIONS

11.1 There are no direct community safety implications arising from the JSNA End of Life chapter.

12. HEALTH AND WELLBEING

12.1 The purpose of the JSNA End of Life chapter is to assess the related health and wellbeing needs across Rutland. Its findings will also inform the LLR End of Life strategy which is due to be produced by the Integrated Care Board, service plans, and commissioning.

13. CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

13.1 The JSNA End of Life chapter has been produced using a combination of local and national sources. Unmet needs of the local population have been identified, and recommendations to address these have been formulated. This chapter will be used to inform the refresh of the LLR End of Life Strategy being undertaken by the Integrated Care Board.

13.2 The Health and Wellbeing Board is recommended to:

1. Endorse the recommendations arising from the JSNA End of Life chapter, which seek to address the unmet needs and gaps identified therein.

2. Note that the JSNA End of Life chapter will be used to inform the refresh of the LLR End of Life Strategy which will be undertaken by the Integrated Care Board.

14. BACKGROUND PAPERS

14.1 Published JSNA chapters to date can be accessed at https://www.rutland.gov.uk/my-services/health-and-family/health-and-nhs/joint-strategic-needs-assessment/. The JSNA End of Life chapter will be uploaded alongside these shortly, once it has undergone final approval by the steering group.

15. APPENDICES

15.1 There are no appendices to the report.

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

Rutland County Council

Rutland County Council

JSNA End of Life Chapter

Health and Wellbeing Board

October 2022

Level of Need

Indicator	Rutland (2020)	Trend over preceding 5 years	England
Mortality Rate	780 per 100,000	-	1,042 per 100,000
Premature Mortality Rate	205.8 per 100,000	-	358.5 per 100,000
Preventable Mortality Rate	68.2 per 100,000	-	140.5 per 100,000
Deaths occurring in hospital	33.9%	-	41.9%
Deaths occurring at home	33.9%	-	27.4%
Deaths occurring in care homes	27.5%	-	23.7%
Deaths occurring in a hospice	3.1%	-	4.5%

Significantly better then England
Not significantly different from England
Significantly Worse then England

Increase from previous time period
Decrease from previous time period

Level of Need

Based on results of a survey undertaken as part of the JSNA End of Life chapter:

- 67% of bereaved people do not believe it was easy for their loved one to access support services.
- 67% of bereaved people were happy with the care and support their loved one received.
- 62% of bereaved people did not feel they had a good understanding of the bereavement support services that were available to them.
- 61% of bereaved people felt it was not clear how they access bereavement support services.
- 57% of informal carers felt they did not receive sufficient support or training to care for someone near the end of life.

Level of Need

Quotes from local people:

"I had to cope alone. The only support received was when my partner was receiving oncology treatment or was admitted to PCH/the hospice. It would be far better if additional support at home was offered upfront. You have enough on your plate without

1. *Having to try and find out what help is available*
2. *Keep pestering, when no help is forthcoming. I was supporting my partner alone, and taking him to all his medical appointments"*

"I was not aware of any services. From diagnosis we were mostly alone in organising all care. Social services refused to advise on appropriate care as we were 'self funding'. We were not made aware of any end of life care or bereavement services outside of the care we were paying for privately."

"Lack of explanation regarding medication from hospital at discharge, lack of information regarding the roles and responsibilities of the district teams, lack of equipment (walker) that was promised from hospital, lack of communication and explanation of the CHC system/status."

"I feel that the main gap in services is that if a person wants to die at home, clinical services overnight are not available at a level which is required or in a timely manner"

Unmet Needs / Gaps

- People need to be supported in having conversations about death and end of life preferences.
- There is a lack of coordination of services, with the burden often falling on those nearing the end of life and their loved ones.
- People are often unaware of sources of support, and accessing these can be complex.
- There are limited out of hours services available for people in the community.
- Following a bereavement, people may feel abandoned by health and social care staff due to a lack of routine follow up.
- Informal carers do not feel sufficiently supported, particularly with regards to the training and advice they receive.
- Health and social care staff do not always feel they have sufficient training to support them in working with those approaching the end of life.

Recommendations: Further Exploration of the Issue

- Undertake a tailored piece of engagement to capture the views, preferences, and experiences of those who are themselves approaching the end of life.
- Produce a health equity audit to further explore inequalities in end of life care and how services can be tailored to better address the needs of disadvantaged groups.
- Further explore the reasons for deaths taking place at hospital / hospice / home / care home, to better understand if this is due to patient choice or factors such as a lack of community services meaning there is insufficient capacity to support people dying at home. To particularly consider those who live elsewhere but die in a care home.
- Explore how accurately advance care plans are being followed and enacted, particularly for patients attending hospitals outside of LLR which may have different systems to those used locally.

Recommendations: Facilitating Conversations

- Seek to modify social norms by utilising behaviour change theory and social marketing, to improve the acceptability of discussing death and end of life preferences.
- Consider how conversations relating to end of life preferences and planning can be initiated at times surrounding major life events, by incorporating a Making Every Contact Count plus (MECC+) approach.
- Seek to increase the number of people with an advance care plan.
- Encourage healthcare staff to initiate advance care planning discussions during early interactions, particularly for those with degenerative conditions such as dementia who will be less able to contribute meaningfully as their condition progresses.

Recommendations: Increasing Public Understanding

- Undertake local campaigns aimed at enhancing the public's understanding of what is meant by end of life, the terms frequently used in relation to it, and the role of different services.
- Improve awareness of existing, locally available services.
- Build on work by Dying Matters to provide a central source of information and signposting advice to end of life and bereavement services.

Recommendations: Delivering Services

- Develop a more robust community out of hours offer so that support for those approaching the end of life and their carers is available throughout the week.
- Improve the coordination of services working together to deliver end of life care, to reduce the burden currently placed on patients and their loved ones.
- Promote continuity of care within services, particularly with primary and community services, to support the building of trusted relationships between patients and their health or social care provider.
- Work to introduce beds specifically for end of life care provision locally in Rutland, to ease travel burdens and facilitate respite care.
- Consider how to introduce a form of routine follow up with those who have undergone a recent bereavement.

Recommendations: Supporting Carers and Staff

- Improve the advice and support available to informal carers, so that they feel better equipped with the skills and knowledge to support their loved one.
- Consider how regular check-ins with informal carers can take place.
- Support informal carers in taking respite care, so as to ensure their own wellbeing.
- Ensure training is available and accessible for staff who do not regularly deliver end of life care as a core part of their role.

Conclusion

The Health and Wellbeing Board is asked to:

- Endorse the recommendations arising from the JSNA End of Life chapter
- Note that the JSNA End of Life chapter will be used to inform the refresh of the LLR End of Life Strategy which will be undertaken by the Integrated Care Board

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Report No: 162/2022
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

11th October 2022

UPDATE ON LEICESTER, LEICESTERSHIRE, RUTLAND INTEGRATED CARE SYSTEM

Report of the Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board

Strategic Aim:	All	
Exempt Information:	No	
	Councillor S Harvey, Portfolio Holder for Health, Wellbeing and Adult Care	
Contact Officer(s):	Sarah Prema, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Board	email sarah.prema@nhs.net
Ward Councillors	NA	

DECISION RECOMMENDATIONS
That the Committee: 1. Notes the update on the Leicester, Leicestershire and Rutland Integrated Care System.

1. PURPOSE OF THE REPORT

1.1 This report provides the members of the Rutland Health and Wellbeing Board with an update on the Leicester, Leicestershire and Rutland Integrated Care System.

2. BACKGROUND AND MAIN CONSIDERATIONS

2.1 The Leicester, Leicestershire and Rutland Integrated Care System comprises of the LLR Health and Care Partnership and the LLR Integrated Care Board. Both came into legal existence on 1st July 2022. At the same time the three previous Clinical Commissioning Groups in LLR were disestablished.

2.2 The Health and Care Partnership is formed between all of upper tier local authorities in LLR and the LLR Integrated Care Board to improve care, health and wellbeing of the population.

2.3 The Integrated Care Board is a statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing the NHS budget and arranging for the provision of health services in the area.

3. UPDATE ON HEALTH AND WELLBEING PARTNERSHIP

3.1 In June 2022 a joint meeting between the shadow LLR Integrated Care Board and the three Health and Wellbeing Boards in LLR came together to discuss the priorities for the Health and Wellbeing Partnership. The outcome from this meeting was the following three priorities:

- The Cost of Living Crisis
- Access to services
- Harnessing the collective public sector resources to support our population

3.2 These priorities were approved at the first meeting of the Health and Wellbeing Partnership in August 2022. The partnership is due to discuss the first of these topics in more detail at a workshop event in October 2022.

3.3 The Health and Wellbeing Partnership has agreed to meet on a quarterly basis with a membership made up of Health and Wellbeing Board representation; Integrated Care Board representation and HealthWatch, see Appendix A.

3.4 In addition, each quarter a wider working group will come together to discuss the priorities set out in 3.1 together with contributing to the wider work of the partnership. This wider group is made up of members of the three Leicester, Leicestershire and Rutland Health and Wellbeing Boards and the Integrated Care Board.

3.5 A requirement of the Health and Wellbeing Partnership is to produce an Integrated Care Strategy for their system. This strategy needs to be in initial draft form and published in December 2022, this is to enable it to inform the strategic direction of the Integrated Care Board as they plan for 2023/24 and beyond. Guidance on the development of this strategy can be found at https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies/guidance-on-the-preparation-of-integrated-care-strategies

3.6 All three local Health and Wellbeing Boards have revised their Health and Wellbeing Strategies and this gives us a really good starting point from which to develop an integrated care strategy. Work is ongoing to develop the strategy and will be considered at a working group meeting in October 2022 and approved by the Partnership in December 2022.

3.7 Given this is an initial draft there will be further work to complete in 2023 to produce a final strategy.

4. INTEGRATED CARE BOARD

4.1 The LLR Integrated Care Board was established on 1st July 2022. At it's first meeting the Board signed off a range of governance arrangements and policies to support it in delivering its functions. A copy of the governance structure is attached as Appendix B.

4.2 Further meetings took place in July and August 2022 which discussed a range of topics including our plans for emergency and urgent care services through Winter; primary care and elective care. In addition, assurance reports were received from the ICB's sub committees on finance, performance and quality. Details of the papers can be found at https://leicesterleicestershireandrutland.icb.nhs.uk/about/board-meetings/

4.3 The Integrated Care Board is required to develop a 5 year plan which takes account of the Health and Care Partnerships Integrated Care Strategy. This strategy needs to

be published for March 2023. Early work has commenced on the development of the strategy with work ongoing during Quarter 3 and Quarter 4.

4.4 The LLR ICB held a public question and answer session in September 2022 which gave an opportunity for members of the public to have a conversation with the leadership of the local ICB about various aspects with a particular focus on primary care services. The event was attended by circa 40 members of the public together with a similar number online. There are plans to do this on quarterly basis based around different topics. This work is in addition to the ICB normal communication and engagement activity and will provide a valuable opportunity for ongoing dialogue.

4.5 The focus for the LLR Integrated Care Board over the next few months is to manage the winter period with a view of improving access; reducing waits; and improving discharge. In addition, the Board is working to ensure delivery of the yearly operational plan as we move into the final half of 2022/23 and start the preparation of the 5 Year plan and the 2023/24 Operational Plan.

4.6 Transformation continues across the system and some examples of the work being done can be found in the quarterly Health and Care Together Newsletter that can be found at https://leicesterleicestershireandrutland.icb.nhs.uk/wp-content/uploads/2022/09/LLR-HealthCare-E-Zine-Autumn.pdf

4.7 Topics covered in the Autumn Newsletter issue include the implementation of Virtual Wards; launch of Crisis Cafes; Tackling Cancer Inequality; Supporting Young Victims of Violent Crime; AI and Skin Cancer Diagnosis; and a grant scheme to support a wide range of improvements.

5 APPENDICES

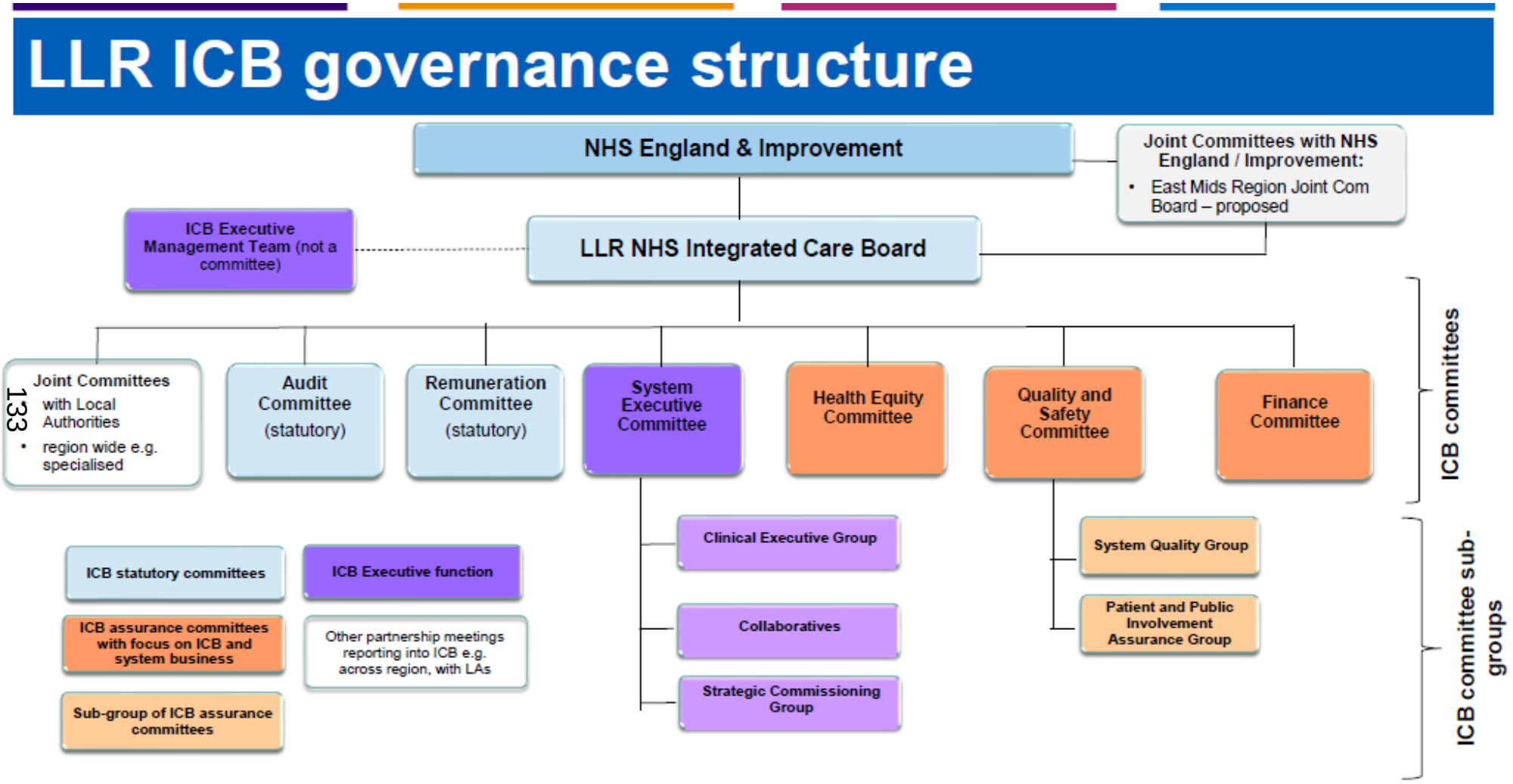
5.1 **Appendix A** – Membership of Leicester, Leicestershire and Rutland Health and Wellbeing Partnership

5.2 **Appendix B** - Leicester, Leicestershire and Rutland Integrated Care Board Governance

APPENDIX A: MEMBERSHIP OF THE LEICESTER, LEICESTERSHIRE AND RUTLAND HEALTH AND WELLBEING PARTNERSHIP

Member
Chair Leicester City Health and Wellbeing Board
Chair Leicestershire County Council Health and Wellbeing Board
Chair Rutland County Council Health and Wellbeing Board
Chair Leicester, Leicestershire and Rutland Integrated Care Board
Director Public Health Leicestershire County and Rutland
Director Public Health Leicester City
Strategic Director for Social Care and Education Leicester City Council
Director of Adults and Communities Leicestershire County Council
Director of Children and Family Services Leicestershire County Council
Director of Adult Services Rutland County Council
Director of Children's Services Rutland County Council
Chief Executive LLR Integrated Care Board
Chief Executive University Hospitals of Leicester
Chief Executive Leicestershire Partnership Trust
Chief Strategy Officer LLR Integrated Care Board
Chief Operating Officer LLR Integrated Care Board
Leicester and Leicestershire Healthwatch
Rutland Healthwatch

APPENDIX B: LEICESTER, LEICESTERSHIRE AND RUTLAND INTEGRATED CARE BOARD GOVERNANCE



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Report No:164/2022
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

11 October 2022

JOINT HEALTH AND WELLBEING STRATEGY UPDATE

Report of the Portfolio Holder for Health, Wellbeing and Adult Care

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Cllr S Harvey, Portfolio Holder for Health, Wellbeing and Adult Care	
Contact Officer(s):	John Morley, Strategic Director for Adult Services and Health	01572 758442 jmorley@rutland.gov.uk
	Mike Sandys, Director Public Health RCC	0116 3054259 mike.sandys@leics.gov.uk
	Debra Mitchell, Deputy Director of Integration and Transformation, LLR CCGs	07969910333 debra.mitchell3@nhs.net

DECISION RECOMMENDATIONS
That the Committee: 1. Notes the further development of the JHWS Delivery Plan through the content of this report

1 PURPOSE OF THE REPORT (MANDATORY)

1.1 The Joint Health and Wellbeing Strategy (JHWS) is a statutory responsibility of the Health and Wellbeing Board (HWB) and falls under its governance.

1.2 The purpose of this report is to update the board on the progress of implementation of the JHWS across the six priority areas and the key enablers.

2 IMPLEMENTATION OF THE STRATEGY

2.1 Rutland's Joint Health and Wellbeing Strategy was formally approved at the 5 April Health and Wellbeing Board.

2.2 The overall aim of the joint strategy, which will be delivered across five years, is for 'people to live well in active communities.' It aims to 'nurture safe, healthy and caring communities in which people start well and thrive together throughout their lives.' In order to achieve its objectives, the Strategy is structured into seven priorities following a life course model.

2.3 At the May Integrated Delivery Group (IDG) meeting, leads were nominated for each of the JHWS priorities at both HWB and IDG level, with the aim of supporting the balanced and collaborative delivery of the strategy via IDG and the HWB.

2.4 Since the last HWB each of the priority areas have established delivery groups to take forward the work plan for each of the strategic priorities. Each of the subgroups report in to the IDG which in turns reports to the Rutland Joint Health and Wellbeing Board.

2.5 During October 2022, a robust governance process will be finalised that supports the continued monitoring of the implementation of the Rutland Joint Health and Wellbeing Strategy.

2.6 **Appendix A** is the Quarterly Highlight Report for each of the strategic priorities and enablers detailed within this report.

2.7 **Appendix B** is an Outcomes Summary Report which sets out the most recent Public Health data for indicators relevant to each Strategy priority. It highlights whether Rutland rates are below, similar to or above national rates, or it compares Rutland to a group of 16 similar areas in the country. The reports are used by priority teams for targeting and prioritisation.

3 PROGRESS ON STRATEGIC PRIORITIES

3.1 Priority One: Enabling the Best Start in Life

3.1.1 This strategic priority is supported by the Children and Young People's Partnership Board. The key deliverables within this priority now form an integral part of the role and remit of this Board.

3.1.2 The key deliverables of this priority are:

- Healthy child development in the first 1001 critical days (conception to 2 years old)
- Confident families and young people
- Access to health services

3.1.3 The achievements to date include:

- Completion of baseline assessment of Early Intervention services via Early Help System Guide
- Completion of High-Level Implementation plan and formation of multi-agency steering group; first meeting held and terms of reference agreed
- Commissioning of visuals and graphic design components to aid brand launch and raise awareness of hub offer for families and professionals

3.2 Priority Two: Staying Healthy and Independent – Prevention

3.2.1 At the August meeting of the IDG it was agreed that a Staying Healthy subgroup would be formulated to support this strategic priority and report to IDG. This group is in the process of being established.

3.2.2 The key deliverables of this priority are:

- Options appraisal for developing a prevention front door for Rutland.
- Implementation low level of prevention offer in all front-line staff through LLR Healthy Conversations training (Making Every Contact Count Plus (MECC+))
- Review the oral health needs of Rutland

3.2.3 The achievements to date include:

- Agreed at IDG to establish a Staying Healthy Group as a subgroup of IDG
- IDG approval to develop an options appraisal for a prevention front door.
- Social prescribing platform implemented for the RISE team.
- MCC+ plus training delivered to RISE team.
- Oral health needs assessment has been started

3.2.4 The key focus for the next period is:

- Develop options appraisal for prevention front door and assess capacity, infrastructure and resource to scope and implement a coordinated prevention front door for Rutland.
- Further embed MECC+ across Rutland and Ensuring all frontline staff see prevention as a core part of their role in Rutland and attend MECC+ training.
- Complete oral health needs assessment for HWB Jan 2023

3.3 Priority Three: Healthy Aging and Living Well with Long Term Conditions

3.3.1 This strategic priority is supported by the establishment of the Integrated Neighbourhood Network which meets monthly and reports to the IDG.

3.3.2 The key deliverables of this priority are:

- Timely and well-coordinated support enabling people living with ill health to live well, without ill health dominating, postponing deterioration, ageing well.
- Tailored support to help individuals live well with changing health circumstances through MDT working
- Collaborative coordinated care – recruitment to neighbourhood facilitator underway
- Integrated and multidisciplinary working through the monthly Rise team MDT meetings is supporting people with complex health needs.
- Cross-boundary inequality of access to support for people diagnosed with dementia
- Active work on falls prevention in care homes, using a personalised approach

for greater impact.

- To develop a falls prevention strategy specific to each Care Home environment, creating a culture of individualised care for best practice.

3.3.3 The achievements to date include:

- Integrated and multidisciplinary working through the monthly RISE (Rutland Integrated Social Empowerment Service) MDT meetings are supporting people with complex health needs.

- WHZAN pilot has commenced with nine Rutland care homes. The Whzan Blue Box is an all-in-one telehealth case. It measures vital signs, records photos, and performs multiple assessments. This enables signs of deterioration or illness in a resident to be identified earlier, for a clinical response or carer support

- Recruitment of neighbourhood facilitator – interviews taking place this month

- Rutland social prescribing platform live from 1st Sept 2022.

- 3 conversations innovator site identified some staff to codesign cohort of people to work with

- Dementia UK have introduced a new national project called Closer to Homehttps://www.dementiauk.org/get-support/closer-to-home/Families are now able to access wherever they live.

- RCC falls prevention Occupational Therapist [OT] is currently working with two Care Homes to create a bespoke falls prevention strategy for each home.

- Three of the Rutland Care Homes now have a dedicated Falls Prevention Champion, with the plan for there to one in each care home. The Champions meet weekly with RCC OT, to discuss practice, training, and staffing. Falls cases and falls patterns across the care home are reviewed and actions plans discussed. The OT identifies and recommends environmental adaptations and assistive technology which could support in reducing falls risks.

- Good hospital discharge performance – high reablement success and minimising use of interim beds means patients successfully going straight home. MiCare capacity is good and we have not had to use an interim bed since before June – but no weekend social worker could potentially cause us problems.

- The Rutland Care Provider forum has been ongoing since last December, with the last forum occurring Wednesday 7th September. Attendance at these forums varies, but the last one was 50% of care homes and 33% of home care providers (this includes all spot and framework). The next forum in December will hopefully be face to face which should encourage some attendance.

- All Rutland providers are engaging with the capacity tracker. All care providers, bar one, have updated the tracker within the past 2 weeks.

3.3.4 The key focus for the next period is:

- Looking at further development of the successful Rise adults MDT meeting model to children's and safeguarding focused meetings.

- Evaluation of Whzan pilot

- Neighbourhood facilitator to identify individuals to benefit from proactive care management through a population health management approach.

- Onboarding all partners and content of the RIS to the Rutland social prescribing platform

- Training and support for partners to use the social prescribing platform

- Comms for the public to be aware of the social prescribing platform

- Further engagement with staff across neighbourhood to join the 3 conversations innovator site

- Admiral nurses support through virtual clinics, with the hope this can also become face to face

- Carers strategy going to cabinet Oct 18th, 2022, for approval. This is an all age LLR strategy with a Rutland specific delivery plan.

- Dementia. LLR strategy currently being reviewed following covid. Diagnosis rate is due to severe backlog at memory services, due to staffing issues and the service being closed during Covid. Referrals into memory service remain high. Memory services are wanting a room available in Oakham to have a memory clinic local to the area

- LD- Following Covid, Face to face annual health checks is priority due to communication and support required.

- Falls A third Care Home identified for the programme. Initial meetings to take place October 2022.RCC OT to continue to promote and encourage other providers to join the programme. RCC OT to look to collate data relating to this service.

3.4 Priority Four: Ensuring Equitable Access to Services for all Rutland Residents

3.4.1 This strategic priority is supported by the Rutland Strategic Health Partnership Board.

3.4.2 The Key deliverables of this priority are:

- Understanding access issues

- Increasing access and availability to diagnostic and elective services closer to home.

- Improving access to primary and community health and care services

- Improve access to services and opportunities for people less able to travel, including through technology

- Enhance cross boundary working across health and care with key neighbouring areas

3.4.3 The key achievements to date include:

- A plan has been agreed for Rutland PCN to deliver an enhanced access service on a rotational basis across the four GP sites which will provide pre-bookable, same day access and preventative services Monday to Friday 6.30 - 8.00pm and Saturday 9.00 - 5.00pm. This service is due to commence on 1st October 2022.

- Following recruitment of a care co-ordinator through the ARRS, and in conjunction with the PCN Direct Enhanced Service (DES) the PCN have agreed plan that proactively seeks to identify patients who are housebound/frail elderly to care plan and reduce the risk of falls and deterioration in condition.

- The PCN now has 180 blood pressure monitors to support patients to monitor the blood pressure at home, negating the need to be referred on to secondary care.

- After the success of the diagnostic pilot, the PCN have been contracted to deliver four diagnostic tests locally on an ongoing basis and further diagnostics are being considered such as Doppler tests. This avoids patients having to be referred into secondary care and also ensure that the patients are seen quicker, closer to home.

- RCC CC Property Services have identified a potentially suitable site at Oakham Enterprise Park for mobile MRI. Discussions are ongoing.

- A business case is being formulated to look at some Dermatology activity to be considered for delivery in a community setting whether that be in a community hospital or GP practice

- LPT / ICB Reviewing demand and capacity for a plain film and ultrasound provision moving forward, of which Rutland Memorial Hospital is included within this review.

3.5 Priority Five: Preparing for our Growing and Changing Population

3.5.1 This strategic priority is supported by the establishment of the Rutland Health Strategic Health Developments Board which meets every six weeks and reports in to the IDG.

3.5.2 The key deliverables of this priority are:

- Planning and developing 'fit for the future' health and care infrastructure

- Health and care workforce fit for the future

- Health and equity in all policies, in particular developing a healthy built environment aligned for projected growth

3.5.3 The key achievements to date include:

- Maximisation of the additional role's reimbursement scheme. Recruitments, including 7 clinical pharmacists joining a PCN-formed academy in collaboration with Nottingham University to train as advanced practitioners (diagnostic skills and more autonomous than clinical pharmacists - benefits to patients, workforce, and practices).

- Rutland Health PCN are being engaged as part of phase 1 of LLR programme to develop Clinical/Estates Strategy. Planned 16-week development

- Oakham business case is in the process of being finalised for the utilisation of S106 funding to convert one of the three patient waiting areas into additional clinical space.

3.6 Priority Six: Ensuring People are Well Supported in the Last Phase of their lives.

3.6.1 This strategic priority is supported by the LLR End of Life and Palliative Care Task Force that meets monthly and feed in to the IDG.

3.6.2 The key deliverables of this priority are:

- Each person is seen as an individual

- Each person has fair access to care

- Maximising comfort and wellbeing

- Care is co-ordinated

- All staff are prepared to care

- Communities are prepared to help

3.6.3 The key achievements to date include:

- A joint strategic needs assessment end of life and palliative care has been undertaken for Rutland which will inform the strategy and work programme moving forward with an LLR End of Life strategy to be in draft form by March 2023

- System-wide launch of ReSPECT V3 planned for 2023 - this will include training and comms to system partners.

- A proposal has been written that will support Rutland to become one of the first Compassionate Counties in the country. It aims to facilitate and broker various parts of the communities which includes organisations to create a better understanding of death, dying, and bereavement and to enable social action to happen in communities for example Bereavement Help Points, Compassionate Neighbours.

- Compassionate Neighbours are trained volunteers who provide support to palliative patients and their families in the local area for a few hours (3-4) each week. They provide simple but valuable emotional and practical support for patients, their carers and loved ones, with activities such as keeping a patient

company whilst their carer takes a break, chatting over lunch in a local café, or perhaps just having a phone call

- A review has also been undertaken against the RCPG Daffodil standards that seeks to inform Rutland's end of life and palliative care workplan ensuring prioritisation, personalisation, planning for end of life and palliative care in the integrated systems of care within Rutland.

4 CROSS CUTTING THEMES - ENABLERS

4.1 As a part of the formulation of the strategy there was an acknowledgement that some areas cut across many of the priorities and also so integral to their delivery that they should be seen as enablers. The enablers sitting within the Rutland Joint Health and Wellbeing strategy are:

- Supporting good mental health
- Reducing health inequalities
- Covid recovery and readiness
- Communications and engagement

4.1.1 Supporting Good Mental Health

4.1.2 The aim here is to move towards an integrated neighbourhood-based approach to meeting mental health needs in Rutland by developing of a neighbourhood mental health delivery plan. Working with a number of local, community partners, both statutory and non-statutory based on the local assessment of needs, which brings together and coordinates a neighbourhood network approach to delivering improvements to mental health in Rutland.

4.1.3 In the last quarter, RCC has undertaken the successful recruitment of a Senior Mental Health Neighbourhood lead. A neighbourhood workshop has taken place with the focus on mental health within Rutland that has started to explore the reported inequalities, gaps and ideas around what people would like to see for mental health provision in Rutland.

4.2 Reducing Health Inequalities

4.2.1 As a part of this enabler workstream, the following priorities have been identified:

- Complete Health Inequalities Needs Assessment on Rutland
- Embed a proportionate universalism approach to service delivery
- Strengthen health inequalities leadership and accountability across Rutland

4.2.2 The strategic lead for public health has undertaken a full needs assessment of the Health Inequalities in Rutland. As a result of this insightful report a recommendation will be made for a Joint Health and Wellbeing Development session on the final report to work through the recommendations and identify areas of focus moving forward so that this can be prioritised within the Joint Health and Wellbeing Strategy Delivery Plan.

4.3 Covid Recovery and Readiness

4.3.1 As a part of the primary care covid recovery, also linking to the primary care access, the latest GPAD data shows that all four practices in Rutland have recovered to pre-pandemic appointment levels, on average, 7% more appointments than 2019 levels. 60% of appointments are face to face with a majority of decreases in DNA's with only Empingham showing an increase in July.

4.3.2 As a result of the Covid pandemic it was acknowledged that there was a disruption and displacement of proactive care for people living with long-term conditions, and as a result this would likely result in exacerbation and complications for patients and therefore this could add to further waves of demand for unscheduled care over the coming months whilst in recovery for primary care, emergency, and hospital admissions.

4.3.3 In response to this, a programme of proactive care was rolled out which looked to reduce the backlog for routine monitoring for patients within long term conditions. This is further supported by the establishment of an enhanced access service that goes live on 1st October and will give patients the opportunity to access a range of additional appointments, same day, proactive and preventative, Monday to Friday 6:30 – 8:00pm and Saturdays from 9:00 – 5:00pm.

4.3.4 In September, the autumn Covid booster programme re-commenced in Rutland, transferring from Oakham Enterprise Park, back to the PCN for delivery. Prioritisation commenced with care home and housebound patients and then;

- frontline health and social care workers
- all adults aged 50 years and over
- persons aged 5 to 49 years in a clinical risk group
- persons aged 5 to 49 years who are household contacts of people with immunosuppression
- persons aged 16 to 49 years who are carers.

4.4 Communications and Engagement

4.4.1 Communication and engagement are an integral enabler of the Rutland Joint Health and Wellbeing Strategy. All the priorities have deliverables that include communications and engagement activities within them.

4.4.2 A multi-stakeholder group has been pulled together to map all the deliverables within the plan that require communications and engagement so that we can ensure that it is joined up and there is no duplication. As a part of this group, we will also link into the system comms and engagements strategy to ensure that we articulate what can be informed at a strategic level but also what elements require a more targeted Rutland focus.

4.4.3 This work will be prioritised within the next month and by the end of October we will have a clear communications and engagement plan for all the mapped activities that sit within the Joint Health and Wellbeing Strategy delivery plan.

5 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

5.1 There has been a positive start to implementation of the 5-year strategy, with many activities taking place in the first 6 months. The Integrated Delivery Group, on behalf of the Health and Wellbeing Board will continue to drive and monitor implementation to improve the health and wellbeing of the Rutland Population.

5.2 The HWB is asked to note the following key points for discussion and consideration with regards to progress on the implementation of the Rutland Joint Health and Wellbeing Strategy:

5.3 Comments are invited on:

- The report format and governance arrangements moving forward so as to ensure that the right level of information is provided.

- Further to the completion of the health inequalities assessment for Rutland, it is recommended that a standalone JHWB development session is considered to go through the findings.

5.4 HWB are asked to note:

- Paper is going to the October Scrutiny Committee on Dental provision in Rutland.

- An oral Health Needs Assessment is planned to be carried out by January 2023.

- Recommendations from the draft End of Life and Care JSNA for Rutland will be incorporated into the work of the EoL and Palliative Care Group

6 BACKGROUND PAPERS

6.1 There are no background papers.

7 APPENDICES

7.1 Appendix A JHW Strategy Highlight Report Priority Overview

7.2 Appendix B JHW Strategy Outcomes Summary Report

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

Rutland JHWB Highlight Report Completion Guidance

Monthly reporting on the key deliverables within the Rutland Joint Health & Wellbeing Strategy is required to enable us to monitor progress and provide support to ensure successful delivery of the Strategy. The updates you provide will help us formulate reports to the Rutland Joint Health and Wellbeing Board, The Integrated Delivery Group and The Rutland Strategic Health Developments Project Board.

Reporting Period: Already populated. In this first instance this is a quarterly update but monthly updating of the project dashboard is required moving forward. A structured reporting process is just being formulated.

Strategic Priority: Complete for the Strategic Priority or enabler that you have the delivery lead for.

Reporting Lead: Name of the person with responsibility of reporting on the progress of the Strategic Priority or enabler.

Supporting Governance: Name of the Project Group responsible for the delivery of the strategic priority and frequency of meetings.

Overall Strategic Priority Delivery RAG Status: **RED** – Project team have concerns regarding overall delivery. Escalation is required. **AMBER** – There are a number of risks identified but still manageable with mitigations, **GREEN** – Project Team are confident on delivery of the strategic priority and will be delivered within expected timescales and scope.

Overall Strategic Priority Risk RAG Status: **RED** – There are a significant number of risks associated with delivery of the Strategic Priority and no mitigations in place to address. Escalation is required. **AMBER** – There are risks associated with delivery of the Strategic Priority and mitigations in place to resolve. No need for escalation at this point but monthly updates required. **GREEN** – No identified risks identified that will impact on the delivery of the Strategic Priority or any than have been identified have been successfully mitigated.

Overall Anticipated Improvement on Outcome Trajectory RAG Status: **RED** – Risk of significant under-achievement. Escalation is required. **AMBER** – Some areas flagged as possible cause for concern and are being addressed. **GREEN** – Positive movement in all/majority of outcome metrics expected.

Key Objectives & Deliverables: What are the key objectives and deliverables of the Strategic Priority in 2022/2023.

Key Achievements in This Reporting Period: What key actions have taken place in the last quarter the support the delivery of the Strategic Priority. i.e. meetings, stakeholder engagement, project plan, key milestones met, risk mitigations.

Challenges: What challenges may have occurred such as stakeholder engagement, timescales, delays.

Next Steps: Planned activity for the next quarter associated with the delivery of the Strategic Priority.

Key Risks and Mitigations: These should be the high level risks that have been identified by the project team and detail of the mitigations that have been put in place and should include timescales.

Points for Discussion or Escalation: Any areas of concern, strategic steer required on nest steps and escalation of any risks that have been unable to be mitigated by the project team.

Rutland JHWB Highlight Report Programme Overview

Reporting Period:	Jul-Sept 2022	**Overall Strategic Priority Delivery RAG Status:**	
Programme Overview		**Overall Anticipated Improvement on Outcome Trajectory at Current Stage**	
SRO Lead:	Debra Mitchell/John Morley	**Reporting Lead:** Katherine Willison/Charlotte Summers	
Supporting Governance :	Rutland Joint Health and Wellbeing Board		

Status Summary

Key Objectives & Deliverables:

- Clear delivery plans for each of the strategic priorities and enablers
- Supporting governance for continued reporting and monitoring
- Identified senior responsible officers and project leads

Key Challenges and Risks:

- A change in personnel central to the delivery of the overarching governance has created a temporary gap but plans are in place to mitigate.
- Funding of projects that require investment – prioritisation of key deliverable and prioritise through funding/grant schemes that become available in year.

Key Achievements in This Reporting Period:

- Supporting governance agreed across all priorities
- Reporting mechanisms drafted and timetable for monitoring in draft.
- Establishment of priority groups
- Commencement of communications and engagement mapping.
- Place clinical lead appointed – Dr James Burden
- Submission of levelling up bid

Mitigations:

- Recruitment to vacant posts has been undertaken and ICB have supported in the interim.
- A review of all project lines will be undertaken to establish which are reliant on any in year funding and will be prioritised.

Next Steps:

- Finalise reporting mechanism and monitoring timetable
- Conclude communications and engagement exercise
- Agree BCF funding bid process and mobilise

Key Points for Discussion or Escalation:

- Comments are welcome on the current reporting format so that this can be fed in to the finalisation of governance arrangements in October.

Rutland JHWB Highlight Report

Reporting Period:	Jul-Sept 2022	**Overall Strategic Priority Delivery RAG Status:**	
Strategic Priority:	Best Start for Life Item 1.1.1 (Family Hub)	**Overall Anticipated Improvement on Outcome Trajectory at Current Stage**	
SRO:	Bernadette Caffrey	**Reporting Lead:**	
Supporting Governance :	Family Hub Steering Group (reports to Children and Young People's Partnership every six weeks)		

Status Summary

Key Objectives & Deliverables:

- Clear Start for Life offer for families – to include development of a family hub offer

Key Challenges & Risks:

- Rutland is not eligible for Transformation funding to support the development of a family hub
- Lack of funding may impede achievement of any capital work or service development needed
- Capacity of steering group members to deliver against complex implementation plan given timeframe

Key Achievements in This Reporting Period:

- Completion of baseline assessment of Early Intervention services via Early Help System Guide
- Completion of High Level Implementation plan and formation of multi-agency steering group; first meeting held and terms of reference agreed
- Commissioning of visuals and graphic design components to aid brand launch and raise awareness of hub offer for families and professionals

Mitigations:

- Some repurposing of existing funding is under consideration
- Task and finish approach to include steering group members plus colleagues occasionally co-opted from relevant agencies to manage requirements.

Next Steps:

- Launch rebranded children's centre as first family hub site with full 1001 days offer available (January 2023)
- Launch Family Hub Website with Comms prior to site rebrand as above (December 2022)

Points for Discussion or Escalation:

Rutland JHWB Highlight Report

Reporting Period:	Jul-Sept 2022	**Overall Strategic Priority Delivery RAG Status:**	
Strategic Priority:	Best Start for Life 1.1.5 (dental services)	**Overall Anticipated Improvement on Outcome Trajectory at Current Stage**	
SRO:	Bernadette Caffrey	**Reporting Lead:**	
Supporting Governance :			

Status Summary

Key Objectives & Deliverables:

- Further investigations into unmet need

Key Challenges and Risks:

- Commissioning currently sits with NHSE and will be transferring to the ICB at the end of March 2023.
- Insufficient Dentists in the locality.

Key Achievements in This Reporting Period :

- NHSE have produced a report for RCC Scrutiny Committee on 'Access to Dental Services within Rutland', with support from local Public Health colleagues. The report was due for the cancelled 8th September Scrutiny, with the next Scrutiny meeting due on 13th October.

Mitigations:

- Dental paper on service provision written and going to October Scrutiny Committee.

Next Steps:

- Quantitative analysis is near complete, with plans for engagement and qualitative analysis in Winter 22 prior to the Board
- Additionally, Public Health are developing an Oral Health Needs Assessment for Health & Wellbeing Board in January 23.

Points for Discussion or Escalation:

Paper with regards to dental Service Provision is going to the October Scrutiny Committee.

Rutland JHWB Highlight Report

Reporting Period:	Jul-Sept 2022	**Overall Strategic Priority Delivery RAG Status:**	
Strategic Priority:	Staying Healthy & Independent: Prevention	**Overall Anticipated Improvement on Outcome Trajectory at Current Stage**	
SRO:	Vivienne Robbins, Adrian Allen	**Reporting Lead:**	
Supporting Governance :	IDG (monthly), PH team (monthly)		

Status Summary

Key Objectives & Deliverables

- Options appraisal for developing a prevention front door for Rutland.
- Implementation low level of prevention offer in all front line staff through LLR Healthy Conversations training (Making Every Contact Count Plus (MECC+))
- Review the oral health needs of Rutland

Key Challenges & Risks

- Capacity, infrastructure and resource to scope and implement a coordinated prevention front door for Rutland.
- Ensuring all frontline staff see prevention as a core part of their role in Rutland and attend MECC+ training.
- Prevention is not prioritised over operational immediate pressures.

Key Achievements in This Reporting Period

- Agreed at IDG to establish a Staying Healthy Group as a sub group of IDG
- IDG approval to develop an options appraisal for a prevention front door.
- Social prescribing platform implemented for the RISE team.
- MCC+ plus training delivered to RISE team.
- Oral health needs assessment started.

Mitigations:

- Mitigation to ensure all staff see the value of prevention and part of their role.

Next Steps:

- Develop options appraisal for prevention front door
- Further embed MECC+ across Rutland
- Complete oral health needs assessment for HWB Jan 2023.

Points for Discussion or Escalation:

- Oral health needs assessment (JSNA chapter) for Jan 2023 agenda.

Rutland JHWB Highlight Report

Reporting Period:	Jul-Sept 2022	**Overall Strategic Priority Delivery RAG Status:**	
Strategic Priority:	Priority 3 – Living with ill health	**Overall Anticipated Improvement on Outcome Trajectory at Current Stage**	
SRO	Emmajane Perkins	**Reporting Lead:**	
Supporting Governance :	IDG (monthly), Integrated neighbourhood meeting (monthly)		

Status Summary

Key Objectives & Deliverables

- Timely and well-coordinated support enabling people living with ill health to live well, without ill health dominating, postponing deterioration, ageing well.
- Tailored support to help individuals live well with changing health circumstances through MDT working
- Collaborative coordinated care – recruitment to neighbourhood facilitator underway
- Integrated and multidisciplinary working through the monthly Rise team MDT meetings is supporting people with complex health needs.
- cross-boundary inequality of access to support for people diagnosed with dementia
- Active work on falls prevention in care homes, using a personalised approach for greater impact. To develop a falls prevention strategy specific to each Care Home environment, creating a culture of individualised care for best practice.

