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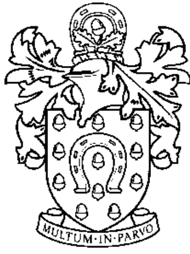

Rutland County Council

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 in the Council Chamber, Catmose, Oakham, Rutland LE15 6HP on **Tuesday, 24th January, 2023** 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/

Although social distancing requirements have been lifted there is still limited available seating for members of the public. If you would like to reserve a seat, please contact the Governance Team at governance@rutland.gov.uk. The meeting will also be available for listening live on Zoom using the following link: https://us06web.zoom.us/j/84996300872

A G E N D A

1) WELCOME AND APOLOGIES RECEIVED

2) RECORD OF MEETING

To confirm the record of the meeting of the Rutland Health and Wellbeing Board held on the 11th October 2022 and the record of the SPECIAL meeting held on the 13th December 2022.
(Pages 7 - 20)

3) ACTIONS ARISING

To review and update the actions arising from the meeting held on the 11th October 2022.
There were no actions arising from the meeting held on the 13th December 2022.

No.	Ref.	Action	Person
1.	9a	HEALTH INEQUALITIES IN RUTLAND The Group welcomed the plan for a development session on health inequalities and agreed that Mitch Harper should arrange the development session for a date after the publication of the expected census data.	**Mitch Harper**
2.	11	Councillor Harvey, Debra, Katherine and John to meet to identify an agreed format for the update reports.	**Councillor Harvey, Debra Mitchell, Katherine Willison and John Morley**
3.	11	Katherine to collate falls data and distribute a briefing to Board members for their information.	**Katherine Willison**
4.	15	Councillor Harvey, Dr James Burden and Mike Sandys to arrange a joint communication regarding the winter vaccination to give the public clear guidance.	**Councillor Harvey, Dr James Burden and Mike Sandys**

4) 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.

5) 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.

6) QUESTIONS WITH NOTICE FROM MEMBERS

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

7) NOTICES OF MOTION FROM MEMBERS

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

STANDING AGENDA ITEMS

8) JOINT STRATEGIC NEEDS ASSESSMENT: UPDATES & TIMELINE

To receive an update from Mike Sandys, Director of Public Health for Leicestershire & Rutland, LCC

A. JOINT STRATEGIC NEEDS ASSESSMENT: OVERVIEW **10 MIN**

To receive an update from Adrian Allen, Assistant Director – Delivery and Hanna Blackledge, Public Health Intelligence Lead, Public Health.

B. HEALTH INEQUALITIES AND END OF LIFE CARE **10 MIN**

To receive Report No. 17/2023 on the Health Inequalities and End of Life Care and Support chapters from Mitch Harper, Strategic Lead – Rutland, Public Health. Both chapters can be viewed here: https://www.lsr-online.org/2022-2025-jsna.html
(Pages 21 - 168)

C. ORAL HEALTH NEEDS ASSESSMENT **10 MIN**

To receive Report No. 18/2023 from Hanna Blackledge, Business Intelligence, Lead Public Health Analyst, Leicestershire County Council.
(Pages 169 - 240)

9) LEICESTER, LEICESTERSHIRE & RUTLAND (LLR) INTEGRATED CARE SYSTEM: UPDATE **5 MIN**

To receive a verbal update from Sarah Prema, Chief Strategy Officer, LLR ICB.

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

To receive Report No. 20/2023 from Katherine Willison, Health and Integration Lead, RCC.
(Pages 241 - 292)

A. COMMUNICATIONS AND ENGAGEMENT STRATEGY AND PLAN

(Pages 293 - 302)

11) BETTER CARE FUND **10 MIN**

To receive Report No. 16/2023 from Councillor S Harvey, Portfolio Holder for Health, Wellbeing and Adult Care and presented by Katherine Willison, Health

and Integration Lead, RCC.
(Pages 303 - 308)

12) UPDATE FROM THE SUB-GROUPS

A. CHILDREN AND YOUNG PEOPLE PARTNERSHIP **5 MIN**

To receive an update from Councillor David Wilby, Chair of the Rutland Children and Young People Partnership including the Group's Terms of Reference for formal approval by the Board.
(Pages 309 - 312)

B. INTEGRATED DELIVERY GROUP **5 MIN**

To receive an update from Debra Mitchell, Deputy Chief Operating Officer, LLR ICB including the Group's Terms of Reference for formal approval by the Board.
(Pages 313 - 316)

C. RUTLAND MENTAL HEALTH NEIGHBOURHOOD GROUP **10 MIN**

To receive Report No. 15/2023 from Mark Young, Senior Mental Health Neighbourhood Lead, RCC including the Group's Terms of Reference for formal approval by the Board.
(Pages 317 - 332)

ADDITIONAL AGENDA ITEMS

13) STAYING HEALTHY PARTNERSHIP **10 MIN**

To receive a briefing from Adrian Allen, Assistant Director - Delivery, Public Health
(Pages 333 - 336)

14) 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 337 - 338)

15) ANY URGENT BUSINESS **5 MIN**

16) DATE OF NEXT MEETING

The next meeting of the Rutland Health and Wellbeing Board will be on Tuesday, 21st March 2023 at 2.00 p.m.

---oOo---

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.	James Burden (Dr) VICE CHAIR	Clinical Place Leader, Rutland Health Primary Care Network
3.	David Wilby (Councillor)	Portfolio Holder for Education and Children's Services
4.	Dawn Godfrey	Strategic Director of Children and Families (DCS), RCC
5.	Debra Mitchell	Deputy Chief Operating Officer, LLR ICB
6.	Duncan Furey	Chief Executive Officer, Citizens Advice Rutland
7.	Ian Crowe	Armed Forces Representative
8.	Janet Underwood (Dr)	Chair, Healthwatch Rutland
9.	John Morley	Strategic Director for Adults and Health (DASS), RCC
10.	Lindsey Booth (Insp)	NPA Commander Melton & Rutland, Leicestershire Police
11.	Louise Platt	Executive Director of Care and Business Partnerships, Longhurst Group
12.	Mark Powell	Deputy Chief Executive, Leicestershire Partnership NHS Trust
13.	Mike Sandys	Director of Public Health for Leicestershire & Rutland, LCC
14.	Sarah Prema	Chief Strategy Officer, LLR ICB
15.	Simon Barton	Deputy Chief Executive, UHL NHS Trust
16.	Steve Corton	Ageing Well Team Support, NHS England - Midlands

OFFICERS ATTENDING:

	Name	Title
17.	Adrian Allen	Assistant Director - Delivery, Public Health
18.	Jane Narey	Scrutiny Officer, RCC
19.	Katherine Willison	Health and Wellbeing Integration Lead, RCC
20.	Mark Young	Senior Mental Health Neighbourhood Lead, RCC
21.	Penny Sharp	Strategic Director for Places, RCC

FOR INFORMATION

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

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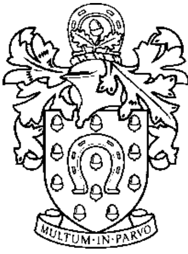


Rutland County Council

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 via Zoom on Tuesday, 11th October, 2022 at 2.00 pm

PRESENT

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.	Debra Mitchell	Deputy Chief Operating Officer, LLR ICB
4.	Duncan Furey	Chief Executive Officer, Citizens Advice Rutland
5.	Ian Crowe	Armed Forces Representative
6.	James Burden (Dr)	Clinical Place Leader, Rutland Health Primary Care Network
7.	Janet Underwood (Dr)	Chair, Healthwatch Rutland
8.	John Morley	Strategic Director for Adults and Health (DASS), RCC
9.	Mark Powell	Deputy Chief Executive, Leicestershire Partnership NHS Trust
10.	Mike Sandys	Director of Public Health for Leicestershire & Rutland, LCC
11.	Paul Kear (Sgt)	Leicestershire Police
12.	Simon Barton	Deputy Chief Executive, UHL NHS Trust
13.	Steve Corton	Ageing Well Team Support, NHS England - Midlands

APOLOGIES:

14.	Dawn Godfrey	Strategic Director of Children and Families (DCS), RCC
15.	Louise Platt	Executive Director of Care and Business Partnerships, Longhurst Group
16.	Sarah Prema	Chief Strategy Officer, LLR ICB
17.	Penny Sharp	Strategic Director for Places, RCC

ABSENT:

18.	Lindsey Booth (Insp)	NPA Commander Melton & Rutland, Leicestershire Police
19.	Adrian Allen	Head of Service Design & Delivery, Public Health, LCC

OFFICERS PRESENT:

20.	Jane Narey	Scrutiny Officer, RCC
21.	Katherine Willison	Health and Wellbeing Integration Lead, RCC

IN ATTENDANCE:

22.	Karen Kibblewhite	Head of Commissioning Health and Wellbeing, RCC
23.	Emma Jane Perkins	Head of Service - Community Care Services, RCC
24.	Mitch Harper	Public Health Strategic Lead (Rutland), LCC
25.	Shaun McGill (Dr)	Specialty Trainee in Public Health Medicine (ST3), NHS England – Midlands

1 WELCOME AND APOLOGIES RECEIVED

Councillor Harvey welcomed everyone to the meeting. Apologies were received from Dawn Godfrey, Louise Platt, Sarah Prema and Penny Sharp.

2 CHAIR'S STATEMENT

The Chair confirmed that a copy of her statement would be distributed with the minutes. It was noted that Viv Robbins from Public Health had left to take up a new role but that Adrian Allen, Public Health's Head of Service Design & Delivery Health would attend these meetings as her replacement. Members were also informed that Sandra Taylor had left her role as Health and Wellbeing Integration Lead at Rutland County Council and that Katherine Willison had taken over the role. The Chair welcomed both to the Health and Wellbeing Board.

3 RECORD OF MEETING

The minutes of the Rutland Health and Wellbeing Board meeting held on the 12th July 2022 were approved as an accurate record.

4 ACTIONS ARISING

Action 1
The Chair to notify Board members of the date for the first meeting of the Health and Wellbeing Partnership.
Councillor Harvey confirmed that she had notified Board members of the date.

Action 2
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.
Debra Mitchell reported that there had been changes in key personnel since the last meeting so the new report formats had been discussed at the Integrated Delivery Group but were for formal approval and feedback at this meeting.

Action 3
All members of the Board were requested to complete the consultation on the proposed Rutland Pharmaceutical Needs Assessment.
Action completed.

Action 4
A report on primary care access, diagnostics and outpatients and elective care services was requested to be presented at the next meeting.
It was confirmed that the item was on the agenda for discussion but would be presented by Debra Mitchell as Sarah Prema had sent her apologies.

5 DECLARATIONS OF INTEREST

There were no declarations of interest declared.

6 PETITIONS, DEPUTATIONS AND QUESTIONS

There were no petitions, deputations or questions received.

7 QUESTIONS WITH NOTICE FROM MEMBERS

There were no questions with notice from members

8 NOTICES OF MOTION FROM MEMBERS

There were no notices of motion from members.

9 JOINT STRATEGIC NEEDS ASSESSMENT: UPDATES & TIMELINE

---oOo---
Mitch Harper joined the meeting at 2.06 p.m.
---oOo---

a) HEALTH INEQUALITIES IN RUTLAND

Report No. 159/2022 was received from Mike Sandys, Director of Public Health for Leicestershire & Rutland, LCC and was presented by Mitch Harper, Public Health Strategic Lead (Rutland). During the discussion, the following points were noted:

- Data regarding issues being reported by women armed forces veterans would require further investigation locally and nationally.
- It was noted that the report only included data from GP surgeries within Rutland but that many Rutland residents were registered at GP surgeries located outside of Rutland. Mitch Harper confirmed that he would be happy to widen the boundary access in order to include data from the GP surgeries located outside of Rutland but used by Rutland residents e.g. Melton Mowbray.
- It was confirmed that under the Core20PLUS5 project, Rutland did not qualify for the Core20 funding as it did not meet the deprivation levels required but that it would receive a small amount of funding from the PLUS5 funding.
- The Group welcomed the plan for a development session on health inequalities and agreed that Mitch Harper should arrange the development session for a date after the publication of the expected census data.

ACTION: Mitch Harper

RESOLVED
That the Committee:

a) **NOTED** the report findings and approved publication of the needs assessment on the Rutland Joint Strategic Needs Assessment (JSNA) website.
b) **WELCOMED** the 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
c) **NOTED** that Mitch Harper would arrange the development session for a date after the publication of the expected census data.

---oOo---
Dr Shaun McGill joined the meeting and Mitch Harper left the meeting at 2.29 p.m.
---oOo---

b) END OF LIFE NEEDS ASSESSMENT

Report No. 160/2022 was received from Mike Sandys, Director of Public Health for Leicestershire & Rutland, LCC and was presented by Dr Shaun McGill, Specialty Trainee in Public Health Medicine (ST3), NHS England – Midlands. During the discussion, the following points were noted:

- The End of Life support service was reported by service users as 'complicated' and 'difficult to access', with a lack of co-ordination between services.
- The Board welcomed the feedback from service users and it was felt that the majority of recommendations would be low cost, quick win changes.
- It was requested that the title for Priority 6 - 'Dying Well' be changed e.g. 'Dying Gracefully' or 'Dying with Dignity' but it was confirmed that 'Dying Well' was the national name for the project but that a different phase could be used locally.

RESOLVED
That the Committee:

a) **ENDORSED** the recommendations arising from the JSNA End of Life chapter, which sought to address the unmet needs and gaps identified therein.
b) **NOTED** that the JSNA End of Life chapter would be used to inform the refresh of the LLR End of Life Strategy which would be undertaken by the Integrated Care Board.
c) **INTEGRATED** the JSNA End of Life chapter into Rutland's Place Led Delivery Plan and changed the local title for Priority 6 'Dying Well'.

---oOo---
Dr Shaun McGill left the meeting at 2.29 p.m.
---oOo---

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

Report No. 162/2022 was received from Sarah Prema, Chief Strategy Officer, LLR ICB and was presented by Debra Mitchell, Deputy Chief Operating Officer, LLR ICB. During the discussion, the following points were noted:

- A joint development session was held on the 11th October 2022 regarding the cost of living crisis as part of the LLR Health and Wellbeing Partnership meeting.

- The next meeting of the LLR Health and Wellbeing Partnership would be held on the 27th October 2022 and this would be another joint development session.
- It was noted that the Health and Wellbeing Partnership must produce an Integrated Care Strategy. This strategy must be published in a draft format by the 25th December 2022 so that it informed the strategic direction of the Integrated Care Board as they planned for 2023/24 and beyond. Therefore, a SPECIAL in-person meeting of the Rutland Health and Wellbeing Board would be held on Tuesday, 13th December 2022 at 2.00 p.m. in the Council Chamber at Rutland County Council for the Board to formerly approve the draft Integrated Care Strategy.
- It was also noted that the Integrated Care Board must develop and publish a 5-year plan by March 2023, which would take account of the Health and Care Partnership's Integrated Care Strategy.

RESOLVED
That the Committee:

a) **NOTED** the update on the Leicester, Leicestershire and Rutland Integrated Care System.

11 JOINT HEALTH AND WELLBEING STRATEGY

Report No. 164/2022 was presented by Katherine Willison, Health and Integration Lead, RCC. During the discussion, the following points were noted:

- The Chair informed attendees that the update reports received on the progress of the JHWS across the six priority areas were currently not acceptable as the Board needed to measure itself against its targets to see how it was progressing and if the six priorities were moving forward. It was proposed that Councillor Harvey, Debra, Katherine and John meet to identify an agreed format for the update reports.

  ACTION: Councillor Harvey, Debra Mitchell, Katherine Willison and John Morley
- It was queried if there was any data that detailed where the greatest number of falls occurred and what measures had been implemented to help prevent falls at home. It was confirmed that the Falls Prevention Programme had been running across LLR for some years and that the Occupational Therapy Service was in contact with social housing providers, the police, the fire service and GP services regarding the 'housing MOT' project, which provided support regarding falls prevention in people's homes. Katherine confirmed that she would collate falls data and distribute a briefing to Board members for their information.

  ACTION: Katherine Willison

RESOLVED
That the Committee:

a) **NOTED** the further development of the JHWS Delivery Plan through the content of this report.