Next Steps:

- Looking at further development of the successful Rise adults MDT meeting model to children's and safeguarding focused meetings.
- Evaluation of Whzan pilot
- Neighborhood facilitator to identify individuals to benefit from proactive care management through a population health management approach.
- Onboarding all partners and content of the Ris to the Rutland social prescribing platform
- Training and support for partners to use the social prescribing platform
- Comms for the public to be aware of the social prescribing platform
- Further engagement with staff across neighbourhood to join the 3 conversations innovator site
- Admiral nurses support through virtual clinics, with the hope this can also become face to face
- Carers strategy going to cabinet Oct 18th 2022 for approval. This is an all age LLR strategy with a Rutland specific delivery plan.
- Dementia. LLR strategy currently being reviewed following covid. Diagnosis rate is due to severe backlog at memory services, due to staffing issues and the service being closed during Covid. Referrals into memory service remain high. Memory services are wanting a room available in Oakham to have a memory clinic local to the area
- LD- Following Covid, Face to face annual health checks is priority due to communication and support required.
- Falls A third Care Home identified for the programme. Initial meetings to take place October 2022.RCC OT to continue to promote and encourage other providers to join the programme. RCC OT to look to collate data relating to this service.

Key Achievements in This Reporting Period

- Integrated and multidisciplinary working through the monthly Rise team MDT meetings are supporting people with complex health needs.
- Whzan pilot commencing with 9 Rutland care homes
- Recruitment of neighbourhood facilitator – interviews taking place this month
- Rutland social prescribing platform live from 1st Sept 2022.
- 3 conversations innovator site identified some staff to codesign cohort of people to work with
- RCC falls prevention Occupational Therapist [OT] is currently working with two Care Homes to create a bespoke falls prevention strategy for each home.
- Each Care Home now have a dedicated Falls Prevention Champion. All Rutland providers are engaging with the capacity tracker.

Key Challenged & Risks Mitigations:

- All partners engaging on the new Rutland social prescribing platform in order that the full benefit across the place is achieved
- 3 conversations innovator site not fully supported and the benefits of change not achieved
- Housing. High increase in homelessness due to family breakdown, cost of living, DV. Also have pressure of H4U sponsorship scheme. Rutland is a non-holding stock authority. Also, very high rents which also contribute to homelessness, as people cannot afford to go the private landlord route
- hospital discharge team unable to recruit a Social Worker to cover weekends (it's just not an attractive post, particularly when the funding is only fixed term)

Mitigations

Capacity to implement all neighbourhood initiatives at pace

Release of funding to start some projects identified – compassionate communities, digital PCN programme

Points for Discussion or Escalation:

Identification of funding and release for neighbourhood programmes.

Rutland JHWB Highlight Report

Reporting Period:	Jul-Sept 2022	**Overall Strategic Priority Delivery RAG Status:**	
Strategic Priority:	Priority 4 - Equitable Access	**Overall Anticipated Improvement on Outcome Trajectory at Current Stage**	
SRO	Sarah Prema	**Reporting Lead:** Jo Clinton	
Supporting Governance :	Rutland Strategic Health Partnership Board		

Status Summary

Key Objectives & Deliverables

- Understanding the access issues
- Increase the availability of diagnostic and elective health services closer to home
- Improving access to primary and community health and care services
- Improving access to services and opportunities for people less able to travel, including through technology
- Enhance cross boundary working across health and care with key neighbouring areas

Key Challenges & Risks:

- Estates capacity
- Recruitment

Key Achievements in This Reporting Period

- Rutland PCN will start to deliver an enhanced access service Monday to Friday 6.30 - 8.00pm and Saturday 9.00 - 5.00pm from Oct.
- Consideration giving to local sessions on how to use the NHS app and patient online services. Linkages to the pilot model in the city
- Successful recruitment of 7 clinical pharmacists and formulation of a training academy in conjunction with Nottingham University.
- Currently a pilot being offered by ICRS to specific county resident post codes. Referrals continue to increase for County patient
- RCC CC Property Services have identified a potentially suitable site at OEP for mobile MRI
- Currently working with the PCN to ascertain Doppler activity numbers and working with PCL to ascertain Doppler scan equipment costs and site requirements.
- A business case is being formulated to look at some Dermatology activity to be considered for delivery in a community setting
- LPT / ICB Reviewing demand and capacity for a plain film and ultrasound provision moving forward
- PIFU Specialty models of care in development

Mitigations:

- Rutland have been prioritised for the completion of a clinical estates strategy.
- Links with local planners established to try to maximise allocations of S106 and CIL funding moving forward.

Next Steps:

- Enhanced Service will commence from 1st October 2022
- Start to review data on Aristotle for high ED utilisation
- Mobile MRI – Secure charitable funding and move to detailed feasibility and costings
- Follow up with LLR Alliance around plans for Optometry
- LLR ICB Community Diagnostics Hub paper finalised
- Explore the possibility of commissioning local and expand the number of diagnostic tests available locally for Cardiac and Respiratory investigations

Points for Discussion or Escalation:

Rutland JHWB Highlight Report

Reporting Period:	Jul-Sept 2022	**Overall Strategic Priority Delivery RAG Status:**	
Strategic Priority:	Priority 5 – Growth and Change	**Overall Anticipated Improvement on Outcome Trajectory at Current Stage**	
SRO Lead:	Sarah Prema	**Reporting Lead:** Jo Clinton	
Supporting Governance :			

Status Summary

Key Objectives & Deliverables

- Planning and developing 'fit for the future' health and care infrastructure
- Health and care workforce fit for the future
- Health and equity in all policies, in particular developing a healthy built environment aligned for projected growth

Key Challenges and Risks:

Key Achievements in This Reporting Period

- Successful PCN Recruitment of 7 WTE clinical pharmacists to improve access for CVS risk management
- Rutland Health PCN are being engaged as part of phase 1 of LLR programme to develop Clinical/Estates Strategy. Oakham practice Business case is still being finalised
- Feasibility work for RMH has been commissioned by the ICB and is in development
- Stage 1 Outline Proposal submitted to National LUF Team , Further deliverables subject to stage 1 outcomes
- LPT and Rutland pilot teams ready go live with Shared Care Record inc progress on extended UHL data
- Routine partnership meetings with neighbouring authorities in place with sharing of information and data
- Develop presentation of CCG Stamford North Population Projections and health impact in Rutland from OOA growth specifically
- ICB have agreed an approach in principle with RCC for modelling non local plan
- North Place Alliance LLR representation confirmed on ongoing basis and for event to be held in July
- Areas of particular focus for cross border working has been considered and this has been shared with Stamford for discussion at next North Place Partnership

Key Risks and Mitigations:

- EoL Care Planning identification of cohort at risk
- Digital Inclusion resource funding
- PCN Premises plans

Next Steps:

- Premises Business Case approvals
- NHSE National programme to release further details about Lloyd George Record Digitisation over the summer
- ICB is in the process of providing comments on the Local Plan Issues and Options
- ICB Estates team and RCC have agreed information needs, process, and frequency with RCC who are looking to produce/share initial information
- Refine PRISM product specification and confirm finances
- Await feedback on North Place Partnership event on feedback in LLR / Rutland context
- Confirm whether CYP phlebotomy is in scope of Stamford provision
- Explore key opportunities to cross border provision with Stamford Hospital / Stamford hospital service partners
- Await Stage outcome for LUF bid anticipated in Oct which ill inform next steps.
- Review feasibility findings for RMH

Points for Discussion or Escalation:

Rutland JHWB Highlight Report

Reporting Period:	Jul-Sept 2022	**Overall Strategic Priority Delivery RAG Status:**	
Strategic Priority:	Priority 6 – Dying Well	**Overall Anticipated Improvement on Outcome Trajectory at Current Stage**	
SRO	James Burden	**Reporting Lead**: Charlotte Summers	
Supporting Governance :	EoL and Palliative Care Task and Finish Group/ Rutland Integrated Neighbourhood Network		

Status Summary

Key Objectives & Deliverables

- Each person is seen as an individual and have fair access to care
- Maximising comfort and wellbeing
- All staff are prepared to care and care is co-ordinated.
- Communities are prepared to help

Key Challenges and Risks:

- Funding availability for individual projects such as the 24/7 advice and guidance for EoL patients, carers and clinicians and compassionate communities.
- RESPECT template roll out delayed due to technical difficulties with acute systems. Revised timescales and assurance requested.

Key Achievements in This Reporting Period

- Started to work through the ambitions framework to identify key priority areas for EoL and Palliative Care at a system level to enable us to look at where our gaps are in terms of delivering support to patients across LLR and what this means to Rutland patients.
- Home First communications campaign to take place, which will include end of life services/pathways and help raise awareness
- First draft of the Rutland EoL and Palliative Care completed.
- A review of Rutland against the RCPG Daffodil standards for EoL and Palliative Care.
- Presentation on Rutland's ambition to become on of the country's first compassionate county's.

Key Risks and Mitigations:

- Funding prioritisation process being established
- Delays in template roll out are being picked up at a system level.

Next Steps:

- Align LLR JSNAs to determine priorities for the proposed EOL Strategy which should be completed by the end of 2022 and identification of support for this work in those areas of need.
- Completion of the ambitions framework
- Review of current commissioned EoL/Palliative care services local to Rutland and on the borders.

Points for Discussion or Escalation:

- Invite suggestions for any perceived key service gaps for Rutland patients and their carers relating to EoL and Palliative care.

Rutland JHWB Highlight Report

Reporting Period:	Jul-Sept 2022	**Overall Strategic Priority Delivery RAG Status:**	
Strategic Priority:	Health Inequalities	**Overall Anticipated Improvement on Outcome Trajectory at Current Stage**	
SRO Lead:	Adrian Allen	**Reporting Lead:**	
Supporting Governance :	IDG (monthly), PH team (Monthly), LLR Prevention and HI meeting (bi-monthly)		

Status Summary

Key Objectives & Deliverables

- Complete Health Inequalities Needs Assessment on Rutland
- Embed a proportionate universalism approach to service delivery
- Strengthen health inequalities leadership and accountability across Rutland

Key Challenges and Risks :

- Ensuring Rutland health inequalities are understood across the wider system. across the place and system.

Key Achievements in This Reporting Period

- Completion of Health Inequalities Needs Assessment
- Presentation of needs assessment to RCC corporate team
- Linking Rutland to LLR system work on health inequalities

Mitigations:

- Mitigation is presenting the results of the health inequalities needs assessment to a wide audience

Next Steps:

- Consider the recommendations from the needs assessment and how these can shape change in the future.
- Consider how to implement a health in all policies approach.

Points for Discussion or Escalation:

- Health inequalities needs assessments recommends a wider development session to review the recommendations and next steps.

Rutland JHWB Highlight Report

Reporting Period:	Jul-Sept 2022	**Overall Strategic Priority Delivery RAG Status:**	
Strategic Priority:	7.1 Mental Health	**Overall Anticipated Improvement on Outcome Trajectory at Current Stage**	
SRO Lead:	Justin Hammond	**Reporting Lead:** Mark Young	
Supporting Governance :	Integrated Development Group and Integrated Neighbourhood Network		

Status Summary

Key Objectives & Deliverables

- Increase access to perinatal Mental health support services, wherever Rutland women have chosen to give birth.
- Understand the gaps in service reported by service users where children and young people need help with low level mental health needs.
- Increasing local resource to respond to children and young people's mental health needs
- Supporting service locally such as crisis cafes and mental health services and support for farmers and veterans.
- Increased response to low level mental health issues
- Move towards an integrated neighbourhood based approach to meeting mental health needs in Rutland
- Annually assessing the physical health needs of people with Serious Mental Illness (SMI) in Rutland
- Aiding people with serious mental illness into employment
- Delivering psychological therapies (IAPT - VitaMinds) for individuals as locally as possible to Rutland

Key Challenges and Risks:

- Funding availability

Key Achievements in This Reporting Period

- Recruitment of senior mental health facilitator
- Facilitated an initial neighbourhood workshop to look at mental health provision in Rutland, potential gaps and inequalities
- The inequalities need assessment has been carried out which included mental health.

Mitigations:

- Funding prioritisation process being established

Next Steps:

- Follow up workshop on mental health provision in Rutland.
- Development session to look at the Inequalities needs assessment and gaps for mental health identified.
- Prioritisation if areas for focus in 2022/2023

Points for Discussion or Escalation:

Rutland JHWB Highlight Report

Reporting Period:	Jul-Sept 2022	**Overall Strategic Priority Delivery RAG Status:**	
Strategic Priority:	Covid Recovery and Readiness	**Overall Anticipated Improvement on Outcome Trajectory at Current Stage**	
SRO Lead:	Debra Mitchell	**Reporting Lead:** Charlotte Summers	
Supporting Governance :	Integrated Development Group		

Status Summary

Key Objectives & Deliverables

- Review the impact of the Covid-19 pandemic period on emerging demand for prevention services
- Restoration and recovery
- Consider the service offer for patients with long Covid, including accessibility.
- Pandemic readiness - Maintaining a collaborative health protection approach and response ready for future Covid-19 surges or other future pandemics.
- Booster campaigns

Key Challenges and Risks

- Clinical and estates capacity

Key Achievements in This Reporting Period

- Recovery to pre-pandemic levels for primary care appointments
- Reduction in waiting lists and covid backlog particularly for patients with LTC's.
- Commencement of autumn covid booster campaign including identification of cross border vaccination sites. All 4 GP practices have signed up to deliver the programme with daytime, evening and weekend clinics available.
- Flu vaccinations are available in the same slot for those that opt in (different vaccination)
- Work ongoing to reduce 104 and 52 week waits for elective care

Mitigations:

- Rutland have been prioritised for the completion of a clinical estates strategy.

Next Steps:

- Continue to recover and prepare for the impact of winter.

Points for Discussion or Escalation:

Rutland JHWB Highlight Report

Reporting Period:	Jul-Sept 2022	**Overall Strategic Priority Delivery RAG Status:**	
Strategic Priority:	Communications and Engagement	**Overall Strategic Priority Risk RAG Status:**	
SRO Lead:	Debra Mitchell	**Reporting Lead:** Charlotte Summers	
Supporting Governance :	Integrated Development Group		

Status Summary

Key Objectives & Deliverables

- To ensure that people have the information they need: to feel empowered to play a full role in maintaining their own health and wellbeing; to access health and wellbeing services to support them in living well; and, to take part in helping to shape services.
- To increase the public's understanding and awareness of the role of the Rutland Health and Wellbeing Board in shaping the conditions for local health and wellbeing.
- To more fully involve the public and professional stakeholders in informing the design and delivery of strategies, plans and services to respond to individual and local needs.

Key Challenges and Risks:

- Multiple pieces of work being undertaken that overlap, need to ensure a consistent approach

Key Achievements in This Reporting Period

- Agreement of a communications and engagement plan
- Establishment of a communications and engagement group

Mitigations:

- Exercise to map all communications and engagement work that links from the strategic priorities and enablers.

Next Steps:

- Map all communications and engagement work that links from the strategic priorities and enablers.
- Ensure a joined up and inclusive approach.
- Understand the work of the system communications and engagement group.

Points for Discussion or Escalation:

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Joint Health and Wellbeing Strategy 2022-2025: Outcomes Summary Report

Rutland

September 2022

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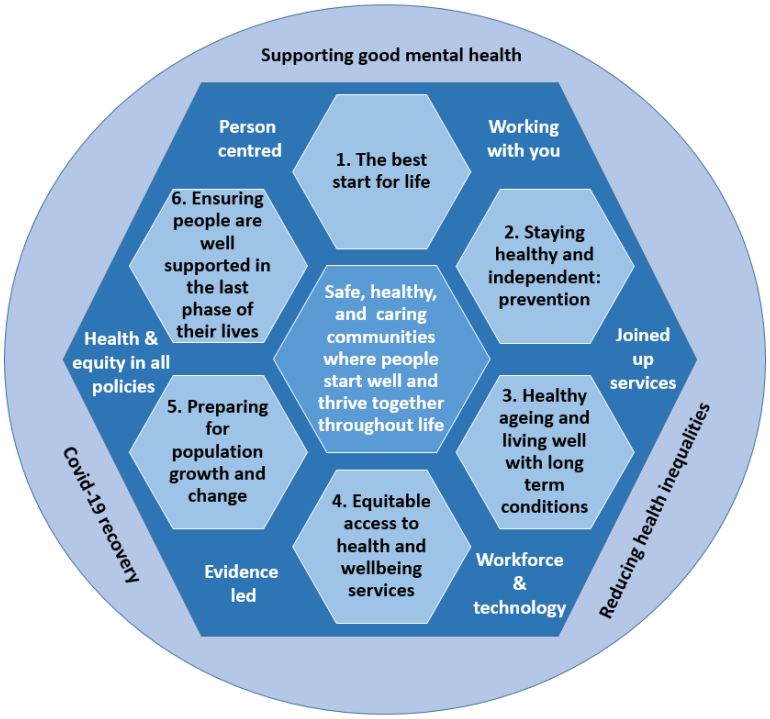
Produced by the Business Intelligence Service at Leicestershire County Council.

Purpose of Report

In line with the Rutland Joint Health and Wellbeing Strategy (2022-2025), this report has been produced to support and monitor the performance of indicators that are linked to each priority area within the strategy. A dashboard of indicators has also been developed to aid discussion and monitor progress.

The Rutland Joint Health and Wellbeing Strategy has six priority areas for action, with three cross cutting themes. The diagram below summarises the priorities and principles:



The outcomes summary report and dashboards will be updated on a quarterly basis to support the delivery of the Rutland Joint Health and Wellbeing Strategy. It is important to note that the dashboard will continue to be developed as the strategy evolves and the delivery plan is developed.

The dashboard sets out, in relation to each indicator, the statistical significance compared to the overall England position or relevant service benchmark where appropriate. A RAG rating of 'green' shows those that are performing better than the England value or benchmark and 'red' indicates worse than the England value or benchmark.

Appendix 1 provides more details on the similar areas to Rutland.

Priority 1: Enabling the best start in life

Performance Summary

- Out of all the comparable indicators presented for the enabling the best start in life priority, seven are green, 13 are amber and five are red. Two indicators have no comparison, and two indicators are lower than national.

- Rutland performed significantly worse than England/benchmark for the following five indicators:

  Children in care immunisations - Rutland is ranked 16th out of 16 in 2021. The proportion of children in care for at least 12 months whose immunisations were up to date increased from 56.0% in 2020 to 62.0% in 2021. Rutland has performed significantly worse than England since 2019.

  Proportion of children receiving a 12-month review - Rutland is ranked 15th out of 16 in 2020/21. The proportion of children receiving a 12-month review has decreased from 86.2% in 2019/20 (where it performed statistically similar to the England average) to 37.0% in 2020/21.

  Proportion of new birth visits (NBVs) completed within 14 days - Rutland is ranked 12th out of 16 in 2020/21. The proportion of NBVs completed within 14 days has decreased from 85.5% in 2019/20 (where it performed statistically similar to the England value) to 82.5% in 2020/21.

  Population vaccination coverage for HPV (one dose) for 12-13 years old (Males) - Rutland is ranked 16th out of 16 in 2020/21. The latest value for Rutland is 62.5%, which is below the benchmarking goal of 80%.

  Population vaccination coverage for HPV (one dose) for 12-13 years old (Females) - Rutland is ranked 16th out of 16 in 2020/21. The latest value for Rutland is 61.2%, which is below the benchmarking goal of 80%.

- Of the seven green indicators, Rutland ranks 1st (best performing) when compared to its similar neighbours for the following indicators: Year 6: Prevalence of overweight (including obesity), School readiness: percentage of children achieving a good level of development at the end of reception and Hospital admissions caused by unintentional and deliberate injuries in children (0-14 years).

- There are currently six indicators where, when compared to similar areas, Rutland performs in the bottom three (worse performing):

  - Children in care immunisations
  - Neonatal mortality and stillbirth rate
  - Proportion of children receiving a 12-month review
  - HPV Vaccination coverage for one dose (12-13 year) (Females)

Source:
*NHS Outcomes Framework
**UHL Hospital Admissions Data
*** Office for National Statistics (ONS)

- HPV Vaccination coverage for one dose (12-13 year) (Males)
- Percentage of 5 year olds with experience of visually obvious dental decay

Source:
*NHS Outcomes Framework
**UHL Hospital Admissions Data
*** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Priority 1: The best start for life

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
C04 - Low birth weight of term babies	P	>=37 weeks g..	2020	1.7	2/16	1.3	2.9	2.9	▶	●
C09a - Reception: Prevalence of overweight (including obesity)	P	4-5 yrs	2019/20	23.1	10/14	18.2	25.8	23.0	▶	●
Estimated number of children and young people with mental d..	P	5-17 yrs	2017/18	752.2	1/14	752.2	9,588.2	Null	—	●
New referrals to secondary mental health services, per 100,0..	P	<18 yrs	2019/20	4,602.8	4/16	2,966.6	10,475.9	6,977.4	—	●
A&E attendances (0-4 years)	P	0-4 yrs	2019/20	397.6	4/16	316.1	679.0	659.8	▶	●
Admissions for lower respiratory tract infections in infants ag..	P	<1 yr	2020/21	Null	Null	Null	Null	94.9	—	●
C05a - Baby's first feed breastmilk	P	Newborn	2018/19	77.6	3/16	79.6	63.0	67.4	—	●
Children in care immunisations	P	<18 yrs	2021	62.0	16/16	100.0	62.0	86.0	—	●
General fertility rate	F	15-44 yrs	2020	47.3	1/16	47.3	64.2	55.3	▼	●
Neonatal mortality and stillbirth rate	P	<28 days	2019	7.1	15/16	3.1	9.7	6.6	▶	●
Proportion of children receiving a 12-month review	P	1 yr	2020/21	37.0	15/16	95.1	13.1	76.1	—	●
Proportion of infants receiving a 6 to 8 week review	P	6-8 weeks	2020/21	76.4	12/16	99.4	12.3	80.2	—	●
Pupils with special educational needs (SEN): % of school pupil..	P	School age	2018	13.1	4/15	10.6	18.9	14.4	▶	●
Average Attainment 8 score	P	15-16 yrs	2020/21	54.3	2/16	56.7	48.4	50.9	—	●
C06 - Smoking status at time of delivery	F	All ages	2020/21	8.8	6/16	5.8	13.3	9.6	—	●
C07 - Proportion of New Birth Visits (NBVs) completed within ..	P	<14 days	2020/21	82.5	12/16	96.1	44.6	88.0	—	●
C08a - Child development: percentage of children achieving a ..	P	2-2.5 yrs	2020/21	80.9	10/15	92.3	53.8	82.9	—	●
C09b - Year 6: Prevalence of overweight (including obesity)	P	10-11 yrs	2019/20	26.6	1/14	26.6	35.1	35.2	▶	●
Children in care	P	<18 yrs	2021	43.0	5/16	37.0	111.0	67.0	▶	●
D04e - Population vaccination coverage - HPV vaccination coverage for one dose (12-13 year old)	F	12-13 yrs	2020/21	61.2	16/16	98.3	61.2	76.7	▼	●
	M	12-13 yrs	2020/21	62.5	16/16	93.8	62.5	71.0	—	●
E02 - Percentage of 5 year olds with experience of visually obv..	P	5 yrs	2018/19	25.3	10/11	13.1	31.9	23.4	—	●
Hospital admissions as a result of self-harm (10-24 years)	P	10-24 yrs	2020/21	309.9	2/16	304.2	794.5	421.9	▶	●
School pupils with social, emotional and mental health needs: ..	P	School age	2021	2.4	7/16	1.9	3.5	2.8	▲	●
B02a - School readiness: percentage of children achieving a go..	P	5 yrs	2018/19	77.8	1/16	77.8	69.1	71.8	▶	●
C11a - Hospital admissions caused by unintentional and delib..	P	0-4 yrs	2020/21	84.5	1/16	84.5	145.3	108.7	▶	●
C11a - Hospital admissions caused by unintentional and delib..	P	<15 yrs	2020/21	49.6	1/16	49.6	97.5	75.7	▶	●
E01 - Infant mortality rate	P	<1 yr	2018 - 20	3.4	11/16	2.4	6.4	3.9	—	●
Hospital admissions for mental health conditions	P	<18 yrs	2020/21	127.4	12/16	72.9	251.0	87.5	—	●

Statistical Significance compared to England or Benchmark:
Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel:
▼ Decreasing, ▼ Decreasing and getting better, ▼ Decreasing and getting worse, ▲ Increasing, ▲ Increasing and getting better, ▲ Increasing and getting worse, ▶ No significant change, — Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

Produced by Business Intelligence Service
Updated September 2022

Priority 2: Staying healthy and independent: prevention

Performance Summary

- Out of all the comparable indicators presented for the staying healthy and independent: prevention priority, four are green, three are amber and three are red.

- Rutland performed significantly worse than England/benchmark for the following indicators:

  Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check – Rutland is ranked 14th out of 16 in 2021. The latest value for Rutland is 38.6%, which is significantly worse than the national average of 44.8%.

  Cancer screening coverage - breast cancer – Rutland is ranked 15th out of 16 in 2021. The latest value for Rutland is 58.2%, which is significantly worse than the national average of 64.1%.

  Population vaccination coverage (shingles) for 71 years – Rutland is ranked 16th out of 16 in 2019/20. The latest value for Rutland is 31.4%, which is significantly worse than the national average of 48.2%.

- Of the four green indicators, Rutland ranks 1st (best performing) when compared to its similar neighbours for the following indicators:
  Percentage of physically active adults.
  Cancer screening coverage-cervical cancer (aged 50 to 64 years)

- There are currently four indicators where, when compared to similar areas, Rutland performs in the bottom three (worse performing):

  - Loneliness: Percentage of adults who feel lonely often/always or some of the time
  - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check
  - Cancer screening coverage - breast cancer
  - Population vaccination coverage – Shingles vaccination coverage (71 years)

Source:
*NHS Outcomes Framework
**UHL Hospital Admissions Data
*** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Priority 2: Staying healthy and independent: prevention

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
B19 - Loneliness: Percentage of adults who feel lonely often / always or some of the time	P	16+ yrs	2019/20	24.8	14/16	13.9	26.7	22.3		
C16 - Percentage of adults (aged 18+) classified as overweight or obese	P	18+ yrs	2020/21	59.5	2/16	59.0	68.3	63.5		
C26b - Cumulative percentage of the eligible population aged 40-74 offered an NHS Health Check who received an NHS Health Check	P	40-74 yrs	2017/18 - 21/22	38.6	14/16	82.0	34.8	44.8		
C28d - Self-reported wellbeing - people with a high anxiety score	P	16+ yrs	2020/21	19.5	2/15	19.4	26.4	24.2		
C17a - Percentage of physically active adults	P	19+ yrs	2020/21	74.0	1/16	74.0	64.4	65.9		
C24a - Cancer screening coverage: breast cancer	F	53-70 yrs	2021/22	58.2	15/16	78.1	58.2	64.1		
C24b - Cancer screening coverage: cervical cancer (aged 25 to 49 years old)	F	25-49 yrs	2021/22	75.0	8/16	77.0	68.2	68.0		
C24c - Cancer screening coverage: cervical cancer (aged 50 to 64 years old)	F	50-64 yrs	2021/22	79.6	1/16	79.6	73.7	74.7		
C24d - Cancer screening coverage: bowel cancer	P	60-74 yrs	2021/22	71.1	2/16	72.2	65.3	65.2		
D06c - Population vaccination coverage – Shingles vaccination coverage (71 years)	P	71	2019/20	31.4	16/16	56.8	31.4	48.2		

Statistical Significance compared to England or Benchmark:
Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel:
Decreasing, Decreasing and getting better, Decreasing and getting worse, Increasing, Increasing and getting better, Increasing and getting worse, No significant change, Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

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Priority 3: Healthy ageing and living well with long term conditions

Performance Summary

- Out of all the comparable indicators presented for the healthy ageing and living well with long term conditions priority, one is green, two are amber and one is red.

- Rutland performed significantly worse than England/benchmark for the following indicator:

  Excess winter deaths index – Rutland is ranked 16th out of 16 in 2019/20. The latest value for Rutland is 50.2%, which is significantly worse than the national average of 17.4%. Previously, the percentage of excess winter deaths in Rutland had remained statistically similar to the national average since 2001/02.

- There are currently three indicators where, when compared to similar areas, Rutland performs in the bottom three (worse performing):

  - Percentage of cancers diagnosed at stages 1 and 2
  - Hip fractures in people aged 65 and over
  - Excess winter deaths index

Source:
*NHS Outcomes Framework
**UHL Hospital Admissions Data
*** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Priority 3: Healthy ageing and living well with long term conditions

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
C23 - Percentage of cancers diagnosed at stages 1 and 2	P	All ages	2019	53.3	15/16	61.6	53.3	55.0		
C29 - Emergency hospital admissions due to falls in people aged 65 and over	P	65+ yrs	2020/21	1,536.2	1/16	1,536.2	2,437.6	2,023.0		
E13 - Hip fractures in people aged 65 and over	P	65+ yrs	2020/21	608.4	15/16	425.4	647.5	528.7		
E14 - Excess winter deaths index	P	All ages	Aug 2019 - Jul 2020	50.2	16/16	9.1	50.2	17.4		

Statistical Significance compared to England or Benchmark:

- Better
- Worse
- Higher
- Similar
- Not compared
- Lower

Direction of Travel:

- Decreasing
- Decreasing and getting better
- Decreasing and getting worse
- Increasing
- Increasing and getting better
- Increasing and getting worse
- No significant change
- Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

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Priority 4: Ensuring equitable access to services for all Rutland residents

Performance Summary

- The one indicator presented below for the ensuring equitable access to services for all Rutland residents priority is the Access to NHS dental services – successfully obtained a dental appointment indicator.

- The percentage of people who successfully obtained an NHS dental appointment in the last two years has decreased from 94.6% in 2019/20 (where Rutland performed in the 2nd best quintile nationally) to 77.7% in 2020/21, where Rutland now performs in the middle quintile. Rutland is ranked 8th out of 16 when compared to its nearest neighbours.

Source:
*NHS Outcomes Framework
**UHL Hospital Admissions Data
*** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Priority 4: Equitable access to health and wellbeing services

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator			Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Access to NHS dental services - successfully obtained a dental appointment	P	18+ yrs 2020/21	77.7	8/16	85.4	65.0	77.0	▶	●

Statistical Significance compared to England or Benchmark:
- Better
- Worse
- Higher
- Similar
- Not compared
- Lower

Direction of Travel:
- ▼ Decreasing
- ▼ Decreasing and getting better
- ▼ Decreasing and getting worse
- ▲ Increasing
- ▲ Increasing and getting better
- ▲ Increasing and getting worse
- ▶ No significant change
- ▬ Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

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Priority 5: Preparing for our growing and changing population

Performance Summary

- Out of all the comparable indicators presented for the preparing for our growing and changing population priority, one is green and four are amber. Three indicators were not suitable for comparison.
- , Rutland ranks 1st (best performing) when compared to its similar neighbours for the following indicators:
  Violent Crime: violence offences per 1,000 population

Source:
*NHS Outcomes Framework
**UHL Hospital Admissions Data
*** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Priority 5: Preparing for population growth and change

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Air pollution: fine particulate matter (historic indicator)	N/A	Not applicable	2020	6.2	8/15	4.8	7.3	6.9		
Average weekly earnings	P	16+ yrs	2021	551.3	4/16	575.3	402.7	496.0		
B08a - Gap in the employment rate between those with a physical or mental long term health condition (aged 16 to 64) and the overall employment rate	P	16-64 yrs	2020/21	6.4	3/16	5.4	16.3	10.7		
B12b - Violent crime - violence offences per 1,000 population	P	All ages	2020/21	13.7	1/16	13.7	34.4	29.5		
B15a - Homelessness - households owed a duty under the Homelessness Reduction Act	N/A	Not applicable	2020/21	4.9	2/16	2.7	15.0	11.3		
B17 - Fuel poverty (low income, low energy efficiency methodology)	N/A	Not applicable	2020	11.9	9/16	6.7	16.7	13.2		
B18b - Social Isolation: percentage of adult carers who have as much social contact as they would like	P	18+ yrs	2018/19	38.2	2/15	38.7	11.7	32.5		
Percentage of adults cycling for travel at least three days per week	P	16+ yrs	2019/20	1.1	11/16	4.4	0.6	2.3		

Statistical Significance compared to England or Benchmark:

- Better
- Worse
- Higher
- Similar
- Not compared
- Lower

Direction of Travel:

- Decreasing
- Decreasing and getting better
- Decreasing and getting worse
- Increasing
- Increasing and getting better
- Increasing and getting worse
- No significant change
- Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

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Updated September 2022

Priority 6: Ensuring people are well supported in the last phase of their lives

Performance Summary

- Out of the four comparable indicators presented for the ensuring people are well supported in the last phase of their lives priority, two are amber, one is higher and one is lower.

- Rutland performed significantly higher than England/benchmark for the following indicator:

  Percentage of deaths that occur at home – Rutland is ranked 16th out of 16 in 2020. The proportion of deaths that occur at home (all ages) has increased from 27.6% in 2019 (where it performed statistically similar to England) to 33.9% in 2020, which is significantly higher than the national average of 27.4%.

- Rutland performed significantly lower than England/benchmark for the following indicator:

  Percentage of deaths that occur in hospital – Rutland is ranked 2nd out of 16 in 2020. The proportion of deaths that occur at hospital (all ages) has decreased from 39.5% in 2019 to 33.9% in 2020. Rutland has performed significantly lower than England for this indicator since 2019.

Source:
*NHS Outcomes Framework
**UHL Hospital Admissions Data
*** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Priority 6: Ensuring people are well supported in the last phase of their lives

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
Percentage of deaths that occur at home	P	All ages	2020	33.9	16/16	23.5	33.9	27.4		
Percentage of deaths that occur in care homes	P	All ages	2020	27.5	11/16	20.4	32.8	23.7		
Percentage of deaths that occur in hospital	P	All ages	2020	33.9	2/16	33.5	45.4	41.9		
Temporary Resident Care Home Deaths, Persons, All Ages (%)	P	All ages	2020	29.3	3/16	26.3	45.6	35.2		

Statistical Significance compared to England or Benchmark:

- Better
- Worse
- Higher
- Similar
- Not compared
- Lower

Direction of Travel:

- Decreasing
- Decreasing and getting better
- Decreasing and getting worse
- Increasing
- Increasing and getting better
- Increasing and getting worse
- No significant change
- Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

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Cross Cutting Themes:

Supporting Mental Health

Performance Summary

- Out of all the comparable indicators presented for supporting mental health, four are green and six are amber.

- Of the four green indicators, Rutland ranks 1st (best performing) when compared to its similar neighbours for the following indicators:
  Admission episodes for alcohol-related conditions (Broad): New method
  Percentage of physically active adults
  Emergency Hospital Admissions for Intentional Self-Harm (Persons)
  Emergency Hospital Admissions for Intentional Self-Harm (Females)

Source:
*NHS Outcomes Framework
**UHL Hospital Admissions Data
*** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Mental Health Indicators

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
90535 - Depression and anxiety among social care users: % of social care users	P	18+ yrs	2018/19	44.5	2/14	43.9	58.8	50.5	▬	●
Admission episodes for alcohol-related conditions (Broad): New method. This indicator uses a new set of attributable fra..	P	All ages	2020/21	1,018.8	1/16	1,018.8	1,659.5	1,499.8	▶	●
B18a - Social Isolation: percentage of adult social care users who have as much social contact as they would like	P	18+ yrs	2019/20	48.6	5/16	54.4	39.3	45.9	▬	●
		65+ yrs	2019/20	45.5	13/16	34.3	48.5	43.4	▶	●
B18b - Social Isolation: percentage of adult carers who have as much social contact as they would like	P	18+ yrs	2018/19	38.2	2/15	38.7	11.7	32.5	▬	●
		65+ yrs	2018/19	34.1	13/15	13.4	42.1	34.5	▬	●
B11 - Domestic abuse-related incidents and crimes	P	16+ yrs	2020/21	23.1	2/16	22.5	37.3	30.3	▬	●
C14b - Emergency Hospital Admissions for Intentional Self-Harm	P	All ages	2020/21	127.4	1/16	127.4	333.7	181.2	▶	●
	F	All ages	2020/21	141.7	1/16	141.7	490.3	238.3	▶	●
	M	All ages	2020/21	110.1	9/16	85.5	178.4	126.4	▶	●
C17a - Percentage of physically active adults	P	19+ yrs	2020/21	74.0	1/16	74.0	64.4	65.9	▬	●
Depression: Recorded prevalence (aged 18+)	P	18+ yrs	2020/21	10.3	1/16	10.3	14.5	12.3	▲	●
C28d - Self-reported wellbeing - people with a high anxiety score	P	16+ yrs	2020/21	19.5	2/15	19.4	26.4	24.2	▬	●
Mental Health: QOF prevalence (all ages)	P	All ages	2020/21	0.7	1/14	0.7	1.2	0.9	▶	●

Note: The rankings for B18a (65+ yrs) and B18b (65+ yrs) should be 4/16 and 3/15 respectively, not 13/16 and 13/15. Their Best/Lowest and Worst/Highest values should also be swapped.

Statistical Significance compared to England or Benchmark:
- Better
- Worse
- Higher
- Similar
- Not compared
- Lower

Direction of Travel:
- ▼ Decreasing
- ▼ Decreasing and getting better
- ▼ Decreasing and getting worse
- ▲ Increasing
- ▲ Increasing and getting better
- ▲ Increasing and getting worse
- ▶ No significant change
- ▬ Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

Produced by Business Intelligence Service
Updated September 2022

Reducing Health Inequalities

Performance Summary

- Out of all the comparable indicators presented for reducing health inequalities, three are green and one is amber.

- Of the three green indicators, Rutland ranks 1st (best performing) when compared to its similar neighbours for the following indicators:
  Healthy life expectancy at birth (Males)
  Life expectancy at birth (Males).

Source:
*NHS Outcomes Framework
**UHL Hospital Admissions Data
*** Office for National Statistics (ONS)

Rutland Joint Health and Wellbeing Strategy - Cross Cutting Theme: Reducing health inequalities

Ranking, Best and Worst columns are compared to the nearest neighbours only. Rank: 1 is calculated as the best (or lowest when no polarity is applied).

Indicator				Value	Rank	Best/Lowest	Worst/Highest	England	DoT	RAG
A01a - Healthy life expectancy at birth	F	All ages	2018 - 20	66.8	9/16	70.1	59.3	63.9		
	M	All ages	2018 - 20	74.7	1/16	74.7	61.9	63.1		
A01b - Life expectancy at birth	F	All ages	2018 - 20	85.0	3/16	85.4	83.2	83.1		
	M	All ages	2018 - 20	83.2	1/16	83.2	79.0	79.4		

Note: For A01b - Life expectancy at birth for males, the Worst/Highest value should be 79.2, not 79.0.

Statistical Significance compared to England or Benchmark:
Better, Worse, Higher, Similar, Not compared, Lower

Direction of Travel:
Decreasing, Decreasing and getting better, Decreasing and getting worse, Increasing, Increasing and getting better, Increasing and getting worse, No significant change, Cannot be calculated

Data Source: Office for Health Improvement & Disparities
https://fingertips.phe.org.uk/

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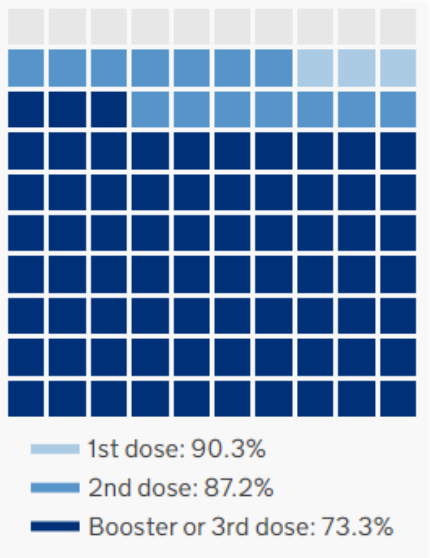
Updated September 2022

Covid Recovery

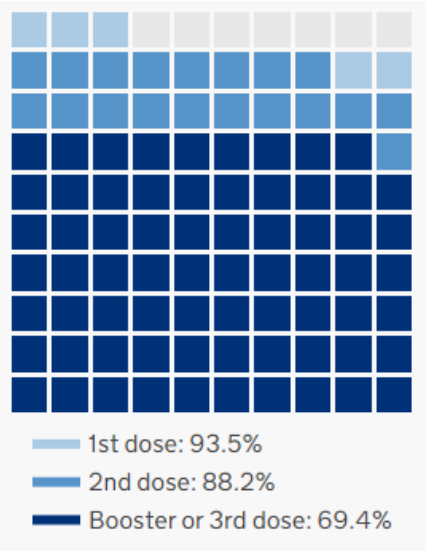
- **COVID-19 vaccinations (% Uptake)**

  The Covid-19 vaccination uptake in Rutland is higher than England for booster/dose 3 for those aged 12 and over, as of 15th June 2022. The percentage uptake for dose 1 and dose 2 in Rutland is lower in comparison to the national average for those aged 12 and over.

Covid-19 Vaccination Uptake in Rutland (12+)



Covid-19 Vaccination Uptake in England (12+)



Source: Coronavirus (COVID-19) in the UK dashboard (https://coronavirus.data.gov.uk/)

- **COVID-19 Hospital Admissions at University Hospitals of Leicester (UHL)****

  From March 2020 to 10th September 2022 (since the start of the pandemic), there have been a total of 116 hospital admissions with Covid-19 at UHL from Rutland residents. Out of the 116 admissions, 79% were aged over 60 and 21% were aged under 60. It is important to note that Rutland residents would also attend other hospitals across the border.

- **COVID-19 Deaths*****

  As of week 35 in 2022, there have been a total of 105 Covid-19 deaths in Rutland. Of the total deaths involving Covid-19 in Rutland, 54 (51.4%) were in a hospital setting and 41 (39.0%) were in a care home setting.

  Since the beginning of the pandemic (week 12, 2020) there have been a total of 1020 deaths (all causes) in Rutland.

  Based on the average mortality data for 2015-19, we would expect 930 deaths in Rutland for this period. This reveals an excess of 90 deaths from any cause in Rutland during this period.

Source:
*NHS Outcomes Framework
**UHL Hospital Admissions Data
*** Office for National Statistics (ONS)

Appendix 1

Similar areas to Rutland

The Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbours model seeks to measure similarity between Local Authorities. The nearest neighbours to Rutland are listed below.

Nearest CIPFA neighbours to Rutland available from fingertips include:

- Bedford
- Buckinghamshire UA
- Central Bedfordshire
- Cheshire East
- Cheshire West and Chester
- Cornwall
- Dorset
- East Riding of Yorkshire
- Herefordshire
- North Somerset
- Shropshire
- Solihull
- South Gloucestershire
- West Berkshire
- Wiltshire

Source:
*NHS Outcomes Framework
**UHL Hospital Admissions Data
*** Office for National Statistics (ONS)

If you require information contained in this leaflet in another version e.g. large print, Braille, tape or alternative language please telephone: 0116 305 6803, Fax: 0116 305 7271 or Minicom: 0116 305 6160.

જો આપ આ માહિતી આપની ભાષામાં સમજવામાં થોડી મદદ ઇચ્છતાં હો તો 0116 305 6803 નંબર પર ફોન કરશો અને અમે આપને મદદ કરવા વ્યવસ્થા કરીશું.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਵਿਚ ਕੁਝ ਮਦਦ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 0116 305 6803 ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਅਸੀਂ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਦਵਾਂਗੇ।

এই তথ্য নিজের ভাষায় বুঝার জন্য আপনার যদি কোন সাহায্যের প্রয়োজন হয়, তবে 0116 305 6803 এই নম্বরে ফোন করলে আমরা উপযুক্ত ব্যক্তির ব্যবস্থা করবো।

اگر آپ کو یہ معلومات سمجھنے میں کچھ مدد درکار ہے تو براہ مہربانی اس نمبر پر کال کریں 0116 305 6803 اور ہم آپ کی مدد کے لئے کسی کا انتظام کر دیں گے۔

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Jeżeli potrzebujesz pomocy w zrozumieniu tej informacji w Twoim języku, zadzwoń pod numer 0116 305 6803, a my Ci dopomożemy.

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Report No: 163/2022
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

11 October 2022

BETTER CARE FUND PROGRAMME – 2022-2023 PLAN SUBMISSION

Report of the Portfolio Holder for Health, Wellbeing and Adult Care

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Cllr S Harvey, Portfolio Holder for Health, Wellbeing and Adult Care	
Contact Officer(s):	John Morley, Strategic Director for Adult Services and Health	01572 758442 jmorley@rutland.gov.uk
	Katherine Willison, Health and Wellbeing Integration Lead	01572 758409 kwillison@rutland.gov.uk
Ward Councillors	NA	

DECISION RECOMMENDATIONS

That the Committee:

1. Notes the content of the report

2. Notes the Rutland 2022-23 Better Care Fund plan, submission of which to the BCF national team on 26 September 2022 was signed off by the Chair of the Health and Wellbeing Board.

1 PURPOSE OF THE REPORT

1.1 The purpose of this report is to brief the Health and Wellbeing Board (HWB) on the 2022-23 Better Care Fund (BCF) Programme Plan.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The **end of year report for the Rutland BCF programme for 2021-**22 was signed off by the HWB chair and was submitted to the national BCF team on 27 May 2022

2.2 The Programme Plan for 2022 -23 was submitted to the national BCF team on 26 September 2022. It includes:

- A Narrative providing a summary of how the budget is being spent and how it is planned to be spent for each area of expenditure

- A Planning Template detailing

  - Planned Expenditure
  - Confirmation that the National conditions of the BCF have been met
  - Ambitions and plans for performance against BCF national metrics
  - Any additional contributions to BCF section 75 agreements

- A completed intermediate care capacity and demand plan submitted alongside the BCF plan (not subject to assurance)

2.3 BCF National condition 4: implementing the BCF objectives. This national condition requires areas to agree a joint plan to deliver health and social care services that support improvement in outcomes against the fund's 2 policy objectives. These are: enable people to stay well, safe and independent at home for longer; people have the right care at the right place at the right time.

In meeting these objectives, commissioners should agree how services will continue to promote the independence and address the needs of people who are at risk of losing independence including admission to residential care or hospital. They should continue to focus on ensuring people are discharged in a way that maximises independence and leads to the best possible outcomes.

2.4 The plan encompasses a range of schemes aligned with Rutland's priorities of Unified Prevention, Holistic health management in the community, Hospital flows and Enablers. Services include the Community Wellbeing Service which provides advice and support and includes Citizens' Advice; Social Prescribing including joint GP and RCC RISE Team. Integrated care services support people with long term conditions and frailty which includes physiotherapy; Disabled Facilities Grants help to finance adaptations and equipment to enable people to live in their homes for longer. The plan includes Carers support workers including Admiral Nurses who provide support and advice for the carers of people living with dementia. Regarding hospital flows, the plan assists to fund staffing to support Reablement and timely discharge from hospital, plus crisis management to avoid hospital admissions.

2.5 High Impact Change Model for Transfers of Care

These are approaches identified as having a high impact on supporting timely and effective discharges through joint working across the social care and health system. This is a significant area for the BCF, with 31% of the budget being allotted to this area. It includes approaches such as improved discharge to care homes and multi-disciplinary teams supporting discharge. A summary of a self-assessment in this area was included in the plan.

See appendix A for the Narrative document for full details.

2.6 **Income:**

Funding for 2022-23 is set out in Table 1. Showing the minimum NHS funding contributions to the Better Care Fund, channelled via the integrated care boards

(formerly via the Clinical Commissioning Groups) A uniform 5.66% increment has been awarded to all Health and Wellbeing Board areas. The Disabled Facilities Grant had an uplift of 3%

Table 1: BCF budget for 2022-23

Funds	**(£)**
NHS Minimum contribution	2,634,018
Improved BCF	281,818
Disabled Facilities Grant	270,255
Additional contributions (prior years' underspend) RCC	45,000
Additional contributions (prior years' underspend) ICB	21,000
Total	**3,189,091**

2.7 **Expenditure:**
Spend on the programme including the 2021-22 BCF, Improved BCF, and Disabled Facilities Grant allocations and previous underspend built into the programme totalled £3,123,091.

2.8 **Metrics:**
Performance is good against the key indicators:

- **Avoidable admissions**
  These continue to be low. This is supported by coordinated crisis response services which avoid conveyance to hospital.
- **Discharge to usual place of residence**
  The Percentage of people discharged from hospital to their usual place of residence remains over 90%, despite challenges of domiciliary care capacity.
- **Residential admissions**
  Supported by services such as falls prevention, carer support and crisis response, the numbers have dropped to the usual low level for Rutland following the pandemic.
- **Reablement**
  Successful Reablement is delivered through the therapy service and the inhouse domiciliary care provider MiCare. The target is set at 90% for 2022-23, having reached an estimated success rate of 96.3% for 2021-22.

2.9 Rutland's 2022-23 plan was approved by John Morley on behalf of the Council, while all three LLR returns went to the LLR CCG Executive Management Team on 26/9/22 for IBC approval. Finally, the HWB Chair approved the Rutland return on behalf of the Rutland Health and Wellbeing Board prior to its submission on 26/9/22.

3 CONSULTATION

3.1 Not applicable at this time.

4 ALTERNATIVE OPTIONS

4.1 Not applicable at this time.

5 FINANCIAL IMPLICATIONS

5.1 As in previous years, local partners have proceeded to deliver the current year's BCF programme 'on trust', based on consensus across the Council and CCG/IBC, pending national publication of guidance.

6 LEGAL AND GOVERNANCE CONSIDERATIONS

6.1 The plans have been produced with involvement and input from ICB. The plans received sign off by the Executive Team at the ICB.

7 DATA PROTECTION IMPLICATIONS

7.1 There are no new Data Protection implications. The annual report contains only anonymised data.

8 EQUALITY IMPACT ASSESSMENT (MANDATORY)

8.1 Not applicable to the annual report.

9 COMMUNITY SAFETY IMPLICATIONS

9.1 There are no identified community safety implications from this report.

10 HEALTH AND WELLBEING IMPLICATIONS

10.1 The Better Care Fund programme is an important element of Rutland's response to enhancing the health and wellbeing of its population, representing more than £3m of ICB and LA funding to be used for integrated health and care interventions. This report sets out that Rutland continues to be committed to improving the outcomes of the population.

11 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS (MANDATORY)

11.1 The Committee is recommended to note the Rutland 2022-23 Better Care Fund plan, submission of which to the BCF national team on 26 September 2022 was signed off by the Chair.

12 BACKGROUND PAPERS

12.1 There are no additional background papers to the report.

13 APPENDICES

13.1 Appendix A: Rutland 2022-23 BCF Programme Narrative Plan

13.2 Appendix B: Rutland 2022-23 BCF Plan Return: Key Sections

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

Rutland Better Care Fund Programme 2022-23

Programme of the Rutland Health and Wellbeing Board

Contents

BCF narrative plan template: There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

1 Context and Governance

This document, combined with the Excel workbook 'BCF 2022-23 Planning Template Rutland' sets out the Rutland Better Care Fund (BCF) Programme for 2022-23.

The area covered coincides with the unitary Local Authority boundary of Rutland County Council, which is a 'place' as defined in the NHS Long Term Plan. Rutland falls within the wider health and care footprint of the Leicester, Leicestershire and Rutland (LLR) Integrated Care System (ICS).

1.1 Governance

The BCF programme is governed by, and has been developed under the leadership of, the Rutland Health and Wellbeing Board (HWB) which meets on a quarterly basis and brings together the following:

- Rutland County Council (RCC) (members and officers, including for People services and Public Health),
- NHS Leicester, Leicestershire and Rutland (LLR) – the LLR Integrated Care Board (ICB),
- the Rutland Primary Care Network (PCN) on behalf of its constituent practices,
- Leicestershire Partnership Trust (LPT),
- Healthwatch Rutland,
- Citizens Advice Rutland, on behalf of the wider Voluntary and Community Sector (VCS) community,
- NHS England,
- Longhurst Housing Association, on behalf of the social housing sector,
- Leicestershire Constabulary,
- plus such other persons as are appropriate to the Board's agenda.

Operationally, the programme is managed by the Integrated Delivery Group (IDG) which is a formal sub-group of the HWB chaired by the Integrated Care Board, with the Director of Adult Social Services (DASS) being the vice chair. The IDG meet monthly to monitor and progress two inter-related strategies running in parallel, the BCF programme and the newly agreed Joint Health and Wellbeing Strategy 2022-27 (JHWS).

The full BCF programme as set out here will be approved through the delegated authority of the chair of the HWB and presented to the ICB Executive Management Team alongside the Leicester and Leicestershire BCF programmes. The next HWB meeting will be held on October

1.2 Engagement

Programme development has been led by the Integrated Delivery Group (IDG), involving all its members (RCC, LLR ICB, LPT, the Rutland PCN and Healthwatch Rutland). VCS partners have also been involved as providers of services which are integral to the current BCF programme.

While there has been limited time to engage broadly on this year's BCF programme (also with programme development taking place across the peak of the summer period), the

Council undertook wide local engagement across 2021-22 with both partner agencies and the public to prepare its new Joint Health and Wellbeing Strategy (JHWS) 2022-27. We see the JHWS and BCF programme as closely inter-related programmes. The BCF programme submitted is therefore well aligned with key messages and priorities from this engagement process (with the exception that the JHWS has a broader scope, e.g. also covering interventions for children, young people and families, and with a greater emphasis on mental health and end of life care).

2 Programme overview

Priorities for 2022-23, key changes since previous BCF plan, including commissioning changes

BCF programmes have been being delivered in Rutland since late 2014, through a succession of one or two year plans, as directed by national government. Their scope and approach has evolved over time in response to changing policy directions and local needs. The 2022-23 programme has strong continuity with that delivered in 2021-22.

The programme remains structured into four high-level priorities. Actions at the next level down have evolved or been reshaped in response to national policy guidelines and local opportunities and needs, as set out in **Section 3** below.

1. **Unified prevention:** improving individual health and wellbeing, and the vitality of communities.
2. **Holistic health management in the community:** services for those people living with ill health, particularly those whose needs are complex, providing a range of 'home first' coordinated support tailored to the care needs of individuals, helping them to live well and, wherever possible, to sustain their independence.
3. **Hospital flows:** reducing avoidable hospital admissions and ensuring prompt, safe and sustainable discharge.
4. **Enablers:** support to the programme itself, alongside analytics, technology and communications and engagement.

The programme is set out in more detail in section 3, where this demonstrates the *local approach to meeting condition 4:*

(i) enabling people to stay well, safe and independent at home for longer (Priorities 1 and 2); and
(ii) providing the right care in the right place at the right time (Priorities 2 and 3).

Among the key changes in the programme this time are the following:

- The contract for the integrated Community Wellbeing Service (Priority 1) ended in March 2022 and it has been replaced by the direct commissioning of an adjusted blend of wellbeing services meeting local priorities and complementing the Council's RISE social prescribing service.
- We have increased resources for public and partner engagement (Priority 1), opening up the scope for more co-design and co-production of solutions in line with national guidance around the delivery of Joint Health and Wellbeing Strategies.

- In prevention and community intervention, an Integrated Neighbourhood Team approach is enriching collaboration and coordination across local partners, also supported by the new social prescribing management and referral platform. As part of this, cohort-based population health management analysis is helping to inform the targeting of preventative services.
- The commissioned dementia support service (Priority 2) has been recommissioned with a greater emphasis on pre/peri diagnostic support and integrated working with the Council's Admiral Dementia Nurses.
- Hospital discharge services have evolved in line with national Discharge to Assess changes (Priority 3, see section 4).

3 Meeting the BCF policy objectives

Approach to embedding integrated, person centred health, social care and housing services. National condition four requires an overarching approach to meeting the BCF policy objectives to: (i) enable people to stay well, safe and independent at home for longer; and (ii) provide the right care in the right place at the right time

Outline, for each objective set out the approach to integrating care, including how collaborative commissioning will support this and how primary, community and social care services are being delivered to support people to remain at home, or return home following an episode of inpatient hospital care.

Plans for supporting people to remain independent at home for longer should reference: steps to personalise care and deliver asset-based approaches; implementing joined-up approaches to population health management, and preparing for delivery of anticipatory care, and how the schemes commissioned through the BCF will support these approaches; and multidisciplinary teams at place or neighbourhood level.

3.1 LLR's strategic context for prevention and integrated care closer to home

National condition four requires areas to agree an overarching approach to meeting the inter-related BCF policy objectives to:

- Enable people to stay well, safe and independent at home for longer
- Provide the right care in the right place at the right time

In LLR at a system level, a key enabler to the achievement of the BCF objectives is the principle of '**Home First'**. Home First services support people to remain in their homes when they are having a health or social care crisis rather than needing to go into hospital or a care home. Home First services also help people get home from hospital quickly and provide them with rehabilitation and reablement to help restore their health, wellbeing and independence.

'Home First' is an overarching principle of the whole Integrated Care System, which requires all teams and individuals involved in health and care to ask "why is this person not at home?" or "how best can we keep this person at home?". It also supports the concept that not every patient's progression is linear.

There are **10 key aspects to the Home First** programme, as set out below, elements of which are funded by LLR's BCF programmes.

Elements 2, 3, 8 and 9 below have particular relevance to the national BCF prevention priority (enabling people to stay safe, well, and independent at home for longer), while **all of these priorities contribute to the national BCF aim of providing the right care in the right place at the right time**.

1 Transforming and building community services capacity through growing the LLR virtual ward model

A virtual ward is a team of professionals working to manage a group of patients in the community. It allows patients to get the care they need at home, safely and conveniently, rather than being in hospital. Using a combination of remote monitoring by healthcare professionals and home visits, virtual wards can help prevent hospital admissions or allow for an earlier, supported discharge. It has been shown that people make a better recovery in their own surroundings and that staying in hospital longer than necessary can have a detrimental effect on their condition and their independence.

By Winter it is hoped that 275 patients across LLR will be able to be looked after simultaneously across nine virtual wards including frailty, cardiology, acute respiratory and diabetes. The number of beds will increase to more than 440 by December 2023. (Rutland represents 4% of the LLR population and would be using these services in a broadly proportionate way.)

The virtual ward service has been arranged by NHS LLR and will be provided by a collaborative of local organisations, including University Hospitals of Leicester NHS Trust, Leicestershire Partnership NHS Trust, Local Authorities and the local hospice, LOROS.

Among the priorities will be: to increase utilisation of existing virtual ward beds, ensuring appropriate use to avoid admission/ facilitate earlier discharge; and to enhance step up and step-down access to virtual ward beds through growing the LLR unscheduled care hub.

2 Transforming and building community services through Home First Urgent Crisis Response and reablement

The aim of this priority is to deliver an urgent community response within two hours for more patients than in 2021-22 and achieve this target at least 80% of the time for the system.

Urgent crisis response referrals will be increased through: Emergency Department front door diversion; enhancing pendant alarm referral routes; alignment to other local offers; expansion of the falls crisis response offer; and maintaining delivery of rehabilitation and reablement within 2 days at least 80% of the time across LLR.

3 Embedding integrated neighbourhood working and delivering anticipatory care

- Embedding operational MDTs and an anticipatory care/population health management (PHM) approach to jointly manage frail, complex and high-risk patients, ensuring that all neighbourhood teams have well-functioning MDTs in place by October 2022;

- Ensuring consistent use of care co-ordinators, care navigators and social prescribers to maximise use of the Voluntary and Community Sector and other wellbeing offers;
- Developing high-performing Integrated neighbourhood leadership teams consistently across LLR with full engagement, clear governance and shared purpose, underpinned by a local PHM plan by March 2023.
- Increasing the identification of carers enabling support to be offered;
- Developing an Integrated Neighbourhood Team maturity matrix;
- Increasing care planning to 55% of vulnerable patients;
- Recruiting additional care co-ordinators and finalising an MDT draft framework; and
- Recruiting MDT Facilitator roles through LAs (underway).

4 Reducing community services waiting lists

- Developing a system understanding of community services waiting lists; and
- Developing clear plans to reduce and address these waiting lists through prioritisation, efficiencies and investments where required.

5 Improving awareness, identification, and management of frailty

- Increasing the use of effective care planning (including ReSPECT forms to capture care wishes), ensuring that all vulnerable patients (end of life, frailty and care home) have quality care plans in place;
- Addressing the care planning backlog to ensure that 95% of vulnerable patients have an agreed care plan in place by October 2022;
- Ensuring care planning underpins effective decision making through availability and use by all partners;
- Increasing frailty identification and assessment by 25% by October 2022 through: the development and delivery of frailty training across primary care, community services, care homes and acute; and, planning and delivering a public awareness campaign.

6 Strengthening the community palliative and end of life care response

LLR partners will support more people to die in their place of choice through:

- Increased identification of people in their last year of life via increased use of ReSPECT planning;
- Improved access to end of life care provision through the design and mobilisation of a 24/7 advice line for patients, carers and professionals;
- Enhancing the end of life discharge pathway by testing an integrated end of life social care bridging and co-ordination offer and undertaking quality and co-production reviews of patient and carer experiences at the end of life.
- Ensuring end of life remains everyone's business through appropriate training and support
- Refreshing place-level JSNAs and the LLR all-age end of life strategy. The JNSA development will be undertaken on a rolling basis from 2022 to 2026.

7 Implementing the enhanced health in care homes (EHCH) model

- Ensuring full and consistent delivery of all parts of the EHCH PCN DES, including allocating named GPs for all care homes and residents;
- Piloting the use of a care home virtual ward with remote monitoring for patients with a frailty score of seven or above or a higher risk of admission, and developing a plan for further roll out by September 2022;
- Embedding comprehensive geriatric assessments and effective MDTs across all care homes by August 2022;
- Determining the ongoing model of care for bed based reablement care;
- Implementing the National Early Warning Score (NEWS) which is a tool for identifying and responding to acute illness. When used in care homes, staff measure residents' vital signs and record them on a tablet computer, which calculates a NEWS to share with health partners; and

Complementing this by piloting WHZAN and Spirit digital technologies in care homes to support the identification of deterioration using NEWS2. The Whzan Blue Box is an all-in-one telehealth case. It measures vital signs, records photos, and performs multiple assessments and questionnaires including NEWS2. Signs of deterioration or illness are identified earlier, for a clinical response or carer support. This is being implemented from 1st oct to end of Dec 2022 and a full evaluation will be published after then – (Jan 2023)- results of the pilot will inform whether further investment is supported and whether these digital observation tools are continued.

8 Implementing equitable falls prevention and management across LLR

- Evaluating and developing longer term plans for the falls crisis response model to maintain an equitable response across LLR by August 2022;
- Developing a plan for early identification and support for people at risk of falls by October 2022; and
- Embedding a consistent falls management offer across LLR.

9 Implementing an integrated therapy model that maximises shared resources

The Integrated Therapies Vision is to best utilise LLR therapy resources across LLR where services provided are similar or across patient pathways where there are key therapy interfaces. This will support seamless and effective patient care, efficiencies, flow, admission avoidance, and a single model of care within certain pathways with agreed standards and ways of working. This needs to be underpinned by a robust LLR Therapy workforce plan. Among the changes are:

- Maximising the use of LLR's integrated therapy workforce across ICS shared roles, a single leadership model, a single clinical model and shared waiting lists across each pathway;
- Development of a single clinical model and pathway for stroke therapy;
- Introducing an extended seven day therapy offer at Rutland County Council by March 2023; and

- Development of an integrated therapy model for community health and social care.

10 Growing community capacity through the workforce

- Engaging with independent providers of care home and domiciliary care, through provider forums, to support system resilience and the integration agenda;
- Co-design of a responsive system-wide Home First career pathway encouraging more effective integration and sharing of future workforce capacity by collectively developing a pipeline by championing of new roles and shared training and development; and
- Further exploration of Multi-Professional Teams/ co-location/ collaborative working to ensure consistent working practices and to promote better integration of the LLR workforce as well as care pathway delivery improvements.

3.2 How the programme supports national policy aims

Priorities 1 to 4:

Priority 1 and, to a lesser extent, priority 2 are prevention focussed, maximising wellbeing and independence, while Priorities 2 and 3 are focussed on ensuring the right care in the right place at the right time.

Priority 1: Unified Prevention, is targeted towards improving individual health and wellbeing, and the vitality of communities. While maintaining health and independence is an increased priority nationally in 2022-23, it has been a long-standing focus of the Rutland BCF programme as part of a wider health and care demand management strategy aiming to keep people as well and independent as possible for as long as possible. Actions are centred around the following:

- **The Council's RISE service**. This is a close collaboration between RCC and the four GP practices of the Rutland PCN, providing social prescribing assistance and more specialist wellbeing services for those living with multiple comorbidities and/or low level mental health challenges. The service takes a personalised, asset based approach, helping people to engage with what motivates them in their lives, and to use this to drive changes that improve their health and wellbeing.

  The team is also now leading on **multi-disciplinary neighbourhood facilitation and coordination**, acting as a central point of information on health, social care and voluntary sector services and as a hub for coordinated collaborative working between associated partners. As part of this, they have made two key changes: putting in place a BCF funded social prescribing referral system which supports secure and efficient referrals and monitoring of impacts; and, introducing a population health management approach to case finding, using algorithms to interrogate GP data to identify cohorts sharing characteristics that mean they are likely to benefit from the prevention and wellbeing services provided by the social prescriber link workers, PCN pharmacists, case coordinators, health coaches, etc.
- **Online self-service information** is a key enabler in prevention, so the Rutland Information Service (RIS) online directory is also included under this priority to ensure it can play its full part in the wider collaborative prevention network and in reaching the public with high quality wellbeing-related information. The system helps communities to make the best of local assets. It promotes tailored public health campaigns and makes it

easier for people to find opportunities to live healthily, including by engaging with a wide range of groups and activities, connecting socially in their communities and increasing their activity levels.

- **Wellbeing services delivered by a number of local VCS organisations**, including: the Citizen's Advice Rutland Information and Advice service supporting people with welfare advice and support, referrals to the Foodbank, and referrals on for wider health and wellbeing support; and a sensory impairment service supporting people with sensory impairments discharged from hospital and in the community, enabling them to remain independent and at home for longer, and to maintain other aspects of their health. Activity this year also includes a one-off piece of work to develop the VCS Strategy for Rutland, which will identify how the VCS can best develop to support our wider communities, including around reducing inequalities.
- **There is a rapid response social work service** for those needing urgent social work support to avert or address a crisis. This service, which works closely with the above-mentioned services, supports the preventive approach at the statutory social work front door. The work centres on responding quickly to a crisis to prevent further deterioration in the home situation. This can include commissioning services within the home or short respite, with a return home if safe to do so. An important aspect of this service is professional input to assess risk and to keep people safe in their own homes, if possible.
- Finally, in a boost to **co-design/co-production**, resource has been provisioned to reinforce personalisation in shaping individual service responses and to increase opportunities for service users/patients to use their lived experience to help to inform and shape future services.

Priority 2: Holistic Health Management in the Community is focused on services for those people living with ill health, particularly those whose needs are complex, providing a range of coordinated support tailored to the care needs of individuals and helping them to live well and, wherever possible, to sustain their independence. This includes community health services, therapy and social care working together in integrated ways.

- There is ongoing commitment to **collaborative working in physiotherapy**, where recruitment challenges were overcome last year to ensure a full strength team. The Therapy Team Manager has driven forward the integration agenda and has forged close ties with the local LPT Therapy Team Manager. They meet regularly and referrals are moved between the two services to ensure the most efficient allocation of resources. As such, waiting lists are kept to a minimum whilst allowing the therapists to have greater input into safeguarding cases and falls prevention work.
- Core services are complemented by a range of **additional, often preventative, support** which is called on as required as part of a personalised approach to care. Relevant service users benefit from some of the actions set out in Priority 1, plus the Housing MOT, Assistive Technology, support for care-givers (see also Section 5), and dementia support.
- The **Admiral Nurse service is a key part of dementia support** in Rutland and has continued to grow and develop over the last year. An extended service continues to work closely with primary and secondary care to support people to live well with dementia and, where appropriate, to delay accessing a care home or hospital admission. **Advanced Care Planning** (ACP) remains a priority across LLR, further embedding use of genuine ACP and RESPECT forms. Alongside this, the commissioned Age UK Leicestershire and Rutland dementia contract was renewed in April 2022 for 3 years to cover a new **pre/peri diagnosis support**. This targets support for those on waiting lists for memory services which are now longer following services being halted during the pandemic. The contract change also has the Age UK worker working more closely with the Admiral Nurses, using

the same case recording and picking up step-up and step-down cases from the Admiral Nurses.

- As last year, complementing these preventative interventions, the bulk of **Disabled Facilities Grants** are being delivered as non means tested Health and Prevention Grants, sustaining independence, preventing falls and reducing carer breakdown through routine small adaptations such as level access showers and stairlifts. It is important that people have equal access to appropriate services wherever they live and whatever their circumstances. See Section 6 for more detail.
- A dedicated role supports local **care homes** to participate in **multi-disciplinary working** with health and social care partners, including improved care planning, anticipatory care and prevention of unwarranted deterioration using the Whzan Blue Box monitoring system (see below). A further role supports the domiciliary care market with sustainability and expansion of provision available in Rutland along with providing a brokerage service.

Priority 3: Hospital Flows addresses crisis response and hospital discharge, including: avoiding unwarranted deterioration; swift and safe transfers of care after a spell in hospital; and support for post-hospital recovery, including through reablement. The integrated discharge team, and the Micare person-centred care and reablement team are key elements of this. Following changes to working practices in the teams last year around Discharge to Assess, there is broad continuity in the roles being funded this year.

- RCC currently has a **seven-day therapy offer** funded until March 2023. Having the ability to visit patients over the weekend following discharge from hospital gives working families more opportunity to be involved in their relatives' care planning. Weekend working also allows Discharge to Assess cases to be progressed more promptly, helping to move cases on in a safe and timely fashion to free up care capacity for new discharges. RCC has also just recruited to a social work post covering weekends – again, only funded until March 2023, which should make the Discharge to Assess process even more efficient.
- The Council's in-house care provider and reablement team, in turn, provides **care and support enabling safe and timely discharges**, including through a home first approach to ensure that people can be discharged to their usual place of residence wherever possible with appropriate short-term support. In this role, they also help to inform 'right sized' care decisions for the longer term.
- **Reablement**, starting within 2 days of referral, is also primarily delivered by Micare, which follows the NICE guidance on intermediate care as "a multidisciplinary service that helps people to be as independent as possible. It provides support and rehabilitation to people at risk of hospital admission or who have been in hospital. It aims to ensure people transfer from hospital to the community in a timely way and to prevent unnecessary admissions to hospitals and residential care". The Micare integrated health and social care offer is delivered by community-based nursing, therapy and Micare carers to support people and their carers when there is a change in need. They also provide a **step up crisis response service** offering short-term care and support following a referral via health or social care emergency routes to reduce the risk of unwarranted hospital admission e.g due to a health crisis, a temporary inability to transfer, risks following a fall or a carer crisis.
- Complementing the above, we are increasing **anticipatory and proactive care** helping to prevent hospital admission and enable step down. Coordination through Micare and Rise will support proactive care management of long-term conditions and reduce the risk of unwarranted deterioration, while the Whzan Blue Box patient monitoring system in both cohorts, combined with the National Early Warning Score (NEWS2), will enable early identification of deterioration. Whzan allows vital signs to be taken and then remotely

accessed by clinicians including in primary care, so that timely clinical decisions and escalations can be made which can help to avoid escalation through inappropriate pathways.

For further details on the approach to hospital discharge, see Section 4.

Finally, **Priority 4: Enablers** includes provision for programme management and delivery, and other actions assisting the successful delivery of the programme and achievement of its aims, notably relating to analytics, technology and engagement capacity.

4 Supporting hospital discharge

Plans for improving discharge and ensuring that people get the right care in the right place, should set out how ICB and social care commissioners will continue to: (i) support safe and timely discharge, including ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support. (ii) Carry out collaborative commissioning of discharge services to support this. Include confirmation of self-assessment of implementation of the High Impact Change Model for managing transfers of care and any agreed actions for improving future performance.

Alongside the Home First programme set out above, we continue to work at system and place level on supporting safe and timely hospital discharge.

Working closely with the LLR Discharge Hub, Rutland has had an integrated Hospital Discharge Team for several years, consisting of social workers, care managers, therapists and nurses. This responds to a local pattern whereby many Rutland patients are hospitalised in Trusts outside the ICS. The two nurses and the physiotherapist and technical instructor in the team are employed by the local community health provider (Leicestershire Partnership Trust - LPT) but embedded within a joint Hospital Discharge/Reablement service. Having nurses working within the team makes transfer of care considerably smoother as they manage patients who may need Decision Support Tools completing, non-weightbearing patients and those who require nursing care.

All members of the team bring their own professional areas of expertise and support each other as required. It is particularly useful having a multidisciplinary team when triaging Home First forms because they are better able to identify where further clarification is required. This enables the team to place patients more accurately onto the correct Pathway for discharge and allows for more successful outcomes. The team continue to learn from each other and to gain a better understanding of their colleagues' respective disciplines.

High Impact Change Model – self-assessment
Teams continue to keep their practice under review, including relative to the High Impact Change Model.
Rutland has undertaken a self-assessment against the high impact change model of care for 22/23. Attached is the summary of the assessment conducted and the work to progress through the levels of maturity.

RCC HICM Review - 2022-23.docx

Dr Ian Sturgess recently reviewed Urgent and Emergency Care in LLR, making a number of recommendations. Currently, all three Local Authorities run a 'selective' model of reablement on discharge – determining on a case by case basis which patients will benefit most from a period of reablement. However, Dr Sturgess recommended an 'inclusive' model where the majority of discharges – whether Pathway 1 or 2 – should receive some form or reablement, rehabilitation or recovery. To enable this to happen for Pathway 1 cases, there will be a need to expand the capacity of RCC's in-house care team (MiCare) and potentially to recruit an additional therapist and care manager. The Discharge Team is currently reviewing historical data to determine what the increased staffing numbers would need to be and their cost.

The Team currently spot purchases Pathway 2 Discharge to Assess beds in Rutland. While this is flexible and local, it is not the most efficient use of resources, and also presents the disadvantage that therapy cover is not uniformly developed across the homes, and that care home staff are primarily trained to 'do for' residents rather than to reable them. Options are being explored across the ICS, potentially leading to a joint tendering exercise for Pathway 2 Therapy beds. While this may bring improvements, it is not the optimum solution for Rutland residents as the beds are likely to be located in either Leicester City or Leicestershire. Rutland residents would like a Rutland-specific resource so that they can be closer to their families. Other options for local dedicated provision are being considered, including establishing a council-run facility. In this case, the Therapy Team would have an on-site presence with equipment and facilities on-hand for more intensive reablement – ideally leading to more patients ultimately returning home. Owning a residential facility would have the added benefit of helping the Council to limit the increasing cost to the Council of residential care – something which will be even more needed with the introduction of the funding reforms in October 2023.

RCC HICM Review - 2022-23.docx

5 Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

The Care Act 2014 places a duty on Local Authorities to promote wellbeing and support carers to achieve outcomes that matter to them. Priorities include preventing, reducing and delaying the need for services.

According to the Act, Carers' assessments must seek to establish not only the carer's needs for support, but also the sustainability of the caring role itself, which includes both the practical and emotional support the carer provides to the adult. Factored into this must be a consideration of whether the carer is, and will continue to be, able and willing to care for the adult needing care. This will allow local authorities to make a realistic evaluation of the carer's present and future needs for support and whether the caring relationship is sustainable…The carer's assessment must also consider the outcomes that the carer wants to achieve in their daily life, their activities beyond their caring responsibilities, and the impact of caring upon those activities.

The BCF programme reflects a long-standing commitment to supporting unpaid carers, both through payments under the Care Act for interventions for carers, including respite care, and through the work of the Council's Carers Team and other involved officers.

A Senior Practitioner provides leadership on carers support, working with internal and external partners, prioritising and coordinating activities. They contribute to the local delivery plan for the LLR Carers Strategy and promote community engagement that helps to identify more carers, enabling the priorities in the strategy to- achieved.

The Carers' Team in turn comprises two officers – a significant commitment in a small ASC team. One of their priorities is to identify more carers, and earlier in their caring journey, both to provide support and advice to those individuals to improve their day to day lives, and to understand wider carer needs across Rutland to inform effective services. 'Carers passports' have been established and give carers a sense of recognition thereby promoting their wellbeing. They will be an integral part of how we go forward to develop carer friendly communities. For shops, businesses and services, they aim to encourage them to ensure they are accessible to carers.

Information and advice is given to carers which enables them to put systems into place which make their role more manageable and sustainable and avoid deterioration into crisis. An important aspect of this is encouraging and enabling carers to look after their own wellbeing so as to be in a better position to care for their loved one. A crisis may lead to avoidable admissions to residential care or hospital for the cared for person and/or the carer. Contingency planning is carried out as part of this work.

Timely, person-centred and empathetic support from the carers team, working in collaboration with other colleagues in health, social care and the voluntary sector, promotes carers' psychological wellbeing and enables them to maintain their caring role and the independence of their household, while reducing the need for more costly care and support. Practical work includes advocating for carers to support them to access sources of funding and benefits.

Community engagement and information sharing events are an opportunity to engage with both the public and professionals around carers' needs, and these are being extended to reach less well connected individuals and communities.

One area of challenge which was highlighted by Carers UK has been carers' experience of hospital discharge. In response, the carers team are collaborating with hospital discharge teams and main acute hospitals (UHL, PCH) to support identification of carers and instances where carers may need additional help (eg. coping with changed care needs on discharge).

Wider staff have reported that this is beneficial to their practice and understanding of the needs of carers.

There is an ongoing risk of crisis for carers so, alongside the above, RCC's Rapid Response Service provides same-day responses to prevent crisis, including where there is a risk of carer breakdown or avoidable hospital admission.

The needs of carers also vary depending on the situation of the person who is being cared for. Complementing the Carers Team, Rutland has also made a commitment to Admiral Dementia Nurses as part of its BCF programme. They support the carer as much as the cared for person through their stages of their journey with this progressive condition.

£k has been allocated for carers Direct Payments, providing carers with respite or support with practical tasks. The above work to support carers in making their lives more manageable has enabled the Council to reduce their spend on these Direct Payments.

6 Disabled Facilities Grants (DFG) and wider services

What is your approach to bringing together health, social care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Rutland County Council is a unitary authority and therefore does not draw up formal agreements with districts around the use of the DFG. Instead, there is close working between relevant in-house services and with commissioned providers as set out below. Housing services are also managed in Rutland as part of Adult Social Care, which supports good working relationships and a shared ethos of preventative working and achieving the best outcome for individuals requiring our services. Resettlement is a service within this team, supporting people in Rutland to remain well and support community cohesion.

The Disabled Facilities Grant (DFG) is used to fund both standard DFG projects and smaller, swifter Health and Prevention (HaP) Grants, typically for adaptations such as home access improvements, stair lifts and level access showers. The DFG continues to be managed in-house, delivering a preventative and creative service which places the individual at the centre of the process. The Council's continued commitment to delivering adaptations without delay, including through the pandemic, has ensured it delivers on presenting need. There are no lengthy wait times for any level of adaptation, offering preventative solutions, optimising wellbeing and reducing carer burden. The Trusted Assessor approach with the Council's commissioned 'Housing MOT' Service (a broader home check leading to a range of referrals and other advice) has now been embedded into practice, reducing duplication and delays.

The Council's Therapy Team Manager and Principal Occupational Therapists continually review service demands and delivery to ensure that the service remains accessible, responsive and is delivered to a high standard. Understanding the importance of technology in increasing independence, health and wellbeing and in reducing care needs has led to the development of a DFG Assistive Technology Occupational Therapist post. Developed in line with the newly published DFG guidance and in consultation with Foundations, the national

body for the Home Improvement Agency, this new role offers specialist advice on how Assistive Technology can be incorporated into a scheme of works to maximise the benefits of home adaptations.

The Council is in the process of writing a standalone Regulatory Reform policy whose purpose is to maximise the benefits and increase understanding of the ways DFG funding can be used creatively. An example of this last year was providing grant funding for an accessible community space that delivered greater benefits to a wider community rather than to a single household through as would be the case through an individual grant award.

As the Housing MOT has proved a successful model for assessment, intervention and signposting for a healthy home, we have replicated this model to launch a Digital MOT for Rutland. The Digital MOT provides an assessment of need, establishing the extent to which a person is or could be digitally enabled, and any barriers to this. Replicating the MOT model a suite of offers have been considered to meet a diverse range of needs. Age UK are partnering with the local Housing Improvement Agency to provide a multiple option offer to upskill people, and a technology loan service. The Council is collecting initial data to demonstrate outcomes and, if successful, hopes to fund this ongoing in the future to combat digital exclusion.

7 Equality and health inequalities

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Where data is available, how differential outcomes dependent on protected characteristics or for members of vulnerable groups in relation to BCF metrics have been considered
- Any actions moving forward that can contribute to reducing these differences in outcomes

Health inequalities are avoidable and unfair differences in health between different groups of people. They concern not only people's health outcomes, but also the differences in care they receive and the opportunities they have to lead healthy lives.

In 2021-22, a health inequalities plan was developed by LLR ICS partners to consolidate LLR's approach to reducing health inequality. This spans both equality for people with protected characteristics under the Equality Act 2010, and inequality in access to services or in outcomes that people may experience due to a wider range of other disadvantages, including the wider determinants of health (low incomes, rural isolation, lifestyle choices, etc). The plan is helping to support the response to health inequalities both in Rutland and the wider LLR health and care system.

Building on this strengthened LLR framework, a Rutland Health Inequalities Needs Assessment is currently in progress as a key part of Rutland's Joint Strategic Needs Assessment. This assessment, which has involved engagement with a wide range of Rutland partners, aims to develop a greater understanding of inequalities across Rutland.

Inequalities can often be masked by whole population dashboards in rural areas, requiring closer analysis in order to surface patterns and issues with greater confidence.

The assessment is covering the four overlapping dimensions of health inequality:

- socioeconomic groups and deprivation;
- inclusion health and vulnerable groups;
- protected characteristics in the Equality Duty; and
- geography.

Recommendations will identify opportunities to apply a proportionate universalism approach, providing universal services with an element of targeting residents and communities most in need, ultimately reducing inequality.

BCF delivery this year and BCF planning and delivery going forward will be aligned to the findings and recommendations of the needs assessment, ensuring allocations are supporting those experiencing the poorest health outcomes, or with worse access to services.

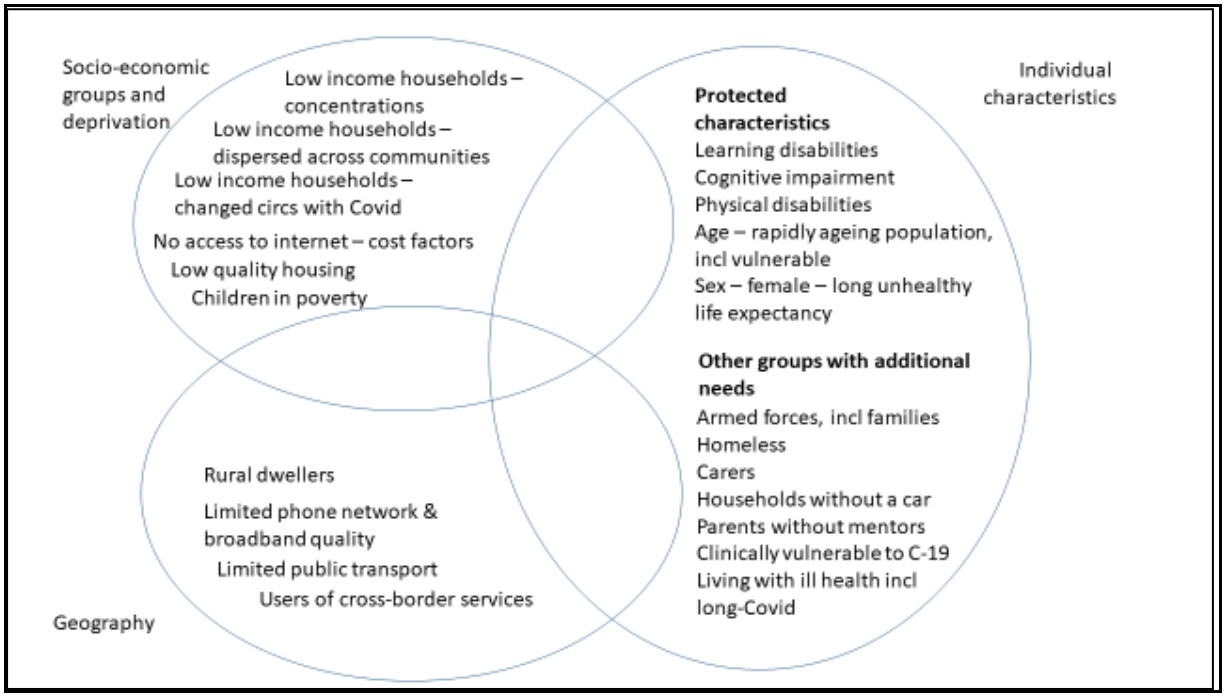
In parallel, health inequalities have become a strategic focus of the Integrated Delivery Group, the subgroup of the Health and Wellbeing Board which operationally drives the BCF programme. This will help ensure partners to work collaboratively on reducing the inequalities presented in the needs assessment, including through the delivery of BCF actions.

A more considered and governed approach to addressing health inequalities will enable more structured mechanisms to monitor progress on reducing inequalities, allowing BCF projects to align and demonstrate their impact in a more coherent way.

Core20Plus5 is a national NHS England and NHS Improvement approach to support the reduction of health inequalities at national and system (LLR) level. Rutland is a relatively affluent area so does not have populations among the 20% most deprived nationally according to the Index of Multiple Deprivation. The ‘Plus’ element, however, allows local places to determine priority disadvantaged groups sitting outside of the core 20% most deprived. The Rutland Health and Wellbeing Board are currently confirming their local ‘plus’ groups based on local intelligence. Once identified, these groups will also be considered in respect of BCF implementation and future planning.

We also recognise that disadvantage is often multi-faceted (see Figure below). Considering equality factors in this way helps to see circumstances in the round to ensure appropriate responses. This underlines the need to tailor services to individuals and their circumstances in order to bring about positive change and reduce avoidable need for health services, also building on available strengths. The County’s social prescribing, health and care services all aim to work within this holistic framework.

Figure 1: Rutland: overlapping inequalities



The following examples illustrate how Rutland's 2022-23 BCF programme has the capacity to enhance equity, promoting equity of access and outcomes as a cross-cutting aspect of health and care delivery under the programme.

Under Priority 1: Unified Prevention

- Strengthening social prescribing capacity through RISE and the Community Wellbeing Service to ensure that a holistic, personalised response is provided to any individual whose mental or physical health, or ability to live with ill health, could be improved through actions complementing clinical interventions, wherever they live in Rutland and whatever their characteristics and circumstances. Social Prescribing teams actively work to reach different populations who may not come forward via GP practices, for example undertaking outreach into Rutland villages, offering wellbeing support as part of inclusive social events such as the Rural Coffee Connect, and attending wellbeing events at the military base.
- Supporting wellbeing interventions including funding for Vista, which targets people facing challenges due to sensory impairment, and Citizens Advice Rutland, which works to support people facing financial difficulties or other discrimination.