12 BETTER CARE FUND

Report No. 163/2022 was presented by Katherine Willison, Health and Integration Lead, RCC. During the discussion, the following points were noted:

- The next BCF submission would be for a 2-year rolling programme.

RESOLVED
That the Committee:

a) **NOTED** the content of the report
b) **NOTED** 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.

13 UPDATE FROM THE SUB-GROUPS

a) CHILDREN AND YOUNG PEOPLE PARTNERSHIP

A verbal update was received from Councillor David Wilby, Chair of the Children and Young People Partnership. During the discussion, the following points were noted:

- The turnover of staff continued to cause some issues.
- Attendance at schools continued to be good but schools had reported an increase in issues regarding pupil behaviour following the pandemic.
- Excellent results had been received in the GCSE and 'A' level examinations.
- A positive Peer Review had been carried out on the SEND service.
- The work regarding the 'Family Hub' was progressing.
- Unaccompanied asylum seeking children (UASC) continued to work well with many now doing post-16 courses.
- 37 Ukrainian children were currently attending Rutland schools.

b) INTEGRATED DELIVERY GROUP

A verbal update was received from Debra Mitchell, Deputy Chief Operating Officer, LLR ICB. During the discussion, the following points were noted:

- A 'Staying Healthy Partnership' would be established as a sub-group of the Integrated Delivery Group. First meeting would be held in November 2022 and chaired by the Public Health team, with a focus on staying healthy and independent.
- There had been two key staff changes. Viv Robbins and Sandra Taylor had moved to new roles but they had been replaced by Adrian Allen and Katherine Willison respectively. Viv and Sandra were thanked for all their hard work and Adrian and Katherine were welcomed to their new roles.
- Reporting structures had been reviewed and focus was now needed on the Communication and Engagement Plan.
- Councillor Harvey stated that the updated Terms of Reference for both sub-groups needed to be formerly approved by the Health and Wellbeing Board at the next meeting in January 2023.

AGENDA

14 HEALTH UPDATE

a) PRIMARY CARE UPDATE

Presentations were received from Dr James Burden, Clinical Place Leader, Rutland Primary Care Network (PCN). During the discussions, the following points were noted:

- Changes in protocols had enabled long-term conditions to be managed by other health professionals e.g. clinical pharmacists rather than doctors.
- Work was needed within the Communications and Engagement Plan to inform the public on how the health service had changed and what additional roles there were now that worked alongside that of the traditional GP.
- The Government's national 'Workforce Recruitment Strategy' was being implemented successfully in Rutland to recruit health professionals to the area.
- The Enhanced Access survey had received 9000 responses. Healthwatch Rutland and the Chairs of the various Patient Participation Groups were thanked for their assistance in the promotion of the survey.
- The Enhanced Access service started on the 1st October 2022 and under this new service one site of the Primary Care Network (PCN) (Oakham, Uppingham, Market Overton and Empingham) would be open Monday to Friday 6.30 pm to 8.00 pm and Saturday from 9.00 am to 5.00 pm. Only scheduled appointments were allowed but it was open to all patients registered with a Rutland GP.
- Rutland residents who were registered with a GP practice outside of Rutland would be able to access the other GP services who were included as part of that area's Primary Care Network.
- It was noted that better communication was needed to educate and inform patients of the benefits of digital working and how accessing services online enabled GP services to be more efficient.

b) DIAGNOSTICS, OUTPATIENTS AND ELECTIVE CARE SERVICES

A presentation was received from Helen Mather, Elective and Cancer Commissioning Lead, LLR ICB and was presented by Debra Mitchell, Deputy Chief Operating Officer, LLR ICB. During the discussion, the following points were noted:

- 7-day working would be achieved in a phased approach.
- 1 MRI pad for Rutland patients would be implemented.
- The out-of-hours services would remain in place until March 2023.

---oOo---

At 4.27 pm, the Chair proposed that the meeting be extended for a period of 15 minutes for the agenda to be completed. This was seconded by Debra Mitchell and was agreed unanimously by a virtual show of hands.

---oOo---

c) RUTLAND MEMORIAL HOSPITAL: UPGRADES

Report no. 161/2022 was received from Mark Powell, Deputy Chief Executive, Leicestershire Partnership NHS Trust. During the discussion, the following points were noted:

- Mark Powell apologised to the Board about the lack of communication regarding the proposed changes and improvements to Rutland Memorial Hospital and stated that there would be improved communications moving forward.

- £1.2m would be spent on Rutland Memorial Hospital including repairs to the roof, new electrics, the conversion of unused bathrooms to useful storage space and the redecoration of patient areas.
- A stakeholder consultation and engagement process had now been developed and Rutland Healthwatch were engaged in providing the patients' voice.
- Work was expected to be completed by early January 2023.

RESOLVED
That the Committee:

a) **NOTED** the planned £1.2m essential works by Leicestershire Partnership Trust at Rutland Memorial Hospital

15 WINTER VACCINATION PROGRAMME

A presentation was received from Dr James Burden, Clinical Place Leader, Rutland Health Primary Care Network. During the discussion, the following points were noted:

- It was noted that residents could book an appointment for a vaccination via the national vaccination website but that the vaccination would not be done by the residents own GP.
- It was confirmed that if residents wanted the vaccination to be done by their own GP, then they would need to wait until their respective surgery contacted them directly.
- It was proposed that Councillor Harvey, Dr James Burden and Mike Sandys arrange a joint communication regarding the winter vaccination to give the public clear guidance.

ACTION: Councillor Harvey, Dr James Burden and Mike Sandys

---oOo---

At 4.44pm, the Chair proposed that the meeting was extended for a second period of 15 minutes for the agenda to be completed. This was seconded by Debra Mitchell and was agreed unanimously by a virtual show of hands.

---oOo---

16 COST OF LIVING CRISIS

Updates were received from Emma Jane Perkins, Head of Community Care Services and Duncan Furey, Chief Executive Officer, Citizens Advice Rutland. During the discussion, the following points were noted:

- A presentation was received from Emma Jane Perkins – copy attached – which detailed that a pamphlet entitled 'Cost of living support in Rutland' would be available soon for all Rutland residents.
- Further information would also be available in the future from a new Council webpage: www.rutland.gov.uk/livingcosts
- It was reported that contacts to Citizens Advice Rutland had increased by 40% between September 2021 and September 2022. 60% of enquiries were regarding benefits, 10% were regarding housing, 5% were regarding debt and 25% were regarding other issues.
- Enquiries regarding fuel poverty had not yet increased but this was expected as it was suspected that many people had not yet turned their heating on.

- The number of referrals to the food bank by Citizens Advice had increased and the food bank had confirmed that they had received 30% more users than this time than last year.
- It was noted that many people now attending Citizens Advice Rutland and/or the food bank were first time users and many were in paid employment.
- An overview of the income received by people was provided:

  <u>People receiving Universal Credit</u>
  - Single person <25 years of age received £265.31 per month
  - Single person >25 years of age received £334.91 per month
  - Couple <25 years of age received £416 per month
  - Couple >25 years of age received £525 per month

  <u>People receiving state pension</u>
  - Single person received £791 per month
  - Couple received £1207 per month

- Many people were already in debt and/or bill arrears and these numbers were expected to increase as other costs increased e.g. food, fuel, heating, mortgage, rent etc.
- Citizens Advice produced a National Cost of Living Dashboard. This was updated on a regular basis and had national Citizen's Advice data and some Rutland specific data: https://public.flourish.studio/story/1634399/?mc_cid=b3c15a4efa&mc_eid=e1d655cb85
- Dr Underwood confirmed that Healthwatch Rutland would hold a meeting on 3rd November 2022 at 2 p.m. in the Gover Centre at Voluntary Action Rutland on 'How can health inequalities in Rutland be addressed in the face of the escalating cost of living'.

17 REVIEW OF FORWARD PLAN AND ANNUAL WORK PLAN

The work plan was discussed and updated accordingly.

18 ANY URGENT BUSINESS

There was no urgent business

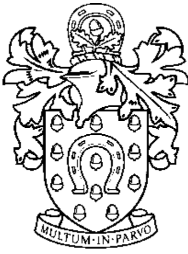
19 DATE OF NEXT MEETING

Tuesday, 13th December 2022 at 2.00 p.m. in the Council Chamber, Catmose, Oakham, Rutland LE15 6HP

No.	Ref.	Action	Person
1.	9a	HEALTH INEQUALITIES IN RUTLAND The Group welcomed the plan for a development session on health inequalities and agreed that Mitch Harper should arrange the development session for a date after the publication of the expected census data.	**Mitch Harper**

2.	11	Councillor Harvey, Debra, Katherine and John to meet to identify an agreed format for the update reports.	**Councillor Harvey, Debra Mitchell, Katherine Willison and John Morley**
3.	11	Katherine to collate falls data and distribute a briefing to Board members for their information.	**Katherine Willison**
4.	15	Councillor Harvey, Dr James Burden and Mike Sandys to arrange a joint communication regarding the winter vaccination to give the public clear guidance.	**Councillor Harvey, Dr James Burden and Mike Sandys**

---oOo---
Chairman closed the meeting at 4.55 pm.
---oOo---



Rutland County Council

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

Minutes of the **SPECIAL MEETING of the RUTLAND HEALTH AND WELLBEING BOARD** held in the Council Chamber, Catmose, Oakham, Rutland, LE15 6HP on Tuesday, 13th December, 2022 at 2.00 pm

PRESENT

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.	David Williams [representing Mark Powell]	Director of Strategy and Business Development, Leicestershire Partnership NHS Trust
4.	Dawn Godfrey	Strategic Director of Children and Families (DCS), RCC
5.	Debra Mitchell	Deputy Chief Operating Officer, LLR ICB
6.	Duncan Furey	Chief Executive Officer, Citizens Advice Rutland
7.	Ian Crowe	Armed Forces Representative
8.	Janet Underwood (Dr)	Chair, Healthwatch Rutland
9.	John Morley	Strategic Director for Adults and Health (DASS), RCC
10.	Mike Sandys	Director of Public Health for Leicestershire & Rutland, LCC
11.	Sarah Prema	Chief Strategy Officer, LLR Integrated Care Service

APOLOGIES:

12.	James Burden (Dr) VICE CHAIR	Clinical Place Leader, Rutland Health Primary Care Network
13.	Louise Platt	Executive Director of Care and Business Partnerships, Longhurst Group
14.	Mark Powell	Deputy Chief Executive, Leicestershire Partnership NHS Trust
15.	Paul Kear (Sgt) [representing Insp. Booth]	Leicestershire Police
16.	Penny Sharp	Strategic Director of Places
17.	Simon Barton	Deputy Chief Executive, UHL NHS Trust

ABSENT:

18.	Lindsey Booth (Insp)	NPA Commander Melton & Rutland, Leicestershire Police
19.	Steve Corton	Ageing Well Team Support, NHS England - Midlands

OFFICERS PRESENT:

20.	Adrian Allen	Head of Service Design & Delivery, Public Health
21.	Jane Narey	Scrutiny Officer, RCC
22.	Katherine Willison	Health and Wellbeing Integration Lead, RCC
23.	Mat Wise	Service Manager - Hospital Team

1 WELCOME AND APOLOGIES RECEIVED

The Chair welcomed everyone to the meeting. Apologies were received from Simon Barton, Louise Platt, James Burden, Mark Powell, Penny Sharp, Sgt Paul Kear

2 DECLARATIONS OF INTEREST

There were no declarations of interest

3 PETITIONS, DEPUTATIONS AND QUESTIONS

There were no petitions, deputations or questions

4 HEALTH AND WELLBEING PARTNERSHIP - DRAFT INTEGRATED CARE STRATEGY

The initial draft of the Integrated Care Strategy from the Health and Wellbeing Partnership was presented by Sarah Prema, Chief Strategy Officer, Leicester, Leicestershire and Rutland Integrated Care Service.

The document was for comment by the Rutland Health and Wellbeing Board before it went out for consultation following its official approval by the Health and Wellbeing Partnership at its meeting on the 15th December 2022. During the discussion, the following points were noted:

- The Health and Wellbeing Partnership was a partnership board between the NHS and its partners including local authorities and was established in July 2022 as part of the changes to the NHS.

---oOo---
Dawn Godfrey joined the meeting at 2.05 p.m.
---oOo---

- The strategies for each health and wellbeing board (Leicester, Leicestershire and Rutland) were the basis for the draft Integrated Care Strategy.
- The Integrated Care Strategy would be based on things that could be done at a system level whilst the individual health and wellbeing strategies were based on things that could be done at a place level.
- Workshops were held by the Health and Wellbeing Partnership in June and October 2022 and 6 priorities were identified.
- Priorities 1 to 4 would be focused on over the next 5 years whilst Priorities 5 and 6 would be focused on over the next 2 years.

  Priority 1: Reducing Health Inequalities
  Priority 2: Preventing illness and helping people to stay well

Priority 3: Championing integration
Priority 4: Fulfilling our role as ‘Anchor’ organisations
Priority 5: Co-ordinated action on the Cost-of-Living crisis
Priority 6: Making it easier for people to access the services they need

- The Integrated Care Strategy would be published by the 31st December 2022 and consultation events would be held in early 2023. It was still in a very draft format and was very much a work in progress.
- It was noted that it was good to see inclusion of the armed forces within the strategy but it was requested that the phrase ‘serving military’ was changed to ‘serving armed forces personnel’ and the phrase ‘military’ was changed to ‘armed forces community.’
- Members commented that there was not enough explicit recognition about the limitations of rural public transportation and the difficulties this created plus there was no information or comment about data sharing with patients. Members were informed that Peterborough City Hospital allowed patients to have some electronic control over their appointments so ensuring that different appointments were not on consecutive days. This system was not currently available at Leicester hospitals.
- The Integrated Care Strategy needed to show that it was linked to the 5-year forward plan of the Integrated Care Board and how it linked with the actions for the identified priorities
- Members agreed that the language within the strategy needed to be amended to be more easily understood by the public.
- The Chief Strategy Officer stated that the strategies for adjoining areas were also being drafted but would be open for viewing and consultation in early 2023.
- Members noted that it was good to see a focus on the cost of living crisis (Priority 5) and the creation of a task and finish group as fuel poverty, food poverty and transport poverty were big issues in parts of Rutland.
- Members were informed that MacMillan Cancer Support could provide free funding/car parking for cancer patients and it was agreed that transport details should be included on the Council’s webpage.
- Members queried if residents could access treatments locally rather than travel to Leicester or Peterborough. It was noted that some treatments i.e. chemotherapy etc. had to be undertaken in the larger hospitals in case of emergencies due to the toxicity of the medication used.
- It was proposed that the example (stated on page 13) of a Joint Health and Wellbeing Strategy action for Rutland should be replaced with a more detailed and specific action.
- It was noted that the older and younger generation were excluded digital access to services due to a lack of digital knowledge and/or the financial cost involved but that the ‘Digital Strategy’ would cover all levels i.e. system, place and location.
- Members agreed that the current Integrated Care Strategy was too vague and needed more detail but it was noted that this would be done following comments received as part of the consultation process.
- The Board concluded that the final strategy would need to be easily understood by the public, that the language used in the document would need to be changed to make it more public facing and that an ‘easy read’ version of the final strategy should be made available.
- The Chief Strategy Officer informed members that the final version of the Integrated Care Strategy would be presented to the Board for formal endorsement

and that a timeline would be given at the next meeting for the details to be added to the Board's Work Plan for 2023/2024.

RESOLVED
That the Board:

a) **AGREED** the initial draft of the Integrated Care System with the amendments proposed by the Rutland Health and Wellbeing Board.

5 ANY URGENT BUSINESS

There was no urgent business

6 DATE OF NEXT MEETING

Tuesday, 24th January 2023 at 2.00 pm in the Council Chamber, Catmose, Oakham LE15 6HP

---oOo---
The Chair declared the meeting closed at 2.58 pm.
---oOo---

Agenda Item 8b

Report No: 17/2023
PUBLIC REPORT

HEALTH AND WELLBEING BOARD

24 January 2023

RUTLAND HEALTH INEQUALITIES AND END OF LIFE NEEDS ASSESSMENT

Report of the Director of Public Health

Strategic Aim:	Healthy and Well	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Sam 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	N/A	

DECISION RECOMMENDATIONS
That the Committee: 1. Approves the Rutland Health Inequalities Needs Assessment and proposed governance approach. 2. Approves the End of Life Needs Assessment and proposed governance approach.