Under Priority 2: Holistic Health Management in the Community

- The Disabled Facilities Grant provides non means tested access to small adaptations within the home (notably level access showers, lifts and other access adaptations) to enable prompt adjustments that allow people living with disabilities to maintain their independence at home for longer.
- Sustaining the focus on supporting people living with dementia and other cognitive impairment to live well with their condition and to access the wider set of health and care services which they may need, including through the County's Admiral Dementia Nurses.

- Interventions helping carers, 6 out of 10 of whom report feeling isolated as a result of their role.

Appendix 1: Abbreviations

BCF Better Care Fund

CCG Clinical Commissioning Group

DFG Disabled Facilities Grant

ED Emergency Department

EHCH Enhanced Health in Care Homes

HaPG Health and Prevention Grant

HWB Health and Wellbeing Board

ICB Integrated Care Board

ICS Integrated Care System

IDG Integrated Delivery Group

LLR Leicester, Leicestershire and Rutland

LPT Leicestershire Partnership Trust

NWAFT North West Anglia Foundation Trust

OT Occupational Therapist

PCH Peterborough City Hospital

PCN Primary Care Network

RCC Rutland County Council

UHL University Hospitals of Leicester

Appendix B

Rutland 2022-2023 BCF Programme Plan

National Conditions

National Condition	Confirmation
a jointly agreed plan between local health and social care commissioners, signed off by the HWB	Yes
NHS contribution to adult social care at HWB level to be maintained in line with the uplift to NHS minimum contribution	Yes
invest in NHS commissioned out-of-hospital services	Yes
implementing the BCF policy objectives	Yes

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Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Rutland

8.1 Avoidable admissions

		2021-22 Q1 Actual	Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	106.4	128.5	115.6	100.9	Rutland has very low rates of avoidable admissions relative to national and local position, influenced by local care approaches and the distance to acute hospitals. Therefore it is unrealistic to propose a significant drop in this rate. We have set a target of a 3% reduction.	Enhanced coordinated services identifying unwarranted deterioration and potential crisis so that swift interventions can be provided that may avoid conveyance.
		2022-23 Q1 Plan	Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Indicator value	105	117	112	103		
	Denominator	40,500	40,500	40,500	40,500		

>> link to NHS Digital webpage (for more detailed guidance)

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	90.3%	90.2%	90.3%	90.3%	In the context of recent years' performance, we have set targets which we believe to be stretching relative to local care pressures. In particular, while extensive local services support hospital patients to return home, the supply of homecare has been challenging over the last year which has led to some need to return patients to a care home setting.	Our discharge team and associated services including the in-house Micare service provide a comprehensive response which aims to provide the support needed to return patients safely to their usual place of residence whenever possible (see narrative).
	Numerator	660	644	674	596		
	Denominator	731	714	746	660		
		2022-23 Q1 Plan	Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan		
	Quarter (%)	90.4%	90.4%	90.4%	90.4%		
	Numerator	628	650	650	650		
	Denominator	695	719	719	719		

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	502.7	363.5	258.3	280.9	The rate of people permanently entering residential care has historically been low in Rutland relative to many other areas wtih successful interventions helping to enable people to remain living at home. It rose sharply during the initial pandemic, potentially with cases where people were unable to manage without their usual support networks and activities. Rates of admissions have quickly improved back to the former very low rates. We have therefore set a target similar to last year's improved position. It is important to support a balanced approach in which entry to a care home is enabled where this is the appropriate personalised response for given individuals based on their wishes, safety and ability to manage independently.	Rutland's social care and discharge teams work to an approach which promotes people remaining safely in their own homes wherever possible, with this supported by a range of enabling services including care coordination, falls prevention, carer support, home adaptations, enablement/reablement and crisis response.
	Numerator	52	38	27	30		
	Denominator	10,345	10,453	10,453	10,679		

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition
Proportion of older people (65 and over) who were	Annual (%)	85.7%	90.0%	96.3%	90.0%	We have increased the denominator to reflect ambitions to deliver a greater amount of reablement. The target is set to 90% for reablement	Successful reablement is delivered through close working between Rutland's occupational therapists and the in-house
	Numerator	24	27	26	45		

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Denominator	28	30	27	50	success which continues to be a challenging level of success to maintain against what in a small area can be a very variable service user cohort.	Micare team who provide the period of reablement support.

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

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Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Rutland

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Rutland	£270,255
DFG breakdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£270,255**

iBCF Contribution	Contribution
Rutland	£218,818
Total iBCF Contribution	**£218,818**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Rutland	£45,000	Previous year's underspend
Total Additional Local Authority Contribution	**£45,000**	

NHS Minimum Contribution	Contribution
NHS Leicester, Leicestershire and Rutland ICB	£2,634,018
Total NHS Minimum Contribution	**£2,634,018**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	Yes

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
NHS Leicester, Leicestershire and Rutland ICB	£21,000	Previous year's underspend to enable a joint
Total Additional NHS Contribution	**£21,000**	
Total NHS Contribution	**£2,655,018**	

	2021-22
Total BCF Pooled Budget	**£3,189,091**

Funding Contributions Comments Optional for any useful detail e.g. Carry over
Additional funding is carry over from previous year (s)

Explaining the evolution of the GP Practice workforce at a National and Local (Rutland) Level

Dr James Burden

Rutland Place Based Clinical Lead,

PCN Clinical Director

GP Partner

Content

- Explaining some of the basics
- GP numbers across the UK
- Health Select Committee into Primary Care Workforce
- Contractual opportunities from government contracts
- Enhanced Access
- The ARRS roles
- The Rutland plan for GP Practices and the ARRS roles
- Free at the point of care, appropriate to need

Explaining some of the basics

- GP Practices are funded through a contract with the Government, most are GMS contracts (5 days a week). Some are called APMS contracts (7 days a week)
- The GP Partners (Directors) have the ability to recruit staff, such as Salaried GPs, Nurses and Health Care Assistants.
- The Practice receives some core funding and attracts extra funding based on achievement of Quality Indicators (QOF)
- QOF indicators are negotiated by Government with the British Medical Association (GP Representatives) and cover things like Blood Pressure monitoring and management of the registered patients against agreed targets.
- The historical hours of opening hours of a GP practice was 8.00 to 6.30pm

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Can’t we just employ more GPs?

Health Select Committee into Primary Care Workforce

- The age of the average GP population is getting older
- Increasing numbers of GPs want a varied career, working in hospital clinics, being a locum in a number of practices or simply driven into retirement by pension and workload factors.
- The historical workforce planning for a “stable GP population” made some decisions 20 years ago the negative effect of which is becoming evident now.
- GPs are actually having more contacts (appointments) with patients now than ever
- Hospitals Consultants are discharging patients with complex care for GPs to monitor in the community eg Diabetes is no longer a hospital condition. Whilst this is the right thing to do, this puts added workload into Primary Care.

Explaining some of the basics – The PCN DES

The Primary Care Network (PCN) DES (National) contract extension

- Provided funding for practices to start to work to help create bigger GP Practices "at scale" – In Rutland the 4 Practices (Empingham, MOSS, Oakham and Uppingham) agreed to work together and formed Rutland Health PCN
- Bigger is meant to mean better
- Improved ability to recruit and utilise clinicians such as Physiotherapists, Specialist Nurses, Teams within a region
- **A section of it is called "Additional Roles and Reimbursement System" "ARRS"**

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Explaining some of the basics – The PCN DES

The PCN DES contract extension – ARRS

- The PCN is only funded for staff it has successfully recruited
- The PCN has a limit on the total amount of funding available
- The contract limits the numbers and type of staff you can recruit i.e. you can't recruit 20 Ambulance staff and decimate the East Midlands Ambulance Service
- All PCNs are competing for the same staff

The Roles

19/20	20/21 – Additional Roles added	21/22 – More roles
• Clinical Pharmacist • Social Prescribing Link Workers	• Physician Associates • First Contact Physiotherapists • Pharmacy Technicians • Health & Wellbeing Coaches • Care Coordinators • Occupational Therapists • Dieticians • Podiatrists • Nurse Associates • Trainee Associates	• Community Paramedics • Mental Health Practitioners

The Enhanced Access addition to the PCN DES

The PCN DES contract extension – Enhanced Access (Longer Opening)

- Within the PCN, at least one of the practices should be open on Monday to Friday from 6.30 pm to 8.00 pm and on Saturday opening is 9.00 am to 5.00 pm these appointments will be available for all patients across the PCN
- Number of appointment hours to be offered links to the number of patients registered in the PCN – Rutland is 44,000 patients = 44 hours per week.
- It does not need to be the GP delivering all of these hours, it is a team effort, but the GP needs to be available to offer supervision for staff.

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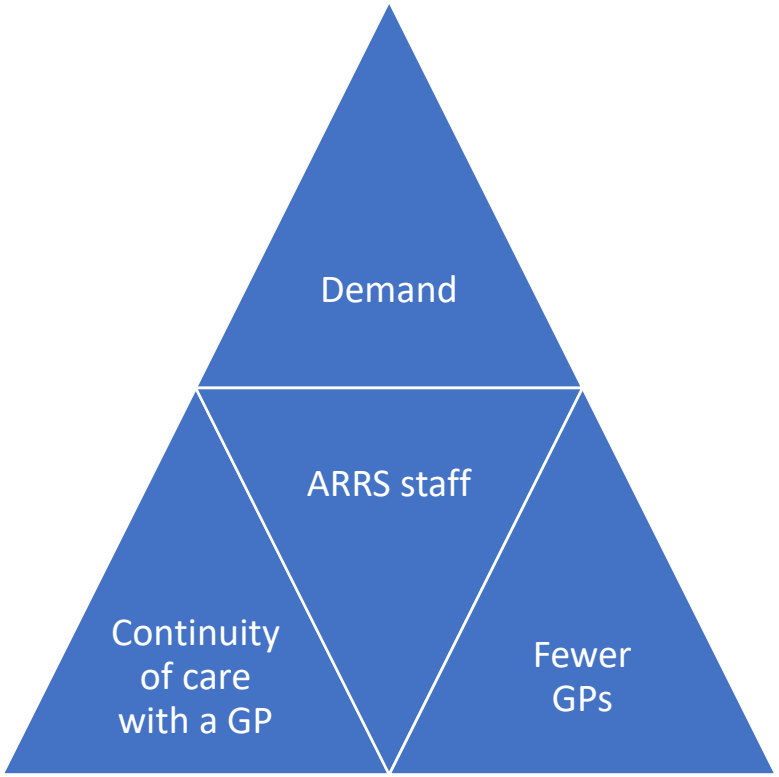
The expectations of only seeing a GP has to change

The impossible triangle

1. Increasing Access
2. Continuity of Care with a GP
3. Reducing number of GPs
4. ARRS staff

It can't actually fit together without ARRS staff



The effect on accessing healthcare

Patients often want and expect to see their GP and only their GP

- Continuity drives up satisfaction, for both the GP and Patient, but limits the number of patients that can be seen by the NHS
- ARRS staff complete many activities with the same level of quality as a GP – termed “GP substitution roles”
- What can these extra professionals deliver for patients?

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Examples of how ARRS staff can help see patients

Clinical Pharmacists

- Prescribe medicines for High BP, Cholesterol, Emphysema (COPD) and Asthma
- Can (when trained) see illnesses like Urine, Chest and Skin Infections

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Mental Health Practitioners

- Manage depression and assess suicide risk

First Contact Physiotherapists

- Diagnosis conditions like a GP or Orthopaedic Consultant
- Would not be treating you, only diagnosing you

Rutland is lovely, so why don't staff move here?

The NHS has a genuine and real workforce CRISIS

- The Health Select Committee has demonstrated all the problems in the NHS
- Local Practices have advertised Clinical roles, for GPs and had no applicants

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To attract clinicians to Rutland, we have to compete against other areas

- We are doing this by innovative work and utilisation of national funding
- Rutland Academy
- Patient Safety Work

The Rutland ARRS plan

How have we used the available money

- 4 Care Coordinators
  - 1 Project Lead, 1 Ukrainian Dr, 2 High Risk Prescribing Project Leads
- 1 Health and Wellbeing Coach
- 1.5 Diagnostic Physiotherapists (First Contact Physio)
- 1 Mental Health Worker
- 10 Clinical Pharmacists (Creation of the Rutland Clinical Pharmacy Academy)
  - 7 will be starting MSc degrees in Nottingham University
  - MSc – 100% Funded by National Apprenticeship Scheme - 20% release clause

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The Rutland ARRS plan

How have we used the available money

- Care Coordinators listed for prestigious HSJ Award for Patient Safety
- Rutland Clinical Pharmacist Academy has filled and other areas are asking how we have managed to do this?
- Diagnostic Physiotherapists have proved successful
- Mental Health Conditions moved away from GPs with high quality consultations
- Social Prescribing has increased by working with the RISE Team in Rutland County Council to improve support for the most vulnerable

The Rutland Health Offer

“Free at the point of care, appropriate to need”

- Increase the number of clinicians employed in the area and develop their skills
- Increase the number of diagnostic clinicians through the MSc degrees
- Increase the productivity of GP contacts by using technology (AccuRx)
- Increase the safety of the systems by using Care Coordinators to target population groups with Health Inequalities
- Increase ‘self care’ by patients (buy own BP monitor, exercise more, talk more)
- Improve communication with patients to advertise the benefits of seeing “GP substitute Clinicians” – It increases access to Healthcare

The Rutland Health Offer

“Free at the point of care, appropriate to need”

- The PCN is utilising every available ££ of funding available
- The GP Practices are using technology to increase productivity
- The backlog of hospital care from the COVID pandemic creates increased workload for GP Practices, as patients contact us whilst they wait to be seen.
- Limitation on space is forcing some clinicians to be working from home
- The Government contract – PCN DES – forces GP practices to remodel their workforce but this has a knock on effect for patients “it’s not like it used to be”
- **This is not just a Rutland problem – it affects the whole of the Country**

Any questions?

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Enhanced Access to General Practice Service via the PCN DES contract

Dr James Burden

Rutland Place Based Clinical Lead,

PCN Clinical Director

GP Partner

Content

- What is the Enhanced Access section of the PCN DES?
- What is contractually required of practices?
- What is happening in Rutland?

What is the Enhanced Access section of the PCN DES?

- In early 2022 the Government announced that the PCN DES contract would be altered and a new section introduced
- The Enhanced Access section required PCNs to deliver additional care to their patients (for us that is Rutland as we have only one PCN) in the hours detailed overleaf
- GP Practices could opt out of the PCN DES but would lose the ARRS section of the contract (additional funding for additional activity)
- All the surgeries in Rutland Health PCN stayed with no resignations
- Service starts on October 1st 2022

Nationally - GMS Access vs Enhanced Access

GMS contract (GP Contract)

- Monday to Friday
- 8.00 am to 6.30 pm
- Weekends covered by Out Of Hours service
- GP does not need to be onsite but can supervise MDT remotely
- Extended access some hours either early or late or at the weekend
- Building is open

Enhanced Access via the PCN

- One site of the PCN is to be open Monday to Friday 6.30 pm to 8.00 pm
- One site to be open on a Saturday from 9.00 am to 5.00 pm
- GP does not need to be onsite but can supervise MDT remotely
- No walk in appointments, only scheduled appointments
- Building is open

Rutland Health PCN Enhanced Access

- Enhanced Access survey received 9000 responses
- The PCN will deliver 44 hours of clinician contact time per week (relating to the 44,000 patients that we serve)
- GPs agreed to be onsite and to deliver face-to-face clinics
- To ensure care remains close to home, and in a manner that is deliverable with our given workforce we will:
  - Rotate the surgeries that open during the week (details overleaf)
  - Rotate the surgeries that open at the weekend (details overleaf)
  - Deliver remote clinics on a Friday with a GP by telephone
- The Acute Care Services at Rutland Memorial Hospital remain unchanged

Rutland Health PCN Enhanced Access

Weekdays	**6.30 - 8.00 pm**
Saturdays	**9.00 – 5.00 pm**

• Monday	Oakham
• Tuesday	Uppingham
• Wednesday	Market Overton
• Thursday	Empingham
• Friday	(Closed – Remote GPs)
• Saturday's	Rotating (Oakham/Uppingham/Oakham/Empingham)

Rutland Health PCN Enhanced Access - Weekends

Delegated to a Provider Company based in LLR, who are providing clinical staff who want to work at the weekends

- 2 x Phlebotomists - morning only as blood gets collected at midday
- 2 x Nurses working all day

- Nurses delivering Cervical Smears, Long Term Conditions such as Diabetes Checks, supervised by remote GP in Oadby
- Patients booked by their own surgery targeting patients who have trouble accessing healthcare during the working week

Rutland Health PCN Enhanced Access - Weekdays

Your surgery open with one of your local GPs

GPs seeing complicated patients who need extra time, or perhaps patients who need their relatives to be present at the consultation

- Complex Care Reviews
- Cancer Care Reviews
- Palliative Care Reviews

Clinical Pharmacists

- Long term conditions medication reviews
- Patients who have difficulty accessing healthcare during the daytime

Rutland Health PCN Enhanced Access - Weekends

Rotational Opening

- Oakham 1st weekend of the month
- Uppingham 2nd weekend of the month
- Oakham 3rd weekend of the month
- Empingham 4th weekend of the month
- To be advertised 5th weekend of the month

Questions?

GP Access – Task and Finish Group

Dr James Burden

GP / PCN Clinical Director / Clinical Place Lead for Rutland

GP Access – Task and Finish Group

Update – The foundations have been laid for improved care

- Enhanced Access is starting on 1st October 2022
- Enhanced Access survey had over 9000 responses
- 9 new prescribing clinicians have been recruited to the PCN
- It is vital that we request patients register for online access
- It is incredibly important for us to persuade patients to use the online systems, recognise the benefits of this technology and accept that in a modern General Practice this type of system is needed
- The PCN Practices need to optimise communication and improvements through effective Patient Participation Groups and through liaison with HealthWatch

Accessing Primary Care
The balance between choice and efficiency

Patients going online is more efficient for the surgeries

In order to maximise the use of our resources we need our patients to play their part in helping access healthcare and this includes online submissions.

Access for vulnerable patients, would be easier if other patients who could use online forms, chose to do this as it would reduce the length of the phoneline and increases availability of receptionists.

Accessing Primary Care
The balance between choice and efficiency

Becoming digital is necessary for most patients

- Providing your email address
- Having a mobile phone or tablet device

Effect for patient and surgery

- Doctor can send you a text message or email that you can respond to and it goes back into your medical records. The GP can create a text message at a prescheduled time during the consultation

  "Could you let me know whether your indigestion has cleared up with the tablets I gave you?"

- Doctor can send a text message or email with a link that allows you to book directly into a clinic for a blood test without having to wait on the phone for the receptionist.

Accessing Primary Care
The balance between choice and efficiency

Improved websites with the support of PPGs and HealthWatch

- Access for vulnerable patients would be better if other patients who could use online forms chose to do this
- Receptionists should be reserved for processes that cannot be easily automated
- Our PPG groups should be used as the conduit to ask patients about their needs, it strengthens the PPGs and increases local involvement with practices.

Accessing Primary Care

Moving forward we should work together to:

- Ensure able patients use the online forms of communication wherever possible
- Ensure the online experience is optimised by working with stakeholders (Patients, Rutland County Council and the Integrated Care Board)
- Ensure that vulnerable patients and those who are truly without on-line access have their telephone calls answered by non time pressured receptionists

Communication with the Practices

Negative comments make things worse for everyone

- GP practices want to have good relationships with patients.
- Negative comments have an impact on the staff.
- If the morale of Practices reduces, it is harder to keep staff, making service levels drop and we enter a vicious circle of cause and effect.

High effort + Low thanks = People leave

- Practices are now having trouble recruiting non-clinical staff, leaving the remaining staff under increased pressure.
- The problems of the NHS will not be solved by negative comments to a receptionist, but a positive comment helps that person feel valued and more likely to stay in post

Communication with the Practices

Improving systems comes through feedback in a structured manner

- We need to help patients to understand the changes to GP Practices, this starts with the Health and Wellbeing Board presentation later in this meeting.
- Webinars to explain the system can help, but we also need to work with the PPGs to improve the online portals and experience before we launch.

Going forwards

- PPGs should be the focus of how we engage and ask for help
- Surveys give us feedback on whether our plans are correct (9000 responses to Enhanced Access survey)

Physical restraints and staffing problems

Physical and staff restraints

- The new Enhanced Access gives greater access for patients.
- This will commence on 1st October 2022.
- The ARRS roles increase the number of clinicians available in the working week
- The ARRS roles have no space to work so are being forced to work from home one day a week
- The physical constraints of the buildings in Rutland remain a limiting factor in patient contact methods.
- Work is underway to review the estates strategy in primary care to tackle this.

Judging success by surveying patients

Survey of patients

- The PCN agrees that surveying patients is important
- We need to ensure that the wording of the survey should reflect the strategic plans for improved access
- If we simply ask, “How easy is it for you see your GP?” the answer is likely to be “not easily”
- If we ask, “How easy was it for you to discuss your cholesterol result with a Clinical Pharmacist?” the answer should be “very easy”

Rutland population or Rutland Practices?

- It would be appropriate to include all the practices serving Rutland patients, Lakeside Corby, Lakeside Stamford, Wansford and Billesdon.

We are starting to deliver an improved Primary Care

Communications with patients, workforce and Enhanced Access

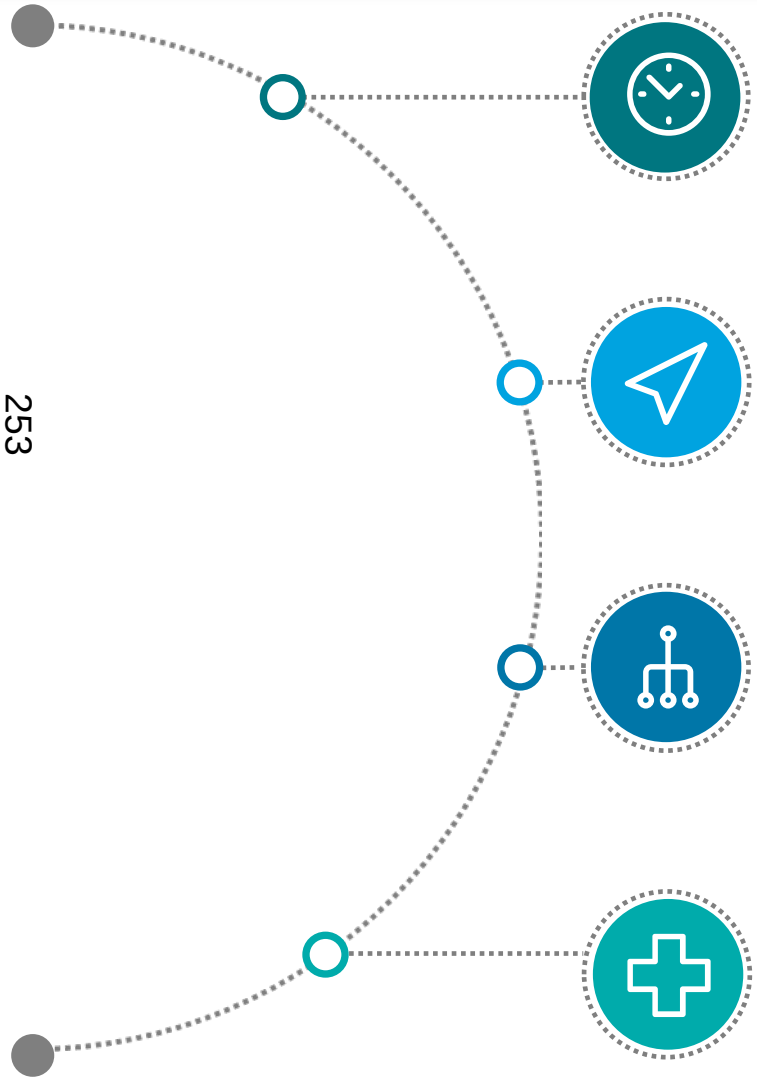
- PCN has worked with the Chairs of the 4 PPGs and Health Watch to improve the wording and the language (less NHS speak) used in the Enhanced Access survey
- Enhanced Access survey was launched with an explanation of how the funding for PCNs is shaping workforce development and how we have been able to recruit Clinical Pharmacists to work in the surgeries.
- Enhanced Access survey was disseminated and received over 9000 replies within 4 weeks of launching
- Feedback from the survey has altered the Enhanced Access survey (Friday Nights) and allowed us to demonstrate that the service was in line with patient desires
- Over the course of September, October and November 7 new Clinical Pharmacists are joining the PCN. In December and January 2023 we have an Advanced Clinical Practitioner and another Clinical Pharmacist joining the PCN. This is 9 new clinicians when some PCNs are struggling to recruit 1 or 2.

Take home messages

For GP Practices to deliver great care to you:

- Ensure the practice have an up to date email address and mobile phone number
- Access the online portals rather than phoning the practice
- Help improve the morale of the staff by saying thank you
- Help improve the systems by joining the PPG or responding to surveys
- Help the GP see the right patients by accepting care will be delivered by members of an Multi-Disciplinary Team such as a Clinical Pharmacist
- Future surveys help us to help you and should be linked to these themes

Elective Care and Diagnostic Update



East Community Diagnostic Centre

- Development of the East CDC business case will start next year with the intention to be operational by 24/25
- 7-day working will be achieved in a phased approach
- 1 MRI pad for Rutland patients will be implemented prior to East CDC going live

Rutland Diagnostic Hub

- Rutland has piloted a diagnostic hub based at Uppingham Surgery
- The Hub delivers 5 cardiorespiratory tests
- The results have been successful and ICB contract discussions are underway to substantively fund the project
- The hub will act as a 'spoke' for the LLR CDC's

Elective Care

- Outpatient developments at Rutland Memorial Hospital
- Prehabilitation plan in development at community locations
- Working closely with the local council and public health to deliver prevention and rehabilitation plans
- Implementation of PIFU pathways

Working across county borders

- Working with out of county ICS's to access elective care and diagnostic pathways

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Report No: 161/2022
PUBLIC REPORT

HEALTH AND WELLBEING COMMITTEE

11 October 2022

RUTLAND MEMORIAL HOSPITAL PLANNED WORKS

Report of the Director of Community Services, Leicestershire Partnership NHS Trust

Strategic Aim:	Healthy and well	
Exempt Information:	No	
Cabinet Member(s) Responsible	Councillor S Harvey, Portfolio Holder for Health, Wellbeing and Adult Care	
Contact Officer(s):	Paul Sheldon, Chief Finance Officer, Leicestershire Partnership Trust	Paul.sheldon@nhs.net
	Sam Leak, Director of Community Services, Leicestershire Partnership Trust	samantha.leak1@nhs.net
Ward Councillors	Councillors P Ainsley and L Toseland	

DECISION RECOMMENDATIONS
That the Committee: 1. Notes the planned £1.2m essential works by Leicestershire Partnership Trust at Rutland Memorial Hospital

1. RUTLAND MEMORIAL HOSPITAL

1.1 Leicestershire Partnership Trust (LPT) is to carry out essential maintenance work at Rutland Memorial Hospital (RMH) in Oakham which are necessary to provide the best environments for patients and staff. The £1.2m capital programme will include significant roof repairs, new electrics, and remodelling to replace disused bathrooms with useful storage space.

2. BACKGROUND

2.1 The Rutland Memorial Hospital is an integral part of the local healthcare provision and the local population have a good community connection to the site and its facilities. The nearest urban centres to Rutland are Leicester, Peterborough and Kettering all over twenty miles distance to travel. RMH is a ten minute walk from the centre of Oakham which is the largest town within Rutland and is the most densely populated in the County.

2.2 Across Rutland it is anticipated that there will be around 2,000 additional residents in the next 5 years. Council is subject to speculative housing development applications whilst it develops its new local plan over the next 2-3 years.

2.3 The RMH site on Cold Overton Road is landlocked but occupies a substantial area of land. The hospital site backs onto the Rutland Care Village. There are residential dwellings to the east of the site with Oakham Medical Practice to the west. The hospital has ample car parking spaces including an area of hardstanding that can be used by mobile imaging units. The site is owned by LPT.

2.4 The eighteen beds are on a single adult's ward provided by LPT. There is a Palliative Care Suite contained within the inpatient accommodation. There is a further ward within RMH that provides outpatient consulting and therapy assessment and treatment areas.

2.5 The inpatient beds are sub-acute step-up, step-down, rehabilitation, and pre-discharge placement (Discharge to Assess) facilities. There are facilities for planned day cases and clean room procedures.

3. POTENTIAL DEVELOPMENT

3.1 The Leicestershire, Leicester and Rutland (LLR) Integrated Care Board (ICB) has commissioned a feasibility study to help determine what services should be delivered for patients from RMH in the future which is separate from the essential works being carried out.

4. PLANNED WORKS

4.1 Surveys of RMH have determined that several areas of works are required including replacing the boilers, remove small amounts of remaining asbestos, and some office space to be turned into space for outpatient treatment. The patient areas will be redecorated towards the end of the project. The electrical replacement programme across site over which will be a continual rolling plan. The total capital expenditure for the essential works is £1.2m.

4.2 Taking advantage of the temporary vacant areas LPT have been assessing several additional areas of work for the ward, such as replacement flooring, updating the kitchen, suspended ceilings, WI-FI points relocation, worktops and storage. An assessment is underway to understand what can be delivered in the overall programme timeframe.

5. CONSULTATION

5.1 A stakeholder consultation and engagement process has been developed with the LPT communications team as part of the Duty to Involve. Rutland Healthwatch has been contacted to ensure the patients voice is included in the programme.

6. ALTERNATIVE OPTIONS

6.1 As the programme of works is essential to provide safe and secure environments for patients and staff no alternative options have been considered.

7. FINANCIAL IMPLICATIONS

7.1 As a planned programme of works the investment of £1.2m is funded from LPT capital resources in 2022/23 financial year. There are no known financial implications for partner organisations.

8. LEGAL AND GOVERNANCE CONSIDERATIONS

8.1 There are no legal or governance considerations for the essential works at RMH.

9. DATA PROTECTION IMPLICATIONS

9.1 A Data Protection Impact Assessments (DPIA) has not been completed for the following reasons because there are risks/issues to the rights and freedoms of natural persons.

10. EQUALITY IMPACT ASSESSMENT

10.1 An Equality Impact Assessment (EqIA) has not been completed for the following reasons: Essential maintenance work required to ensure safety of staff and patients.

11. COMMUNITY SAFETY IMPLICATIONS

11.1 Without the essential works taking place staff, patients and the wider public will be at increasing risk from a deteriorating structure and decorative environment.

12. HEALTH AND WELLBEING IMPLICATIONS

12.1 There no wider implications for the health and wellbeing of the population apart from the improved environment providing a more positive experience for staff and patients using Rutland Memorial Hospital.

13. ORGANISATIONAL IMPLICATIONS

13.1 Due to the nature of the work, the inpatient hospital ward has been relocated, temporarily, to Loughborough Hospital (Charnwood ward) between 22nd August 2022 and January 2023.

13.2 The move occurred with the least disruption possible to the existing patients on Rutland ward. Discharge plans were confirmed for patients on the ward. Communication was held with patients and their relatives to identify the most appropriate community hospital to meet their needs and transport arrangements were made by the ward to ensure safe transfer.

13.3 Patients were allocated to the next available bed closest to their postcode. For patients who are residents in Rutland and the surrounding area this could mean allocation to Melton Mowbray or Market Harborough, if available.

13.4 Reopening **-** We anticipate the work to be completed by early January 2023. Regular communication and engagement will be taking place throughout the works. If there are any changes to the schedule these will be communicated to staff and stakeholders as we become aware.

13.5 Staff have been relocated to Loughborough hospital to provide a replacement service while the works are being completed

14. CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

14.1 To provide the best environments for patients and staff the £1.2m capital investment by Leicestershire Partnership Trust will carry out essential maintenance work at Rutland Memorial Hospital. The work will include significant roof repairs, new electrics, and remodelling to replace disused bathrooms with useful storage space.

14.2 Due to the nature of the work, the inpatient hospital ward has been temporarily relocated to Loughborough Hospital (Charnwood ward) until January 2023. Should there be an unforeseen change to the schedule these will be communicated to staff and stakeholders as soon as possible.

14.3 The Health and Wellbeing Board is asked to note the temporary changes to service delivery due to the essential works.

15. BACKGROUND PAPERS

15.1 There are no additional background papers to this report.

16. APPENDICES

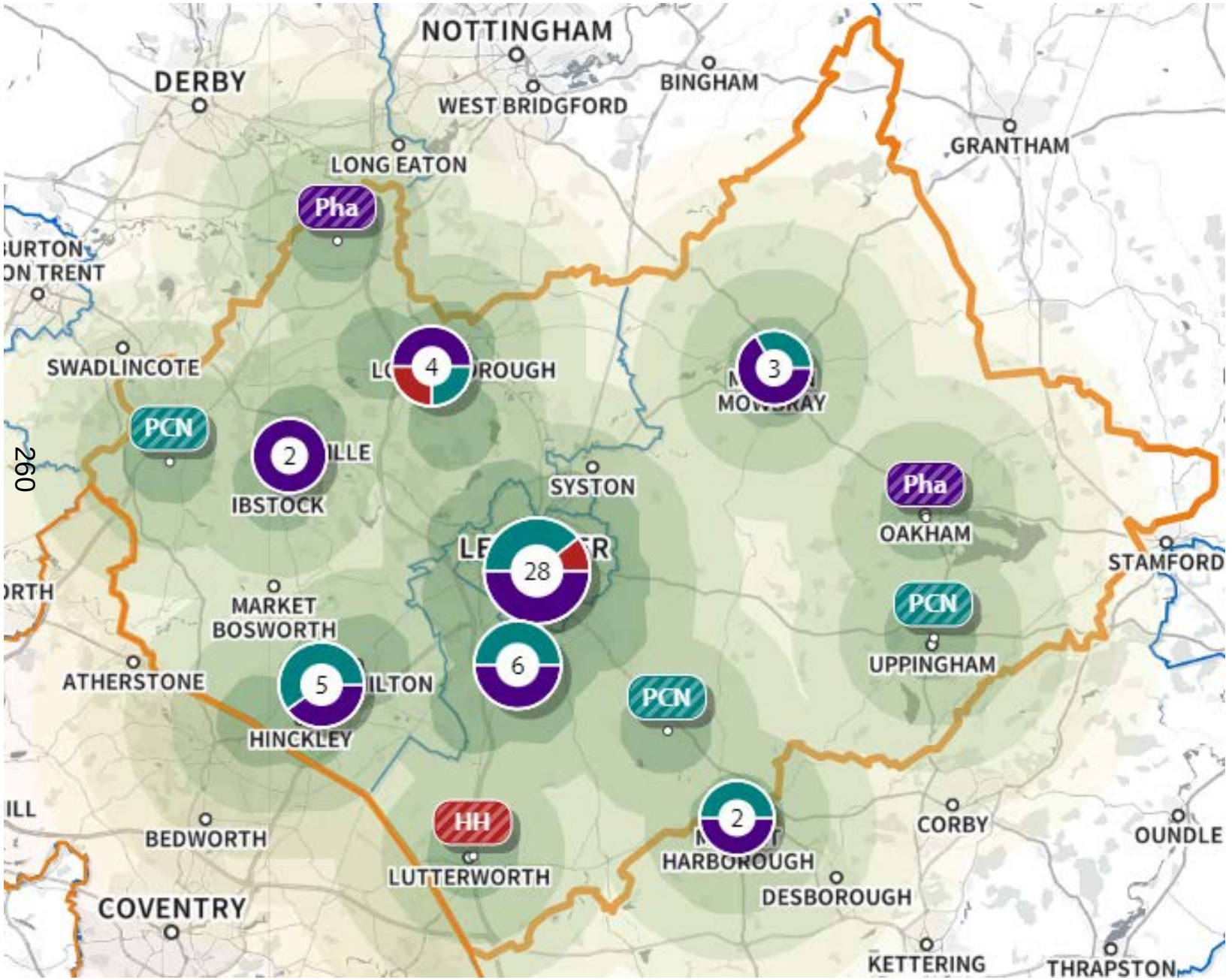
16.1 There are no appendices to this report.

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

Covid Vaccination Programme

Rutland

County Coverage – 10 mile radius from site



- There are 2 providers delivering vaccinations in Rutland:
- Rutland PCN – providing vaccination primarily, to their registered population via the PCN practices
- Rutland Late Night Pharmacy – available to any eligible member of the public via NBS
- Based on Radius of 2 miles walk for urban areas and 10 miles driving radius for rural areas from each site, the whole of LLR is covered with the exception of the tip of Melton and Rutland which are covered by other systems.

Rutland PCN Practices cover about 44,000 patients

	Patient Numbers
Have a GP in Rutland and live in Rutland	Between 35,450 to 35,550
Have a GP in Rutland and	
Live in another LA in LLR	Between 3,500 to 3,520
Live in a LA outside LLR	Between 1,270 to 1,290
Live in Rutland	
With a GP in another LA in LLR	Between 215 to 225
With a GP outside LLR	Between 4,130 to 4,150

In Rutland Vaccination sites – COVID and Flu

- All the 3 GP Partnerships (4 GP Practices) have opted into the service for delivery of COVID vaccinations
- Surgeries will be delivering these vaccinations in the usual way:
  - Clinics during the working day
  - Evening Clinics
  - Saturday Clinics
- Practices will receive weekly deliveries of COVID vaccines, just like the original vaccination programme
- This vaccination can be combined (same visit, different injections) with the Influenza (Flu) vaccination

In Rutland Vaccination sites – COVID and Flu

- The most vulnerable (Housebound and Care Home) patients have already had their vaccine boosters.
- Clinics are starting now for lower risk patients
- Links to book into a clinic will be gradually set out from the surgeries
- There is no need to stay in the building after your vaccination for 15 minutes – unless you have a history of anaphylaxis to other medications

Cross Border Vaccination sites

Non GP Practices

On the border of Rutland there are 3 sites available in Stamford that can be booked via the National Booking System:

- Well Pharmacy - Stamford
- Stamford Day Centre
- Superdrug Stamford

GP Practices in Stamford and Corby

- Sheepmarket Surgery has opted into to the programme and will invite their registered patients
- There is 1 Hyper Local Vehicle available to provide additional vaccination to areas where uptake is either low or there are gaps in geographical access
- Practices in Corby have also opted into vaccinate their patients

Patients living in Rutland registered with OOA GP Practice

Options for vaccination

- Book an appointment with your registered GP Practice
- Book an appointment via the national vaccination website

Problems for OOA patients being vaccinated by Rutland Practices

- Practices would need to temporarily register you at the surgery
- Having vaccination at your surgery helps maintain accurate vaccination histories (especially for Flu jabs)

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Rutland Health and Wellbeing Board
Work Plan 2022-23

STANDING AGENDA ITEMS	AUTHOR
JSNA: Update & Timeline	Mike Sandys, Public Health
LLR Integrated Care System: update	Sarah Prema, Chief Strategy Officer, LLR ICB
Joint Health and Wellbeing Strategy	Katherine Willison, Health and Integration Lead, RCC.
Better Care Fund	Katherine Willison, Health and Integration Lead, RCC.
Update from the Sub-Groups: a) CYPP b) IDG	 Cllr Wilby Debra Mitchell

MEETING DATE	PROPOSED ITEM	AUTHOR	PURPOSE
12/07/22	Election of Vice-Chair	Chair	Decision
	JSNA Scope and Plan (statutory)	Hannah Blackledge & Viv Robbins, Public Health	Decision
	Pharmaceutical Needs Assessment Report - consultation (statutory)	Andy Brown Public Health	Discussion
	Rutland Memorial Hospital a) Health Plan Update b) The Levelling Up Fund	 Sarah Prema, LLR CCG Penny Sharp, RCC Places	Discussion
	Reducing Health Inequalities - Core20Plus5	Sarah Prema, Executive Director for Strategy & Planning, LLR CCGs	Discussion

11/10/22	JSNA: a) Health Inequalities in Rutland b) End of Life Needs Assessment	Mike Sandys, Public Health	Discussion
	~~Local Plan Issues and Options: consultation feedback~~	~~RCC Places~~	~~Discussion~~
	Health Plan Update: • Primary Care Access inc. Primary Care Access T&F Group report,	 Dr James Burden	Discussion

	• Diagnostics, Outpatients and Elective Care Services • RMH Upgrades: Update from LPT	Helen Mather Mark Powell, LPT	
	Winter Vaccination Programme: Update	Dr James Burden	Discussion
	Cost of Living Crisis: Community and Company Involvement	Emma Jane Perkins / Duncan Furey	Discussion
	For Information Only Pharmaceutical Needs Assessment Report (statutory)	Andy Brown Public Health	For Noting
	For Information Only JSNA Demographics - Census 2021 Initial Results	Andy Brown	For Noting

24/01/23	JSNA Overview (statutory)	Hannah Blackledge & Viv Robbins, Public Health	Discussion
	Primary Care Task and Finish Survey	TBC	Decision
	Review of Sub-Group Feedback	Cllr Wilby / Deborah Mitchell (CCG)	Discussion
	Oral Health Needs Assessment	Andy Brown	
	For Information Only Director of Public Health Annual Report (statutory)	Mike Sandys, Director of Public Health	For Noting

21/03/23	Primary Care Task and Finish Survey: Results	TBC	Discussion

PROSPECTIVE AGENDA ITEMS

Proposed Item
Health Services Development
Armed forces health needs assessment
Understanding health patterns for children and young people where the data has highlighted challenges
Public Transport

Report No: 155/2022
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

11 October 2022

PHARMACEUTICAL NEEDS ASSESSMENT 2022

Report of the Director of Public Health

Strategic Aim:	Healthy and well	
Exempt Information	No	
Cabinet Member(s) Responsible:	Cllr S Harvey, Portfolio Holder for Health, Wellbeing and Adult Care	
Contact Officer(s):	Andy Brown - Business Intelligence Team Leader	Telephone 0116 305 6096 email andy.brown@leics.gov.uk
	Mike Sandys, Director of Public Health	Telephone – 0116 3054239 email – mike@sandys@leics.gov.uk
Ward Councillors		

DECISION RECOMMENDATIONS
That the Committee: 1. Notes the work undertaken to produce the draft Pharmaceutical Needs Assessment (PNA) 2022, which has been developed in line with the findings of the public and pharmacy surveys; 2. Notes the outcome of the statutory consultation and approves the final PNA to be submitted and published.

1 PURPOSE OF THE REPORT

1.1 The purpose of this report is to inform the Board of the outcome of the statutory consultation on the draft Pharmaceutical Needs Assessment (PNA) 2022 and to seek approval to the final Rutland PNA for submission and publication.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The purpose of the PNA is to:

- identify the pharmaceutical services currently available and assess the need for pharmaceutical services in the future;
- inform the planning and commissioning of pharmacy services by identifying which services should be commissioned for local people, within available resources, and where these services should be;
- inform decision making in response to applications made to NHS England by pharmacists and dispensing doctors to provide a new pharmacy. The organisation that will make these decisions is NHS England.

2.2 The last PNA for Rutland was produced in 2018 and can be accessed at: **https://www.lsr-online.org/pharmaceutical-needs-assessment1.html**

2.3 The PNA is a statutory document that is used by NHS England to agree changes to the commissioning of local pharmaceutical services. As such, if NHS England receives a legal challenge to the services that they commission based on the PNA, the local authority could also be part of that legal challenge. It is essential that the process that is followed meets the legislation that is set out and that the PNA is a robust document.

2.4 In October 2021, the Department of Health and Social Care published a pharmaceutical needs assessment information pack for local authority health and wellbeing boards to support in the developing and updating of PNAs. The PNA guidance can be accessed via the following link: **https://www.gov.uk/government/publications/pharmaceutical-needs-assessments-information-pack**

2.5 A PNA Reference Group has been established to oversee the detailed production of the PNA documents for Rutland as well as Leicester and Leicestershire to ensure a consistent local approach. Membership of this group includes - local authorities, NHS England, the Local Pharmaceutical Committee, Local Professional Network for Pharmacists and the Leicester, Leicestershire and Rutland Local Medical Committee, Clinical Commissioning Groups and Healthwatch. Although there is a common approach, there will be separate PNAs for Rutland, Leicester and Leicestershire.

2.6 The principal resourcing for the development of the Rutland PNA is provided by the Public Health Department and Business Intelligence Team, with information and advice provided through the PNA Project Team by NHS England, the Leicestershire Pharmaceutical Committee, CCGs and others.

2.7 At its meeting in July the Board considered the draft PNA for 2022 which had been produced based on a range of data analysis, alongside the input of the Stakeholder Reference Group and considered the results of consultation exercises with pharmacists and the general public which had also informed the draft.

2.8 The Board approved the draft PNA for statutory consultation with a range of partners, in accordance with the guidance.

2.9 The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (amended) sets out the minimum information that must be contained within a

PNA and outlines the process that must be followed in its development and can be found at: **https://www.legislation.gov.uk/uksi/2013/349/contents**

3 CONTENT

3.1 The regulations and guidance documents provide information on the PNA content. This has been reflected in the proposed final PNA appended as Appendix A. A similar, though more streamlined, approach has been taken to that in the 2018 PNA, but with more detailed information included in the supporting appendices.

3.2 The PNA Reference Group considered pre-consultation drafts of the Leicestershire and Rutland PNAs at its meeting on 26 April 2022. The document followed a similar format to the 2022 version which met statutory requirements. The views of the Reference Group and Board were incorporated into the draft Rutland PNA document which formed a basis for the Statutory Consultation.

3.3 The draft included analysis and presentation of available data and also the headline results from a survey of both local pharmacies and the general public. The Appendices to the PNA form a lengthy addition to the report and hence have been included for reference in the link attached -- **https://www.lsr-online.org/uploads/32_62a1b0feeea1c475270077.pdf**

4 CONSULTATION

4.1 The draft PNA was subject to a 60-day statutory consultation period which commenced in June 2022. The Pharmaceutical Services Regulations specify that the Health and Wellbeing Board must consult with the following (and drafts have been issued to these bodies to commence the consultation process): -

- the Local Pharmaceutical Committee (LPC)
- the Local Medical Committee
- any persons on the pharmaceutical lists and any dispensing doctors list for its area
- any LPS chemist in its area with whom NHS England has made arrangements for the provision of any local pharmaceutical services
- Healthwatch, and any other patient, consumer or community group in its area which in the view of the Health and Wellbeing Board has an interest in the provision of pharmaceutical services in its area;
- any NHS trust or NHS foundation trust in its area
- NHS England
- any neighbouring HWB.

4.2 The PNA consultation period ran from early June until 21 August 2022. All statutory consultees were notified and asked to submit views as part of the consultation during this period. A questionnaire was also developed to gain feedback on the draft PNA 2022 for Rutland.

4.3 A number of responses were made on the draft PNA questionnaire. Official responses were also made in writing by the Local Pharmaceutical Committee and NHS England. The results of public and pharmacy consultation exercises were discussed at the PNA Reference Group and have been incorporated into the final PNA.

4.4 In relation to the pharmacy responses, 84% use **locum** pharmacists and 63% use **relief** pharmacists, with recruitment difficulties experienced particularly in community pharmacist, dispenser and medicines counter assistant roles. Though 69% felt able to maintain the current level of services with 18% disagreeing. 55% of respondents intended to provide the appliance use review service, with 88% for the hypertension case finding service. Most would be willing to provide NHS and local authority commissioned services with training and/or facilities.

4.5 Over half of respondents do not provide **non-NHS funded** services but most are willing to with training and/or facilities. 58% plan to expand the business with 26% planning to expand online services. Over 80% of respondents indicated that the **number of pharmacies** and the **location** within a 3-mile radius are 'excellent' or 'good' and just under 15% indicated that they were adequate. Ratings for the **range of services** provided within a 3-mile radius are slightly lower, with 71% rating 'excellent' or 'good' and 19% 'adequate'.

4.6 In relation to public responses 80% agree that opening hours meet their needs with 8% disagreeing. 95% found it easy to find a pharmacy open in the day, whilst 49% found it easy in the evening. 57% found it easy at weekends. The majority (76%) are satisfied with **advice from pharmacies.**

4.7 **Quality of service, availability** of medicines and **location** were the most important issues for respondents. Vaccinations were also mentioned as important.

4.8 The majority (95%) agree that the pharmacy provides a **good service** and provides **clear advice.** Some responses highlight some concerns about speaking to a pharmacist **without being overheard. Access to medicines on time and busy pharmacists** were also raised as issues. The majority indicated that they were not likely to use **postal (70%) or online (home delivery) services (52%)** within the next 3 years.

4.9 The statutory consultation has seen full responses from the Integrated Care System set out in Section 14 of the PNA supporting the conclusions and recommendations in the draft PNA and highlighting the important and increased role played by pharmacies in the overall system. The response also highlights systems pressures as well as how a number of improvement issues are being taken forward. A section has also been added to the PNA on the improvement work being taken forward through the Integrated Pharmacy and Medicines Optimisation (IPMO) Plan.

4.10 The Local Pharmaceutical Committee have provided a range of helpful detailed comments. Main points include that assessing pharmacy numbers/growth using 2.1 per 10,000 population as any sort of target would not be helpful and could create anomalies. Given the overall funding situation then pharmacies, to survive, will likely need to be busier and accommodate more population. With technological advances, changes in patient access and hub and spoke type models will increasingly develop. With regard to palliative care medicine supply it was felt that this warranted some improvement and attention and that commissioners should extend the opportunity for more pharmacies to engage in providing this service.

4.11 They also point out that the pandemic has changed the way that community pharmacy is perceived and relied upon. The only healthcare profession that

remained open during the height of the pandemic, enabling patients to access clinical expertise without an appointment. The LPC highlight the immense **pressures today with community pharmacy workforce** shortages due to leakage from the sector into GP practices and PCN roles. A national issue, not just a LLR issue. Furthermore, there are other pressures with uncertainty over future funding arrangements.

4.12 PNA Survey Responses - the PNA survey also supplied a small number of extra public responses as well as one from the acute trust and a pharmacy company. 75% felt the draft PNA accurately reflected current pharmacy provision and that the needs of the population had been adequately reflected. No specific gaps were identified and no disagreement with the recommendations. Comments included that 'we support the recommendations.' As a local acute Trust, we would particularly support increase in DMS activity and expansion of the Community Pharmacy Consultation Services and expansion of the clinical role of Community Pharmacy as important means of avoiding readmission and ensuring good uptake of out of hospital services. The PNA needs to emphasise the need for full access (including data input) to summary care records in order to further develop the clinical services within community pharmacy

5 CHANGES AND ADDITIONS MADE TO THE DRAFT PNA

5.1 The Reference Group have considered the results from the Statutory Consultation and consultation with the public and pharmacists and a number of extra points and amendments have been incorporated into the final PNA. These include: -

- Updated resident data from the recently released census, though this doesn't vary significantly from the population forecast data previously included.
- Statutory survey, submission responses and updated public/pharmacy consultation results
- Information from other area PNAs, where available
- Details on the IPMO Plan
- Caveats on the tables around interpreting the 2.1 per 10,000 population average figure.
- Comments on the positive perceptions and work of pharmacies, especially when being open and providing extra services during the Covid lockdowns.

6 CONCLUSIONS FROM THE PNA

6.1 Rutland benefits from two different types of provider for essential services, community-based pharmacies and dispensing GPs. Combining community pharmacies and dispensing GPs, residents of Rutland have a similar level of access (providers per 10,000 population) when compared to the England average – 2.19 per 10,000 compared with 2.2 nationally.

6.2 45% of residents live within a 15-minute walk-time of a pharmacy or dispensing GP surgery. Access to essential services by car is also reasonable, for such a rural area. Less than 20% of the population live more than a 10-minute drive away from

their nearest pharmacy or dispensing GP practice location. However, 49% of those living in the most deprived areas are more than a 15-minute drive, walk or public transport journey from a pharmacy or dispensing GP practice. The importance of community, voluntary and demand responsive transport for certain groups and individuals to access services is noted.

6.3 **Subject to the points above regarding the importance of continued community, voluntary and public transport provision, no gaps have been identified in the provision of essential services during normal working hours or outside of normal working areas across the whole Health and Wellbeing Board area.**

6.4 **Error! Reference source not found.** shows the number of community pharmacies offering each service. Of the five pharmacies in Rutland, all provide the seasonal influenza vaccination service. Four out of the five are offered the New Medicines Service and the Community Pharmacist consultation service. No pharmacies offered Stoma Customisation, Appliance Use Reviews or Hepatitis C testing service. Pharmacies that do not provide this service are able to signpost patients to the appliance contractors who do. Hepatitis C testing service is nationally not widely available.

6.5 **No gaps have been identified in the provision of advanced services across the whole Health and Wellbeing Board area. No gaps have been identified in the provision of advanced services at present or in the future that would secure improvements or better access to advanced services across the whole Health and Wellbeing Board area**.

6.6 Across Rutland a good range of Community Based Services are therefore offered by pharmacies. The CBS schemes provide the CCGs and Local Authorities with an opportunity to increase the role of pharmacies in delivering the primary care and the public health agendas. Pharmacies are highly valued by the people that use them, and pharmacies have considerable day-to-day accessibility to clients making them an ideal setting for supporting patients and clients to either make informed lifestyle choices or to manage their own health conditions effectively.

6.7 **Based on current information, no gaps have been identified in the provision of enhanced Community Based Services across the whole Health and Wellbeing Board area. No gaps have been identified that if provided either now or in the future would secure improvements or better access to enhanced services across the whole Health and Wellbeing Board area.**

6.8 Pharmacies have successfully extended their offer over recent years and surveys indicate a general willingness to offer more services, if funded and supported to do so. However, feedback has also pointed to pressures and the busyness of some pharmacy staff and some recruitment difficulties, which could provide a potential risk to further expansion of services. Timely access to some medicine supplies was also raised through survey responses.

6.9 Community pharmacy staff are the easiest healthcare workers for members of the public to access, and they are highly valued by their customers. Pharmacy teams provided one of the few easily accessible healthcare services to the population during the Covid-19 pandemic and were widely recognised for their role in supporting residents and communities, including with tests, vaccinations and home

deliveries.

6.10 Pharmacies have an essential role in promoting healthy lifestyles and supporting health and social care in the future, particularly with issues such as patient self-care in the community, which can cut down the number of unnecessary admissions to hospital. The landscape of health care in LLR is changing through local and national policy development and the impact on pharmacies should continue to be monitored.

7 RECOMMENDATIONS

7.1 **NHS England and NHS Improvement (and where relevant Rutland County Council and the ICS) should**:

- Keep locations, opening times, service usage and transport under review to ensure access to pharmacies for essential services is equitable for all Rutland residents.

- Pharmacy service provision should be kept under review, in particular where provision has cross-county border use, to ensure that issues of quality and uniformity of access to advanced and community-based services are regularly considered.

- The availability of public, community and voluntary transport provision to pharmacy and GP dispensing locations should also be kept under review.

- Keep under review recruitment difficulties for some pharmacies and timely access to some medicines and promote more use of the private consultation rooms.

7.2 **Promote optimal use of pharmacy services in promoting health and healthcare management**

7.3 **NHS England and NHS Improvement (and where relevant Rutland County Council and the ICS) should:**

- Ensure the promotion of the healthy lifestyles (Public Health) element of essential services. While NHS England and NHS Improvement retains responsibility for this area of the pharmacy contract, local campaigns should be jointly defined by NHS England and NHS Improvement, Local Authority Public Health and the Clinical Commissioning Group/ICS.

- Consider the opportunity to include and develop the role of pharmacies in commissioning strategies, particularly in relation to providing services which deflect work out of primary care general practice.

- Continue to assess levels of uptake of advanced and Community Based Services and follow-up low or high performers in order to share best practice.

8 ALTERNATIVE OPTIONS

8.1 The PNA is a statutory document with guidance setting out what is expected to be included and in terms of timescales and the process to be followed. Though there is some discretion in terms of how the final document is presented including the

main document and appendices.

9 FINANCIAL IMPLICATIONS

9.1 Pharmacy Services are core funded through NHS England budgets, but also commissioned for extra services from a range of sources. Any changes in services and provision will impact on those particular budgets. The PNA has been developed within existing business intelligence and public health budgets, including the consultation arrangements.

10 LEGAL AND GOVERNANCE CONSIDERATIONS

10.1 The HWB has a statutory responsibility to prepare a PNA for Rutland and publish it by 1 October 2022. At a previous meeting the Health and Wellbeing Board noted the timescales and process for the production of the PNA, along with areas of focus, likely structure, governance and consultation arrangements to inform the draft.

10.2 The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 (amended) sets out the minimum information that must be contained within a PNA and outlines the process that must be followed in its development and can be found at: **https://www.legislation.gov.uk/uksi/2013/349/contents**

10.3 The project plan was tight with respect to delivering an approved PNA by 1 October 2022.

11 DATA PROTECTION IMPLICATIONS

11.1 The surveys undertaken and data handled, which is aggregated and anonymised, has been done so in full compliance with data protection law and protocols.

12 EQUALITY IMPACT ASSESSMENT

12.1 An Equality Impact Assessment (EqIA) has been completed. The PNA has looked to assess a number of equalities issues in terms of access to pharmacy services for different groups and language issues - these are set out in detail in the PNA. The consultation process is being targeted to a number of Equalities Groups.

13 COMMUNITY SAFETY IMPLICATIONS

13.1 None….

14 HEALTH AND WELLBEING IMPLICATIONS

14.1 Pharmacy Services and access to them provide a cornerstone of services to support residents' health and wellbeing. The PNA looks at current services, resident health, health priorities and how services can be developed in the future.

15 ORGANISATIONAL IMPLICATIONS

15.1 Environmental implications – no major environmental implications

15.2 Human Resource implications - The PNA highlights some pressure on existing pharmacy staff and the need for continued supply of the relevant trained workforce to maintain and develop existing provision

15.3 Procurement Implications - The PNA informs commissioning and procurement of future pharmacy services.

16 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

16.1 The Rutland Health and Wellbeing Board needs to produce and agree a PNA in accordance with the necessary statutory guidance by 1 October 2022. The guidance sets out the process for production of a PNA including a 60-day period of statutory consultation on the draft. The Board is asked to approve the final PNA document

17 BACKGROUND PAPERS

17.1 Pharmaceutical Needs Assessment 2022 - Guidance and Information Pack

18 APPENDICES (MANDATORY, SIMPLY STATE IF THERE ARE NO APPENDICES)

18.1 Appendix A – Rutland PNA 2022

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

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Rutland County Council

RUTLAND PHARMACEUTICAL NEEDS ASSESSMENT

Public Health Intelligence

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Produced by the Public Health Intelligence Service at Leicestershire County Council on behalf of Rutland County Council.

FOREWORD AND EXECUTIVE SUMMARY

Introduction

A Pharmaceutical Needs Assessment (PNA) is a wide-ranging assessment of the current and future needs of the local population for pharmaceutical services, such as community pharmacies, dispensing appliance contractors and, in rural areas, dispensing doctors. The PNA is used by appropriate bodies (such as NHS England and NHS Improvement) to inform decisions on provision of pharmaceutical services; plan for the need for new services; decide on relocation of existing premises in response to applications by providers; and commission locally enhanced services from pharmacies.

It is a statutory document produced every three years under the NHS Pharmaceutical and Local Pharmaceutical Services Regulations 2013. The scope of the PNA includes nationally agreed services, classified either as essential, advanced, or enhanced, and provided by the local pharmacy contractors. It also includes the services commissioned locally, whether by the Local Authority (LA) or the previous Clinical Commissioning Groups (CCGs – now the integrated care systems, or ICSs). Prison or hospital pharmacies are not included in this assessment.

Population and Health Needs

Key demographic and health information include that in 2020 the population of Rutland was estimated at nearly 40,800 people. On average, the local population is relatively older than the national average, with over a quarter (25.5%) over the age of 65 (7% higher than England). Based on the 2011 Census, Rutland has a higher-than-average proportion of white population with over 97% (36,300 people) compared to just over 85% across England. Of the 3% (1,068 people) in ethnic minority groups 1% declared their ethnicity as Asian or Asian British, 1% as of mixed ethnic background and 1% as either black or other ethnic groups. The population of Rutland is growing and by 2043 the total population is predicted to reach 46,522 people, a total **population growth** of 17.2%. The disproportionate predicted growth in the older population is most likely to impact the prevalence of long-term conditions, significantly increasing health and care needs in these groups.

Measured by the 2019 **Index of Deprivation**, the population of Rutland is less affected by material deprivation than the average for England, with none of the population in the most deprived 40% of areas nationally. Over a half (53% or 21,000 people) of the Rutland population live in the least deprived quintile of deprivation. However, such statistical indices do not always capture all aspects of socio-economic disadvantage and especially there can be pockets of rural deprivation in some areas of Rutland.

Both overall **life expectancy** and **healthy life expectancy** are better than the national average in Rutland. Thus, men in Rutland can expect to live by almost 4 years longer (to 83 years) than the England average, women by about 2 years (to 85 years). These estimates have been consistently higher than England figures since 2010. Many of the healthy lifestyle indicators, including smoking rates, alcohol admissions or childhood obesity rates, show a relative advantage in Rutland. The same can be said for a variety of health outcome indicators based on mortality and hospital admissions, such as early cardiovascular mortality or rates of violent crime.

However, where Rutland is in a relative disadvantage, is for indicators of **health among the elderly**, for example rates of hip fractures in over 65s, rates of dementia or in excess winter

deaths. Similarly, chronic conditions prevalent in older age groups seem to be overrepresented in Rutland, including hypertension, coronary heart disease, cancer, and asthma which are all significantly higher than England average.

Essential Services

Essential services include dispensing drugs, repeat dispensing, clinical governance (ensuring professional standards), promoting healthy lifestyles, getting rid of unwanted medicines, signposting people to other services and supporting people in caring for themselves.

Rutland has **six pharmacies** and **three dispensing GP locations**. There is one 100-hour pharmacy. The pharmacies are all in the towns of Oakham and Uppingham while the dispensing GPs are in more rural areas. Overall, Rutland has 1.2 community pharmacies per 10,000 population. Rutland is a rural area, so it would be unrealistic to expect the same population coverage of pharmacies as England (2.1 per 10,000). When the number of dispensing GP locations is added to the number of pharmacies, Rutland has a rate of 2.0 contractors per 10,000 population. This is much closer to the 2.2/10,000 corresponding average for England.

Furthermore, Rutland residents in the east of the county are likely to travel across the border to access health services, for example in the town of Stamford. This infers that more services are potentially available to residents than the figures above would suggest. In addition, residents can access distance selling, or internet, pharmacies. None of the Rutland pharmacies are distance selling pharmacies.

Opening Times - pharmacies across Rutland are open at varying times, providing a service somewhere in the county at almost all times: between 7am and 10pm Monday to Thursday and between 7am and 11pm Friday to Saturday, and supported by the 100-hour pharmacy in Oakham. The 100-hour pharmacy is open on Sundays.

Drive and Walk Time - less than 20% of Rutland's population live more than a 10-minute drive away from their nearest pharmacy or dispensing GP practice location. However, 49% of those living in the most deprived areas are more than a 15-minute drive, walk or public transport journey from a pharmacy or dispensing GP practice.

Public Transport - residents have, for public transport, 4 services that operate hourly, 3 services that operate 2-hourly, and a few less frequent rural services. There is a Demand Responsive Transport (DRT) service that runs only in response to pre-booked requests, known as CallConnect, and covering the eastern half of the county as well as crossing the county border to Stamford in Lincolnshire. Community transport services also exist, including Voluntary Action Rutland (VAR), based in Oakham, with a similar voluntary car scheme recently established in Uppingham. Furthermore, several parishes within Rutland also offer informal 'good neighbour' schemes, which include arranging lifts for people. Access to sufficient transport is important to maintain access to pharmacy services in Rutland.

Language - across all areas of Rutland the percentage of the population who cannot speak English well or cannot speak English at all is significantly lower than the national average. The second most spoken languages in Rutland in the 2011 Census were Polish, Oceanic, Chinese and French.

GP Dispensing - these services are provided to patients who live in a designated controlled locality and more than 1 mile (1.6 km) from a nearest pharmacy. Rutland has three dispensing GPs who dispense from five separate locations (main and branch surgeries).

Cross Border Access - cross border access to pharmaceutical services is important, particularly in the east of the County. Its impact can only be assessed fully after publication of corresponding 2022 PNAs from the neighbouring areas, including Lincolnshire, North Northamptonshire and Leicestershire. Versions of both Leicestershire and Lincolnshire 2022 PNAs have concluded that no gaps were identified in the provision of essential, advanced or enhanced services in those areas.

Other Services

Advanced Services - advanced services are services provided by some pharmacies in addition to essential services. They are commissioned by NHS England and Improvement as voluntary agreements. Any pharmacy can choose to deliver these services if they meet the requirements around issues such as being able to provide appropriate premises and staff training. There is good coverage and provision of advanced services by the pharmacies in Rutland including New Medicines service (NMS), seasonal influenza vaccination programme, and the Community Pharmacist Consultation service (CPCS). However, there are no local pharmacies providing stoma customisation or appliance use reviews.

Community Based Services (CBS) - are services commissioned locally, usually by a local authority or a CCG/ICS and tailored to meet the needs of the population. They are based on voluntary agreements and pharmacies are not compelled to offer any or all of the services. CBS ccurrently commissioned by the Rutland County Council include Emergency Hormonal Contraception (EHC), needle and syringe exchange for people with drug addictions, and supervised administration of methadone and other substitutes – the last two services via Turning Point.

LLR Clinical Commissioning Groups also commission the following services extended care services Tier 1- Conjunctivitis and UTI treatment; Extended care services Tier 2a - impetigo, eczema and insect bite treatment; Emergency supply service. There is no palliative medicine supply from current pharmacies. In addition, the Leicestershire Partnership Trust commissions under-18 flu and covid vaccinations.

Consultation Findings

Professional Survey Results

The results show that 85% of pharmacies use locum pharmacists and 76% use relief pharmacists, with recruitment difficulties experienced particularly in community pharmacist, dispenser, and medicines counter assistant roles. Most of respondents felt that they are able to maintain the current level of service, with 18% disagreeing.

Most would be willing to provide NHS commissioned services with training and/or facilities. Eight out of 20 non-commissioned services are provided by the majority of respondents, with most of respondents indicating that they would provide other services with support. Most do not provide non-NHS funded services but are willing to with training. 81% of respondents indicate that the number of pharmacies and the location within a 3-mile radius are ‘excellent’ or ‘good’ and 15% adequate. Ratings for the range of services provided within a 3-mile radius are slightly lower, with 64% rating ‘excellent’ or ‘good’ and 24% ‘adequate’. 61% of respondents plan to expand the business and 32% are planning to expand online services.

User Survey Results

Among the respondents, 80% felt that opening hours met their needs with 8% disagreeing, 95% felt it easy to find a pharmacy open in the day and 49% found it easy in the evening; 32% found it difficult. 57% found it easy at weekends whilst 23% found it difficult. The majority (76%) of respondents were 'very' or 'fairly' satisfied with advice from pharmacies with just 3% 'fairly dissatisfied' and 71% 'very' or 'fairly' satisfied with advice from GP dispensaries with 9% 'fairly dissatisfied'. Availability of medicines, quality of service and location were reported as the most important aspects of pharmacy services. Most (95%) of respondents agreed that their pharmacy provides a good service and provides clear advice. Some of the responses highlighted some concerns about speaking to a pharmacist without being overheard. The majority were not likely to use postal (70%) or online services (52%) within the next 3 years.

Statutory Consultation

The statutory consultation has highlighted general support for the contents and findings of the PNA. Responses highlight the importance of pharmacies within the overall health system, the good work carried out by pharmacies during the covid pandemic and also some of the pressures on pharmacies and others including workforce pressures. An Integrated Pharmacy and Medicines Optimisation Plan and supporting workstreams have been flagged as important in taking forward some of these improvement issues. The PNA survey also supplied a small number of extra public responses as well as one from the acute trust and a pharmacy company. 75% of respondents felt the draft PNA accurately reflected current pharmacy provision and that the needs of the population had been adequately reflected. No specific gaps were identified and no disagreement with the recommendations was expressed.

Conclusions and Recommendations

With six pharmacies and three dispensing GP surgeries, the availability of dispensing providers is sufficient to meet the needs of the local population, with rural access issues supported by the GP dispensing surgeries. The availability of current services is currently adequate to support the growing population. One avenue to explore is the provision of distance selling pharmacies to potentially increase local pharmacy capacity, to ensure that the needs of local people are being met. The PNA should be reviewed in 2025 to ensure that the needs of the population continue to be met. Access to medicine supplies, pressure on pharmacies and use of private areas should also be kept under review.

The provision of Community Based Services across Rutland is considered to be good, but these services should be promoted further, with a focus on consistency of service across the county. The importance of available and accessible public and community transport to ensure effective access to pharmacy services for those without a car is noted and endorsed.

Community pharmacies are the most accessible healthcare professional for members of the public to see, and they are highly valued by their customers. Pharmacies are essential in promoting healthy lifestyles both now and in the future, supporting health and social care, particularly with issues such as helping patients care for themselves (self-care) in the community. This could cut down the number of unnecessary admissions to hospital. The role of pharmacies supporting extended access in General Practice needs to be considered in the future. The landscape of health

care in LLR is changing through local and national policy development and the impact on pharmacies should continue to be monitored.

CONTENTS

List of Tables (some included in separate Appendix pack)

List of Figures

1. Introduction

The Health and Social Care Act 2012 established Health and Wellbeing Boards. From April 2013 Health and Wellbeing Boards became responsible for developing and updating Pharmaceutical Needs Assessments (PNAs). At the same time responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from primary care trusts to NHS England and NHS Improvement.

If a person (a pharmacist, dispenser of appliances or a GP) wants to provide NHS pharmaceutical services, they are required to apply to the NHS to be included on a pharmaceutical list. Pharmaceutical lists are compiled and as at October 2021 are held by NHS England and NHS Improvement. This is commonly known as the NHS "market entry" system.[1]

In order to be included on a relevant pharmaceutical list, the applicant applies by proving they are able to meet a pharmaceutical need as set out in the relevant Pharmaceutical Needs Assessment (PNA). There are exceptions to this, such as applications for needs not foreseen in the PNA or to provide pharmaceutical services on a distance-selling (internet or mail order only) basis.

The last PNA for Rutland was produced in March 2018 by the Rutland Health and Wellbeing Board. The National Health Service (Pharmaceutical and Local Pharmaceutical Services) Regulations 2013 requires all Health and Wellbeing Boards to publish a revised assessment within three years of publication of their first assessment. The timescale for this has been extended by a year due to the coronavirus pandemic. This PNA therefore replaces the 2018 document.

2. Purpose of the PNA

PNAs are key local tools for understanding the provision of pharmaceutical services in a local area and also identifying and assessing which pharmaceutical services need to be provided by local community pharmacies and other providers in the future.

Pharmaceutical Needs Assessments will inform commissioning decisions of pharmacy services by local authorities, NHS England and NHS Improvement, and with their introduction Integrated Care Systems/Boards. PNAs will also identify which services should be commissioned for local people, within available resources, and where these services should be. The PNA has been written against a backdrop of a significant change in the organisational landscape for commissioning.

PNAs are aligned to other relevant local assessments and plans for health and social care such as the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy and they examine the local population demographics and services available in the neighbouring Health and Wellbeing Board areas that may affect local service need.

PNAs identify gaps in service provision and inform decision making in response to applications made to NHS England and NHS Improvement by organisations to provide a new pharmacy. The organisation that will make these decisions is NHS England and NHS Improvement hence the PNA is of particular importance to them.

The Covid-19 pandemic and other recently added services has changed the way community pharmacies are perceived and relied upon. Pharmacies remained open during the height of the pandemic, enabling patients to access clinical expertise without an appointment. The PNA seeks to build upon this enhanced reputation and role.

In summary, the regulations[2] require a series of statements that must be contained in the PNA, see below:

- A statement of pharmaceutical services that the Health and Wellbeing Board has identified as services that are necessary to meet the need for pharmaceutical services
- A statement of pharmaceutical services that have been identified as services that are not provided but which the Health and Wellbeing Board is satisfied need to be provided in order to meet a current or future need for a range of pharmaceutical services or a specific pharmaceutical service
- A statement of pharmaceutical services that the Health and Wellbeing Board has identified as not being necessary to meet the need for pharmaceutical services but have secured improvements or better access
- A statement of the pharmaceutical services that have been identified as services that would secure improvements or better access to a range of pharmaceutical services or a specific pharmaceutical service, either now or in the future; and
- Other NHS services that affect the need for pharmaceutical services or a specific pharmaceutical service.

Other information that will be included or taken into account within the PNA is:

- How the Health and Wellbeing Board has determined the localities in its area
- How it has taken into account the different needs of the different localities, and the different needs of those who share a protected characteristic
- A report on the consultation
- A map that identifies the premises at which pharmaceutical services are provided
- Information on the demography of the area
- Whether there is sufficient choice with regard to obtaining pharmaceutical services
- Any different needs of the different localities; and
- The provision of pharmaceutical services in neighbouring Health and Wellbeing Board areas.

3. Pharmaceutical Services and Pharmacy Contracts

Pharmaceutical services are defined by reference to the regulations and directions governing pharmaceutical services provided by community pharmacies, dispensing GPs and appliance contractors. The Community Pharmacy Contractual Framework with the NHS (CPCF) outlines four tiers of community pharmaceutical services:

Essential Services – all pharmacies, including distance selling pharmacies, are required to provide essential services as part of the NHS Community Pharmacy Contractual Framework (the pharmacy contract).

Advanced Services – are those services that community pharmacy contractors and dispensing appliance contractors can provide as long as they meet the requirements set out in the Secretary of State's Directions.

Enhanced Services – are the third tier of services that pharmacies may provide, and they can only be commissioned by NHS England and NHS Improvement. Community pharmacies may be approached to provide these services or invited to express interest/tender for the opportunity to provide them.

Locally Commissioned Community Based Services - in addition to these nationally determined services, community pharmacies can also be contracted to provide locally commissioned services by local authorities and Clinical Commissioning Groups.

Quality assurance

NHS England and NHS Improvement's local teams monitor the provision of Essential and Advanced Services and the pharmacy contractors' compliance with the terms of the Community Pharmacy Contractual Framework. Each year every pharmacy must complete a short questionnaire which will determine whether a pharmacy needs visiting. The General Pharmaceutical Council also carry out inspections in all registered pharmacy premises to ensure that they comply with all legal requirements and regulatory standards. The inspector will examine how the pharmacy operates with the aim of securing and promoting the safe and effective practice of pharmacy services.[2]

All pharmacies are required to conduct an annual community pharmacy patient questionnaire (Patient Satisfaction Questionnaire) which allows patients to provide feedback to community pharmacies on the services they provide. Due to the current challenges being experienced by pharmacies and the contribution of the pharmacy workforce to the Covid-19 vaccination programme, the Pharmaceutical Services Negotiating Committee (PSNC) reached agreement with NHS England and NHS Improvement and the Department of Health and Social Care that contractors would not be required to complete the Community Pharmacy Patient Questionnaire for 2021/2022.[2]

3.1. Essential Services

As of October 2021, there are eight essential services (listed below) that are offered by all pharmacy contractors as part of the NHS Community Pharmacy Contractual Framework (the 'pharmacy contract').

Table 1: Essential Pharmacy Services

Essential Services	Description
Dispensing Medicines and Appliances	The supply of medicines and appliances ordered on NHS prescriptions, together with information and advice, to enable safe and effective use by patients and carers, and maintenance of appropriate records.

Repeat Dispensing/ Electronic Repeat Dispensing (eRD)	The management and dispensing of repeatable NHS prescriptions for medicines and appliances, in partnership with the patient and the prescriber. The service specification for repeat dispensing covers the requirements additional to those for dispensing, such that the pharmacist ascertains the patient's need for a repeat supply and communicates any clinically significant issues to the prescriber.
Discharge Medicines Service (DMS)	This service was introduced in 2021 and aims to reduce the risk of medication problems when a person is discharged from hospital. Patients are digitally referred to their pharmacy after discharge from hospital. Using the information in the referral, pharmacists are able to compare the patient's medicines at discharge to those they were taking before admission to hospital. A check is also made when the first new prescription for the patient is issued in primary care and a consultation with the patient and/or their carer will help to ensure that they understand which medicines the patient should now be using.
Clinical Governance	Pharmacies have an identifiable clinical governance lead and apply clinical governance principles to the delivery of services. This will include use of standard operating procedures; recording, reporting and learning from adverse incidents; participation in continuing professional development and clinical audit; and assessing patient satisfaction.
Promotion of Healthy Lifestyles (Public Health)	The provision of opportunistic healthy lifestyle advice and public health advice to patients receiving prescriptions who appear to: • have diabetes; or • be at risk of coronary heart disease, especially those with high blood pressure; or • smoke; or • are overweight • and participating in six health campaigns, where requested to do so by NHS England and NHS Improvement.
Disposal of Unwanted Medicines	Acceptance, by community pharmacies, of unwanted medicines by someone living at home, in a children's home or in a residential care home which require safe disposal. Primary Care Organisations will have arrangements for the collection and disposal of waste medicines from pharmacies.
Signposting	The provision of information on other health and social care providers or support organisations to people visiting the pharmacy who require further support, advice or treatment which cannot be provided by the pharmacy.
Support for self-care	The provision of advice and support by pharmacy staff to enable people to derive maximum benefit from caring for themselves or their families.

Source: NHS Community Pharmacy Contractual Framework

3.2. Advanced Services

There were eleven advanced services within the NHS Community Pharmacy Contractual Framework (the 'pharmacy contract') but 4 have been decommissioned and there are now currently 8 available that Community Pharmacies can choose to provide. These services are free at the point of care for all eligible patients.

Table 2: Advanced Pharmacy Services

Advanced Services	Description
New Medicine Service (NMS)	This service was introduced on 1st October 2011. The service provides support for people with long term conditions who have been newly prescribed a medicine to help improve medicines adherence and self-manage their condition. This service is initially focused on particular patient groups and conditions.
Community Pharmacist Consultation Service (CPCS)	Introduced in November 2020 this service replaced the NHS Urgent Medicine Supply service pilot. General Practices and NHS 111 can refer patients for minor illness consultation at pharmacies offering CPCS.
C-19 Lateral Flow Device Distribution	From March 2021 to March 2022, lateral flow device distribution was added to the advanced services available at some community pharmacies. Lateral flow devices were free to collect for members of the public. *This service ceased from 1st April 2022.*
Appliance Use Review (AUR)	This service can be carried out by a pharmacist or a specialist nurse in the pharmacy or at the patient's home. AURs should improve the patient's knowledge and use of any 'specified appliance' by establishing the way the patient uses the appliance and the patient's experience of such use. This is achieved by identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient, including advising the patient on the safe and appropriate storage of the appliance and advising the patient on the safe and proper disposal of the appliances that are used or unwanted.
Stoma Appliance Customisation (SAC)	The service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. If the pharmacist is unable to provide the prescribed service, they should either refer (with the patient's consent) the patient to another pharmacy or provide the patient with the contact details of at least two pharmacies or providers that are able to supply the service.

Seasonal Influenza (flu) Vaccination	Community pharmacy has been providing flu vaccinations under a nationally commissioned service since September 2015 for patients aged 65 and over and at-risk groups, to support GP services in increasing vaccination rates. Each year from September through to March the NHS runs a seasonal influenza (flu) vaccination campaign aiming to vaccinate all patients who are at risk of developing more serious complications from the virus.
Hepatitis C Testing Service	From September 2020 Hepatitis C testing became available as an advanced service from pharmacies who offer this service. This service is focused on provision of point of care testing for Hepatitis C antibodies to people who inject drugs who haven't yet accepted treatment for their substance use. Those who test positive are referred for further confirmatory testing and treatment.
Hypertension Case-Finding Service	Also known as the NHS Blood pressure check, from October 2021 pharmacies provided clinic blood pressure testing to those aged over 40 to identify those with high blood pressure. Where clinically indicated, patients are then offered 24-hour ambulatory blood pressure monitoring, the results of which are shared with the person's GP.
Pandemic Delivery Service	Originally offered to Clinically Extremely Vulnerable people shielding due to the COVID-19 before being offered to people who have been notified of the need to self-isolate by NHS Test and Trace. Delivery of prescriptions from Pharmacies was organised via a variety of methods including volunteer delivery or direct pharmacy delivery. *This service ceased from 5th March 2022.*
Smoking Cessation Service (CSC)	This service enables NHS trusts to refer patients to a community pharmacy of their choice to continue their smoking cessation treatment, including providing medication and support as required.

Source: NHS Community Pharmacy Contractual Framework

3.3. Community Based Services

In addition to the services above, pharmacies can also offer services that are commissioned by local authorities and Clinical Commissioning Groups that have been identified to meet the health needs of their local populations. Some pharmacies can opt into some of these services, but for others activity is controlled by the commissioners (e.g., palliative care.) These services currently include:

Table 3: Community Based Pharmacy Services

Community Based Services	Description
Emergency Hormonal Contraception (EHC)	This is a free service to women up to 25 years of age following unprotected sexual intercourse to prevent unintended pregnancies.
Needle Exchange	A service for intravenous drug users, providing clean needles and so reducing the risk of infection such as hepatitis.

Supervised Consumption	A service for registered drug addicts, providing regular monitored doses of an opiate substitute to support becoming progressively drug free.
Champix Provision	A service to provide Champix (Varenicline) as part of a Patient Group Directive to service users on referral by the Quit Ready Leicestershire Stop Smoking Service. *Currently there has been no provision since January 2021 due to a manufacturer recall.*
Extended Care Services – a range of services including tier 1, 2 and 3 services	The extended care service allows pharmacies to provide treatment for a selection of minor ailments without the patient having to attend a GP or Out of hours service. Advice is also given to reduce the likelihood of repeat need for treatment. The patient must be registered with a GP and may need to be in an eligible group.
Palliative Medicine Supply	Palliative care is aimed at offering the patient the highest possible level of comfort during the last phase of their life. This service aims to facilitate prompt access to palliative care medicines by patients and their representatives. This service also includes provision of urgent antibiotics.
Emergency Supply Service	The Emergency supply service allows pharmacists to prescribe prescription only medicines to a patient previously prescribed the requested drug without a prescription. This means a patient can in emergency situations receive a drug without visiting a doctor and is intended to lessen demand for emergency medical care for repeat prescriptions.
Covid-19 Vaccinations	Community pharmacies have been central to the Government's response to Covid-19, by offering and delivering Covid-19 vaccinations.

Source: NHS Community Pharmacy Contractual Framework

3.4. Pharmacy Contracts

There are four types of community pharmacy contractors. They are:

- Those held on a *pharmaceutical list* (standard contract) - healthcare professionals working for themselves or as employees who practise in pharmacy: the field of health sciences focusing on safe and effective medicines use.

- *Dispensing appliance contractors* – they only dispense prescriptions for appliances. They cannot dispense prescriptions for drugs. Dispensing appliance contractors are not required to have a pharmacist, or a regulatory body and their premises do not have to be registered with the General Pharmaceutical Council. Dispensing appliance contractors tend to operate remotely, receiving prescriptions either via the post or the electronic prescription service, and arranging for dispensed items to be delivered to the patient.

- *Dispensing doctors/practices* – GP Practices can dispense medicines and appliances to patients who live in a controlled locality (rural area) and live more than 1.6km from a pharmacy.

- *Local Pharmaceutical Service (LPS) contract* - allows NHS England and NHS Improvement to commission community pharmaceutical services tailored to specific local requirements. It provides flexibility to include within a single locally negotiated contract, a broader or narrower range of services (including services not traditionally associated with pharmacy) than is possible

under national pharmacy arrangements set out in the 2013 Regulations. All LPS contracts must, however, include an element of dispensing.

3.5. Distance Selling Pharmacies

Distance selling pharmacies (e.g., internet pharmacies) are able to provide the full range of essential, advanced and enhanced services to the population, without face-to-face contact. Distance selling pharmacies will receive prescriptions either via the electronic prescription service or through the post, dispense them at the pharmacy and then either deliver them to the patient or arrange for them to be delivered using a courier. They must provide essential services to anyone, anywhere in England, where requested to do so. They may choose to provide advanced services, but when doing so must ensure that they do not provide any element of the essential services whilst the patient is at the pharmacy premises.

4. What is Excluded from the Scope of the PNA?

The PNA is set out by regulation to cover the community-based pharmacy services that have been described in Section 3 of this report. There are other providers of pharmaceutical services in Rutland that have not been included in the assessment of need.

4.1. Prison Pharmacy

Pharmaceutical services are provided in HM Stocken Prison in Rutland. Health services provided within prisons require a pharmaceutical service to support the delivery of healthcare and the supply of medicines. The unique nature of the environment and the predominance of certain clinical services in some prisons, such as substance misuse services, means that these services are provided by contracted providers with a model that is determined to support the prison population safely.

4.2. Hospital Pharmacy

Around 20% of pharmacists work in hospitals and play an essential role in patient care. Working as part of a multidisciplinary team, hospital pharmacists manage caseloads and provide treatment programmes for all hospital patients. In Rutland, patients will access acute care from a range of hospital providers, including:

- University Hospitals of Leicester NHS Trust
- Community hospitals in Melton and Market Harborough
- Rutland Memorial Hospital
- Stamford Hospital
- Other out of county providers, such as Nottinghamshire, Lincolnshire, Peterborough, Cambridgeshire, Northamptonshire etc.

Whilst in hospital, patients' medicines will be dispensed and managed by hospital pharmacists. Once the patient is discharged to the community their pharmaceutical needs will be met by their community pharmacist.

5. Process Followed for Developing the Pharmaceutical Needs Assessment

The Health and Wellbeing Board has a statutory responsibility to prepare a Pharmaceutical Needs Assessment (PNA) for Rutland by 1 October 2022. The Leicester, Leicestershire and Rutland (LLR) PNA Reference Group has overseen and developed the draft PNA on the Board's behalf. The interagency PNA Reference Group was established because many of the relationships required for the PNA were Leicester, Leicestershire and Rutland (LLR) wide. The team included representation from NHS England and NHS Improvement, the LLR Pharmaceutical Committee and the Local Professional Network for Pharmacists. The Group's terms of reference are attached as **Appendix A.**

The PNA was subject to a 60-day statutory consultation period running from June 2022 to August 2022. A consultation also took place with local pharmaceutical professionals and service users to gather evidence to support the PNA. The results from the consultations and surveys are set out later in the report. Regulation 8 of the Pharmaceutical Services Regulations specifies that the Health and Wellbeing Board must consult with the following –

- the Local Pharmaceutical Committee
- the Local Medical Committee
- any persons on the pharmaceutical lists and any dispensing doctors list for its area
- any LPS chemist in its area with whom the NHS England and NHS Improvement has made arrangements for the provision of any local pharmaceutical services
- Healthwatch and any other patient, consumer or community group in its area which in the view of the Health and Wellbeing Board has an interest in the provision of pharmaceutical services in its area
- any NHS trust or NHS foundation trust in its area
- NHS England and NHS Improvement
- any neighbouring Health and Wellbeing Board

The full range of statutory bodies required were contacted and asked to participate in the consultation. In addition, the consultation was promoted widely to other groups likely to be interested.