1. PURPOSE OF THE REPORT

1.1 The purpose of this report is to gain approval for two Health Needs Assessments as part of the Rutland Joint Strategic Needs Assessment – Rutland Health Inequalities and End of Life.

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 (HWB).

2.2 The Rutland Health Inequalities and End of Life Needs Assessments were discussed at the October Rutland HWB. Points from the discussion were welcomed and the HWB is now asked to approve both Needs Assessments to form part of the Rutland JSNA. Any changes because of the discussion are summarised below.

2.3 The Rutland Health Inequalities Needs Assessment made the following changes after the October HWB discussion. The Primary Care access in section 2 data was rerun to include Melton GP surgeries. Whilst some Rutland residents will use Melton surgeries, it didn't affect the level of accessibility to the nearest GP by drive time. The development session has been set up for the end of January 2023. The session will include Census data released in recent months.

2.4 It is proposed that the Rutland Staying Healthy Partnership (if approved as a HWB subgroup in the 24th January 2023 meeting) shall oversee the delivery of the health inequalities workstream, in accordance with the Rutland Health & Wellbeing Strategy priorities. The Partnership will oversee delivery of the Health Inequalities development session at the end of January 2023 and the implementation of outcomes from this session.

2.5 It is proposed that the Integrated Delivery Group shall oversee the development and delivery of the End of Life Needs Assessment recommendations, in accordance with the Rutland Health & Wellbeing Strategy priorities. The actions will align with Leicester, Leicestershire and Rutland ICB End of Life workstreams as required.

3. REPORT RECOMMENDATIONS

3.1 Approve the Rutland Health Inequalities Needs Assessment and proposed governance approach.

3.2 Approve the End of Life Needs Assessment and proposed governance approach.

4. CONSULTATION

4.1 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. ALTERNATIVE OPTIONS

5.1 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.

6. FINANCIAL IMPLICATIONS

6.1 Completion of the needs assessments 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.

7. LEGAL AND GOVERNANCE CONSIDERATIONS

7.1 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.

8. DATA PROTECTION IMPLICATIONS

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

9. EQUALITY IMPACT ASSESSMENT

9.1 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.

10. COMMUNITY SAFETY IMPLICATIONS

10.1 N/A

11. HEALTH AND WELLBEING IMPLICATIONS

11.1 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.

12. ORGANISATIONAL IMPLICATIONS

12.1 Environmental Implications
N/A

12.2 Human Resource Implications
N/A

12.3 Procurement Implications
N/A

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 N/A

15. APPENDICES

15.1 Appendix A – Rutland Health Inequalities Needs Assessment

15.2 Appendix B – Rutland End of Life Needs Assessment

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

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
Strategy and Business Intelligence
Chief Executive's Department
Leicestershire County Council
County Hall, Glenfield
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Produced by the Strategic Business Intelligence Team at Leicestershire County Council.

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

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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.

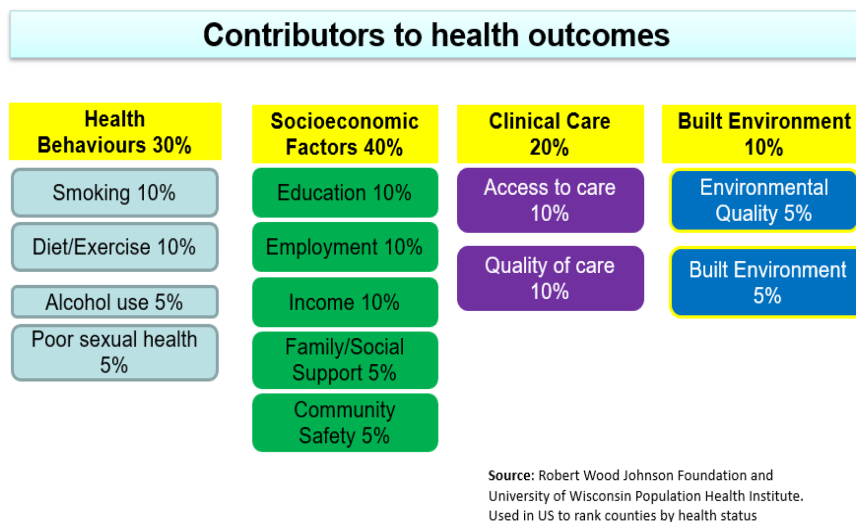


Figure 1 Contributors to health outcomes[6].

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.

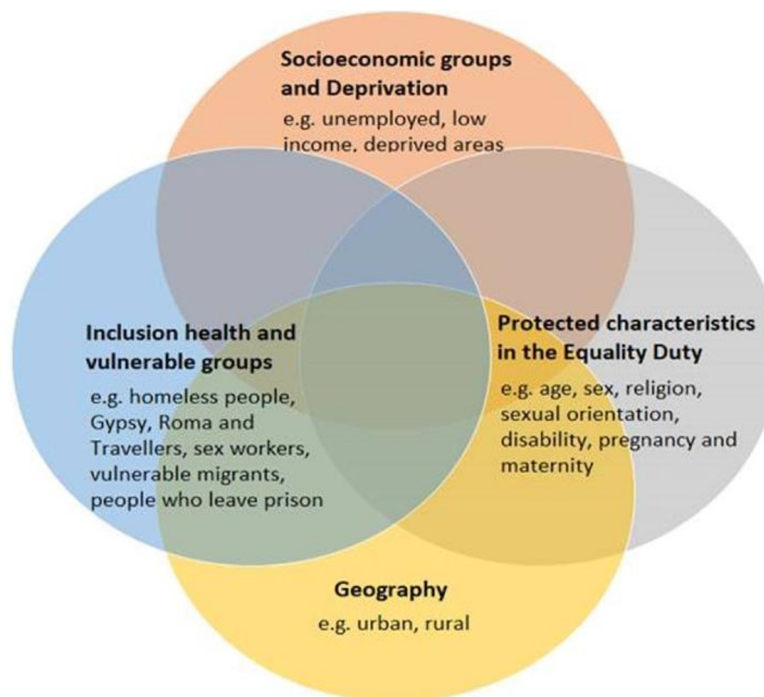


Figure 3 Overlapping dimensions of health inequality.

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.

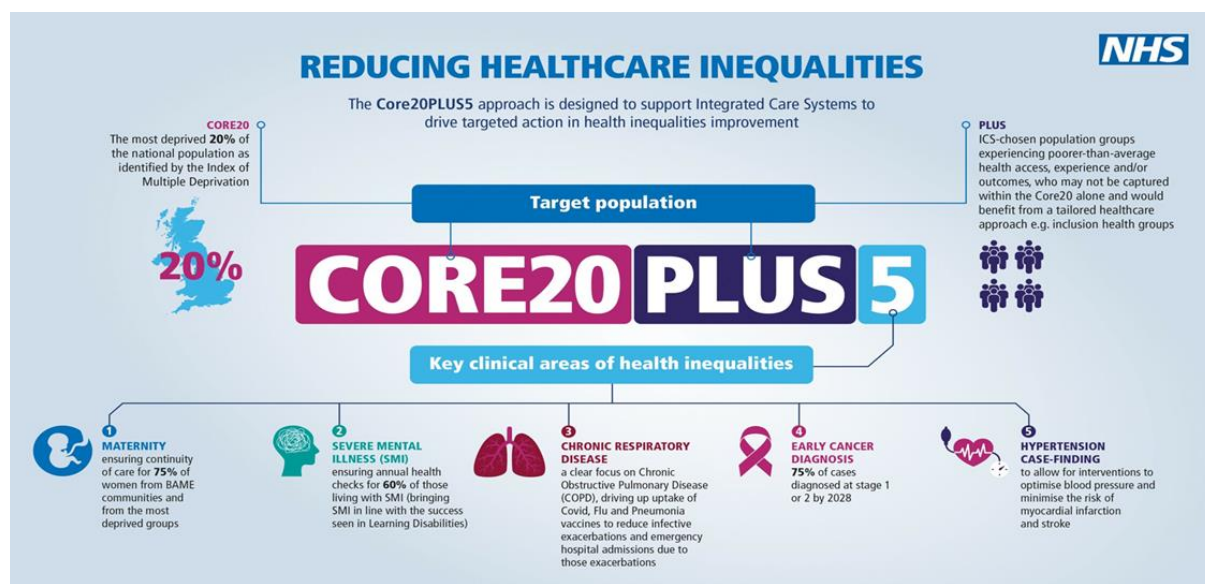


Figure 4 Core20PLUS5, NHS England and Improvement.

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.

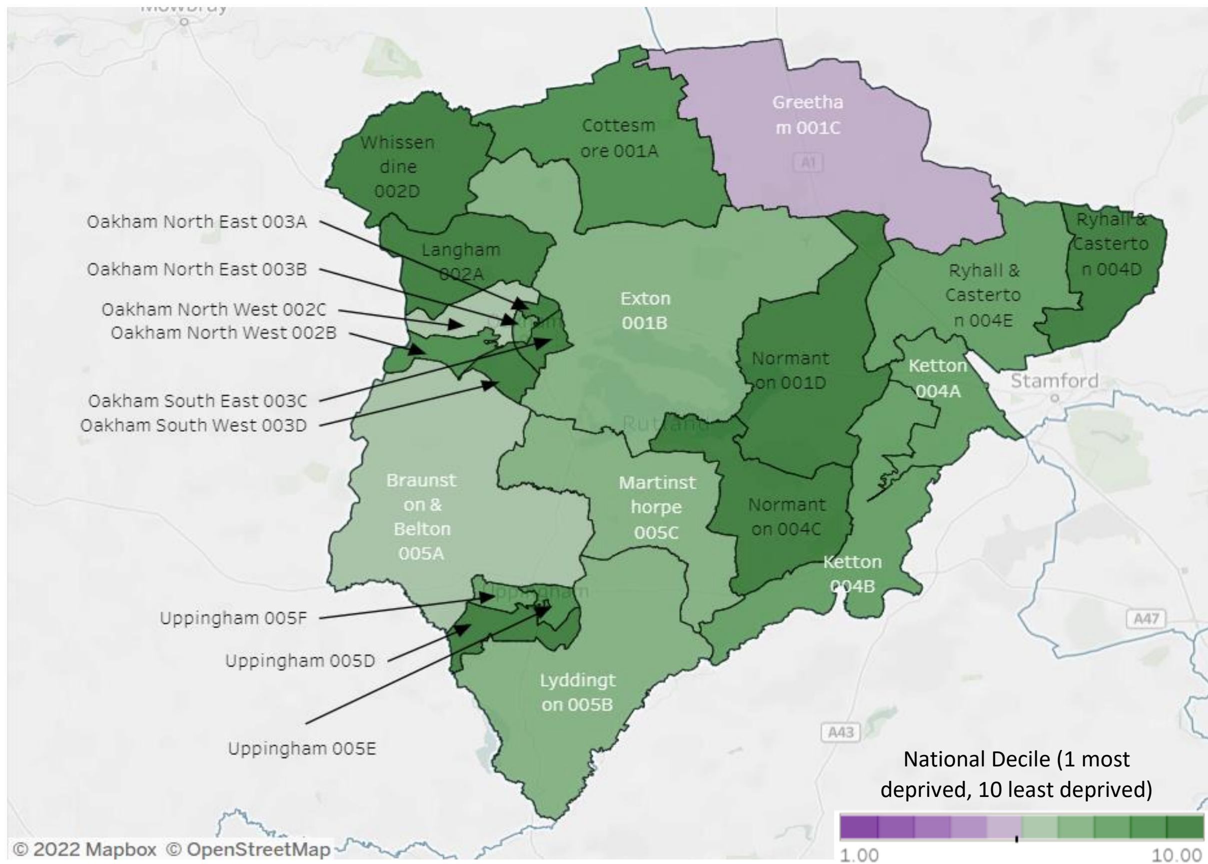


Figure 5 Index of Multiple Deprivation (IMD) in Rutland.

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.

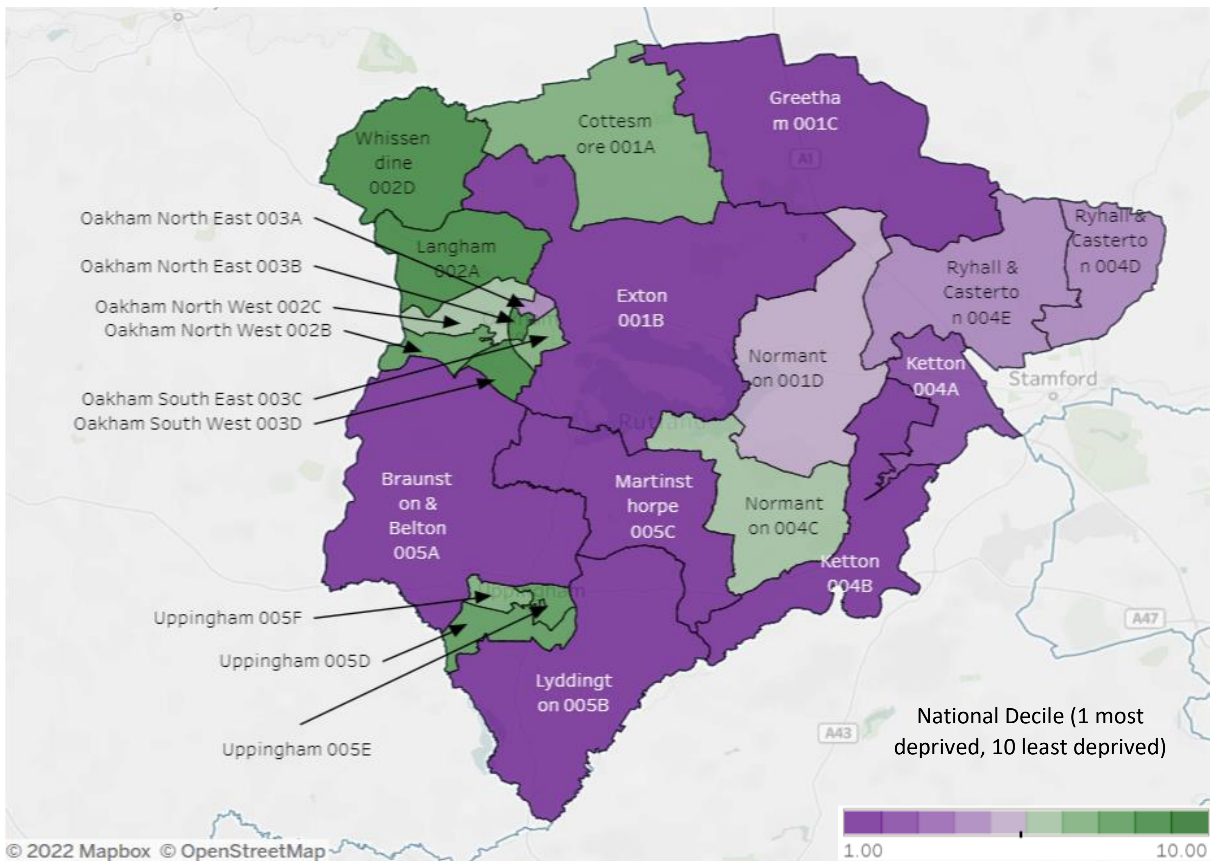


Figure 6 Barriers to Housing & Services[18]