HEALTH NEEDS OF THE POPULATION OF RUTLAND

6. Population of Rutland

Rutland's Joint Strategic Needs Assessment (JSNA) was published in 2018.[3] Since the publication of the JSNA, additional reports have been published to further enrich the evidence base for the health

and wellbeing of the population. A new Rutland Joint Health and Wellbeing Strategy 2022 – 2025[4] was also agreed in 2022. A Public Health Outcomes Framework update has been published for Rutland Council, and the Director of Public Health's Annual Report also updates on population health. The latest report for 2020 focused on providing an overview of health in Rutland and the role of workplace health in improving health.

The Rutland JSNA is available from - https://www.rutland.gov.uk/my-services/health-and-family/health-and-nhs/joint-strategic-needs-assessment

The Rutland Joint Health and Wellbeing Strategy 2022 – 2027 is available from - https://www.rutland.gov.uk/my-services/health-and-family/health-and-nhs/health-and-well-being-strategy/

The Annual Report of the Director of Public Health 2020[5] is available from: http://www.lsr-online.org/reports/director_of_public_health_annual_reports

6.1. Population Estimates

In 2020, the population of Rutland was estimated to be 40,476 people.[6] 9,412 people were aged 65-84 years (23.3%) and 1,450 people were aged 85 years and over (3.6%).[6] On Census day 2021 the size of the usual resident population in Rutland was 41,100 people: this is an increase of 10% (3631) since 2011. Rutland's population increase at 10% compares to a 8% increase for the East Midlands region and a 7% increase for England.

Figure 1 and **Table 4** present the age population structure of Rutland.

Figure 1: 2020 Population Pyramid[6]

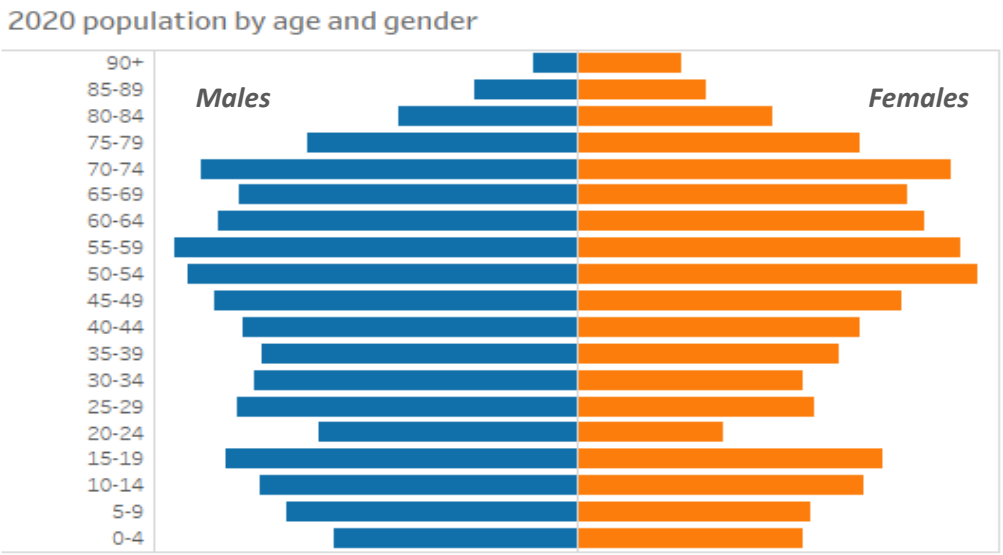


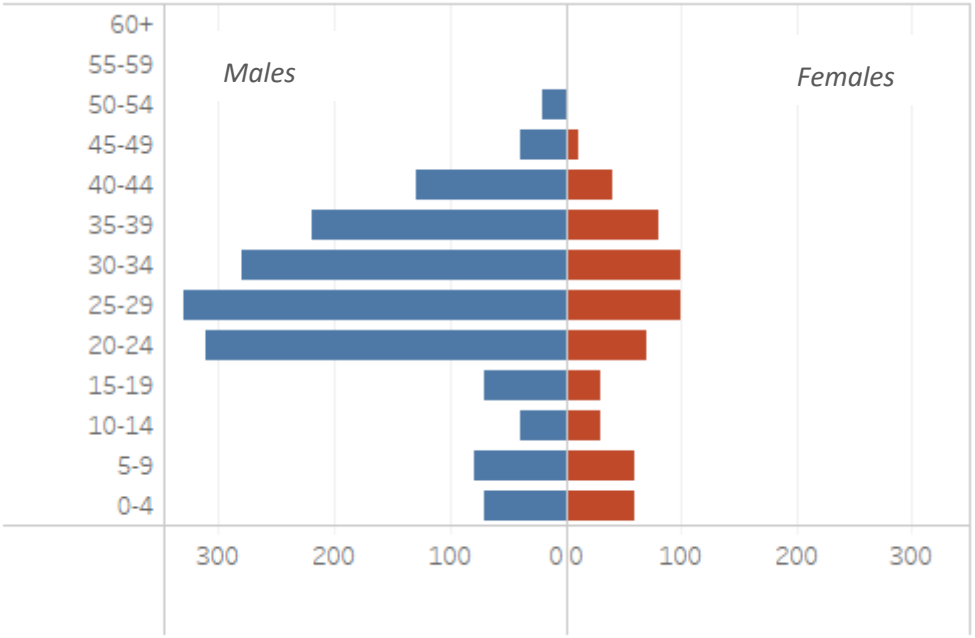
Table 4: 2020 Population Estimates for Rutland by age and gender[6]

Ages	Males	% of Total Population	Females	% of Total Population
0-4	900	2.2%	876	2.2%
5-9	1,081	2.7%	904	2.2%
10-14	1,177	2.9%	1,114	2.8%
15-19	1,305	3.2%	1,184	2.9%
20-24	958	2.4%	569	1.4%
25-29	1,261	3.1%	922	2.3%
30-34	1,198	3.0%	878	2.2%
35-39	1,171	2.9%	1,019	2.5%
40-44	1,243	3.1%	1,095	2.7%
45-49	1,349	3.3%	1,259	3.1%
50-54	1,448	3.6%	1,556	3.8%
55-59	1,497	3.7%	1,487	3.7%
60-64	1,330	3.3%	1,350	3.3%
65-69	1,257	3.1%	1,278	3.2%
70-74	1,393	3.4%	1,453	3.6%
75-79	998	2.5%	1,098	2.7%
80-84	661	1.6%	757	1.9%
85-89	381	0.9%	500	1.2%
90+	165	0.4%	404	1.0%
All Ages	20,773	51.3%	19,703	48.7%

6.2. Military Population

As of October 2021, there were 2,160 Armed Forces personnel and entitled civilian personnel with a Defence Medical Services registration in Rutland.[7] This accounts for 5.3% of the total resident population. Three quarters of those registered with the Defence Medical Services were members of the Armed Forces, whereas the remaining quarter were entitled civilian personnel. Of all registrations, 53% were for male personnel aged 20-39 and 27% were female personnel.

Figure 2: Military Population Pyramid in Rutland, October 2021[7]



Source: MoD. Defence personnel NHS commissioning quarterly statistics, 2021/22

6.3. Deprivation

The Index of Multiple Deprivation 2019 (IMD) is the official measure of relative deprivation in England, part of outputs that form the Indices of Deprivation (IoD).[8] It follows an established methodological framework in broadly defining deprivation to encompass a wide range of an individual's living conditions. People may be considered to be living in poverty if they lack the financial resources to meet their needs, whereas people can be regarded as deprived if they lack any kind of resources, not just income.[9] The Indices of Deprivation 2019 are based on 39 separate measures, combined and weighted seven distinct domains:

- Income deprivation, including Income deprivation affecting children (IDACI) and Income deprivation affecting older people (IDAOPI)
- Employment deprivation
- Health deprivation and disability
- Education, skills and deprivation
- Barriers to housing and services
- Crime; and
- Living environment deprivation.

Figure 3 illustrates the geographical spread of deprivation in Rutland. The classification is based on ranking all 32,844 national LSOAs, or neighbourhoods, and dividing them into 5 equal groups (or quintiles) according to their deprivation rank. It is important to note that in Rutland, there are no areas that are within the 1st or 2nd, most deprived, national quintile. Only three of Rutland's LSOAs can be classified as average deprivation at the national scale (3rd quintile, shaded grey), the remainder of the neighbourhoods are below the national average deprivation (5th least deprived quintile in dark green and 4th in light green).

Figure 3: English Indices of Multiple Deprivation 2019 in Rutland's LSOAs, by national quintile

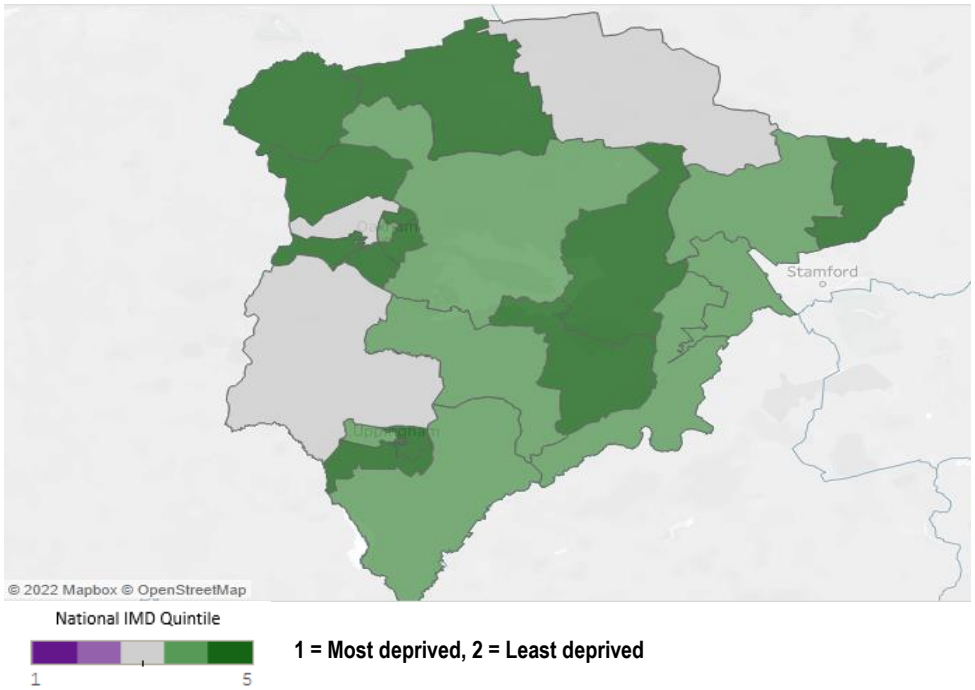
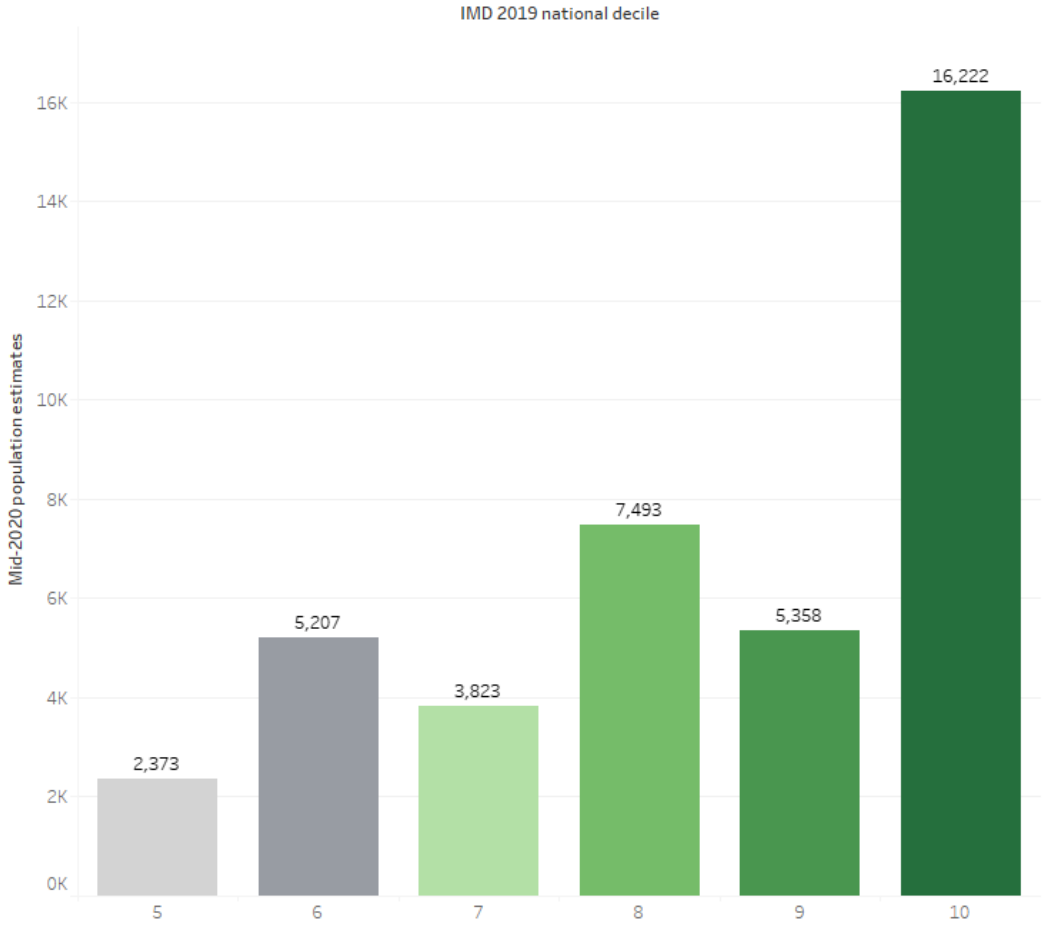


Figure 4 shows how much of the population of Rutland lives in each deprivation decile, and demonstrates that:

- On a national scale, the population of Rutland is less affected by material deprivation than the average for England, with none of the population in the most deprived 40% of areas nationally.
- 53% of the Rutland population live in the least deprived quintile of deprivation, accounting for over 21,000 people.

Figure 4: Rutland Mid-2020 Population and IMD 2019 national decile



Source: Mid-2020 population estimate, ONS, 2021 and Indices of Deprivation 2019, MHCLG,2019.

6.4. Ethnicity

The 2011 Census reported that 35,241 people in Rutland were White British, representing 94.3% of the total population. This is higher than the proportion in England of 79.8%.[10] 2.3% of the population classed themselves as White Other and 0.6% as White Irish.

7. Local Health Needs

7.1. Life Expectancy

Between 2018-20, the life expectancy at birth for males in Rutland was 83.2 years, which is significantly better (higher) than the England average (79.4). Life expectancy at birth for males has remained significantly better (higher) than the England average since 2001-03. Between 2018-20, the life expectancy at birth for females in Rutland was 85.0 years, which is significantly better (higher) than the England average (83.1). Life expectancy at birth for females has remained significantly better (higher) than the England average since 2010-12. [11]

Between 2017-19, the healthy life expectancy at birth for males in Rutland was 71.5 years, this is significantly better (higher) than the England average (63.2). Healthy life expectancy at births for males in Rutland has remained significantly better (higher) than the England average since 2012-14. Between 2017-19, healthy life expectancy at birth for females in Rutland was 63.1 years, this is statistically similar to the England average (63.5). Healthy life expectancy at births for females in Rutland has previously been significantly better (higher) than the England average since 2009-11.[11]

7.2. Lifestyles

Lifestyle statistics presented below relate to the population of Rutland and they are taken from the Public Health Outcomes Framework:[11]

- In 2019, 10.2% of adults (aged 18+) were classified as current smokers. This is significantly better (lower) than the England average (13.9%).
- In 2020/21, the alcohol related hospital admission rate was 1019 per 100,000 (481 admissions). This is significantly better than the England rate (1500 per 100,000 population).
- In 2019/20, 65.3% of adults (aged 18+) were classified as overweight or obese. This is statistically similar to the England average (62.8%).
- In 2019/20, 23.1% of children aged 4-5 years were overweight or obese. This is statistically similar to England average (23.0%). Over the last five years, there has been no significant change in the trend for excess weight in those aged 4-5 years.
- In 2019/20, 26.6% of children aged 10-11 years were overweight or obese. This is significantly better than the England average (35.2%). Over the last five years, there has been no significant change in the trend for excess weight in those aged 10-11 years.
- In 2019/20, 20.2% of adults were physically inactive. This is statistically similar to the England average (22.9%).
- In 2020/21, 19.5% of people reported a high anxiety score for self-reported wellbeing. This is statistically similar to the England average (24.2%).

7.3. Health Profile

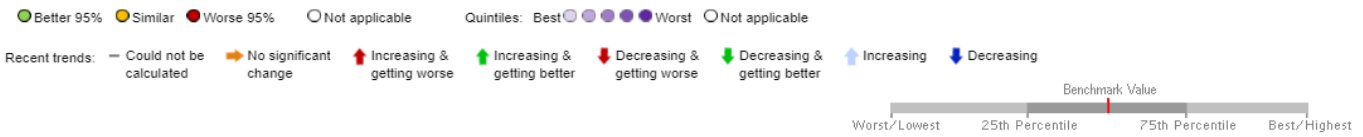
Health profiles are updated by the Office for Health improvement and Disparities and provide a useful snapshot of the health needs of the local population. The key findings are summarised in **Figure 5**.[12] In Year 6, 12.5% (40) of children are classified as obese, better than the average for England. Levels of teenage pregnancy, GCSE attainment (average attainment 8 score) and breastfeeding are better than the England average.

The rate for alcohol-related harm hospital admissions is 519 per 100,000, better than the average for England. This represents 214 admissions per year. The rate for self-harm hospital admissions is 129 per 100,000, better than the average for England. This represents 45 admissions per year. Estimated levels of smoking prevalence in adults (aged 18+) are better than the England average. The rates of new sexually transmitted infections and new cases of tuberculosis are better than the England average.

The rates of hip fractures in older people (aged 65+), the estimated dementia diagnosis rate and excess winter deaths index are worse than the England average. The rates of violent crime (hospital admissions for violence), under 75 mortality rate from cardiovascular diseases, under 75 mortality rate from all causes and children in low-income families are better than the England average.

The health profiles and a range of other data feed into the JSNA assessment process and other reports which shape the priorities in the Rutland Health and Wellbeing Strategy. This then feeds into a range of actions and improvement plans to ensure that the weaker areas highlighted above are addressed. Details of the priorities in the Rutland Health and Wellbeing Strategy are set out later in this PNA as well as where to access updates and progress. A summary of indicators included in the Public Health Outcomes Framework for Rutland is included in **Appendix B**.

Figure 5: Health Profile for Rutland, 2022



Indicator	Period	Rutland			Region England	England	England		
		Recent Trend	Count	Value	Value	Value	Worst/ Lowest	Range	Best/ Highest
Life expectancy at birth (Male) New data	2018 - 20	–	-	83.2	79.2	79.4	74.1		
Life expectancy at birth (Female) New data	2018 - 20	–	-	85.0	82.7	83.1	79.0		
Under 75 mortality rate from all causes	2018 - 20	–	281	221.0	342.9	336.5	570.7		221.0
Under 75 mortality rate from all cardiovascular diseases	2017 - 19	–	53	43.6	72.1	70.4	121.6		43.6
Under 75 mortality rate from cancer	2017 - 19	–	141	110.1	131.3	129.2	182.4		87.4
Suicide rate	2018 - 20	–	3	*	9.9	10.4	18.8		5.0
Killed and seriously injured (KSI) casualties on England's roads (historic data)	2016 - 18	–	64	54.0	41.6	42.6*	97.4		17.7
Emergency Hospital Admissions for Intentional Self-Harm New data	2019/20	→	45	128.6	198.9	192.6	439.3		44.5
Hip fractures in people aged 65 and over New data	2019/20	→	90	851	641	572	912		326
Cancer diagnosed at early stage (experimental statistics)	2017	→	120	54.3%	49.1%	52.2%	41.9%		57.7%
Estimated diabetes diagnosis rate	2018	–	-	73.8%	84.6%	78.0%	54.3%		5%
Estimated dementia diagnosis rate (aged 65 and over) < 66.7% (significantly)	2021	→	332	50.7%	64.8%	61.6%	50.5%		
Admission episodes for alcohol-specific conditions - Under 18s	2017/18 - 19/20	–	-	*	25.6	30.6	111.5		7.7
Admission episodes for alcohol-related conditions (Narrow): Old Method	2018/19	→	214	519	700	664	1,127		389
Smoking Prevalence in adults (18+) - current smokers (APS)	2019	–	3,258	10.2%	14.8%	13.9%	23.4%		8.0%
Percentage of physically active adults	2019/20	–	-	68.6%	65.9%	66.4%	49.4%		77.3%
Percentage of adults (aged 18+) classified as overweight or obese	2019/20	–	-	65.3%	65.4%	62.8%	78.3%		
Under 18s conception rate / 1,000	2019	→	4	5.0	15.4	15.7	37.1		3.9
Smoking status at time of delivery	2020/21	–	18	8.8%	12.6%	9.6%	21.4%		1.8%
Breastfeeding initiation	2016/17	–	257	81.1%	69.7%	74.5%	37.9%		96.7%
Infant mortality rate	2018 - 20	–	3	3.4	4.2	3.9	6.8		1.7
Year 6: Prevalence of obesity (including severe obesity)	2019/20	→	40	12.5%	20.8%	21.0%	30.1%		
Deprivation score (IMD 2015)	2015	–	-	9.6	-	21.8	42.0		5.7
Smoking Prevalence in adults in routine and manual occupations (18-64) - current smokers (APS)	2019	–	-	26.1%	25.5%	23.2%	36.8%		
Inequality in life expectancy at birth (Male) New data	2017 - 19	–	-	*	8.8	9.4	14.8		
Inequality in life expectancy at birth (Female) New data	2017 - 19	–	-	*	7.1	7.6	13.3		
Children in low income families (under 16s)	2016	→	385	6.5%	16.6%	17.0%	31.8%		4%
Average Attainment 8 score	2019/20	–	17,134	55.8	49.0	50.2	42.9		
Percentage of people in employment	2020/21	→	13,700	69.9%	74.7%	75.1%	63.2%		3%
Statutory homelessness - Eligible homeless people not in priority need	2017/18	–	-	*	0.4	0.8	8.1		0.1
Violent crime - hospital admissions for violence (including sexual violence) New data	2017/18 - 19/20	–	25	23.8	37.1	45.8*	127.7		11.3
Excess winter deaths index	Aug 2019 - Jul 2020	–	60	50.2%	18.4%	17.4%	50.2%		0.7%
New STI diagnoses (exc chlamydia aged <25) / 100,000	2020	↓	67	278	408	619	3,547		247
TB incidence (three year average)	2018 - 20	–	2	1.7	6.9	8.0	43.1		0.6

Source: Fingertips, Office for Health Improvement & Disparities, 2022

7.4. Burden of Disease in the Population

The 2020-21 Quality and Outcomes Framework Data collected by GPs gives a good indication of the numbers of patients that GPs are seeing with long term condition **Table 5**).[13]

In Rutland there were:

- 6,977 people on GP hypertension registers, 17.3% of the registered population. This is significantly higher than the England prevalence of 13.9%.
- 2,612 people on GP asthma registers, 6.8% of the registered population. This is significantly higher than the England prevalence of 6.4%.
- 2,084 people on GP diabetes registers, 6.3% of the registered population aged 17 years and over. This is significantly lower than the England prevalence of 7.1%.
- 3,336 people on GP depression registers, 10.3% of the registered population aged 18 years and over. This is significantly lower than the England prevalence of 12.3%.
- 1,433 people on GP coronary heart disease registers, 3.6% of the registered population. This is significantly higher than the England prevalence of 3.0%.
- 1,733 people on GP cancer registers, 4.3% of the registered population. This is significantly higher than the England prevalence of 3.2%.

The Quality and Outcomes Framework data feed into the JSNA assessment process and other reports which shape the priorities in the Rutland Health and Wellbeing Strategy. This then feeds into a range of actions and improvement plans to ensure that the weaker areas highlighted above are addressed. Details of the priorities in the Rutland Health and Wellbeing Strategy are set out later in this PNA.

Table 5: GP Recorded Disease Prevalence in Rutland, 2020/21

England Average | Higher than Engand Average | Lower than England Average | Similar to England

Group	Disease Register		England	Rutland
Cardiovascular	AF - Atrial Fibrillation	Prevalence	2.0%	3.3%
		Register 2020-21	1,243,503	1,316
	CHD - Coronary Heart Disease	Prevalence	3.0%	3.6%
		Register 2020-21	1,850,657	1,433
	HF - Heart Failure	Prevalence	0.9%	1.7%
		Register 2020-21	550,613	702
	HYP - Hypertension	Prevalence	13.9%	17.3%
		Register 2020-21	8,457,600	6,977
	PAD - Peripheral Arterial Disease	Prevalence	0.6%	0.6%
		Register 2020-21	356,958	243
	STIA - Stroke and Transient Ischaemic Attack	Prevalence	1.8%	2.3%
		Register 2020-21	1,093,593	944
Clinical	NDH-Non-diabetic hyperglycaemia	Prevalence	5.3%	10.0%
		Register 2020-21	2,573,210	3,232
High Dependency	CAN - Cancer	Prevalence	3.2%	4.3%
		Register 2020-21	1,948,913	1,733
	CKD - Chronic Kidney Disease (18+)	Prevalence	4.0%	5.2%
		Register 2020-21	1,917,102	1,665
	DM - Diabetes Mellitus (17+)	Prevalence	7.1%	6.3%
		Register 2020-21	3,491,868	2,084
	PC - Palliative Care	Prevalence	0.5%	1.5%
		Register 2020-21	282,431	612
Lifestyle	OB - Obesity (18+)	Prevalence	6.9%	3.8%
		Register 2020-21	3,334,036	1,210
Mental Health & Neurology	DEM - Dementia	Prevalence	0.7%	0.8%
		Register 2020-21	430,857	336
	DEP - Depression (18+)	Prevalence	12.3%	10.3%
		Register 2020-21	5,955,865	3,336
	EP - Epilepsy (18+)	Prevalence	0.8%	0.8%
		Register 2020-21	386,381	242
	LD - Learning Disabilities	Prevalence	0.5%	0.4%
		Register 2020-21	324,291	147
	MH - Mental Health	Prevalence	0.9%	0.7%
		Register 2020-21	574,227	274
Musculoskeletal	OST - Osteoporosis (50+)	Prevalence	0.8%	0.9%
		Register 2020-21	169,090	172
	RA - Rheumatoid Arthritis (16+)	Prevalence	0.8%	0.7%
		Register 2020-21	382,517	242
Respiratory	AST - Asthma	Prevalence	6.4%	6.8%
		Register 2020-21	3,629,071	2,612
	COPD - Chronic Obstructive Pulmonary Disease	Prevalence	1.9%	2.0%
		Register 2020-21	1,170,437	795

Source: QOF - Quality and Outcomes Framework (2020-21).

8. Rutland's Health and Wellbeing Priorities

The new Joint Health and Wellbeing Strategy 2022-27 for Rutland was agreed in 2022.[14] The Strategy is the Health and Wellbeing Board's response to the health and wellbeing needs identified in the Joint Strategic Needs Assessment and a variety of health assessments.[15] The overall aim of the strategy is to help people live well in active communities. This will be progressed over the next five years by work carried out in seven priority areas:

1. Ensuring the best start for life
2. Staying healthy and independent
3. Healthy ageing and living well with long-term conditions
4. Providing equitable access to health and wellbeing services
5. Preparing for population growth and change
6. Making sure people are well supported in the last phase of their lives
7. Cross-cutting themes: good mental health, reducing health inequalities (including for the armed forces community), and COVID readiness and recovery

Updates on progress will be included in the Director of Public Health's Annual Report and on the Health and Wellbeing Section of the website.

CURRENT PHARMACEUTICAL PROVISION

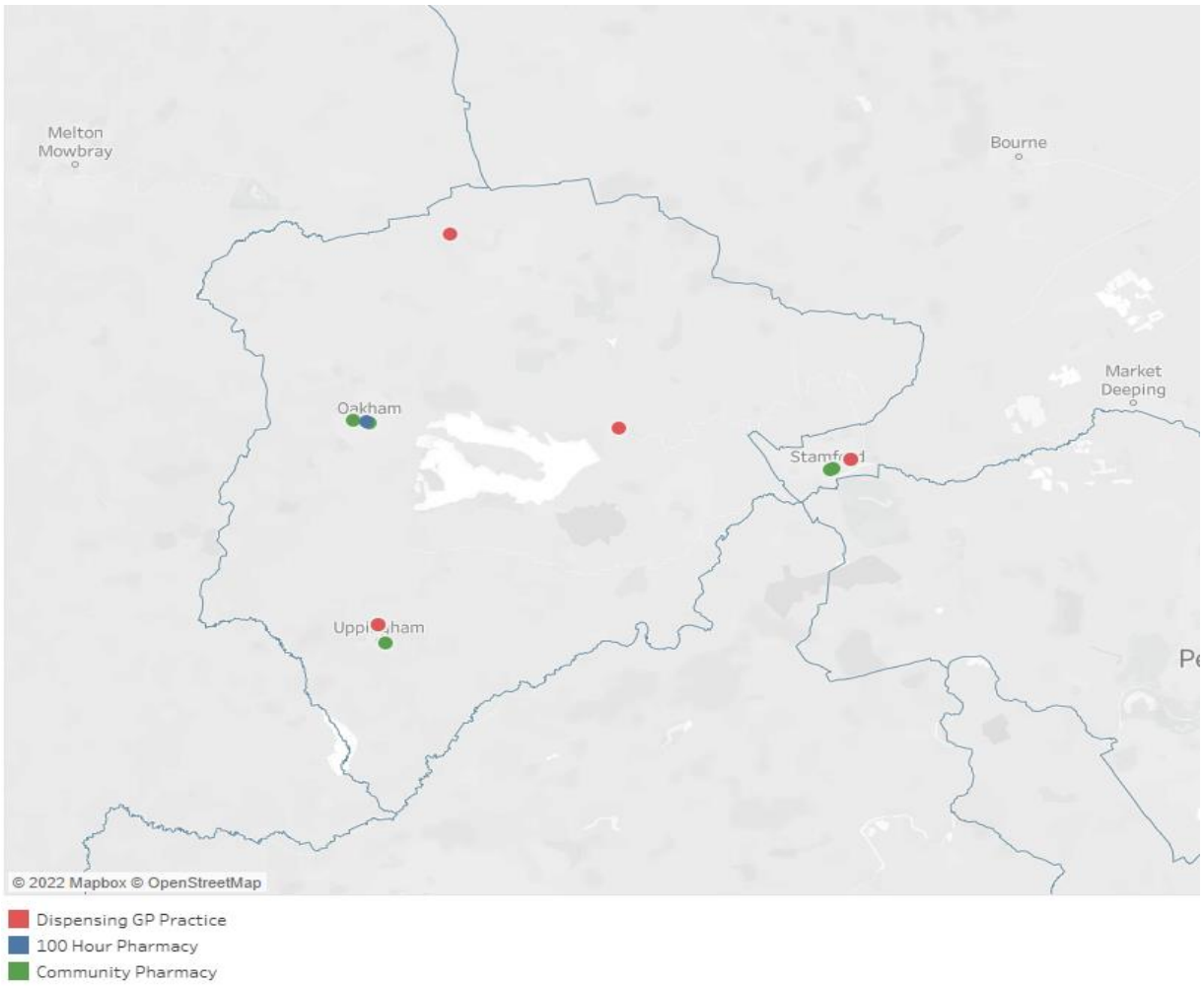
The information about services presented in this report was accessed as of September 2021 and refers to the status of services on 31st March 2021. Where services have changed significantly in the past 12 months this is referenced in the report but the baseline date for the presented data is fixed at this date.

9. Location of Pharmacies

Figure 6 shows the location and type of services in and around Rutland. Rutland has five *(now 6*) pharmacies and three dispensing GP locations. There is one 100-hour pharmacy. The pharmacies are all in the towns of Oakham and Uppingham while the dispensing GPs are in more rural areas.

A Pharmacy reopened in Oakham on April 1st, 2021. This is after the time period of most services data used in this report, as such this pharmacy is not included in most analysis. It has been included on the access analysis to give a true reflection of the pharmacy access at the time of this report.

Figure 6: Rutland Pharmaceutical Services and GP Dispensing Practices, as of 31st March 2021



Source: NHS England and NHS Improvement, Pharmaceutical Dataset, Sept 2021

Overall, Rutland has 1.46 community pharmacies per 10,000 population. In 2020/21 there were 11,636 pharmacies in England.[16] With a population of 56,550,138 people in 2020,[6] the average number of community pharmacies for England is 2.1 per 10,000 population. Rutland is a rural area, so it would be unrealistic to expect the same overall coverage of pharmacies per 10,000 population as England. Local knowledge indicates that Rutland residents in the east of the county are likely to travel across the border to access health services. This stresses the importance of residents in the east of Rutland being enabled to access cross border provision and the importance of information on opening times, transport routes and where to access services post hospital discharge etc. This also infers that more services are potentially available than quoted and the figure is likely to be an underestimate.

Combining community pharmacies (excluding internet pharmacies) and dispensing GPs, as the contractors that are able to provide local residents with dispensing services, gives a better indication of the total population coverage for Rutland. In October 2021, there were 1,050 dispensing GPs in England. When combined with the number of pharmacies, this gives an England average of 2.2 contractors per 10,000 population. Rutland has 2.19 pharmacies and dispensing GP surgery locations per 10,000 population. This is similar to the England average.

9.1. Local Pharmaceutical Service (LPS) contract

NHS England and NHS Improvement commissions no LPS contracts for Rutland

9.2. Distance Selling Pharmacies

In addition to community pharmacies and dispensing GPs, residents are also able to access pharmacy services from distance selling, or internet pharmacies. There are no distance selling or internet pharmacies in Rutland, but residents may access these pharmacies in other areas.

10. Services Available in Rutland

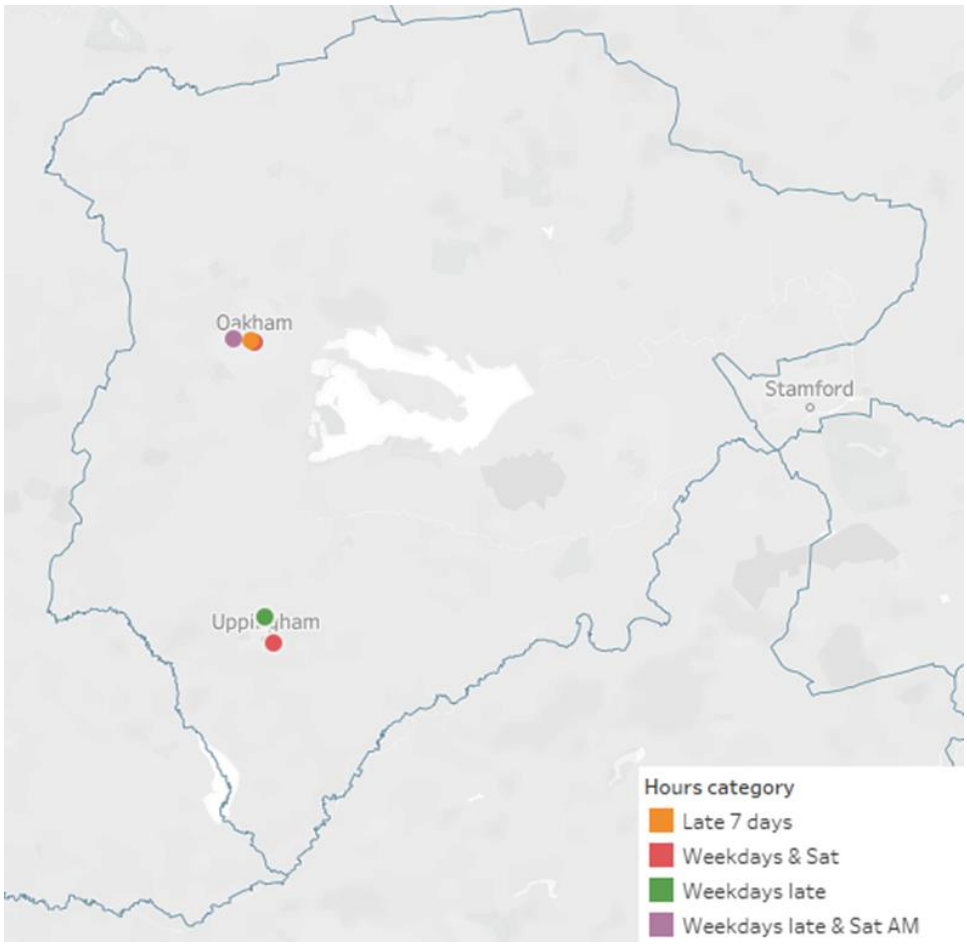
10.1. Essential Services

Essential services are provided by all pharmacies in Rutland, including internet pharmacies, as part of the NHS Community Pharmacy Contractual Framework. These services are managed by NHS England and NHS Improvement. They include dispensing, repeat dispensing, clinical governance, discharge medicine service, promotion of healthy lifestyles, disposal of unwanted medicines, signposting and support for self-care (see **Table 1** on page 13). As of October 2021, there are eight essential services (listed below) that are offered by all pharmacy contractors as part of the NHS Community Pharmacy Contractual Framework (the 'pharmacy contract').

Table 1**Opening Hours**

Pharmacies have core contractual hours of 40 per week and these are agreed with NHS England and NHS Improvement. Pharmacies across Rutland are open at varying times, providing a service somewhere in the county at almost all times: between 7am and 10pm Monday to Thursday and between 7am and 11pm Friday to Saturday, and supported by the 100-hour pharmacy in Oakham. The 100-hour pharmacy is open on Sundays. **Figure 7** shows the Pharmacies located in Rutland categorized by opening hours.

Figure 7-Opening Hours of Pharmacies in Rutland



Source: NHS England and NHS Improvement, Pharmaceutical Dataset, September 2021

- **7 days Standard Hours**-Open 7 days a week, closes before 6pm.
- **Late 7 days**-Open 7 days with late close (post 6pm) at least 6 out 7 days.
- **Weekdays & Sat**-Open weekdays and Saturdays with close before 6pm.
- **Weekdays Late**-Open weekdays with late close (post 6pm).
- **Weekdays late & Sat AM**-Open weekdays with close after 6pm and Saturdays with close before 1pm.

Derbyshire Health United (DHU) Health Care Community Interest Company run the Clinical Navigation Hub and Home Visiting Service, these services have access through an on-call pharmacist, to out of hours on call pharmacy provision for Rutland, which ensures urgent prescriptions are dispensed during the out of hours and bank holiday period.

10.1.1. Prescribing Activity

GP Practices in Rutland prescribed over 951,000 items in 2020.[17] This equates to 24 items per head of registered population, including repeat prescriptions.[18] The largest proportion between 2018 and 2020 was drugs for the cardiovascular system which includes treatments for high cholesterol and hypertension. Drugs for the central nervous system include anti-depressants; those for the endocrine system include treatments for diabetes. More details are shown in **Table 6** and **Figure 8**.

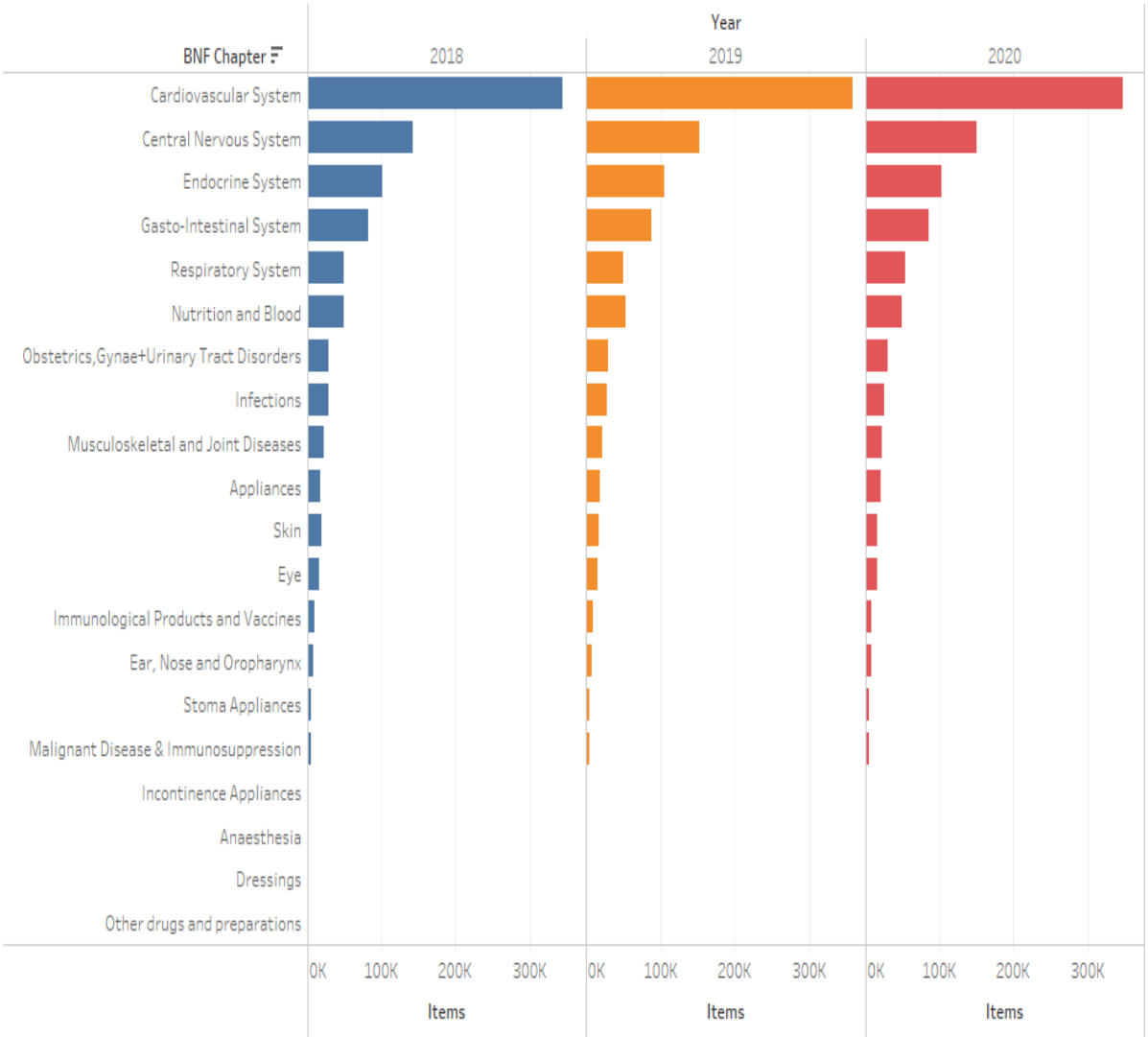
The prescriptions are dispensed by community pharmacies, internet pharmacies and dispensing GP practices.

Table 6: Number of items prescribed for Rutland in 2020

Area	Items Prescribed	Registered population (as at December 2020)	Items per head population
Rutland	951,275	39,745	24

Source: GP Prescribing data, 2021. Open Prescribing beta.

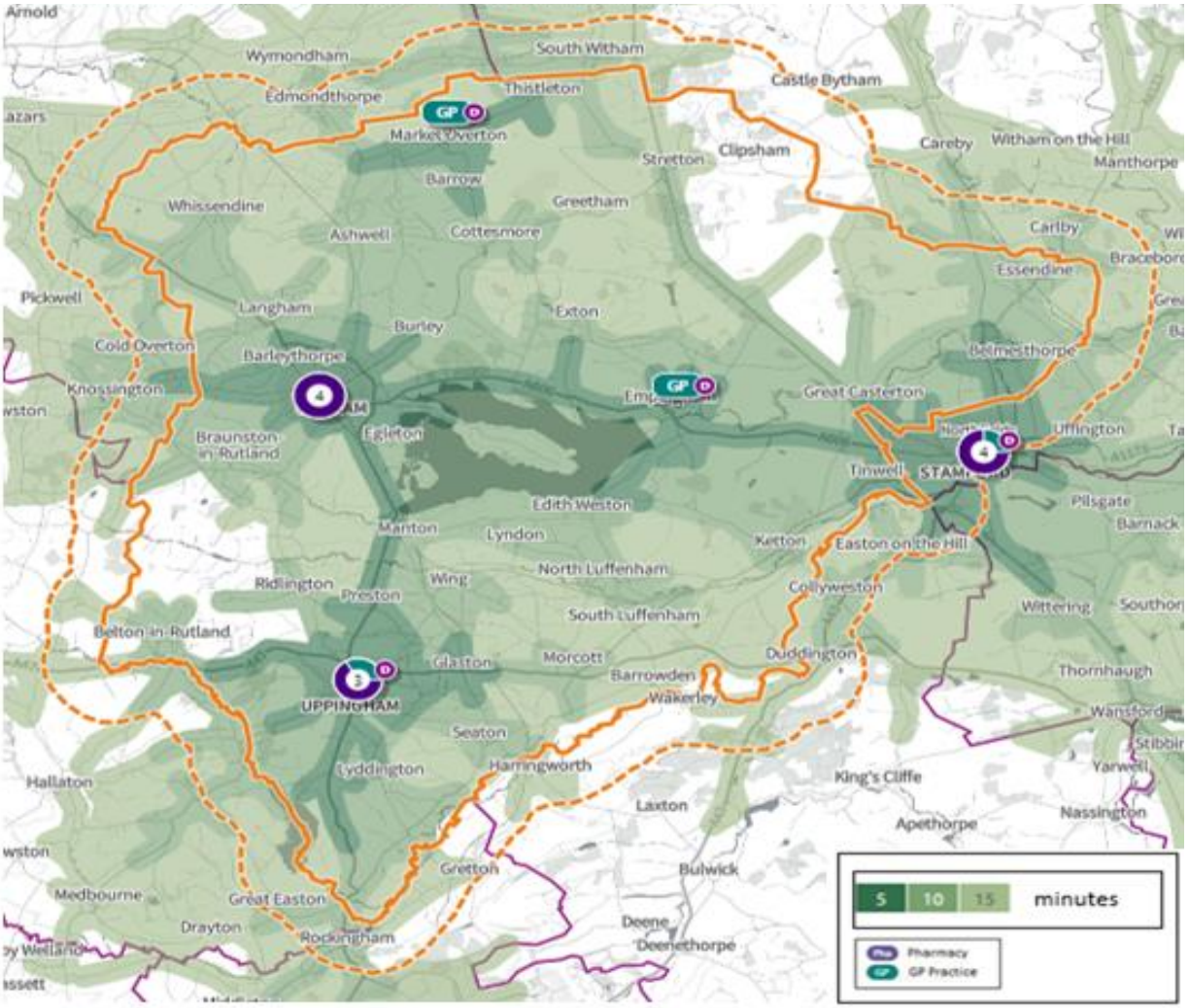
Figure 8: Prescribing Activity by BNF Chapter for Rutland, 2018 to 2020



10.1.2. Drive and Walk Time Analysis

Using the Strategic Health Asset Planning and Evaluation (SHAPE) Place tool[19] it is possible to analyse how long it takes to walk or drive from any Lower Super Output Area (LSOA) in Rutland to the nearest pharmacy or dispensing GP practice location in Rutland. Please note, pharmacies or dispensing GPs that are 1.5km outside of the Rutland boundary have also been included in this analysis. The drive-time map for Rutland pharmacies is shown in **Figure 9**. A Pharmacy reopened in Oakham on April 1st, 2021. This is after the time period of most services data used in this report, as such this pharmacy is not included in most analysis. It has been included on the access analysis to give a true reflection of the pharmacy access at the time of this report.

Figure 9: Drive Time to Nearest Pharmacy



Source: Strategic Health Asset Planning and Evaluation, 2022.

Although large parts of the county appear to be outside of the 10-minute drive boundary, this does not account for the population distribution, with less than 20% of the population living more than a 10-minute drive away from their nearest pharmacy or dispensing GP practice location (

Table 7).

Table 7: Population by drive-time in Rutland

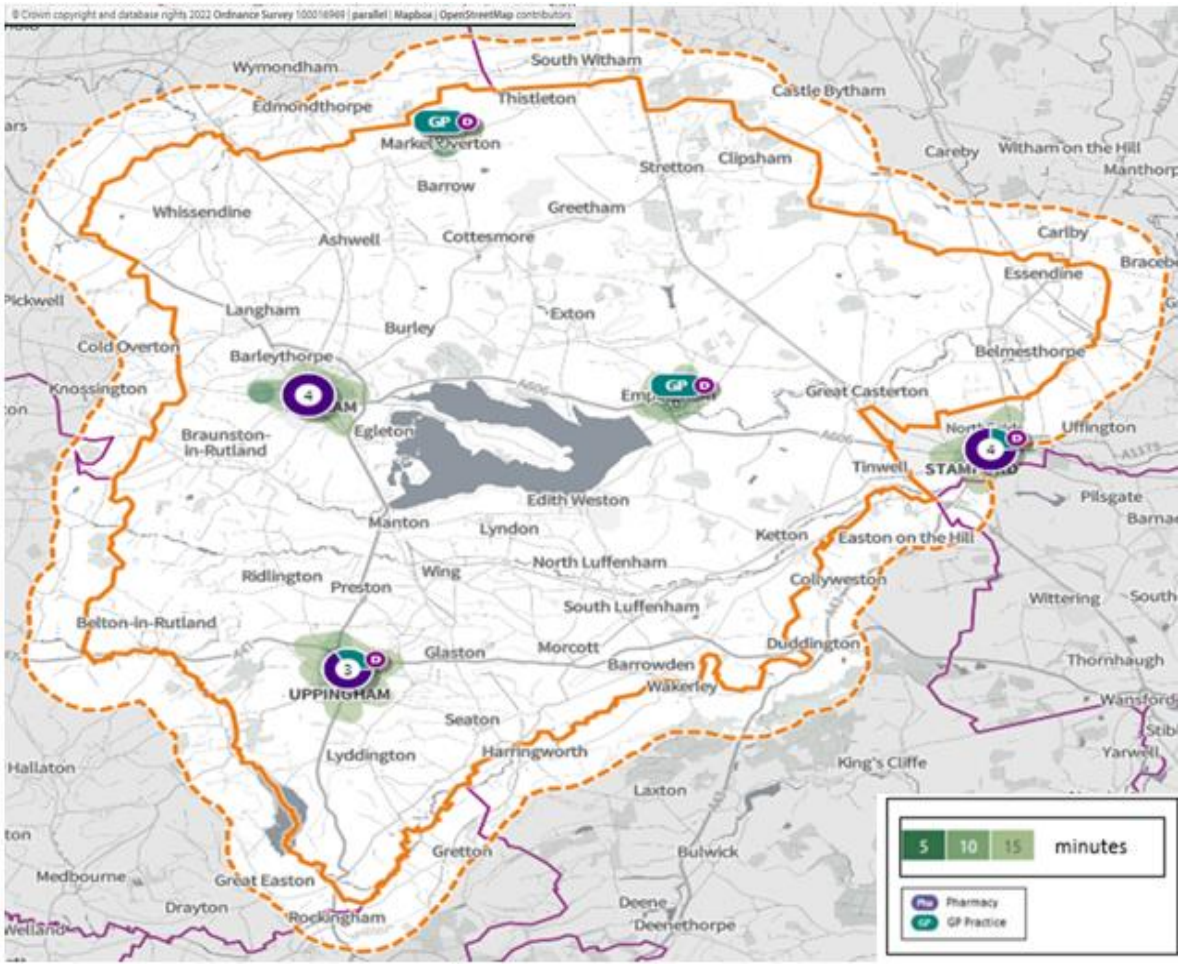
Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
21,610	53.4%	12,042	29.8%	3,096	7.6%	3,728	9.2%

Source: Strategic Health Asset Planning and Evaluation, 2022.

Source: Strategic Health Asset Planning and Evaluation, 2022.

Table 8 and **Figure 10** illustrate **walking times** to pharmacies in the county. Overall, over 54% of the county's population live more than a 15-minute walk from a pharmacy or dispensing GP practice, 9% live between 11- and 15-minutes' walk, 20% live between 6 and 10 minutes and 16% live within a 5-minute walk time.

Figure 10: Walking time to the nearest pharmacy



Source: Strategic Health Asset Planning and Evaluation, 2022.

Table 8: Population by Walk Time in Rutland

Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
6,594	16.3%	8,046	19.9%	3,682	9.1%	22,154	54.7%

Source: Strategic Health Asset Planning and Evaluation, 2022.

10.1.3. Public Transport

There are public transport services available across the county – currently including 4 services that operate hourly, 3 services that operate 2-hourly, and a number of less frequent rural services. These can be viewed on the Rutland County Council website: https://www.rutland.gov.uk/my-community/transport/bus-times-and-travel/

Due to the rural nature of Rutland, the majority of these bus services require financial support from Rutland County Council (and in some cases, from neighbouring authorities) in order to operate. In addition to the conventional fixed route bus services operating in the county, Rutland County Council currently supports a Demand Responsive Transport (DRT) service that runs only in response to pre-booked requests. This service is known as CallConnect and covers the eastern half of the county as well as crossing the county border to Stamford in Lincolnshire.

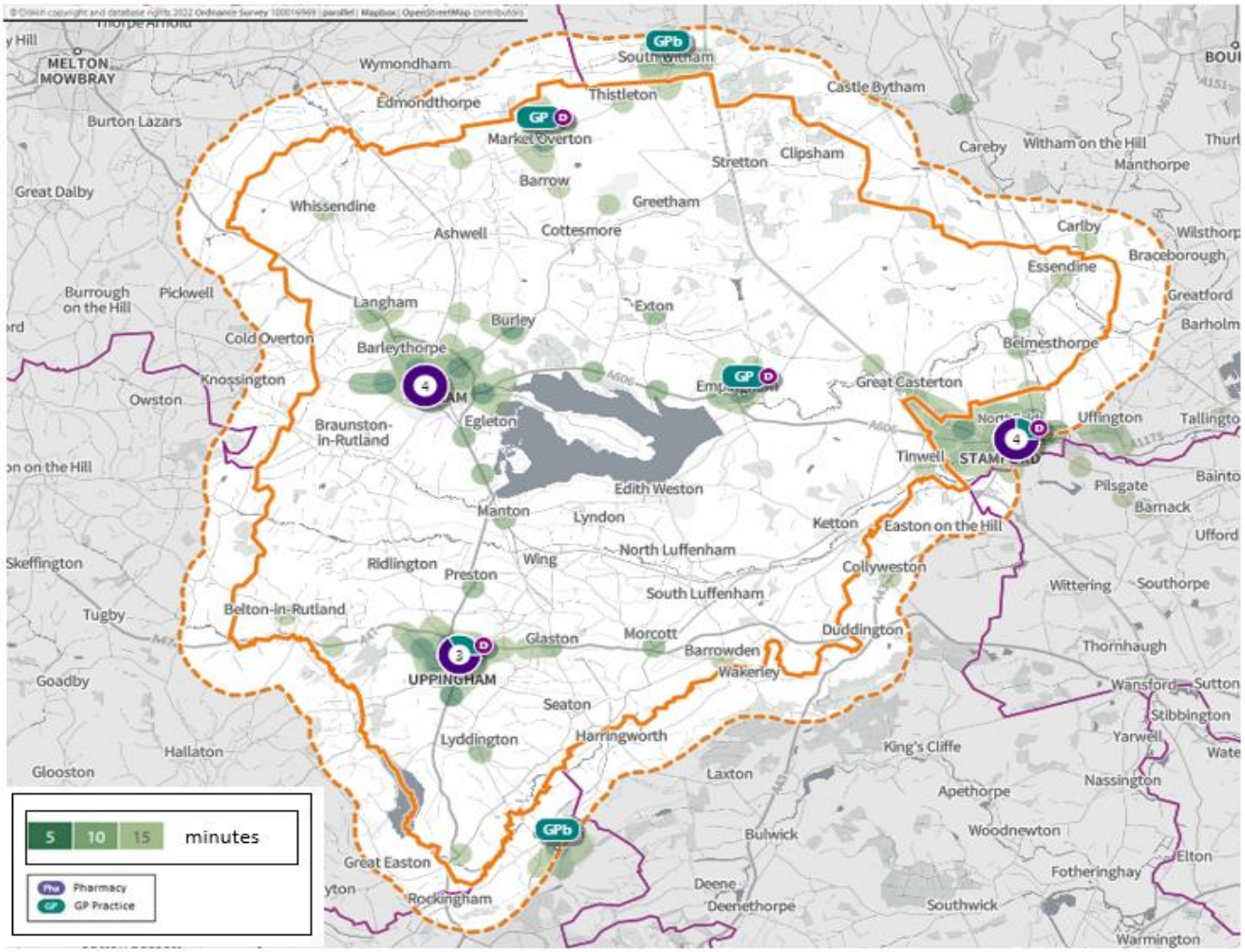
Within Rutland community transport services also exist. Voluntary Action Rutland (VAR), based in Oakham, operates one such scheme and a further, similar voluntary car scheme has recently been established in Uppingham. Furthermore, a number of parishes within Rutland also offer informal 'good neighbour' schemes, which include arranging lifts for people.

In addition to the bus services Rutland has one rail station in Oakham providing (approximately hourly) links to the cities of Leicester, Birmingham, Cambridge and Peterborough, as well as to Stansted Airport. At the time of writing Oakham also sees daily services to and from London serving Corby, Kettering, Wellingborough, Bedford, and Luton. Rutland County Council published their fourth Local Transport Plan in September 2019, this sets out their transport vision for the county up to 2036.

Using the Strategic Health Asset Planning and Evaluation (SHAPE) Place tool[19] it is possible to analyse how long it takes by public transport on a weekday morning from any Lower Super Output Area (LSOA) to the nearest pharmacy or dispensing GP practice location. Pharmacies and dispensing GPs 1.5km outside of the Rutland boundary have been included in this analysis

Table 9 and **Figure 11** illustrate public transport times on a weekday morning to pharmacies in the county. Overall, over 44% of the county's population live more than 15-minutes by public transport from a pharmacy or dispensing GP practice on a weekday morning, 16% live between 11- and 15-minutes' journey, 27% live between 6 and 10 minutes and 13% live within a 5-minute journey time. Weekend and afternoon public transport services will present a different percentage of the population within these journey times. Some residents in certain areas and villages can face longer public transport travel times to access the pharmacy services they need.

Figure 11 Public transport time to the nearest pharmacy on weekday mornings



Source: Strategic Health Asset Planning and Evaluation, 2022.

Table 9: Population by public transport travel time on weekday mornings

Less than 5 minutes		6-10 minutes		11-15 minutes		More than 15 minutes	
Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
5,080	12.6%	11,005	27.2%	6,526	16.1%	17,865	44.1%

Source: Strategic Health Asset Planning and Evaluation, 2022.

10.1.4. Access and Populations affected by Deprivation

An analysis of drive, walk and public transport times by deprivation quintile is presented in **Appendix E** (**Tables 4-6**). It demonstrates that:

- 51% of those living in the most deprived areas in Rutland are within a 5-minute drive of a pharmacy or dispensing GP practice.

- 49% of those living in the most deprived areas are more than a 15-minute drive from a pharmacy or dispensing GP practice; and
- 49% of people living in Rutland's most deprived areas live more than a 15-minute walk from the nearest pharmacy or dispensing GP practice; and
- 49% of people living in Rutland's most deprived areas live more than a 15-minute public transport journey on a weekday morning from the nearest pharmacy or dispensing GP practice.

10.1.5. Access and People by Age Profile and Rurality

The **Tables 7-9** in **Appendix E** show drive, walk and public transport times respectively for the estimated population belonging to age bands. The results indicate that:

- Most of Rutland's population (53%) live within a 5-minute drive of a pharmacy or dispensing GP practice. This is higher for the population aged 15-24 (67%) compared with 51% of the population aged 25-64 years.
- 16% of the population in Rutland live less than a 5-minute walk from their nearest pharmacy or dispensing GP practice. This is higher for the population aged 15-24 years (35%), compared with 13% of the population aged 65-84 years.
- 12.6% of the population in Rutland live less than a 5-minute public transport journey on a weekday morning from the nearest pharmacy or dispensing GP practice. This is lower for those in the 25-64 age group (9.7%) and 65-84 age group (9.1%).

The **Tables 10-12** in **Appendix E** show drive, walk and public transport times respectively for the estimated population by Rural Urban Classification[20]. This illustrates that:

- 100% of those living in 'urban city and town' areas in Rutland are within a 5-minute drive of a pharmacy or dispensing GP practice
- 25% of those living in 'rural village and dispersed' areas are more than a 15-minute drive from a pharmacy or dispensing GP practice.
- 100% of those living in 'rural village and dispersed' areas in Rutland are more than a 15-minute walk from a pharmacy or dispensing GP practice.
- 92% of those living in 'rural village and dispersed' areas in Rutland live more than a 15-minute public transport journey on a weekday morning from the nearest pharmacy or dispensing GP practice.

10.1.6. Access and Language

The 2011 Census found that the main language spoken throughout all Middle Super Output Areas (MSOAs) in Rutland was English.[10] However, understanding the proficiency of English and other languages spoken by the population of Rutland is essential to ensure the population is able to access the appropriate service to treat their health needs.

In all areas of Rutland, the percentage of the population who cannot speak English well or cannot speak English at all is significantly lower than the national average. To further understand the gaps in language provision, **Figure 13** examines the second most prevalent language spoken throughout the MSOAs in Rutland. The figure shows that throughout the county, Polish, Oceanic/Australian language, Chinese and French are the second most prevalent languages in areas of Rutland.

Figure 12: Second most prevalent language throughout Middle Super Output Areas in Rutland, 2011[10]

Source: 2011 Census, ONS, 2012

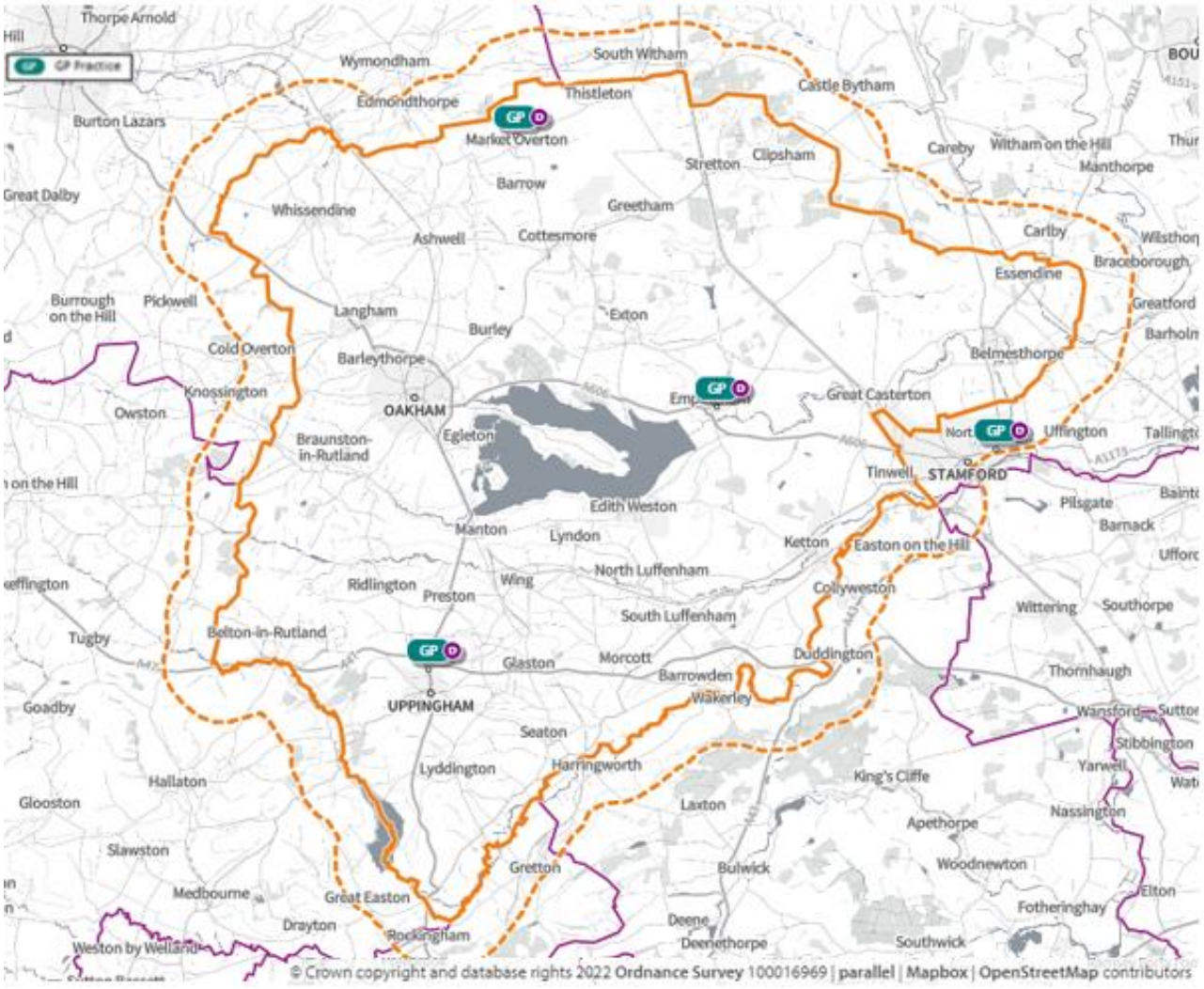
There are however solutions such as language services available to address gaps where there could be challenges accessing services due to language issues.

10.1.7. GP Dispensing

Dispensing doctors may generally only provide pharmaceutical services to patients who live in a designated controlled locality and more than 1.6km (1 mile) from a pharmacy. A controlled locality is an area that has been determined, by NHS England and NHS Improvement, a predecessor organisation or on appeal by the NHS Litigation Authority's Family Health Services Appeal Unit (FHSAU), to be 'rural in character'.[2]

Patients may at any time request in writing that their GP practice provides them with pharmaceutical services. The practice should then check that they meet one of the conditions to be designated a dispensing practice. The purpose of GP dispensing is to recognise the difficulties of providing a full range of essential pharmacy services in rural areas and to provide the patients that live in rural areas with an alternative provider for dispensing services. Rutland has three dispensing GPs which dispense from five different practice locations, as they are able to dispense from their branch and their main surgeries, illustrated in **Figure 13**. The areas that are designated as rural in the Strategic Health Asset Planning (2022).

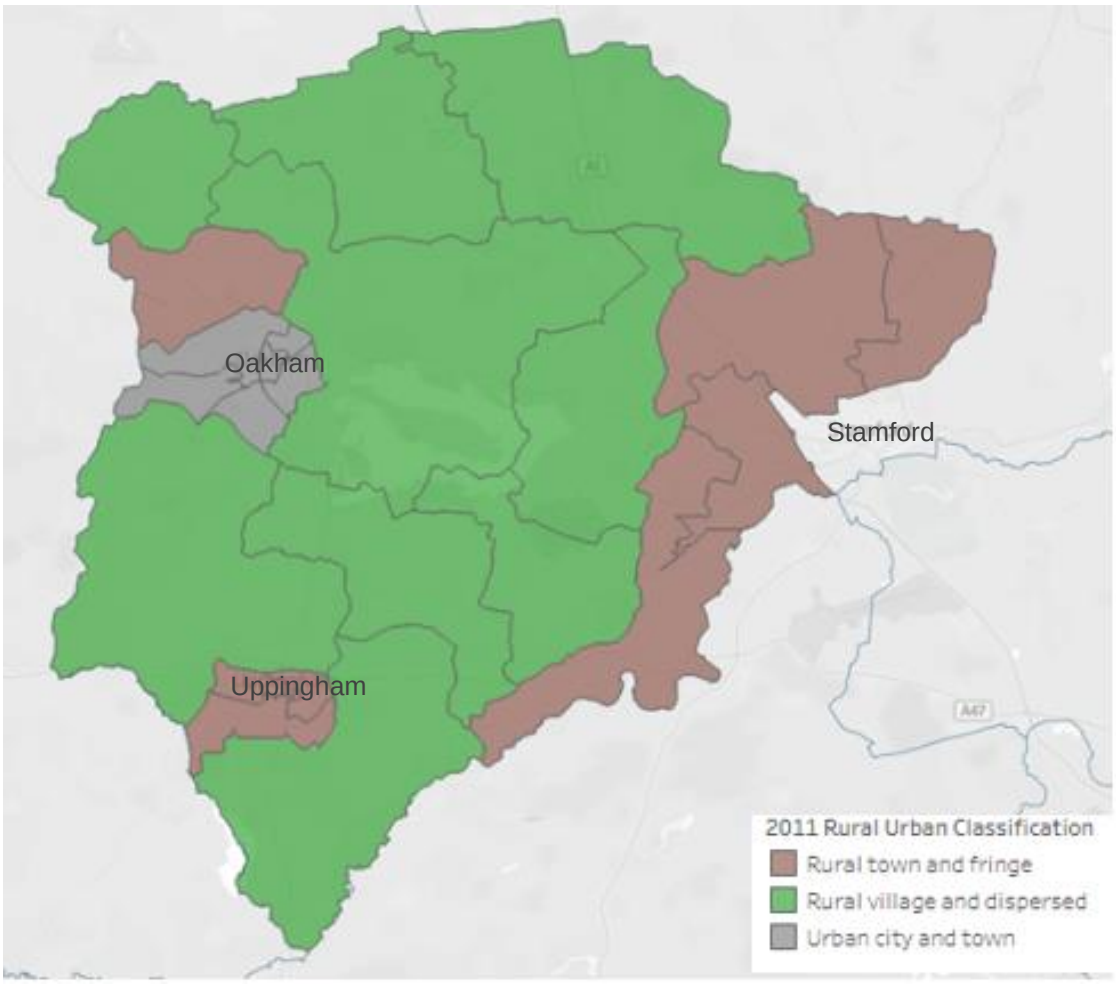
Figure 13: Dispensing GP Practices



Source: Strategic Health Asset Planning and Evaluation, 2022.

Figure 15 represents the controlled localities in Rutland. The dispensing GP surgeries are spread across the localities and whilst a patient may live over a 15-minute walk or 20-minute drive time to their nearest pharmacy or dispensing GP surgery, there is a strong correlation between the walk time analysis and the rural area designation. Designated patients in need of dispensing services will be able to access these as part of their GP visit; but the opening times of GP surgeries will restrict this. The drive and walk time analysis within this report includes the time it will take the people of Rutland to get to either a community pharmacy or a dispensing GP surgery.

Figure 14: Urban and Rural Areas Split, Rutland



Source: 2011 Census, ONS,2012.

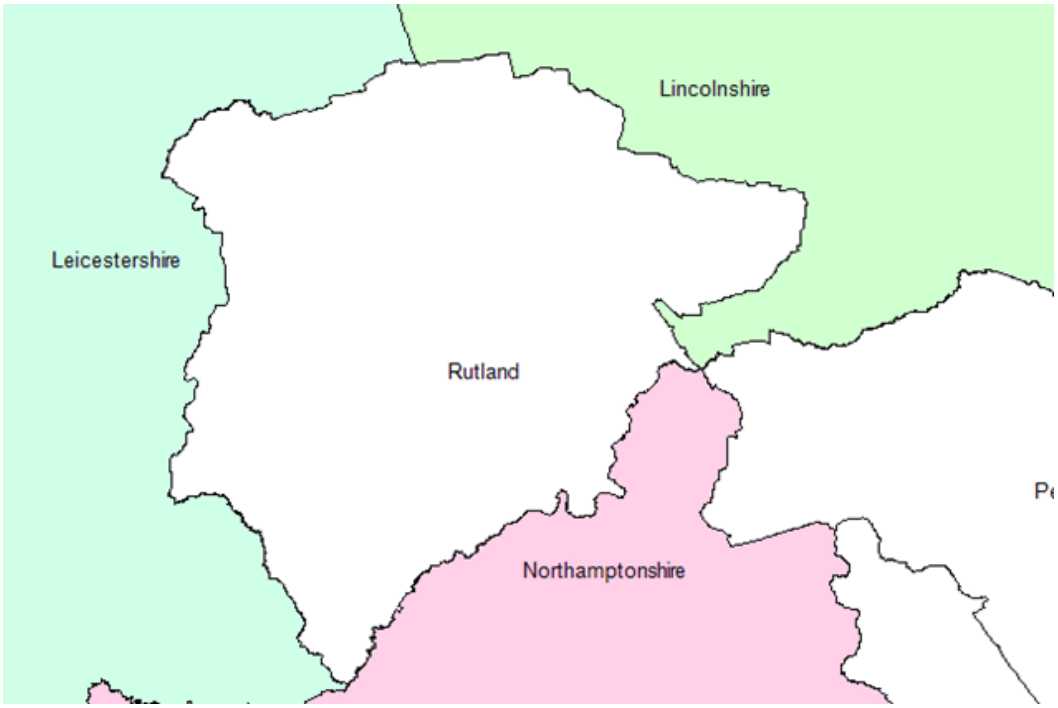
10.1.8. Cross Border Issues

The population of Rutland are able to access pharmacy services from any community or distance selling pharmacy that they choose. This means that they can choose to access services that are near their homes but in another county or unitary authority, services that are near their work or, in the case of internet pharmacies, any registered provider. All the access analysis included in this document includes Pharmacies and dispensing GPs within 1.5km of Rutland's borders. The boundaries that have been considered are illustrated in **Figure 15**.

The Health and Wellbeing Board is a statutory consultee for the PNAs developed in these areas. The most recent published draft PNAs for each area have been used to assess the impact of neighbouring pharmacy provision on the population of Rutland. Responses to the out of area PNA consultation processes will stress the importance of this cross-border provision, particularly in the east of the county to Stamford pharmacies but also to the south east of Rutland.

The most recently published PNAs (2022) or their drafts for each area are briefly summarised below.

Figure 15: Rutland Neighbouring Local Authorities



Leicestershire – the draft 2022 Leicestershire PNA concludes that **no gaps have been identified in the provision of essential, advanced and enhanced services** across the HWB area. A number of detailed points have been made to review and improve overall provision similar to the Rutland PNA. The importance of continued provision for residents in the north-west of Rutland and supporting information has been stressed in response.

Lincolnshire – the draft 2022 Lincolnshire PNA concludes that **no gaps have been identified in the provision of essential, advanced and enhanced services** across the HWB areas. The importance of continued provision from Stamford for residents in the east of Rutland and supporting information has been stressed in response.

North Northamptonshire — the North Northamptonshire HWB final PNA report published in May 2021 concluded that access to pharmaceutical services for the residents of North Northamptonshire was good and the main conclusion was that there are **currently no gaps in the provision of pharmaceutical services**.

Cambridgeshire and Peterborough – the draft PNA 2022 concludes that there is currently sufficient pharmaceutical service provision across Cambridgeshire and Peterborough. Concerns raised include a reduction in the opening hours of many pharmacies, current levels of staffing and recruitment, however **no current or future gaps had been identified** in the provision of necessary and other relevant services. Community pharmacies are regarded as a key public health resource, offering potential opportunities to provide health improvement initiatives and local commissioning organisations are recommended to commission service initiatives in pharmacies.

10.2. Advanced Services

Advanced services are commissioned by NHS England and Improvement from pharmacies. These are voluntary agreements, and any pharmacy can choose to deliver these services as long as they meet the requirements set out in the Secretary of State's Direction around issues such as premises and staff training. These services provide an opportunity for community pharmacists to engage with and empower their patients to take greater control of their health through more effective use of their prescribed medication or appliance. This in turn should help prevent their conditions from unnecessarily getting worse and thus contribute towards savings to the NHS. Advanced services can be provided by community pharmacies and by distance selling pharmacies.

Advanced services such as Covid-19 lateral flow distribution and vaccination programmes have provided high profile, well regarded and important services to residents in recent years and have played an important role within overall provision. These developments have been a successful and well-regarded element of an enhanced role for pharmacies and stress the importance of access to provision moving forwards.

There were 10 advanced services – see **Table 2** - but some of these services, such as C19 lateral-flow provision, have now ended. For some of the services we don't have activity data available – see below.

- New Medicines Service (NMS)
- Stoma Customisation
- Appliance Use Reviews
- Seasonal Influenza (flu) Vaccination Programme
- Community Pharmacist Consultation services (CPCS)
- C-19 Lateral Flow device distribution- **no activity data available -** *ended.*
- Hepatitis C Testing Service
- Hypertension case finding service- **no activity data available.**
- Pandemic delivery service- **no activity data available -** *ended.*
- Smoking Cessation Service (CSC)- **no activity data available.**

Table 10 shows the number of community pharmacies offering each service. Of the five pharmacies in Rutland, all provide the seasonal influenza vaccination service. Four out of the five offered the, New Medicines Service and the Community Pharmacist consultation service. No pharmacies were offering Stoma Customisation, Appliance Use Reviews or Hepatitis C testing services. More details on advanced services activity data are set out in the supporting **Appendix C**.

Table 10: Advanced Services in Rutland

Advanced Services in Community Pharmacies	
Advanced Service	**No. of Pharmacies**
New Medicines Service (NMS)	4
Stoma customisation	0
Appliance Use Reviews	0
Seasonal Influenza (Flu Vaccination Programme)	5
Community Pharmacist consultation services (CPCS)	4
Total Pharmacies	5

Source: NHS England and NHS Improvement, Pharmaceutical Dataset, September 2021

10.3. Quality in Essential and Advanced Services

Quality monitoring of essential and advanced services commissioned by NHS England and NHS Improvement is carried out by self-assessment. A questionnaire is completed by the pharmacy contractor before a visit and then the commissioner will complete the questionnaire upon completion of a monitoring visit. In addition, new pharmacies that have opened and existing pharmacies that have relocated are visited.

10.4. Community Based Services

Community Based Services are additional services that are commissioned by CCGs or by local authorities to meet the health needs of their populations. A number of these services are commissioned from pharmacies (**Table 11**).

The services that are currently commissioned by Rutland County Council are:

- Emergency Hormonal Contraception (EHC)
- Needle and syringe exchange for people with drug addictions; (via Turning Point)
- Supervised administration of methadone and other substitutes; (via Turning Point)
- Champix provision to help people who want to stop smoking; *this has been paused due to discontinuation of production of the treatment.*

The services that are currently commissioned by Leicester, Leicestershire and Rutland CCGs are:

- Extended care services Tier 1- Conjunctivitis and UTI treatment
- Extended care services Tier 2a - Impetigo, Eczema and insect bite treatment
- Palliative medicine supply
- Emergency supply service
- Covid-19 vaccinations - no data available

Table 11: Number of pharmacies providing these local authority commissioned Community Based Services in Rutland as of 31st March 2021

	EHC	Needle Exchange	Supervised Consumption
Rutland	4	1	3

Source: Source: Community Based Service Dataset, Leicestershire County Council and Turning Point Dataset.

These Community Based Services are voluntary agreements and pharmacies are not compelled to offer any or all of the services. Table shows the number of pharmacies offering each service in Rutland.

10.4.1. Emergency Hormonal Contraception

Following an episode of unprotected sexual intercourse, the provision of emergency contraception can help to prevent unplanned pregnancy. Intrauterine devices provide the best method of emergency contraception as they give lasting protection. However, emergency hormonal contraception (EHC) is frequently a preferred method. A public health community-based service contract is currently in place with the aim of reducing unintended conceptions and improving sexual health for young people. Four of the five pharmacies in Rutland offer this service including one 100-hour pharmacy. In 2020/21, the overall consultation rate in Rutland Pharmacies was 6.8 consultations per 1,000 females aged 15-24 years. EHC is also provided by the specialist integrated sexual health service, GP practices in Rutland and by the School Nursing Service. A new EHC drug, Ulipristal, has been found to have a lower failure rate and is effective for up to five days after unprotected sexual intercourse.

10.4.2. Substance Misuse Services

There are currently two Community Based Services for substance misuse, the Needle Exchange Service and the Supervised Methadone Consumption Service. The Public Health Team at Rutland County Council commissions these services through Turning Point, a national charity that supports and treats people with alcohol and substance misuse problems. Turning Point has been commissioned to manage the whole system for people in Rutland with respect to substance misuse, and the pharmacy is a key part of the pathway for community-based services. Turning Point have put in place agreements with pharmacies to deliver needle exchange and supervised methadone consumption to support treatment and harm reduction in the community.

The overall aim of the **Needle Exchange Service** is to reduce the rates of equipment sharing amongst injecting drug users thereby preventing the risks of infection and drug related harm (individual and community). Pharmacies provide access to sterile equipment including needles and syringes and sharps containers for return of used equipment. Where agreed locally, associated materials for example condoms, citric acid and swabs, will be provided to promote safe injecting practice and reduce transmission of infections by substance misusers. Pharmacies offer a user-friendly, non-judgmental, client-centred and confidential service. One pharmacy in Rutland provides this service. This is based in Oakham.

Supervised Methadone Consumption - this service requires the pharmacist to supervise the consumption of methadone or other prescribed drugs at the point of dispensing in the pharmacy ensuring that the dose has been administered to the patient. The pharmacy will provide support and advise the patient including referral to primary care or specialist centres where appropriate. Three pharmacies provide this service in Rutland; two in Oakham, one of which is the 100-hour pharmacy, and one in Uppingham.

10.4.3. Extended Care Services

Of the 5 pharmacies in Rutland in 2020/21 two offered tier 1 extended care services (Conjunctivitis and UTI treatment) both these pharmacies were located in Oakham one of which is a 100-hour pharmacy. One pharmacy offered Tier 2a extended care services (Eczema, Impetigo and Insect bite treatment) this is the 100-hour pharmacy in Oakham.

10.4.4. Palliative Medicine Supply

The palliative medicine supply service requires pharmacies to keep a supply of an agreed list of palliative care drugs to ensure that when prescribed by healthcare providers the drugs can be supplied quickly to palliative patients to ensure their comfort and maintain a good level of care. No Pharmacies in Rutland supplied palliative medicine in 2020/21.

10.4.5. Emergency Supply Service

The Emergency Supply Service allows pharmacists to prescribe prescription only medicines to a patient previously prescribed the requested drug without a prescription. This means a patient can in emergency situations receive a drug without visiting a doctor and is intended to lessen demand for emergency medical care for repeat prescriptions. In 2020/21 three of the five pharmacies in Rutland provided the Emergency Supply Service, including the 100-hour pharmacy in Oakham.

10.4.6. COVID Vaccinations

The East Leicestershire and Rutland CCG also commissioned COVID vaccinations through community Pharmacies, unfortunately no data on this service is available.

More details on community services are set out in the supporting **Appendix D**.

11. Stakeholder Views

A consultation exercise has been undertaken to ask users of pharmacy services and providers of pharmacy services to share their views on the services. The questionnaires and findings are available in the following appendices:

Appendix F – Professionals Pharmacy Questionnaire with Results

Appendix G - Public Pharmacy Questionnaire with Results

11.1. PNA Pharmacy Survey Responses to Initial Questionnaire

91 responses were received from the LLR Pharmacy professionals survey, including 63 from **Leicestershire and Rutland**[1]. The majority of pharmacies in Leicestershire and Rutland receive between 1,000 and 25,000 **enquiries** per year. The average number of **consultations** per week range from 2 to 150 (average 23). 100% have a closed consultation area on the premises and 90% have wheelchair access. Over half have **dementia-friendly** space and **large print** material and a range of other adaptations were made to help people access services.

78% use **locum** pharmacists and 72% use **relief** pharmacists, with recruitment difficulties experienced particularly in community pharmacist, dispenser and medicines counter assistant roles. Though 69% feel able to maintain the current level of services with 18% disagreeing.

43% of respondents intend to provide the appliance use review service, with 52% for the hypertension case finding service. Most would be willing to provide NHS and local authority commissioned services with training and/or facilities.

The majority do not provide **stop smoking service** as an LA commissioned service but 54% would be willing to with training and/or facilities. 8 out of 20 **non commissioned** services are provided by over half of all respondents, with most indicating that they would provide others with support. Over half of respondents do not provide **non-NHS funded** services but most are willing to with training and/or facilities. 59% plan to expand the business with 32% planning to expand online services

79% of respondents indicated that the **number of pharmacies** and the **location** within a 3-mile radius were 'excellent' or 'good' and just under 16% indicated that they were adequate. Ratings for the **range of services** provided within a 3-mile radius were slightly lower, with 61% rating 'excellent' or 'good' and 25% 'adequate'.

11.2. PNA Public Survey Responses to Initial Questionnaire

346 responses were received with around a third from Leicester and the other two thirds from Leicestershire and Rutland. In relation to the **Rutland responses** some of the themes that emerged include that over half (56%) use a **GP practice dispensary** for prescriptions. 51% used a **car** to attend a pharmacy with 80% having **less than 15 minutes** travel time. 69% used a pharmacy at least once a month with 13% using it a few times a month.

87% collected medicines from the pharmacy whilst 13% received delivery by the pharmacy. Most used pharmacies between 9am and 6pm on weekdays. 80% felt opening hours met their needs with 8% disagreeing. 95% felt it easy to find a pharmacy open in the day whilst 49% found it easy in the evening whilst 32% found it difficult. 57% found it easy at weekends whilst 23% found it difficult.

76% were very or fairly satisfied with **advice from pharmacies** with just 3% fairly dissatisfied and 71% very or fairly satisfied with **advice from GP dispensaries** with 9% fairly dissatisfied**. Availability** of medicines, **quality of service** and **location** were the most important aspects of pharmacy

[1] One response from Rutland

services.

Private areas to speak to a pharmacist were also considered important by 82%. Respondents commented on the value of getting vaccinations at pharmacies, advice and also the importance of GP dispensing practices.

Most (95%) agreed that their pharmacy provided a **good service** and provided **clear advice.** Responses highlighted some concerns about speaking to a pharmacist **without being overheard.** Services with **lowest levels of awareness** included advice on physical exercise (5%) and healthy eating advice (8%). 85% of those with **caring responsibilities** indicated that their pharmacy 'always' meets their needs.
The majority indicated that they were not likely to use **postal (70%) or online (home delivery) services (52%)** within the next 3 years.

12. Digital Developments

The Electronic Prescription Service (EPS) enables new and repeat prescriptions to be sent electronically from the GP to the patient's nominated pharmacy. Pharmacies are now able to access an electronic Summary Care Record (SCR) for patients. The NHS SCR is an electronic summary of key clinical information (including medicines, allergies and adverse reactions) about a patient, sourced from the GP record with the patient's consent. SCR was rolled out to pharmacies from March 2016 and will help support safer patient care and treatment. A web-based system called PharmOutcomes[21] collates information on pharmacy services. Local and national analysis and reporting of PharmOutcomes helps improve the evidence base for more effective community pharmacy services.

12.1. Access and Broadband Availability

An average download speed of 10Mbps is required to carry out basic online tasks, such as email, browsing the internet and online shopping, while 'superfast' speeds of 30Mbps are recommended. Data from ThinkBroadband shows that in April 2022, 96.2% of Rutland premises had access to superfast broadband. The Digital Rutland Strategy 2019-2022 sets out plans for superfast broadband to be available to over 97% of Rutland premises on completion of Phase 3 of the Digital Rutland Superfast broadband roll out. Though it is acknowledged that not all people will have the skills and knowledge necessary to carry out tasks such as ordering prescriptions online. As well as some people not being able to afford or willing to purchase digital technology.