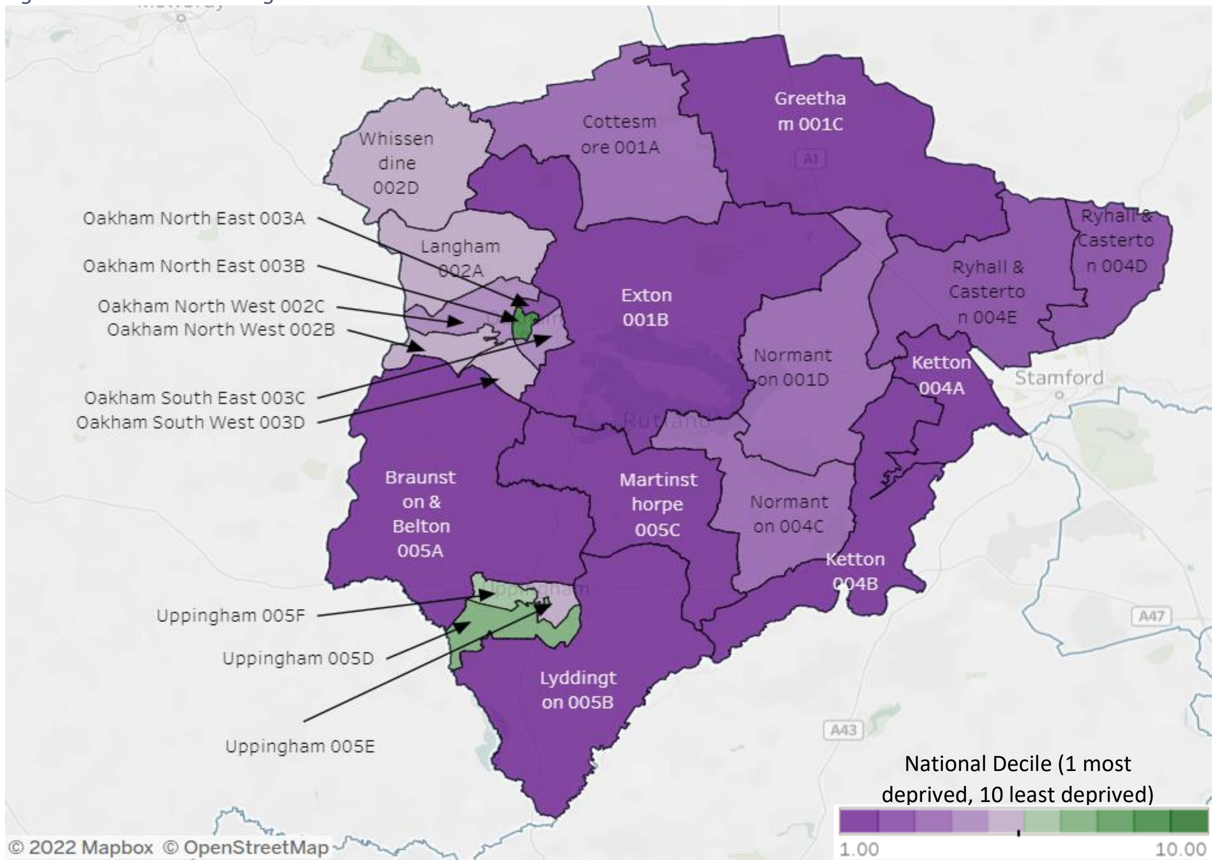


Figure 7 Geographical Barriers Sub-domain.

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.

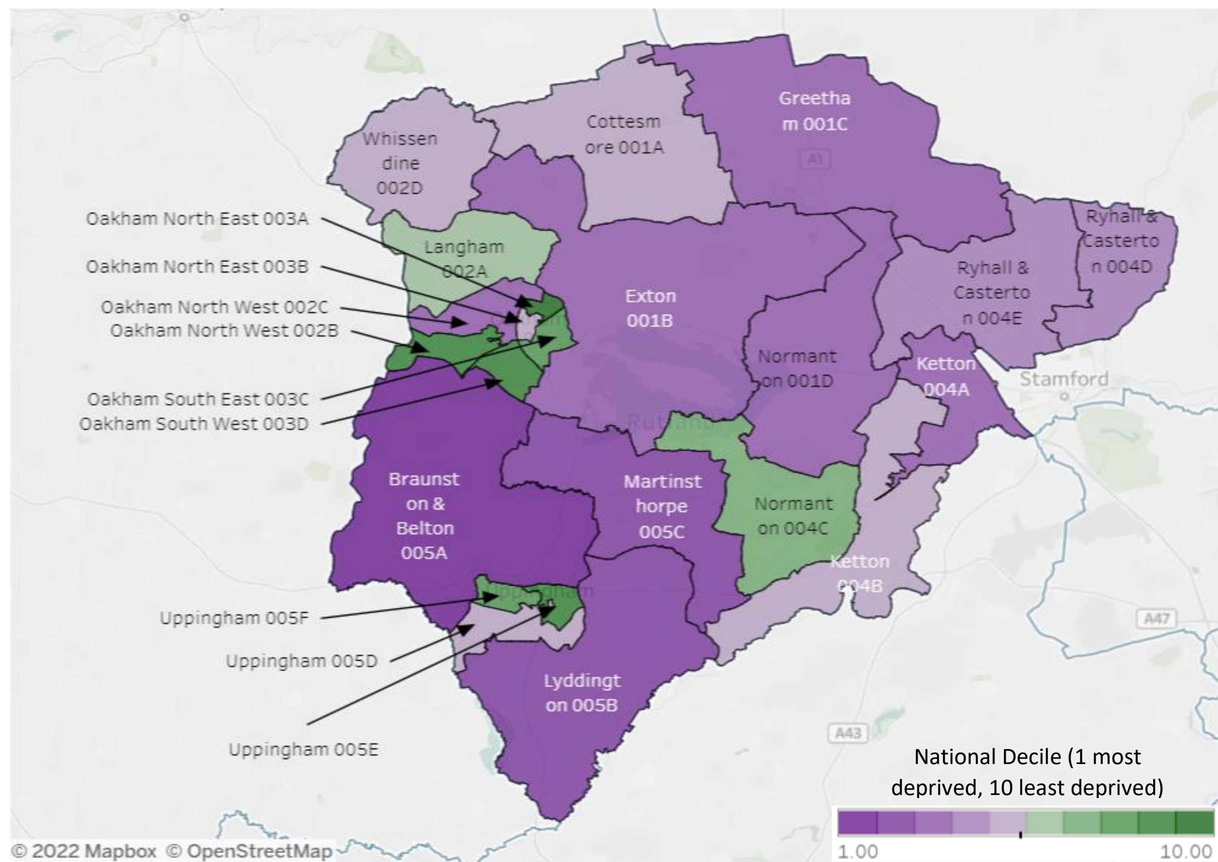


Figure 8 Indoors Sub-domain.

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'.

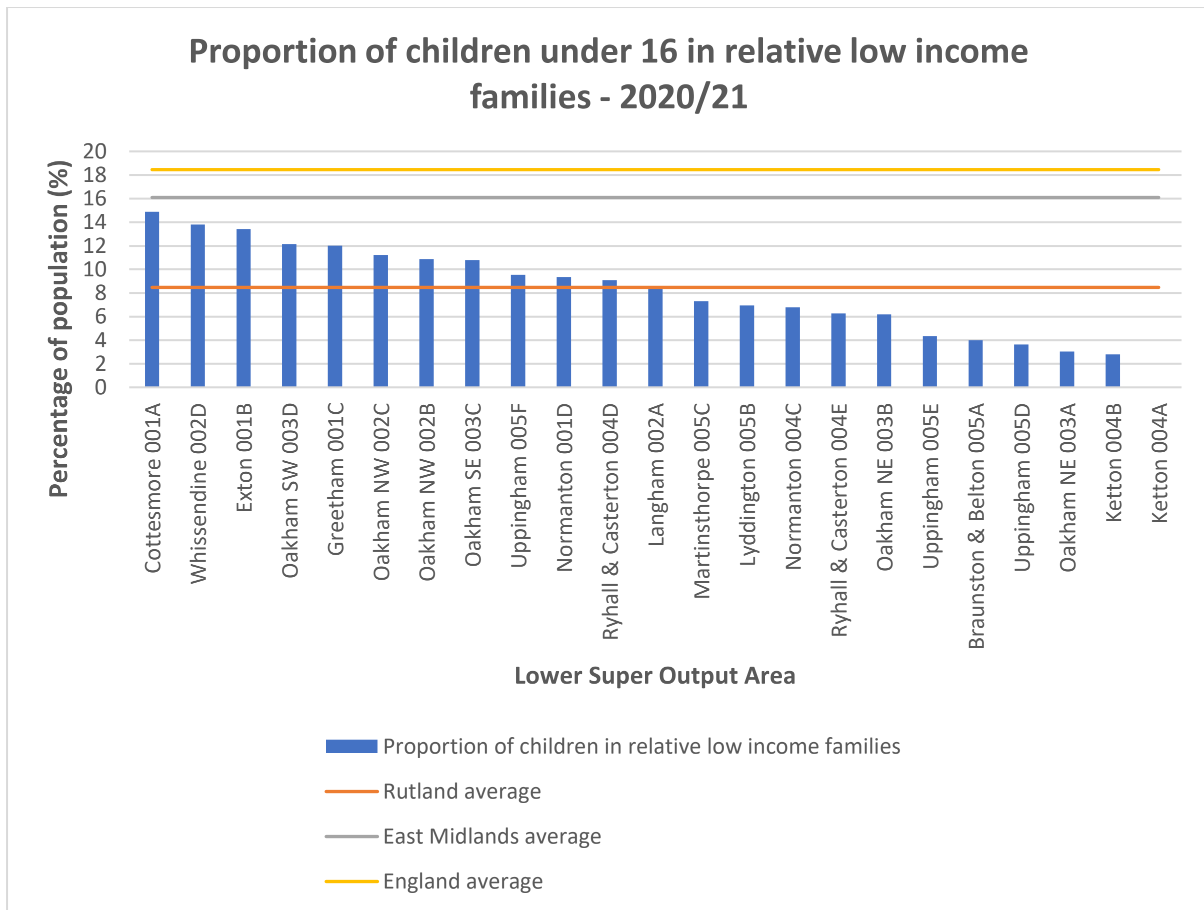


Figure 9 Proportion of children under 16 in relative low-income families - 2020/21.

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.

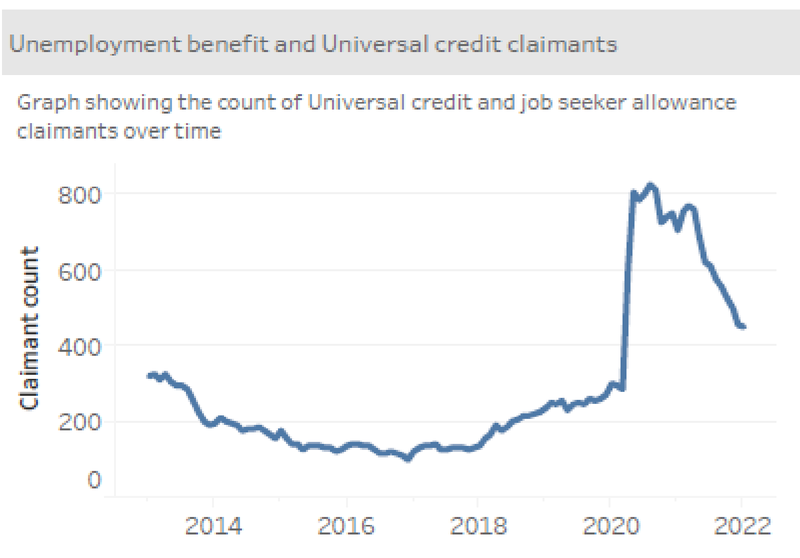


Figure 10 Unemployment benefits and Universal credit claimants.

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.

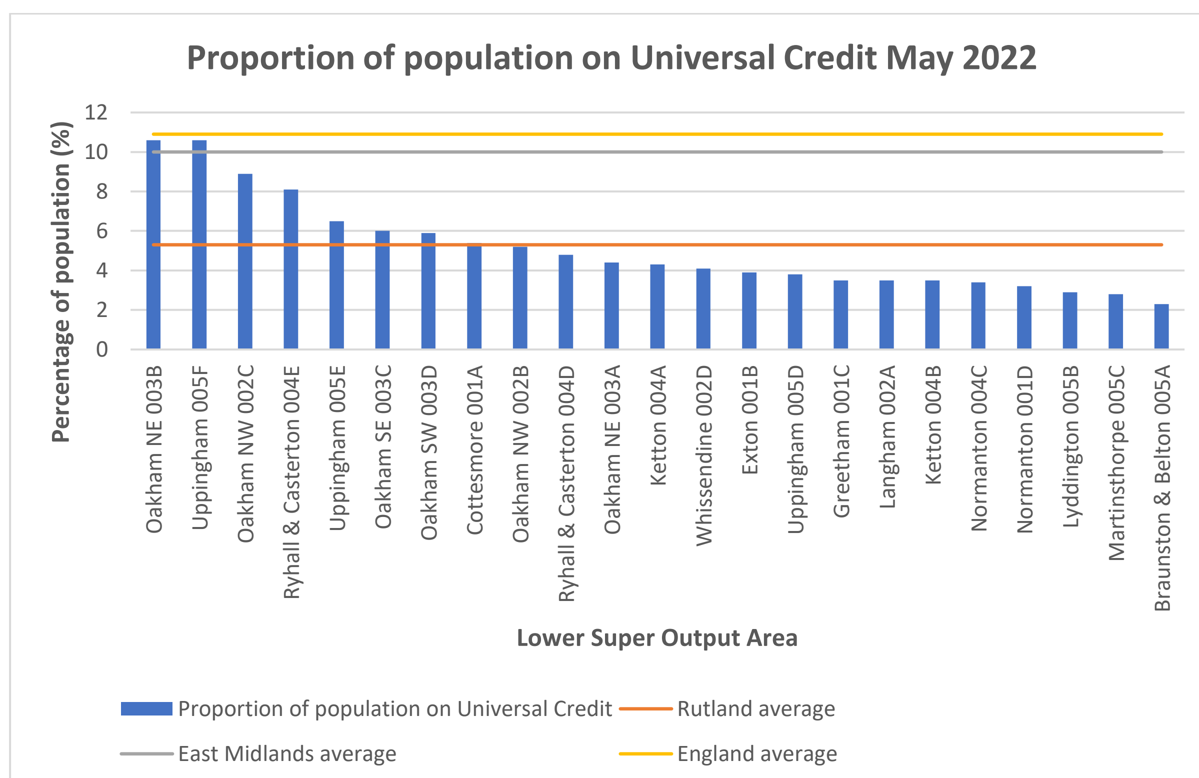


Figure 11 Proportion of population on Universal Credit May 2022.

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.

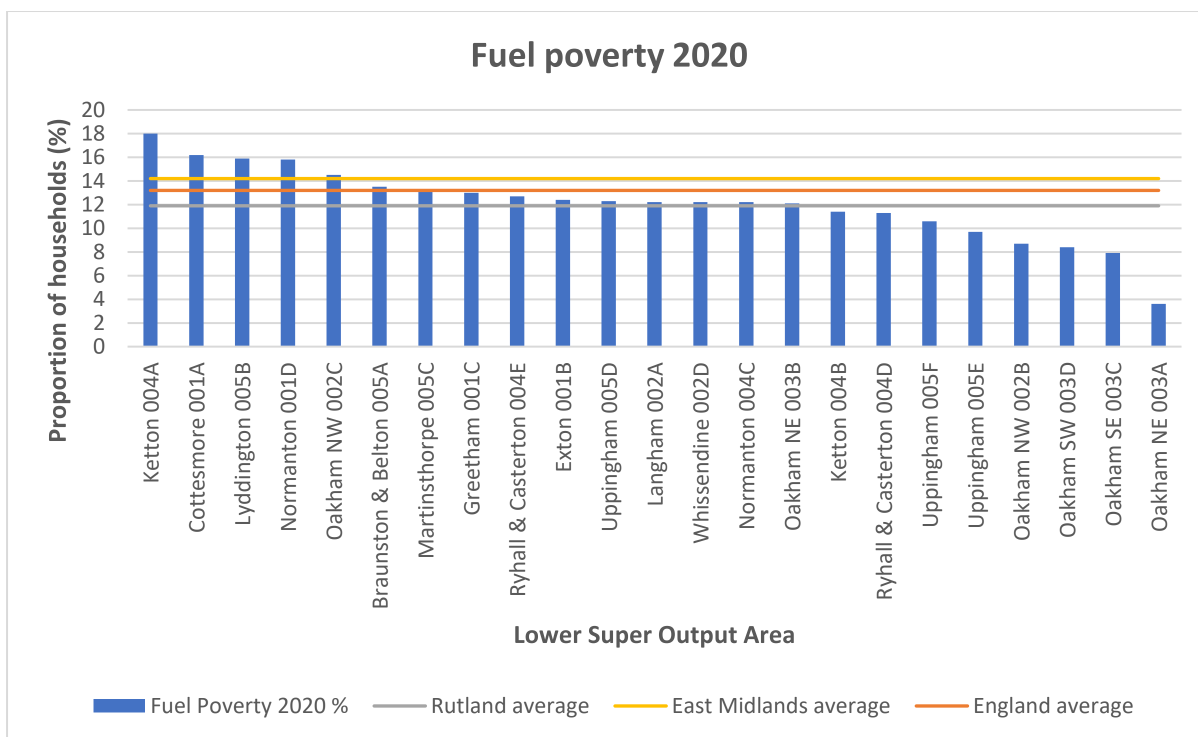


Figure 12 Fuel Poverty 2020.

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.

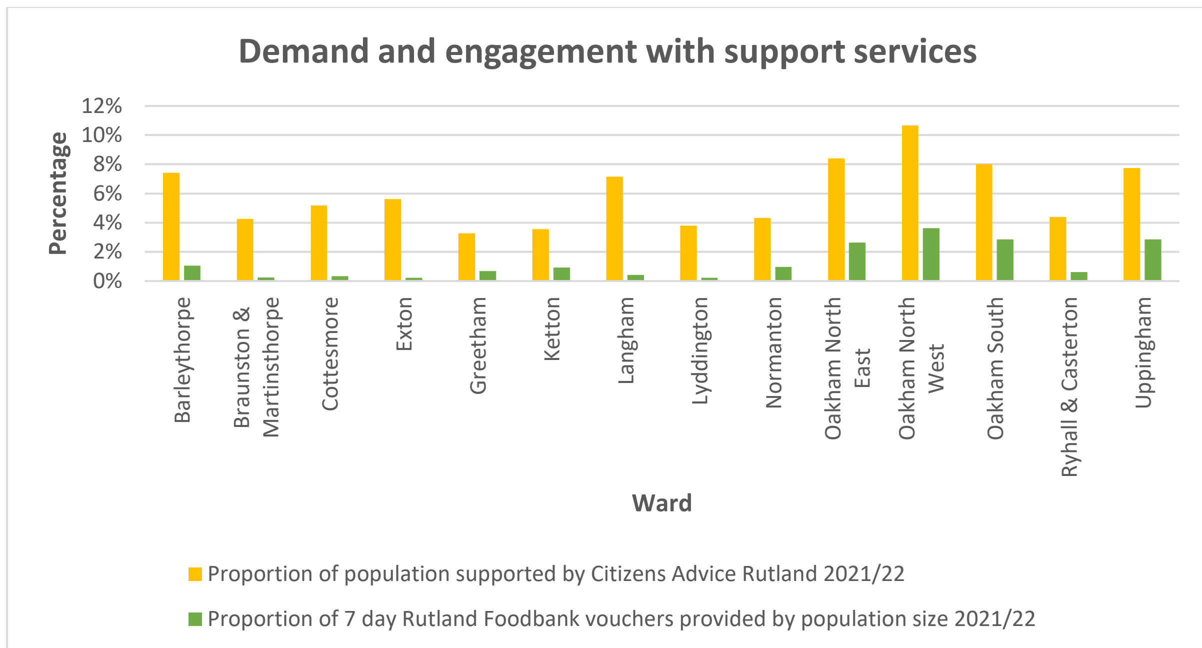


Figure 13 Demand and engagement with support services.

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.

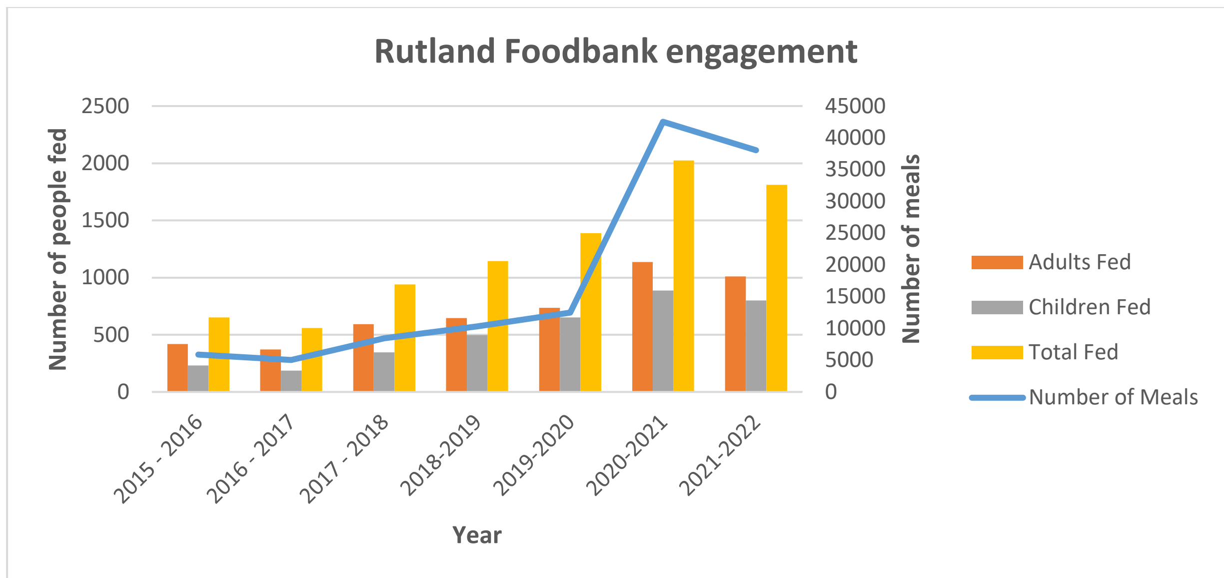


Figure 14 Rutland Foodbank engagement.

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.

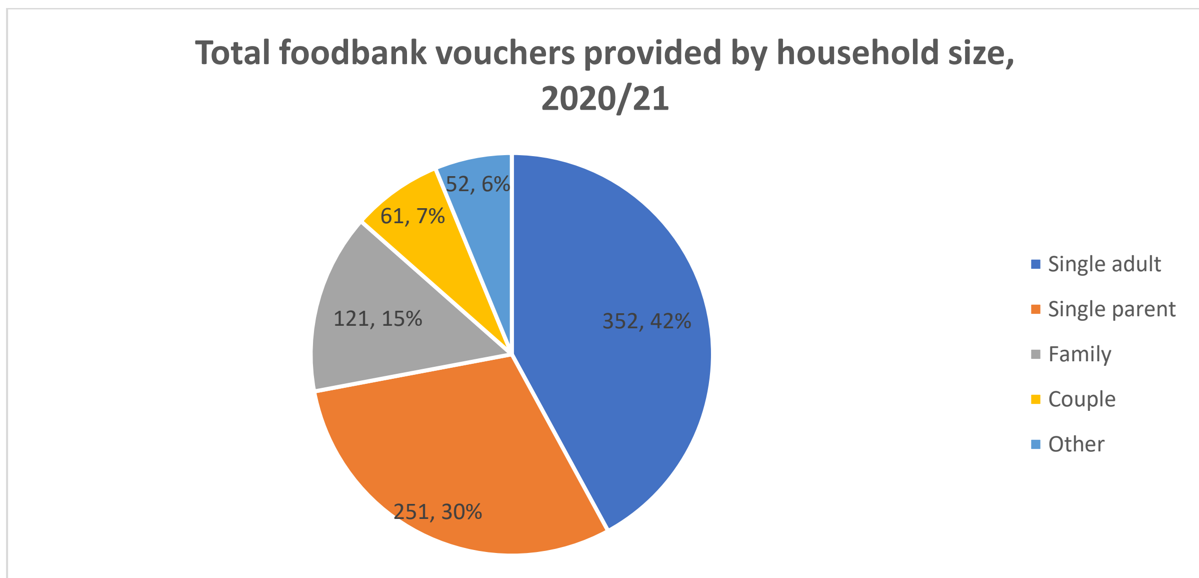


Figure 15 Total foodbank vouchers provided by household size, 2020/21.

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.

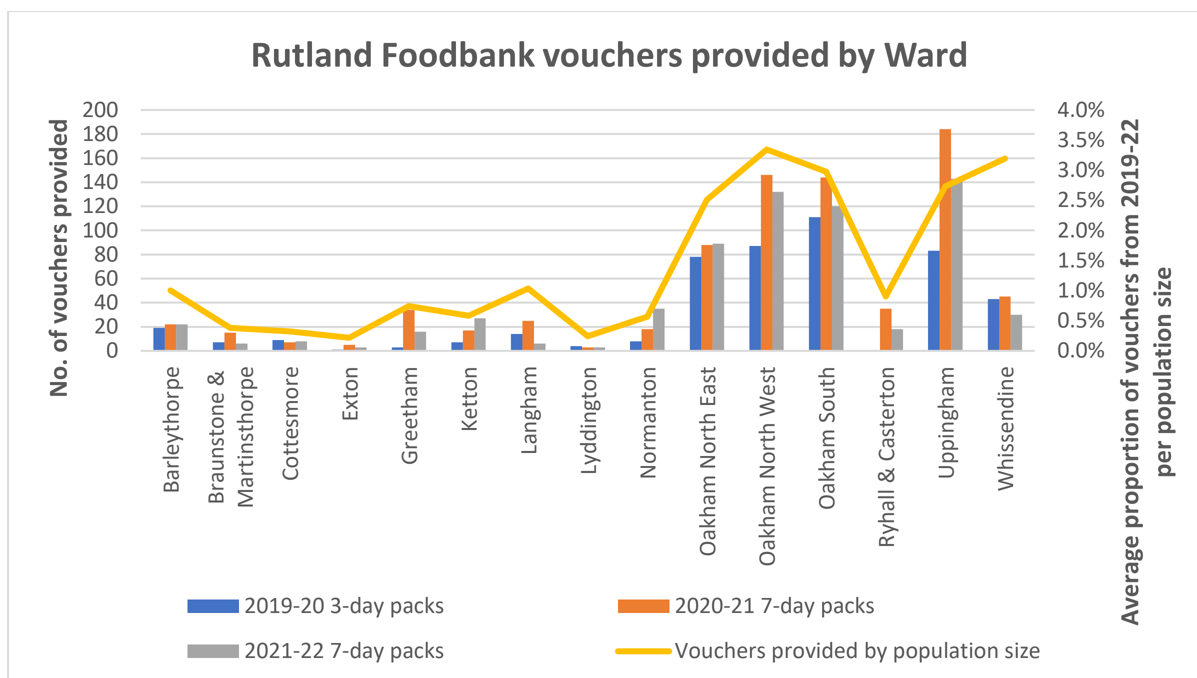


Figure 16 Rutland Foodbank vouchers provided by Ward.

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.

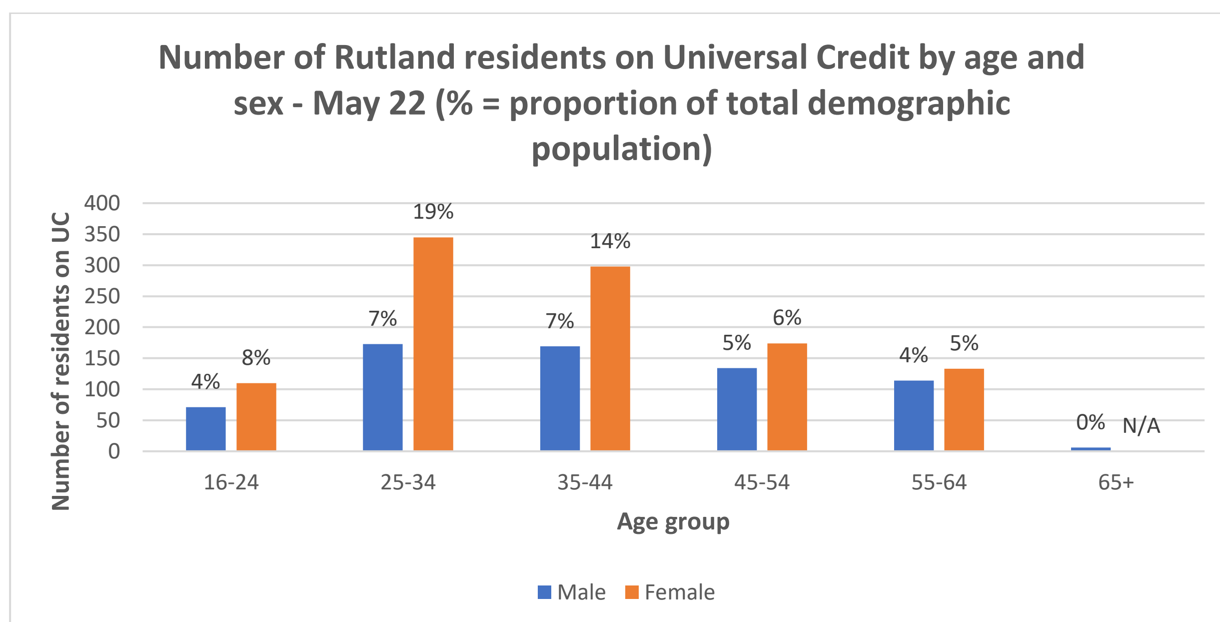


Figure 17 Number of Rutland residents on Universal Credit by age and sex.

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.

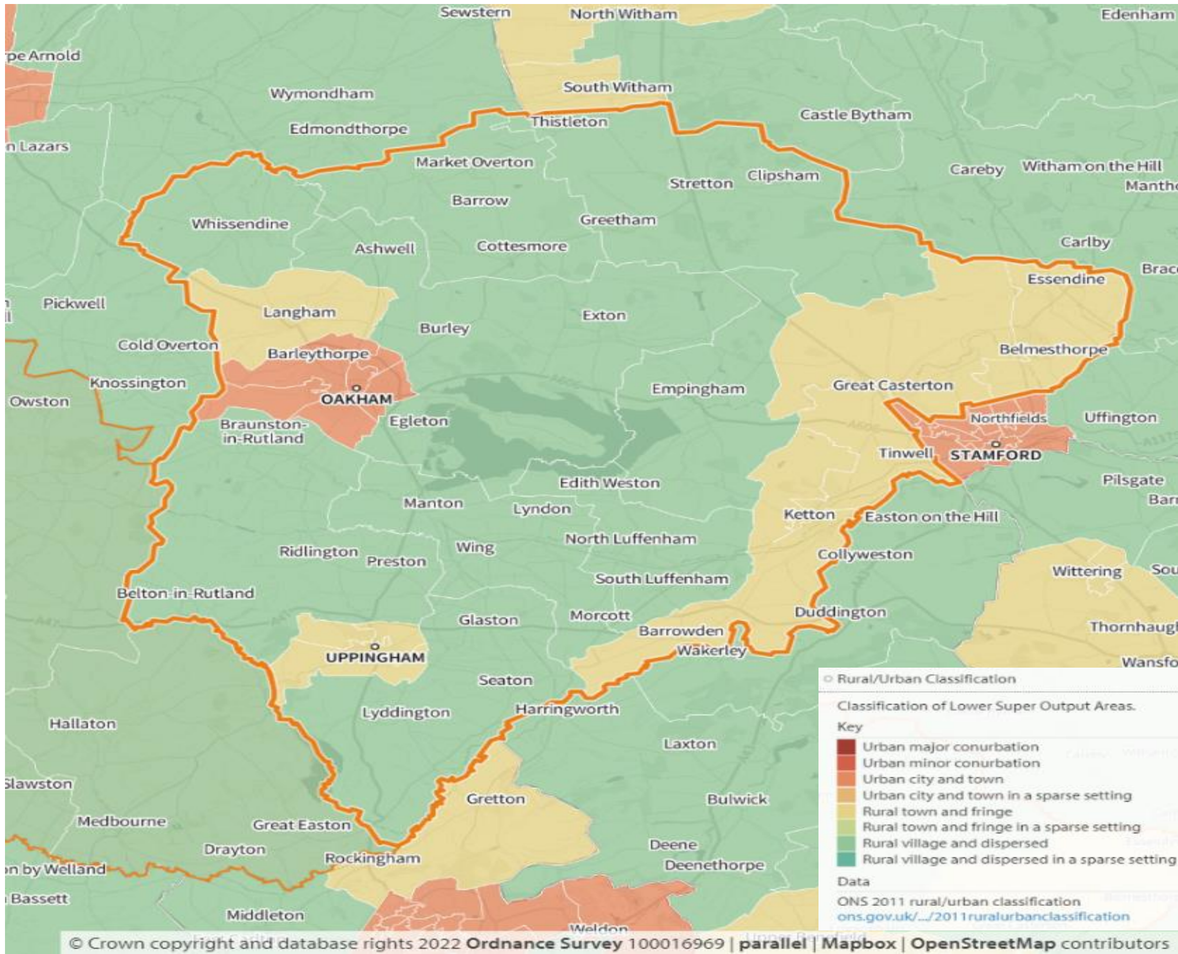


Figure 18 Rural/Urban Classification.