13. Projected Future Needs

13.1. Population Projections

The population of Rutland is growing and by 2043 the total population is predicted to reach c46,500 people, a total population growth of 17.2%.[22] However, the population is not growing uniformly across the different age bands. In the next 25 years, the population is predicted to grow as follows (**Table12**):[22]

- A 3.4% increase in children and young people aged 0-24 years (10,427 people to 10,780)

- An increase in the working age population aged 25-64 of 6.1% (from 19,392 people to 20,575)
- A 43.7% increase in people aged 65-84 (from 8,579 people to 12,324)
- A 118.9% increase in the oldest population group of people aged 85 years and over (from 1,299 people to 2,843).

Table 12: Rutland population projections (in 1,000s) - 2018 to 2043[22]

	2018	2019	2024	2029	2034	2039	2043
0-24	10.4	10.3	10.5	10.8	10.8	10.7	10.8
25-64	19.4	19.7	20.3	20.3	20.1	20.2	20.6
65-84	8.6	8.8	9.5	10.5	11.3	12.1	12.3
85+	1.3	1.3	1.6	1.9	2.5	2.7	2.8
All ages	39.7	40.0	41.9	43.5	44.6	45.7	46.5

Source: 2018-based Subnational Population Projections, Office for National Statistics

By 2043, the population of Rutland is projected to grow to c46,500 people. With now six pharmacies and three dispensing GP surgeries, the availability of dispensing providers is considered sufficient to meet the needs of the local population, with rural access issues supported by the GP dispensing surgeries. One avenue to explore is the provision of distance selling pharmacies to potentially increase local pharmacy capacity, to ensure that the needs of local people are being met. The PNA should be reviewed in 2025 to ensure that the needs of the population continue to be met.

Population projections, calculated bi-annually by the Office for National Statistics (ONS), are based on observed past trends and several assumptions of future migration patterns, mortality, and birth rates. They are increasingly uncertain as they go forward into the future[2], and should be treated with caution. Also, the most recently published projections are still based on 2018 population estimates and may change when revised using the Census 2021 data.

13.2. Future Housing

New housing developments will provide housing for the increase in the population projected by the Office for National Statistics but may also see additional population moving into the area through migration. Population growth linked to plans for housing development are not included in the population projections, but the impact on services will be considered as part of the Health Impact Assessment that is carried out for new housing developments. The recent census release will also be used to update forecasts around current and forecast housing provision and population growth.

[2] Office for National Statistics 2020. QMI Report for Subnational Population Projections.

13.3. Long Term Conditions

The unprecedented increase in the older population will lead to increases in the number of people living with long-term conditions. The Projecting Older People Population Information System (POPPI) provides estimates and projections of the number of people that are likely to be affected by long-term conditions both now and in the future in Rutland.[23]

Table 13 shows the number of people in Rutland predicted to be living with various long-term conditions.

Table 11: Projections of older people, age 65 years and over, with long-term conditions, 2020-2035 from POPPI

	2020	2025	2030	2035
Older adults with a limiting long-term illness	2,554	2,932	3,271	3,569
Older adults who are obese or morbidly obese	3,113	3,451	3,817	4,212
Older adults predicted to have Type 1 or Type 2 diabetes	1,296	1,427	1,572	1,744
Older adults predicted to have depression	885	988	1,087	1,192
Older adults predicted to have dementia	768	864	955	1,129
Older adults predicted to have any cardiovascular disease	3,299	3,749	4,140	4,551
Older adults predicted to have a longstanding health condition caused by bronchitis and emphysema	175	196	218	239

Source: Projecting Older Peoples Populations Information, (POPPI), 2022 Statistics

14. Response to the 60 Day Statutory Consultation

There is a statutory requirement for each Health and Wellbeing Board to consult a number of bodies about the contents of the Pharmaceutical Needs Assessment for a minimum of 60 days. The consultation period **took place between June 2022 and August 2022**. The questionnaire used to collect responses is available in the Appendices.

The statutory consultation questionnaire is available in **Appendix H**. In addition, detailed comments were made by members of the Reference Group and in written submissions. Key points from the consultation are set out below.

14.1. LLR Integrated Care System Response

The draft PNA has been reviewed and we are supportive of the conclusions and recommendations reached. Community pharmacy is integral to healthcare provision to Rutland residents. Accessibility, from both a geographical and opening hours perspective, throughout the week is encouraging, but the rurality of the county can mean that public transport can be challenging. We note, overall, that the pharmacies are meeting the current needs of the Rutland population for essential and advanced services.

*Our partners in **community pharmacy** are embedded within our communities, they are accessible without appointment, and they have unique insights into our residents' health. This is a unique combination of assets that we, as a system, must look to better harness if we are to make demonstrable progress in reducing health inequalities and improving health outcomes. Our local approach to the Core20PLUS5 must include community pharmacy who are often at the heart of the communities.*

*Community pharmacy is integral to our **primary care** offer to residents. We must collectively, continue to fully utilise the expertise and experience and availability of community pharmacists, and their teams, to ensure patients can access the right level of care from the right setting at the right time. We, as a system, must go further and faster, to harness this opportunity not only to continue to drive uptake of flu and COVID-19 vaccinations but also to promote healthy literacy, self-care and prevention. Equally complemented by a continued and appropriative uptake and coverage of advanced services dependent upon place or neighbourhood-based need.*

*We note that significant parts of the Rutland County border on **neighbouring systems** and pharmacy provision. It will be important that we, and our partners at the Local Pharmaceutical Committee, stay abreast of any developments or changes in neighbouring provisions that may impact upon local pharmacy services. We also note that any substantial **housing growth** across Rutland may impact on pharmacy provision. It will be vitally important we work with partners to continually assess the impact of any new housing and population growth to ensure pharmacy provision remains able to meet the current, and future needs, of our residents.*

*A key driver for the establishment of primary care networks (PCNs) is to empower and enable all parts of primary care to work together to improve their populations' health and wellbeing. Community pharmacy are an essential partner is this ambition and we will look to continue to develop and nurture collaborative working relationships between all sectors of primary care for the betterment of our residents. This is particularly of note for the military population of Rutland. The Community Pharmacist Consultation Service (CPCS) is one such example where we look to support 100% coverage across Rutland and a continued increase in activity. Community pharmacy is also integral to our systems clinical service delivery model. The Discharge Medicines Service (DMS) has the evidence and ability to reduce readmissions and occupied bed days, we will continue to **promote uptake** and an increase in activity. Equally the hypertension case finding service is crucial to ensure we increase our prevalence and ensure patients begin to receive timely and appropriate treatment minimising risk of further complications in the future.*

*We also note that healthcare and how healthcare is accessed is changing. Ever more **digital solutions** are at the forefront, be it though the ordering of repeat prescriptions via the NHS app, the electronic prescription service (EPS), electronic repeat dispensing (eRD) or accessing advice and*

*guidance through NHS111. We recognise that benefits of digital solutions and approaches can only be realised if we make progress on **digital literacy** which can be a challenge for some residents. We hope that we can work with and harness the accessibility and availability of community pharmacy to continue to support our residents become more fluent in digital and realise the benefits that technology can bring to healthcare.*

*Community pharmacies in Rutland are integral partners to achieving our priorities, through pharmacy commissioned services such as the urgent supply of **palliative care** medicines service. This service endeavours to ensure there is appropriate access to a range of palliative care drugs in accessible locations particularly in the out of hours period, and when treatment is needed urgently. We note the need for a review of coverage of this service to ensure it can meet current and future needs. This service does uniquely demonstrate the value of our community pharmacy partners and we commit to continue to explore and champion how community pharmacy can support the system to and reach our ambitions and realise our priorities.*

*Finally, it is important to acknowledge the integral role that community pharmacies in Rutland played during the **COVID-19 pandemic**. Throughout the pandemic our partners in community pharmacy remained accessible, available and ensured our patients continued to have timely access to their medicines and healthcare advice and guidance. Community pharmacy then played a key role in the testing and vaccination rollout. The NHS continues to experience **significant levels of pressure**, it is important that we, as a system, continue to leverage the strengths of community pharmacy to support our residents through an expected challenging winter.*

14.2. Local Pharmaceutical Committee Response

The Local Pharmaceutical Committee has commented that they feel that in terms of pharmacy/housing numbers growth, using 2.1 per 10,000 population as any sort of target would be an anomaly. Given the current funding situation then pharmacies in order to survive will need to be busier with a larger population. With technological advances, changes in patient access, hub and spoke type models using a population growth model based on 2.1 per 10,000 population would render some existing pharmacies unviable. In fact, it was felt that the number of 2.1 per 10,000 was currently too high in terms of pharmacy viability.

With regard to palliative care medicine supply it was felt that commissioners should extend the opportunity for more pharmacies to engage in providing this service. The LPC also suggest that the disease burden statistics indicate a higher-than-average prevalence of hypertension, cardiovascular disease, and cancer within the Rutland population, all conditions that increase with age. They suggest a need to ensure GP referrals to pharmacy to support with diagnosis and management of conditions. With encouragement of GP referrals into the BP Check Service and identification of new medicines service for asthma and CVD from GPs to pharmacy. It would also be sensible to promote cancer diagnosis and screening techniques into Rutland when this becomes available through pharmacy.

It is important to note the opening hours of dispensing doctors alongside pharmacies to demonstrate the significance of late night and weekend pharmacy hours, particularly in view of the expected increase in GP available hours later in the year. Also, the extent of prescribing of 24 yearly items per person should indicate the need for provision of repeat dispensing across all

pharmacies and encourage GP practices to provide them to pharmacy and through their own dispensing sites.

The drive time analysis would suggest that there is enough pharmaceutical access and provision within the geography. They also point out that the pandemic has changed the way that community pharmacy is perceived and relied upon. The only healthcare profession that remained open during the height of the pandemic, enabling patients to access clinical expertise without an appointment. The LPC highlight the immense pressures today with community pharmacy workforce shortages due to leakage from the sector into GP practices and PCN roles. A national issue, not just a LLR issue. Furthermore, there are other pressures with uncertainty over future funding arrangements.

14.3. Other Responses to the PNA Survey

The PNA survey also supplied a small number of extra public responses as well as one from the acute trust and a pharmacy company. 75% felt the draft PNA accurately reflected current pharmacy provision and that the needs of the population had been adequately reflected. No specific gaps were identified and no disagreement with the recommendations.

Comments include 'we support the recommendations.' As the local acute Trust, we would particularly support increase in DMS activity and expansion of the Community Pharmacy Consultation Services and expansion of the clinical role of Community Pharmacy as important means of avoiding readmission and ensuring good uptake of out of hospital services. The PNA needs to emphasise the need for full access (including data input) to summary care records in order to further develop the clinical services within community pharmacy

14.4. IPMO Plan

During the statutory consultation the Reference Group also noted the development of the new Integrated Pharmacy and Medicines Optimisation (IPMO) Plan.

Pharmacy and medicines optimisation is a key focus for the Leicester, Leicestershire and Rutland (LLR) ICS and is being integrated into the developing ICS framework. There has been the establishment of the Integrated Medicines Optimisation Design Group (IMODG) as one of nine key design groups within the system, responsible for developing and delivering the system operational plan. The plan sets out the ambition for pharmacy and medicines optimisation and has been developed by the IMODG with wider system support and engagement. This is the first iteration, and it is recognised that further work is required to engage outside of the design group and further develop and refine the plan, including agreeing appropriate timescales and outcome measures.

The broad priority areas identified are those supported by the IMODG sub-groups, namely **pharmacy workforce; antimicrobials; polypharmacy; opiates and ensuring medicines value**. In addition, there are established areas of focus e.g., medicines safety, respiratory prescribing, and support to care homes that are outlined in the plan but sit outside the sub-group structure. The **pharmacy workforce theme** is using funding secured by Health Education England to establish pharmacy faculties in each ICB and a **national pharmacy workforce plan** has also been requested by the Department of Health.

15. Gap Analysis

15.1. Essential Services

Rutland benefits from two different types of providers for essential services, community-based pharmacies and dispensing GPs. Combining community pharmacies and dispensing GPs, residents of Rutland have a similar level of access (providers per 10,000 population) when compared to the England average – 2.19 per 10,000 compared with 2.2 nationally.

45% of residents live within a 15-minute walk-time of a pharmacy or dispensing GP surgery. Access to essential services by car is also reasonable, for such a rural area. Less than 20% of the population live more than a 10-minute drive away from their nearest pharmacy or dispensing GP practice location. However, 49% of those living in the most deprived areas are more than a 15-minute drive, walk or public transport journey from a pharmacy or dispensing GP practice. The importance of community, voluntary and demand responsive transport for certain groups and individuals to access services is noted.

Pharmacies across Rutland are open at varying times, providing a service somewhere in the county at almost all times: between 7am and 10pm Monday to Thursday and between 7am and 11pm Friday to Saturday, and supported by the 100-hour pharmacy in Oakham. The 100-hour pharmacy is open on Sundays. There is therefore reasonable coverage of pharmacy provision across Rutland. Patients that need to access emergency pharmacy services outside of opening times are able to access an emergency pharmacy service through the out of hours service.

Subject to the points above regarding the importance of continued community, voluntary and public transport provision, no gaps have been identified in the provision of essential services during normal working hours or outside of normal working areas across the whole Health and Wellbeing Board area. Furthermore, no gaps have been identified in essential services that if provided either now or in the future would secure improvements or better access to essential services across the whole Health and Wellbeing Board area.

15.2. Advanced Services

Table 10 shows the number of community pharmacies offering each service. Of the five pharmacies in Rutland, all provide the seasonal influenza vaccination service. Four out of the five are offered the New Medicines Service and the Community Pharmacist consultation service. No pharmacies offered Stoma Customisation, Appliance Use Reviews or Hepatitis C testing service. Pharmacies that do not provide this service are able to signpost patients to the appliance contractors who do. Hepatitis C testing service is nationally not widely available.

No gaps have been identified in the provision of advanced services across the whole Health and Wellbeing Board area. No gaps have been identified in the provision of advanced services at present or in the future that would secure improvements or better access to advanced services across the whole Health and Wellbeing Board area.

15.3. Community Based Services (CBS)

In relation to Rutland, 4 pharmacies offered emergency hormonal contraception, 1 needle exchange and 3 supervised methadone/substitutes. The CCG commissions extended care services, palliative

medicine supply, emergency supply service and covid-19 vaccinations. LPT commissions under-18 flu and covid vaccinations.

Across Rutland a good range of Community Based Services are therefore offered by pharmacies. The CBS schemes provide the CCGs and Local Authorities with an opportunity to increase the role of pharmacies in delivering the primary care and the public health agendas. Pharmacies are highly valued by the people that use them, and pharmacies have considerable day-to-day accessibility to clients making them an ideal setting for supporting patients and clients to either make informed lifestyle choices or to manage their own health conditions effectively.

Based on current information, no gaps have been identified in the provision of enhanced Community Based Services across the whole Health and Wellbeing Board area. No gaps have been identified that if provided either now or in the future would secure improvements or better access to enhanced services across the whole Health and Wellbeing Board area.

16. Recommendations

16.1. Equity of service

NHS England and NHS Improvement (and where relevant Rutland County Council and the CCG/ICS) should:

- Keep locations, opening times, service usage and transport under review to ensure access to pharmacies for essential services is equitable for all Rutland residents.

- Pharmacy service provision should be kept under review, in particular where provision has cross-county border use, to ensure that issues of quality and uniformity of access to advanced and community-based services are regularly considered.

- The availability of public, community and voluntary transport provision to pharmacy and GP dispensing locations should also be kept under review.

- Keep under review recruitment difficulties for some pharmacies and timely access to some medicines and promote more use of the private consultation rooms.

Promote optimal use of pharmacy services in promoting health and healthcare management

NHS England and NHS Improvement (and where relevant Rutland County Council and the CCG/ICS) should:

- Ensure the promotion of the healthy lifestyles (Public Health) element of essential services. While NHS England and NHS Improvement retains responsibility for this area of the pharmacy contract, local campaigns should be jointly defined by NHS England and NHS Improvement, Local Authority Public Health and the Clinical Commissioning Group/ICS.
- Consider the opportunity to include and develop the role of pharmacies in commissioning strategies, particularly in relation to providing services which deflect work out of primary care general practice.
- Continue to assess levels of uptake of advanced and Community Based Services and follow-up low or high performers in order to share best practice.

17. Conclusions

The Pharmaceutical Needs Assessment looks at pharmacy cover across Rutland in relation to the health needs of the people who live there. It includes existing services, where they are located, the breadth of facilities they are providing, and the views of people both using them and providing them.

Overall, the PNA shows that the community-based pharmacies are meeting the current needs of the Rutland population for Essential and Advanced services. However, the consistency and quality of the Advanced Services should be continually reviewed, and the uptake increased wherever possible. It also shows the provision of Community Based Services across Rutland to be reasonable but indicates that more should be done to increase the promotion and uptake of these services as well as to ensure its consistency across the County.

The PNA also highlights the importance of public, community and voluntary transport to accessing pharmacy provision in Rutland for those without a car and that this should be supported and kept under review. It also highlights that the move to more digital/online provision will take some further time and there is a risk of digital exclusion for those without technology and skills to use it. Facilities for customers to have a confidential conversation in a pharmacy has also been flagged in the survey and consideration should be given to greater use of confidential meeting spaces.

Pharmacies have successfully extended their offer over recent years and surveys indicate a general willingness to offer more services, if funded and supported to do so. However, feedback has also pointed to pressures and the busyness of some pharmacy staff and some recruitment difficulties, which could provide a potential risk to further expansion of services. Timely access to some medicine supplies was also raised through survey responses.

Community pharmacy staff are the easiest healthcare workers for members of the public to access, and they are highly valued by their customers. Pharmacy teams provided one of the few easily accessible healthcare services to the population during the Covid-19 pandemic and were widely recognised for their role in supporting residents and communities, including with tests, vaccinations and home deliveries.

Pharmacies have an essential role in promoting healthy lifestyles and supporting health and social care in the future, particularly with issues such as patient self-care in the community, which can cut down the number of unnecessary admissions to hospital. The landscape of health care in LLR is changing through local and national policy development and the impact on pharmacies should continue to be monitored.

GLOSSARY OF TERMS

AUR	Appliance Use Review
CBS	Community Based Services
CCG	Clinical Commissioning Group
COPD	Chronic Obstructive Pulmonary Disease
CPCS	Community Pharmacist Consultation Service
DHU	Derbyshire Health United
EHC	Emergency Hormonal Contraception
EPS	Electronic Prescription Service
GP	General Practitioner
HWB	Health and Wellbeing Board
IMD	Index of Multiple Deprivation
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LPS	Local Pharmaceutical Services
LSOA	Lower Super Output Area
MSOA	Middle Super Output Area
NHS	National Health Service
NIAVS	National Influenza Adult Vaccination Service
NMS	New Medicines Service
OHID	Office for Health improvement and Disparities
ONS	Office of National Statistics
OOH	Out of Hours
PHOF	Public Health Outcomes Framework
PNA	Pharmaceutical Needs Assessment
POPPI	Projecting Older People Population Information System
QOF	Quality Outcomes Framework
SCR	Summary Care Record
SCS	Smoking Cessation Service
UTI	Urinary Tract Infection

If you require information contained in this leaflet in another version e.g. large print, Braille, tape or alternative language please telephone: 0116 305 6803, Fax: 0116 305 7271 or Minicom: 0116 305 6160.

જો આપ આ માહિતી આપની ભાષામાં સમજવામાં થોડી મદદ ઇચ્છતાં હો તો 0116 305 6803 નંબર પર ફોન કરશો અને અમે આપને મદદ કરવા વ્યવસ્થા કરીશું.

ਜੇਕਰ ਤੁਹਾਨੂੰ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਸਮਝਣ ਵਿਚ ਕੁਝ ਮਦਦ ਚਾਹੀਦੀ ਹੈ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 0116 305 6803 ਨੰਬਰ ਤੇ ਫ਼ੋਨ ਕਰੋ ਅਤੇ ਅਸੀਂ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਦਵਾਂਗੇ।

এই তথ্য নিজের ভাষায় বুঝার জন্য আপনার যদি কোন সাহায্যের প্রয়োজন হয়, তবে 0116 305 6803 এই নম্বরে ফোন করলে আমরা উপযুক্ত ব্যক্তির ব্যবস্থা করবো।

اگر آپ کو یہ معلومات سمجھنے میں کچھ مدد درکار ہے تو براہ مہربانی اس نمبر پر کال کریں 0116 305 6803 اور ہم آپ کی مدد کے لئے کسی کا انتظام کردیں گے۔

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Jeżeli potrzebujesz pomocy w zrozumieniu tej informacji w Twoim języku, zadzwoń pod numer 0116 305 6803, a my Ci dopomożemy.

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JSNA DEMOGRAPHICS - CENSUS 2021 INITIAL RESULTS

Purpose of Report

1. The purpose of this report is to provide the Board with initial analysis of the first results from the national Census 2021.

Background

2. The national Census was undertaken in March 2021. The initial results were published by the Office for National Statistics (ONS) on 28 June 2022 and comprised five datasets containing the following at local authority level. All results are rounded to the nearest 100.

   - usual resident population by sex
   - usual resident population by 5-year age group
   - usual resident population by sex and 5-year age group
   - usual resident population density
   - number of households

3. The census provides the most detailed picture of the entire population, with the same core questions asked to everybody across England and Wales. There is less margin for error in the census than with surveys based on a sample of the population, because the whole population is included. However, census statistics are estimates rather than counts, and so have measures of uncertainty associated with them. The ONS takes numerous steps to minimise possible sources of error.

National & Regional Context

4. The population of England grew by 6.6% compared with Census Day 2011. The population of the East Midlands grew by 7.7%, making it one of the faster growing regions, as shown in the chart below.

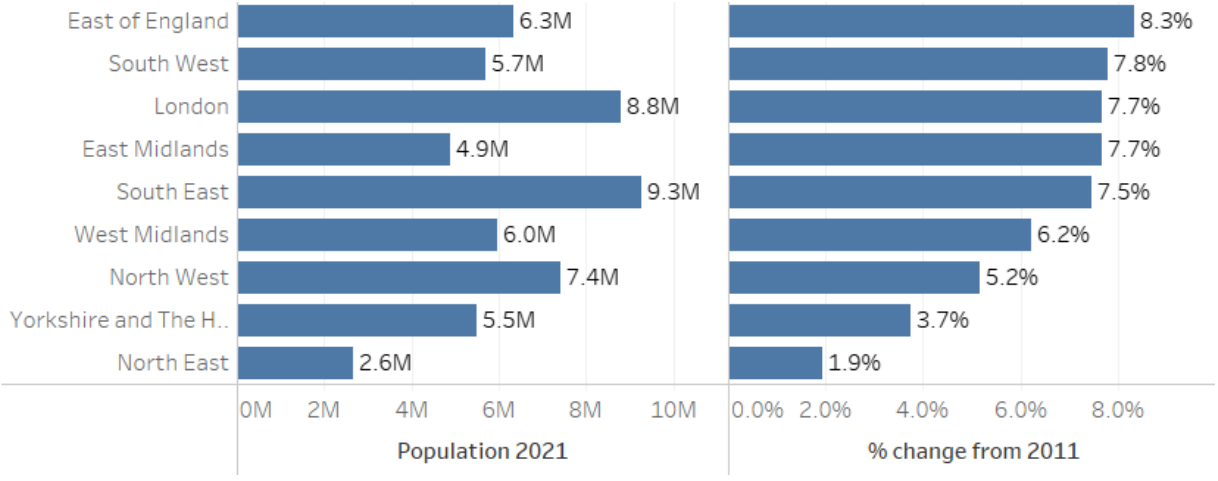
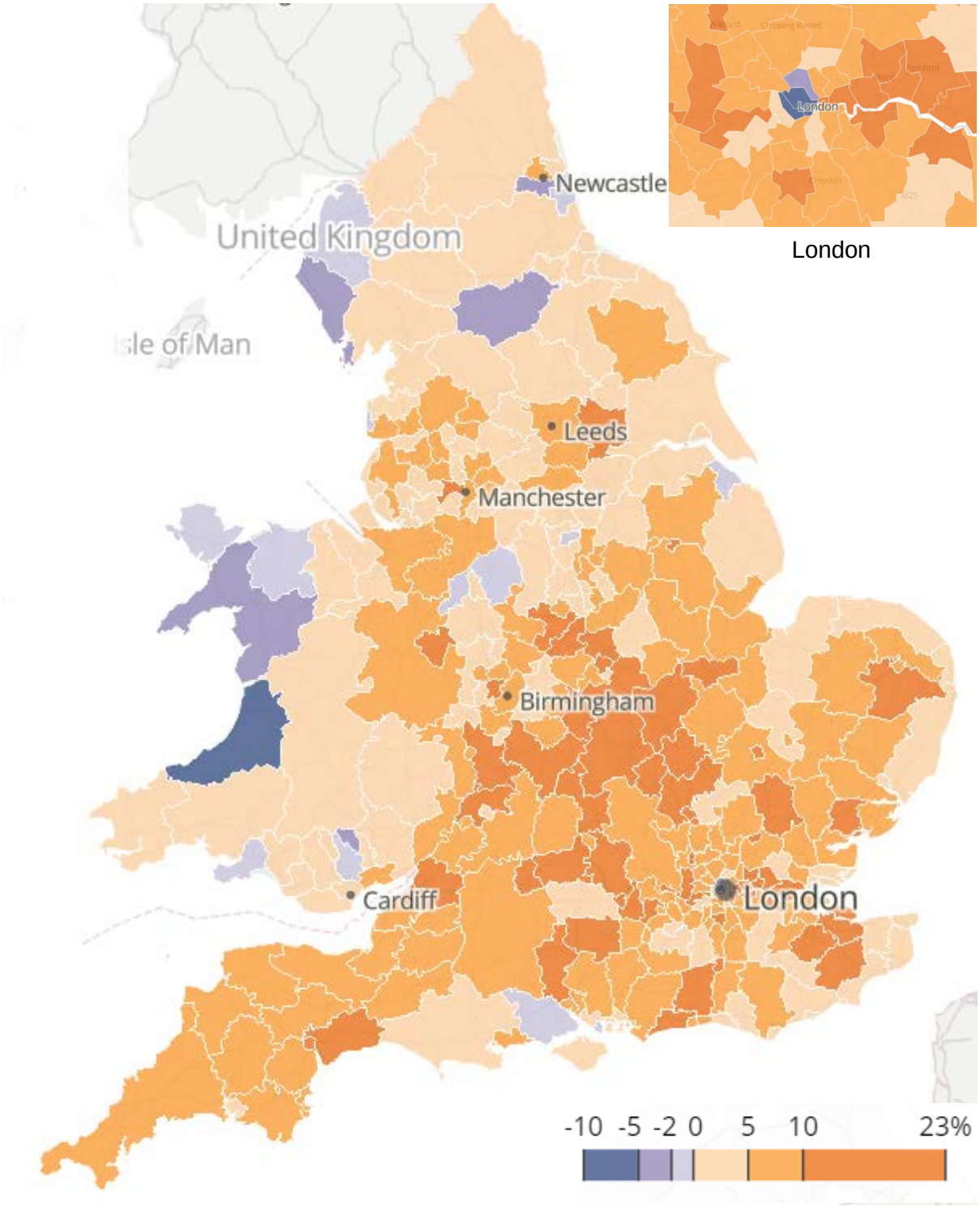


Chart 1: Population Change, 2011 to 2021, Regions

5. The map below shows growth rates at single tier/district level. The map shows a general pattern of lower population growth in Wales, the north and west of England, and in some coastal areas. The higher rates of population growth are found mainly in the Midlands, the South-East and London.



Source: Office for National Statistics - Census 2021

Chart 2: Population Change, 2011 to 2021, Single Tier / District Authorities

Rutland Population Changes

6. The Census results show that the overall population of Rutland has risen from 37,369 in the 2011 Census to 41,000 in the 2021 Census (rounded to the nearest 100). This is an increase of 3,631, which equates to a growth rate of 9.7%. This is higher than the overall increase for England (6.6%), where the population grew by nearly 3.5 million to 56,489,800. The chart below shows the historical growth of the Rutland population since 1951.

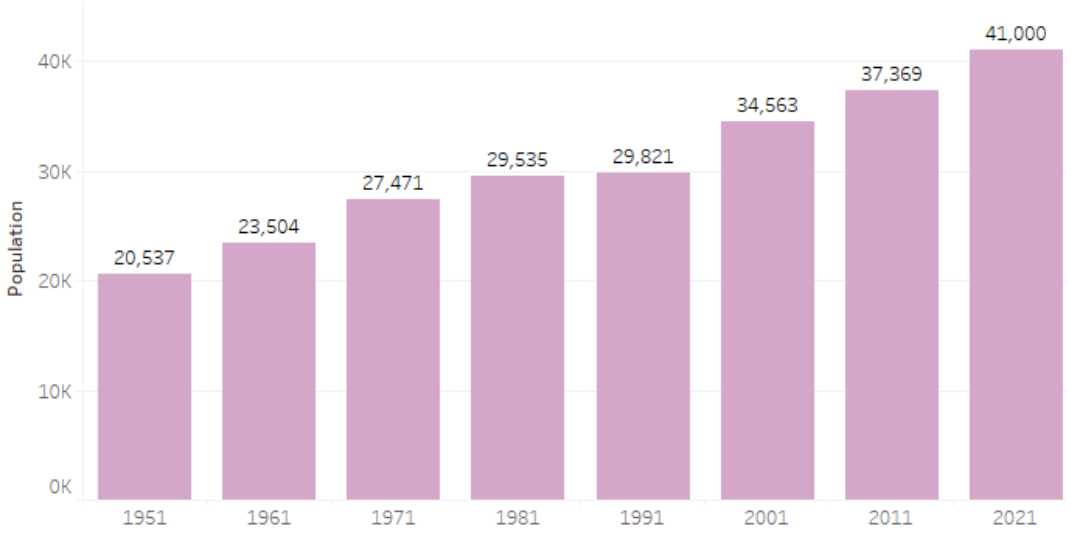


Chart 3: Population Change 1951-2021, Rutland

7. Across the region, population growth since 2011 varies across the single/upper tier local authority areas. Growth was highest in the two Northamptonshire unitaries at 13.5%, followed by Leicester, Rutland, and Leicestershire, as shown in the right-hand column of the chart below.

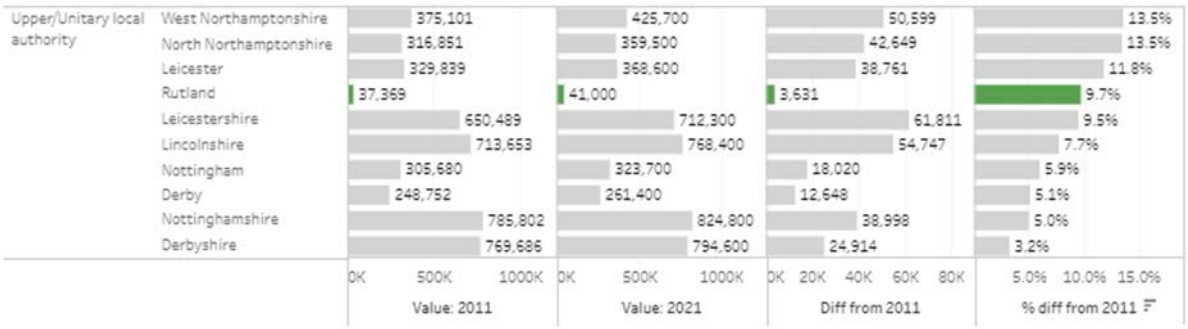


Chart 4: Population Change, 2011 to 2021, East Midlands Single / Upper Tier Authorities

Rutland Analysis by Age Group

8. The chart below shows a 'population pyramid' for Rutland. The chart aggregates rounded numbers from the 2021 census. It shows that the largest 5-year age group for males is 15–19-year-olds and females are 50-54, 55-59 and 70-74 years. The chart also shows that Rutland has more older females than older males.

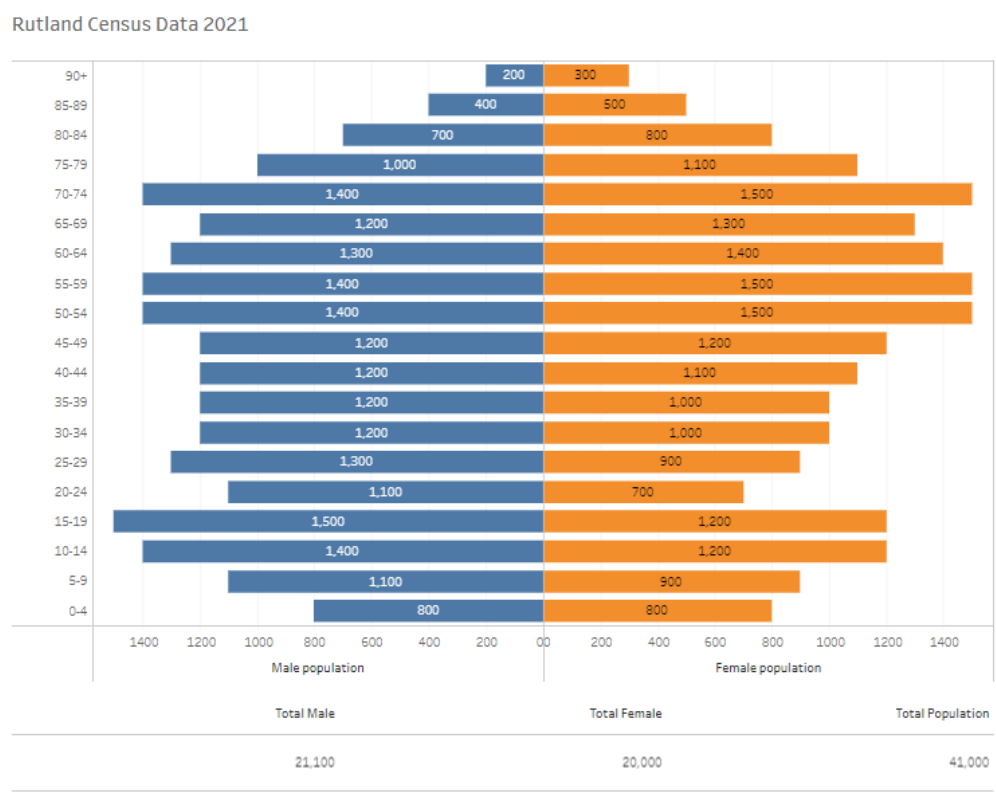


Chart 5: Population by 5 Year Age Group and Sex, Rutland

9. The chart below uses the data from the population pyramid above to show the percentage of the population in each 5-year age group to compare the Rutland population structure (green) with the England population structure (black). The chart shows that there are fewer young adults (20–24-year-olds) and adults (25-49) and more over 50s in Rutland than in the national population.

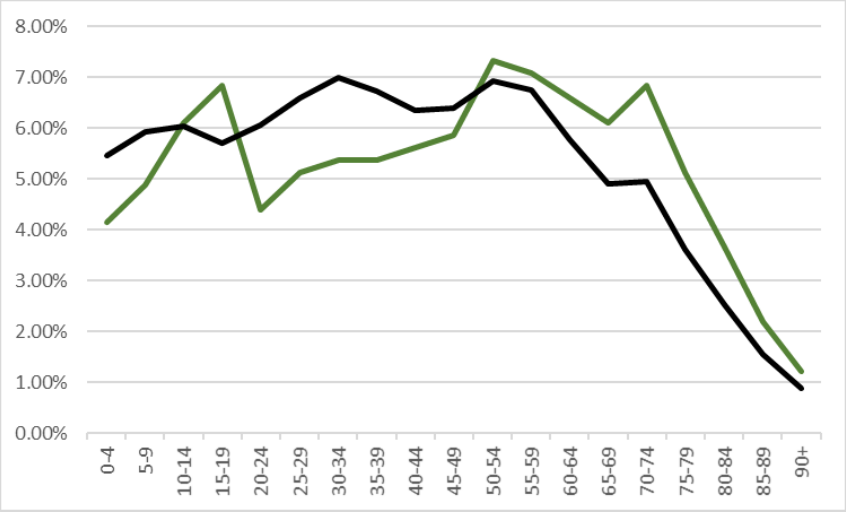


Chart 6: % of Population by 5 Year Age Group, Rutland vs. England

10. The chart below shows the percentage population change between 2011 and 2021 by 5-year age group and sex. It shows that for males, the greatest percentage increase occurred in the age group 90+ years. For females, the greatest percentage increases are in the age groups 75-79 and 70-74 years. The ONS notes that there has been an increase of 31.2% in people aged 65 years and over in Rutland, whereas in England there has been an increase of 20.1%.

11. Across Rutland, for both males and females, there was a reduction in those aged 40-44 and 45-49 years. There was a larger reduction for females aged 35-39, -12.23%, compared to males where there was little change, -1.01%. For females there was little change for age group 25-29 whereas for males there was little change in the age group 20-24. Future Census releases will provide more detail

which may help to explain these changes.

Chart 7: Population % Change by 5 Year Age Group and Sex, Rutland

12. The first chart below shows the breakdown of the Rutland population by broad age group. The second chart shows the percentage change since 2011 by broad age group. Both charts aggregate the rounded numbers provided for each 5-year age group, so the results should be used only as a guide. The second chart shows that the greatest percentage increase from 2011- 2021 was for those aged 80+ (up 32.12%). The greatest percentage decrease from 2011-21 was in the 0-4 age range (down 8.31%).

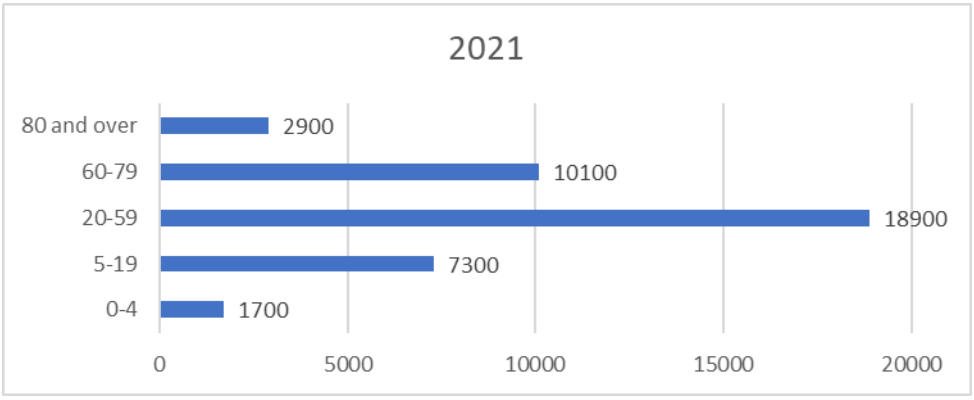


Chart 8: Population by Broad Age Group, Rutland

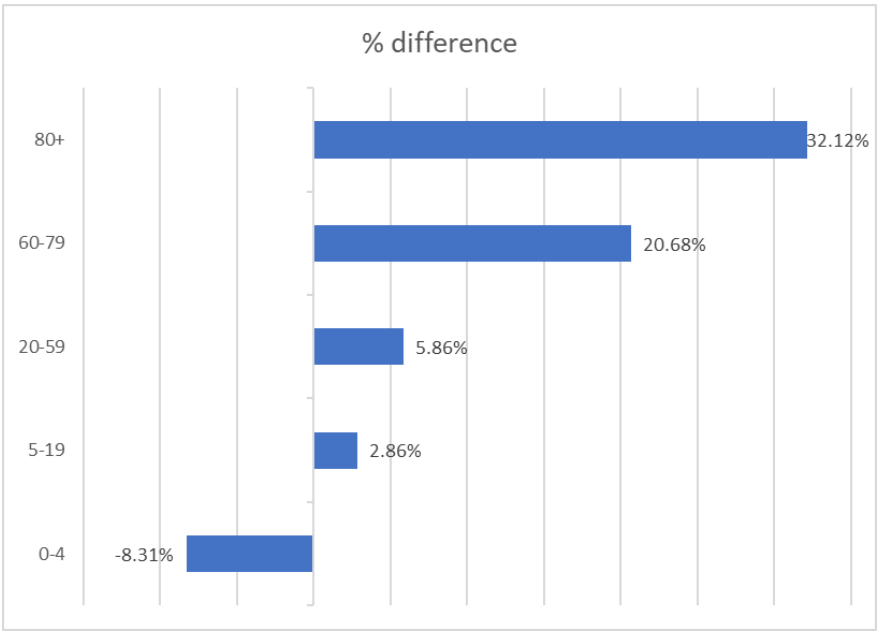


Chart 9: % Change by Broad Age Group, Rutland

Rutland Comparison with ONS Population Estimates

13. The 2021 Census result of **41,000**, (rounded to the nearest 100) is 524 more people than the ONS mid 2020 population estimate, a difference of 1.3%. This suggests that the ONS population estimates are slightly lower than the actual population of the County. The ONS will publish population estimates for mid-2021 in October/November. The results by local authority are set in the table below.

14. The two right hand columns in the table set out differences between the Census results and the 2020 ONS population estimates. Rutland shows 524 more people in the Census.

15. The Leicester City population shows 14,564 more people in the Census than the 2020 mid-year population estimate. This suggests that the ONS population estimates are slightly lower than the actual population of Leicester City.

Local Authority	**2020 Mid-Year Estimate (MYE)**	**2021 Census**	**Difference to 2020 MYE**	**% Difference to 2020 MYE**
Rutland	**40,476**	**41,000**	**524**	**1.3%**
Leicestershire	713,085	712,300	-785	-0.1%
Leicester City	354,036	368,600	14,564	4.1%

Table 1: ONS Mid-Year Population Estimates 2020 and Usual Resident Population 2021 Census

Local Projected Housing Requirements

16. The ONS population estimates are used to project housing need and develop house building targets. Around the country, the Census results are likely to be used by campaigners for both more and less new housing.

17. The ONS noted that as of 2021, Rutland is the fourth least densely populated of the East Midlands' 35 local authority areas.

18. In Rutland, projected housing requirements set out in the Strategic Housing and Market Assessment (SHMA) (last updated 2019) to 2036 are 159 homes per annum. This figure is for the overall housing requirement.

19. A Statement of Common Ground (SoCG) has been developed in order to address Strategic Planning Matters between the parties consisting of Rutland County Council, Peterborough City Council, South Holland District Council and South Kesteven District Council. The four Authorities constitute the Peterborough Sub-Regional Housing Market Area (HMA) and Functional Economic Market Area (FEMA). The SoCG is still subject to individual authority's governance processes and the apportionment of unmet need will be tested through each authority's Local Plan process. The table below sets out the Housing Requirements to 2036 as set out in the Rutland Local Plan 2018-2036. This table brings together different methods of measurement. The emerging Rutland Local Plan identifies a minimum requirement of 130 dwellings per year but allows for some 2,925 houses over the plan period (160 dpa) to provide flexibility.

	Housing requirements		
	SHMA	Standard Method	Local Plans
Rutland	159	130	130[16]
Peterborough	981	942[17]	942[18]
South Kesteven	624	783	650
South Holland	445	416	467

[15] Rounded up from 128 per year.
[16] The Rutland Local Plan seeks to accommodate some 160 dwellings per year in order to provide flexibility.
[17] At the time of preparing the Local Plan. The requirement may have changed subsequently.
[18] Takes account of completions 2016 - 2018

Table 2: Housing requirements based on SHMA, Standard method and Local Plan provision

Future planned releases & timetable

20. The ONS website states that from October 2022 to the end of 2022, they will publish a series of datasets and topic summaries. These will include topic-specific comparisons between census data and other data sources. For example, they will analyse how labour market census data compare with data from the Labour Force Survey. The proposed topic summaries, in publication order, are:

- demography and migration
- ethnic group, national identity, language, and religion
- UK armed forces veterans
- housing
- labour market and travel to work
- sexual orientation and gender identity
- education
- health, disability, and unpaid care

21. Alongside the release of topic summaries, the ONS will make the data available through area profiles. This means that users will be able to view statistics from different topics for a particular area and compare local statistics against national statistics.

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