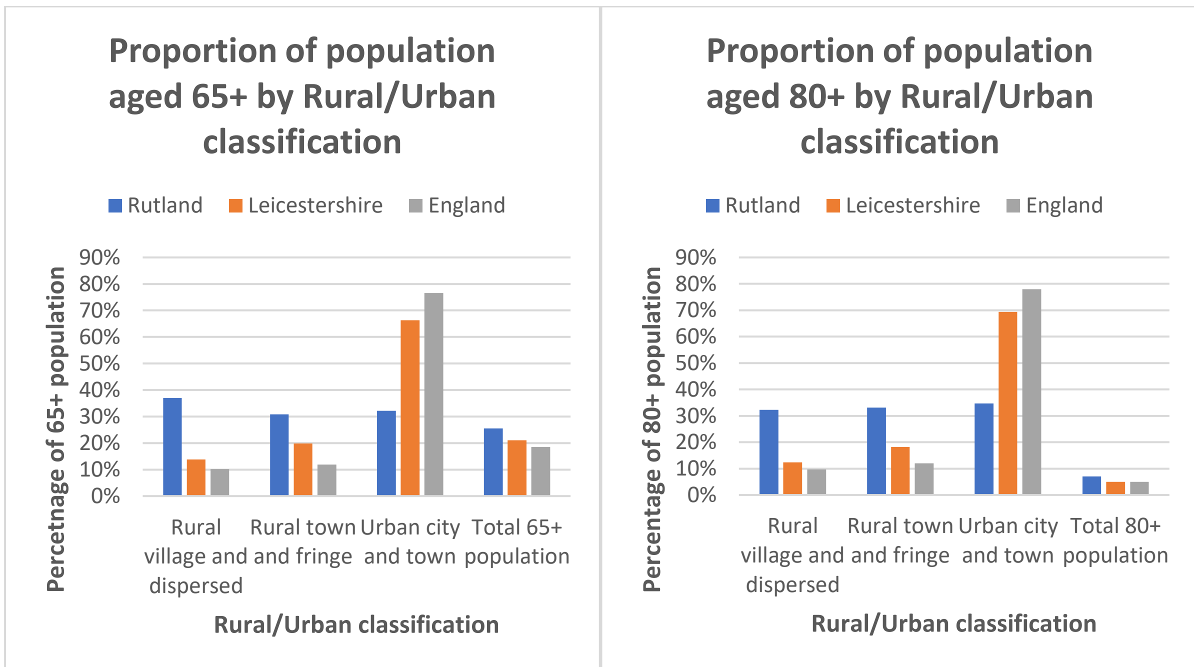


Figure 19 Proportion of population aged 65+ and 80+.

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. Although outside of the buffer, Melton Surgeries were included as it is anecdotately understood a proportion of Rutland residents access them. It is acknowledged there will be other Practices accessed by Rutland residents, however this buffer was used as a guide and to capture the majority of Practices closest by time taken to drive.

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.

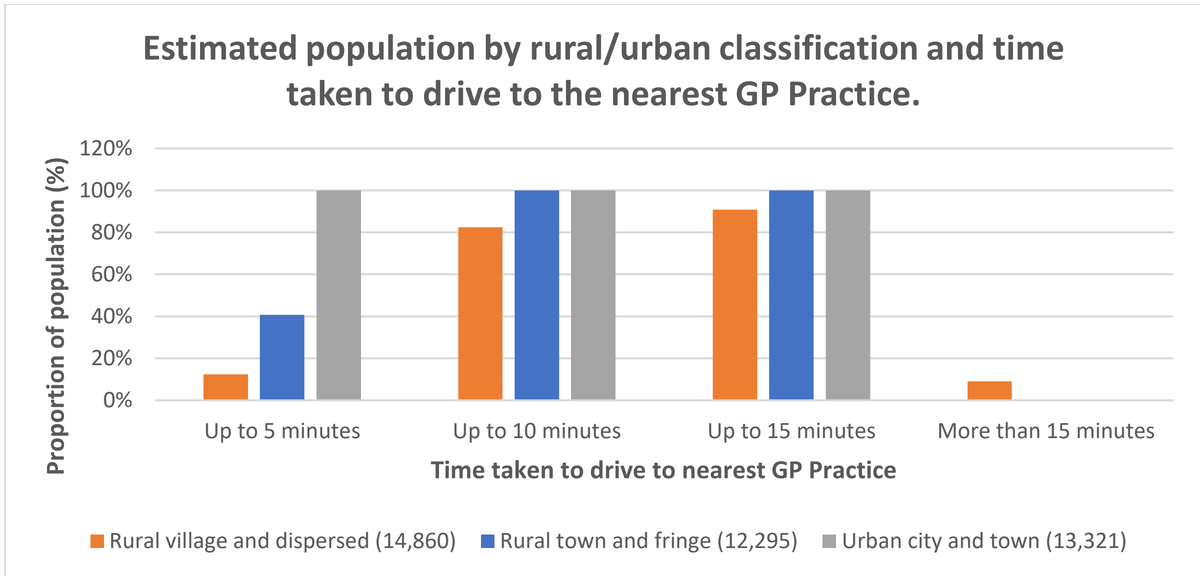


Figure 20 Access to GP Practices by time taken to drive.

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'.

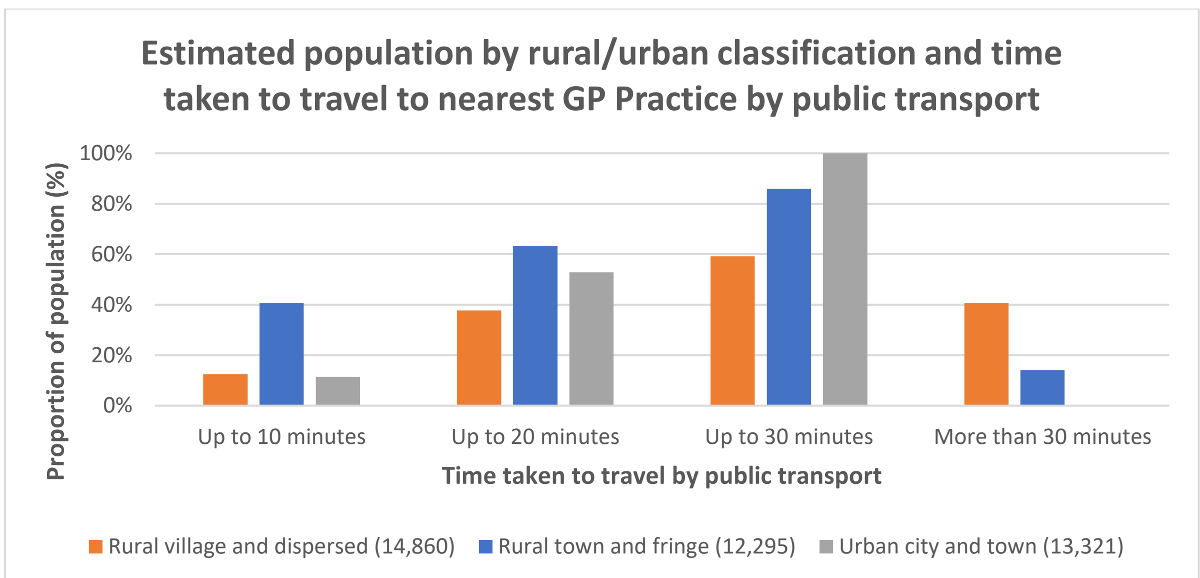


Figure 21 Access to GP Practices by time taken via public transport.

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.

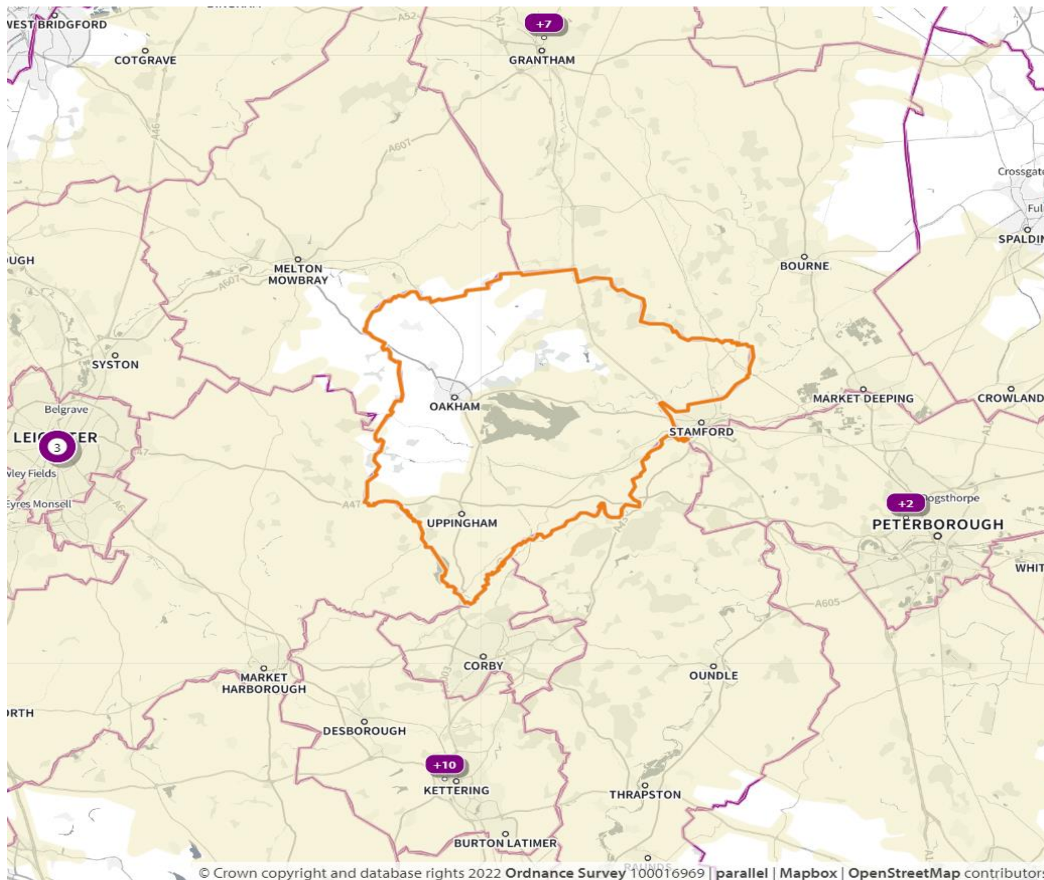


Figure 22 Proportion of Rutland residents within a 30-minute drive of acute hospitals.

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.

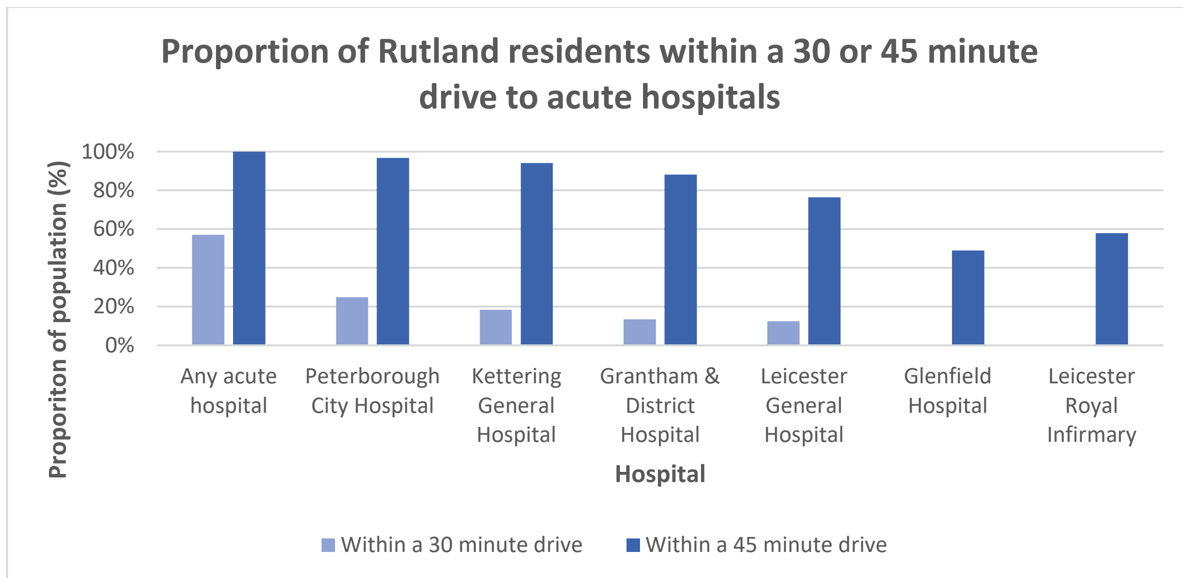


Figure 23 Proportion of Rutland residents within a 30- or 45-minute drive to acute hospitals.

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.

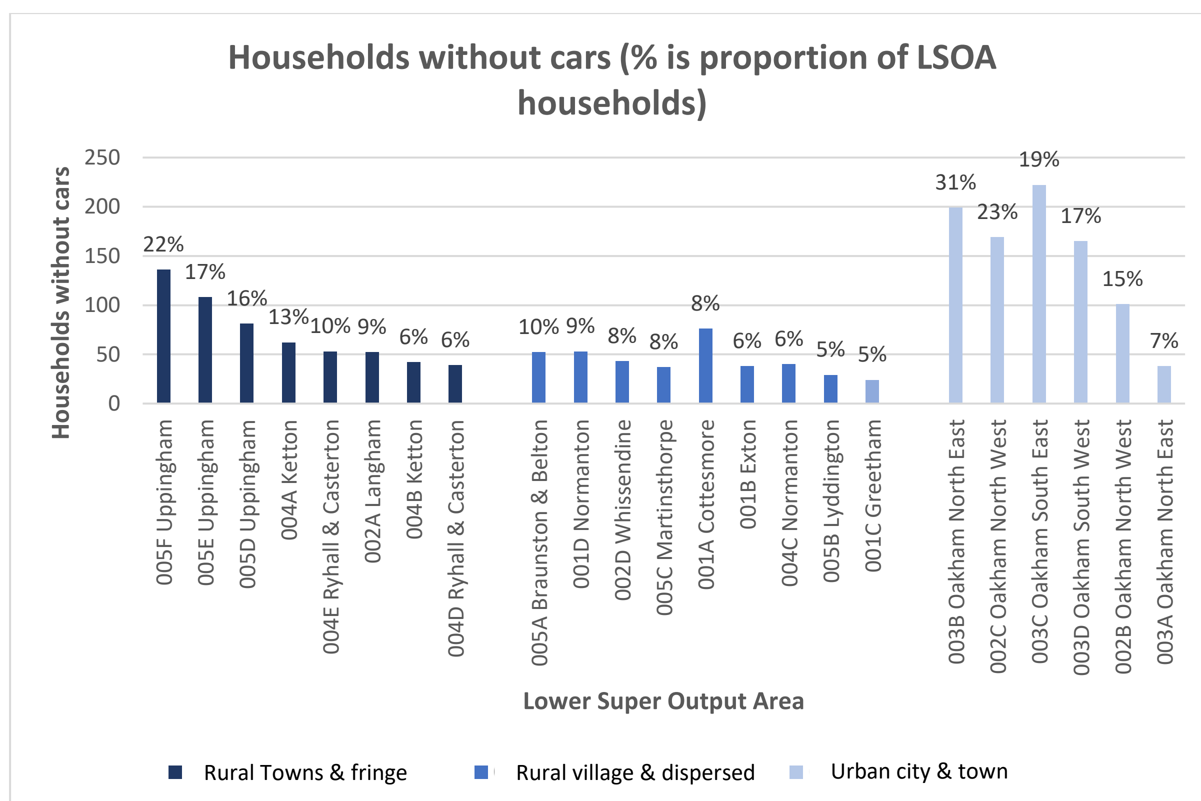


Figure 24 Households without cars (% is proportion of LSOA households).

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.

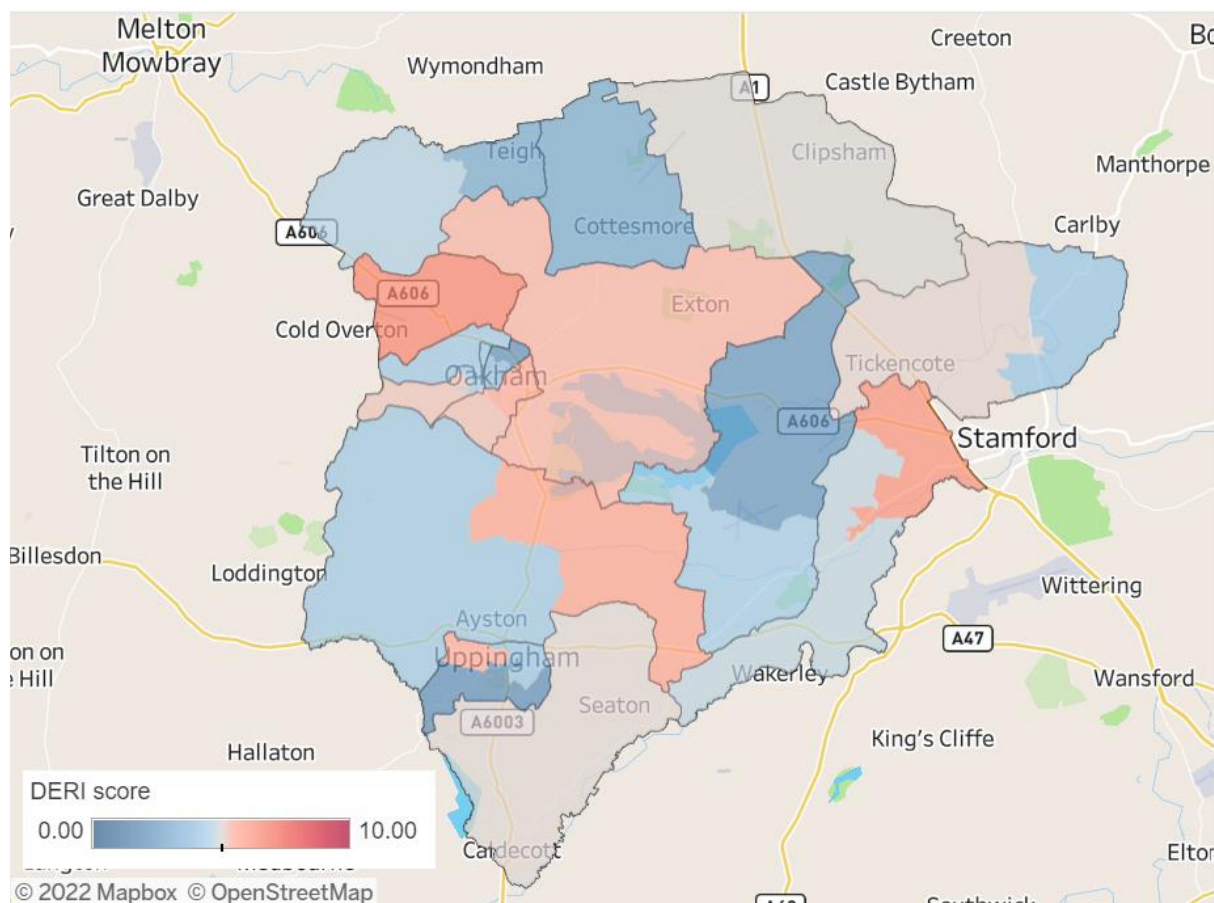


Figure 25 Digital Exclusion Risk Index mapping.

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.

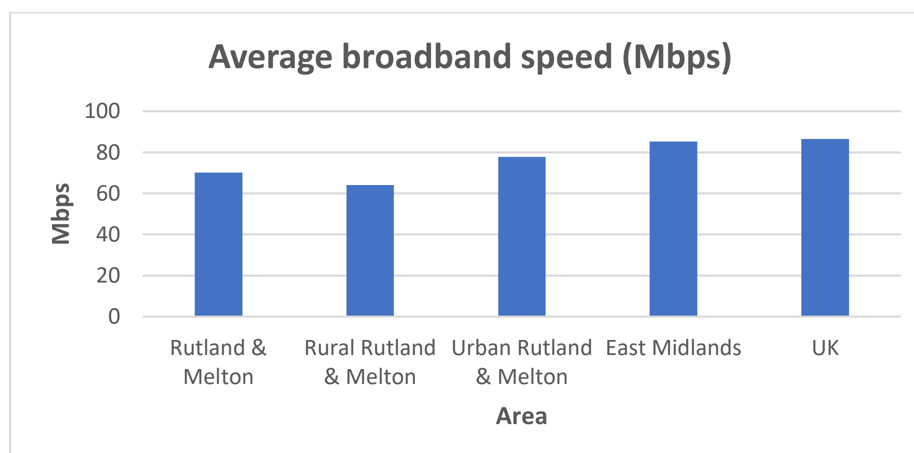


Figure 26 Average broadband speeds.

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.

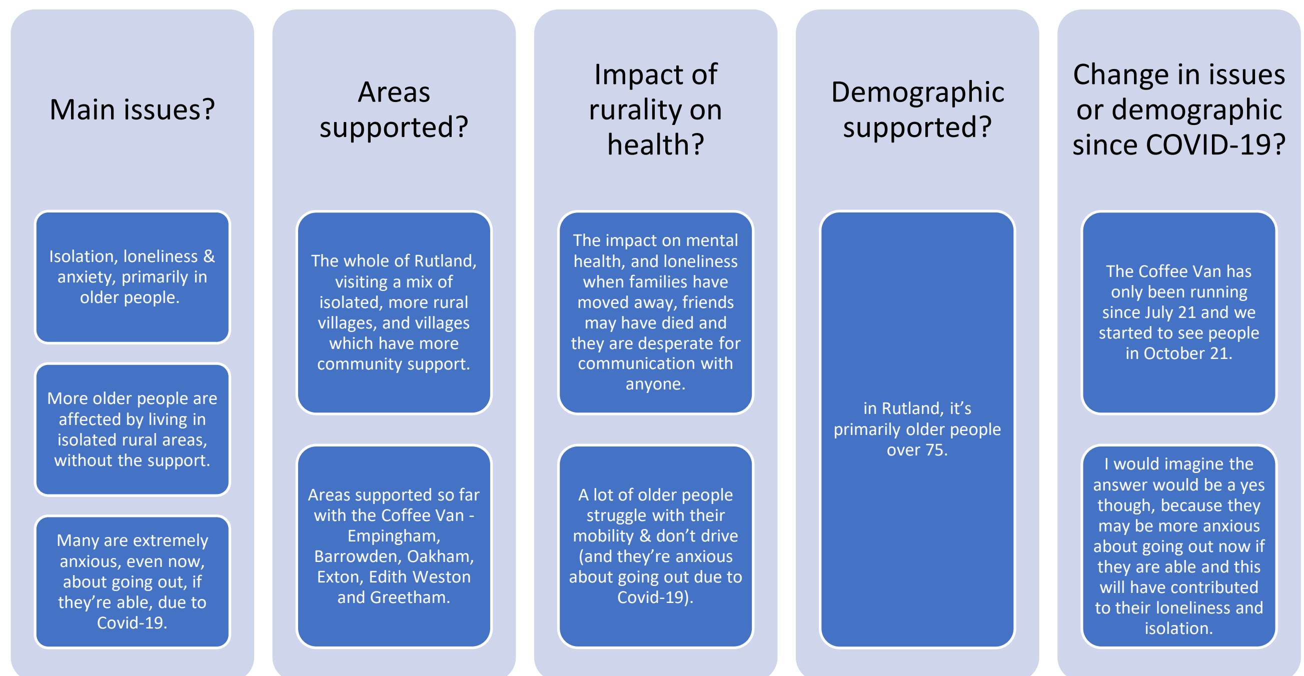
To mitigate against digital exclusion, The Leicester, Leicestershire and Rutland Integrated Care Board have funded local Voluntary and Community Sector organisations to deliver digital literacy programmes amongst groups of people for whom digital inclusion is often more of a challenge. They will be extending 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 off 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 challengi ng 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

- **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.

Mental Health

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.**

Social isolation

- **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.

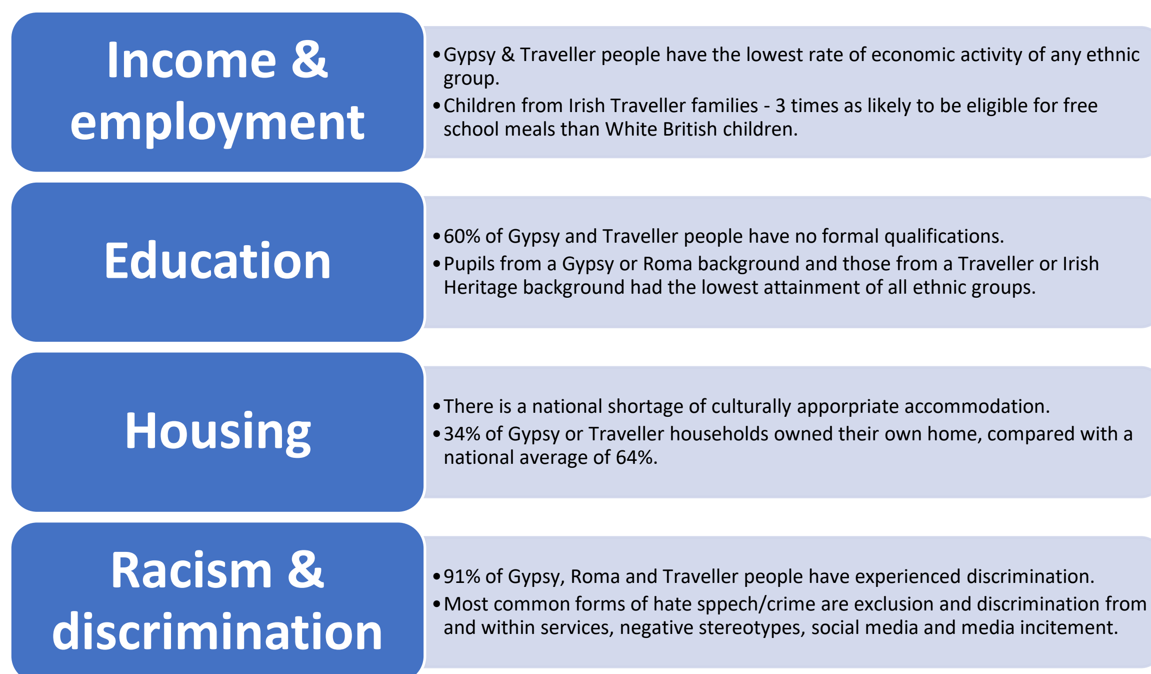
From the 2011 Census, there were 58 White Gypsy or Irish Traveller's in Rutland. There was no Roma category available at the 2011 Census. This represented 0.16% of the total Rutland population. There are 3 authorised sites for Gypsies and Travellers and 3 authorised sites for Travelling Showpeople in 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.

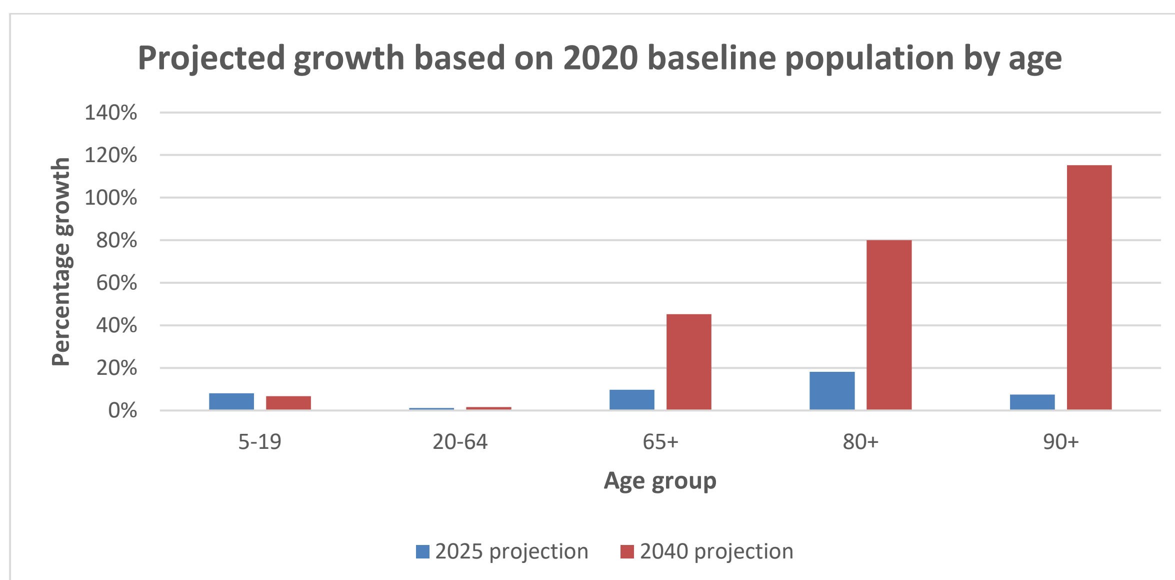


Figure 27 Projected growth based on 2020 baseline population by age.

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%.

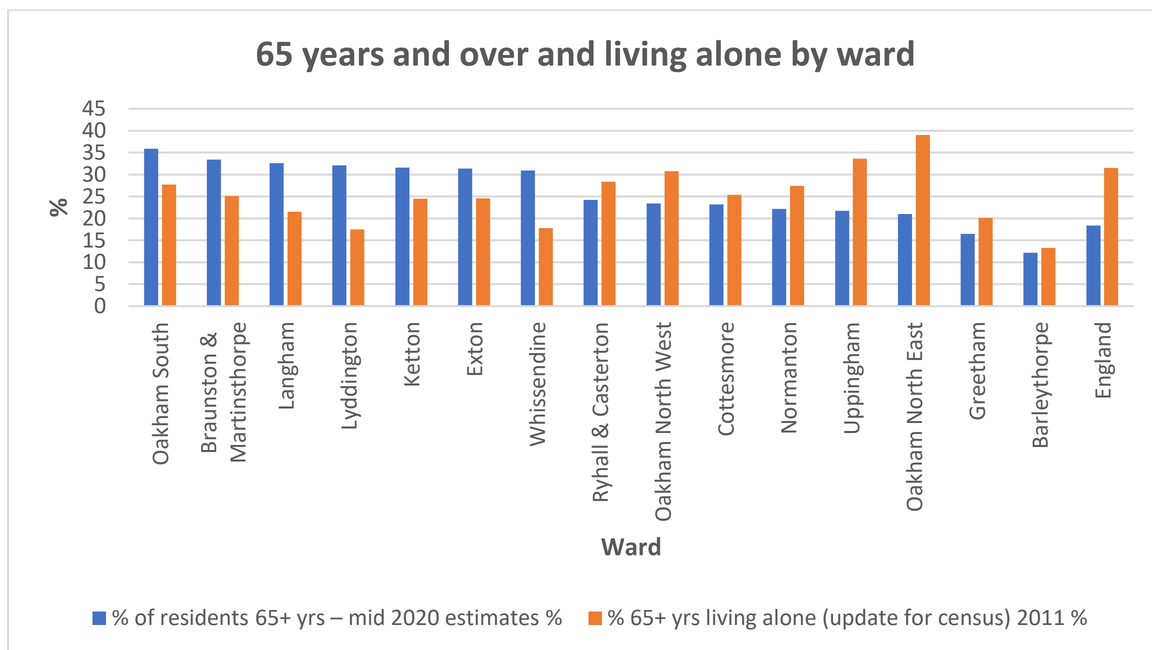


Figure 28 65 years and over and living alone by ward.

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.

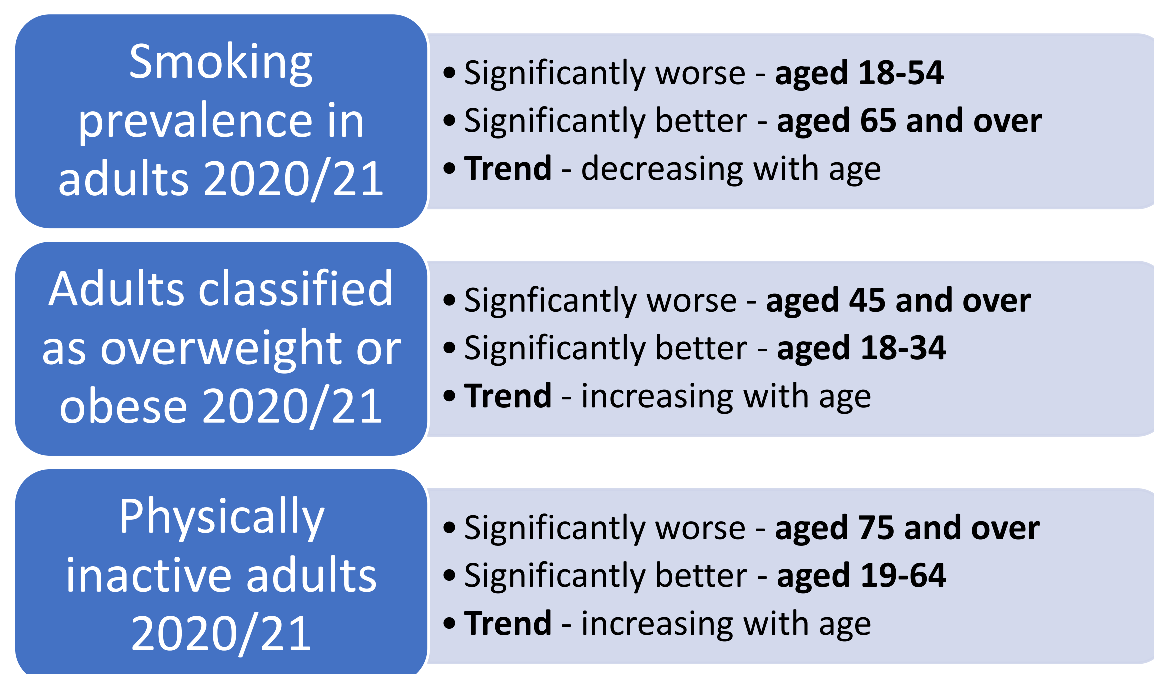
Another area where Rutland performs worse linked to age is the Excess Winter Deaths Index (EWD Index)[77]. The EWD Index is the excess of deaths ratio in people aged 85 and over. The excess winter deaths indicator looks at the ratio of excess deaths in the winter months in winter (*December to*

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.



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.

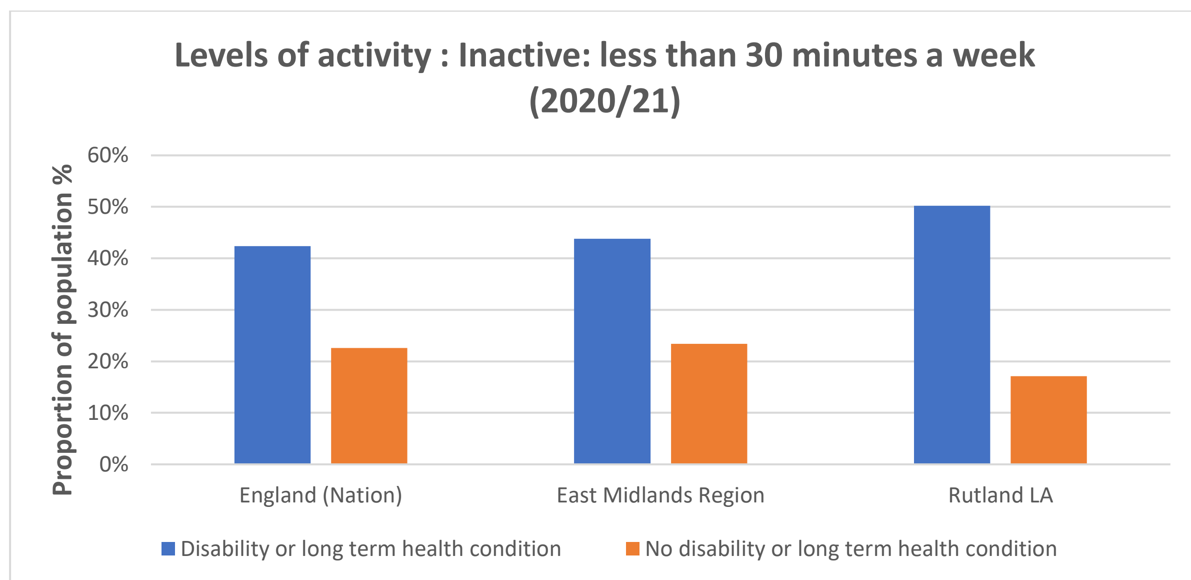


Figure 29 Inactivity by disability status.

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.

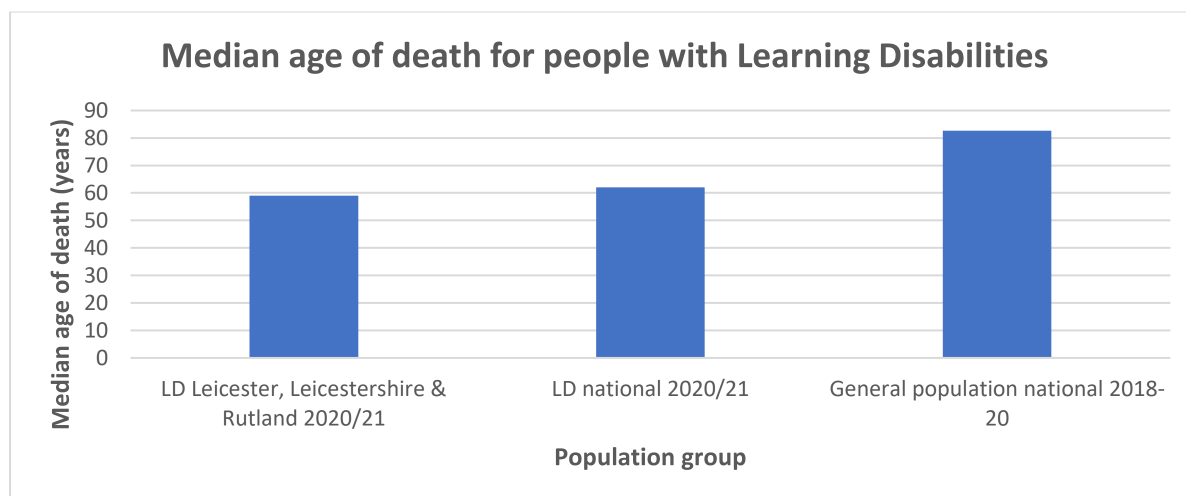


Figure 30 Median age of death for people with Learning Disabilities.

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.

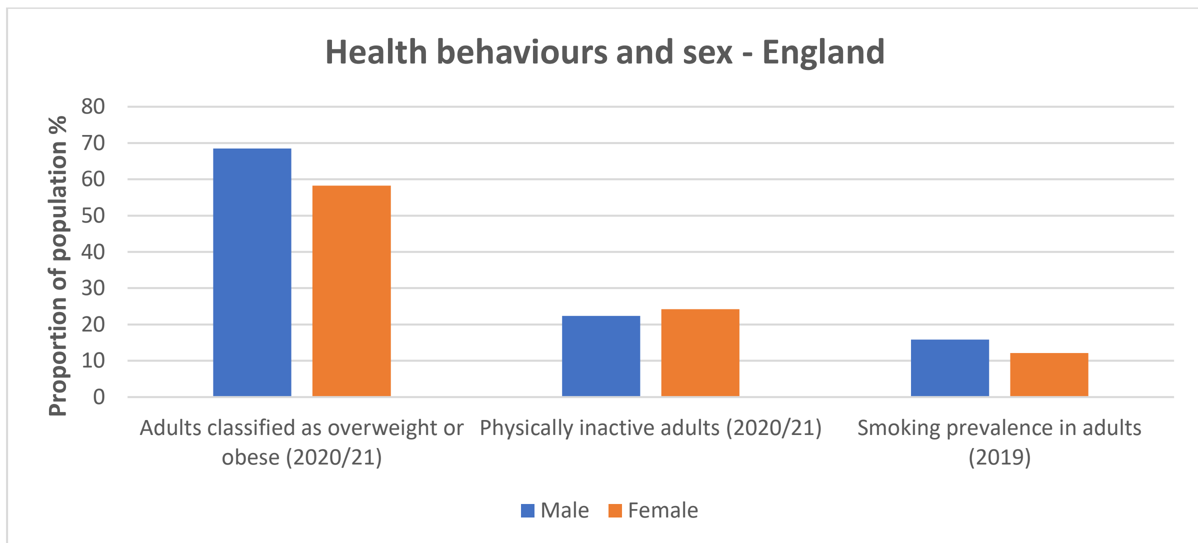


Figure 31 Health behaviours and sex - England.

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%).

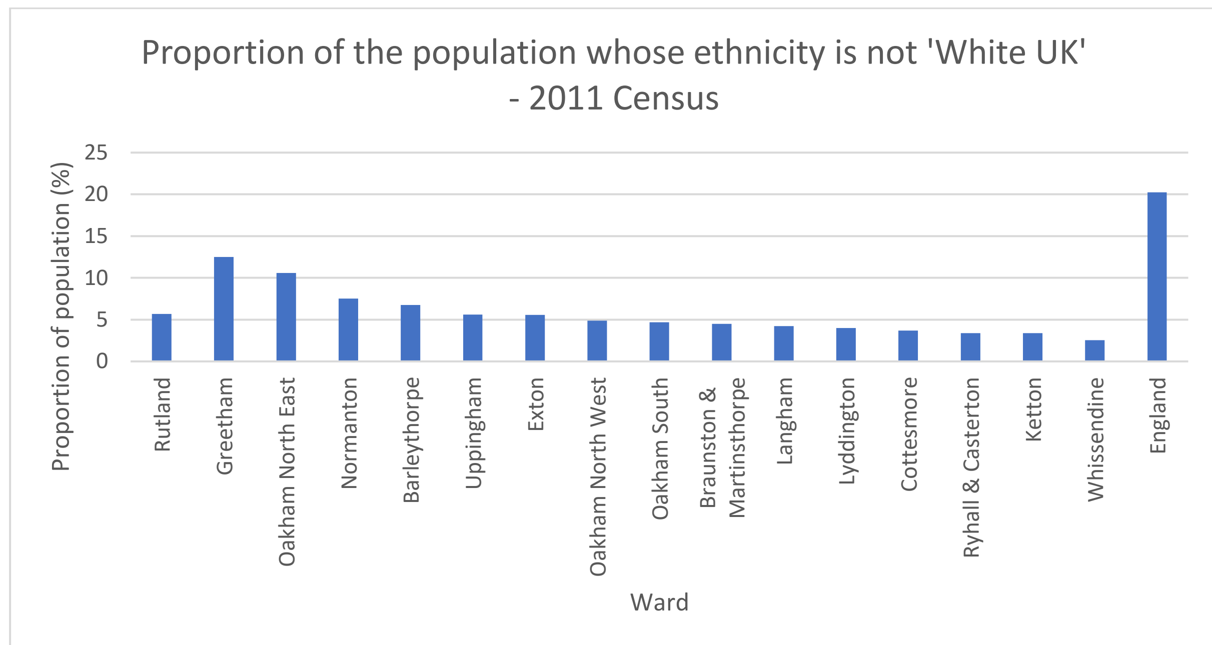


Figure 32 Proportion of the population whose ethnicity is not 'White UK'.

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.

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RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT

End of Life Care and Support

2022

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East Leicestershire and Rutland
Clinical Commissioning Group

Public Health Intelligence

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

FOREWORD

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

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

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

The JSNA has reviewed the population health needs of the people of Rutland in relation to End of Life care and support. This has involved looking at the determinants of the End of life, the health needs of the population in Rutland, its impact, the policy and guidance supporting End of Life care and support, existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this needs assessment are discussed.

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

EXECUTIVE SUMMARY

Adults are usually considered to be approaching the end of life when they are likely to die within the next 12 months (8). The aim of end of life care is to help people to live as well as possible during this period, and to support them in achieving a dignified death (8). It is the responsibility of all to support the delivery of this, with health and social care staff from all settings and specialties having a role.

For Children and Young People, life-limiting and life-threatening conditions are used to describe the population of children who may benefit from input from paediatric palliative care services. For Children and Young People End of life care is generally considered to be the last few weeks/ days as the condition changes and deteriorates.

The death of a loved one, along with the time both leading up to the event and following it, are significant and traumatic periods in people's lives. It affects not just individuals, but also their family and social networks, and local communities. End of life care therefore also seeks to support the individual's family, carers and those who are important to them.

Most people reaching end of life in Rutland are over 75 years of age. Although the majority are older, chapter 2.12 highlights the end of life needs of children and younger people who often require a specific approach to their care. Other population groups highlighted as sometimes requiring adjustment in care or approach to avoid poorer outcomes, experiences and health inequalities include:

- Those living in deprivation
- Homeless people
- Imprisoned people
- LGBT people
- People with learning disabilities
- Ethnic minority groups
- Non cancer diagnosis
- Dementia
- Sudden and unexpected deaths

Identified unmet needs/gaps

Whilst this section has been divided into different components of end of life care and support, many of the themes and issues discussed are common to many if not all aspects.

Advanced care planning

National and local insight tell us that as people become severely ill, they prioritise quality of life over the length of time remaining to them. They also value clear communication, being involved in decisions and being treated as an autonomous individual. The Advanced Care Planning

approach provides people with the opportunity to plan their future care and support while they have the capacity to do so. Despite this, as few as 9.7% of adults have an advance care plan in place prior to their final hospital admission (9). For children and young people, advanced care planning is used more frequently.

Evidence also suggests that whilst people report feeling comfortable talking about topics relating to the end of life, there is poor understanding of the options and services available. Indeed, in one survey, as many as 55% of those in the last years of life reported not knowing where to find information on how to plan in advance for care at the end of life (10). Whilst these resources do exist, it seems that there is a gap in terms of connecting people to them. Only with adequate access to high quality information, can people make informed decisions about their end of life care.

Utilisation and delivery of End of Life and Palliative Care Services

End of Life and palliative care often involves receiving input from multiple organisations and services. Whilst the quality of support received from these services once in receipt of care from them is generally rated highly, a common complaint is that they are difficult to access in the first place.

It has also been frequently reported both nationally and locally, that services coordinate poorly with one another. This is particularly a challenge when patients move from primary to secondary care or vice versa and results in staff often working with incomplete information or without a complete overview and understanding of the persons' needs. Finally, we have heard of challenges in accessing support out-of-hours. This is not only a matter of service users being unsure of how to access it, but also includes a lack of available services.

Support for those who are bereaved

Those who are bereaved have rated the level of support that they received poorly, particularly that in relation to their emotional, social, and practical needs. Once again, service users appear to be happy with the quality of care they receive once they are in receipt of it, but often find themselves unsure of what is available, facing uncertain referral routes, and made to join lengthy waiting lists. In addition to formal services provided by healthcare organisations, there is a wide range of local community groups which are also available. It is unclear however, how widely these are known about. More therefore needs to be done to provide residents with complete and accurate information, and to facilitate the process of connecting them to sources of help and support.

Support for informal carers

The support that carers require can be divided into two broad categories. The first of these is support to undertake their caring role, including through adequate training and the provision of sufficient equipment. The second, is support for them as an individual who is experiencing a traumatic life event as their loved one is unwell. Both forms of support are required if they are to help their loved one and remain well themselves. Sadly, local people report being unhappy with the levels of either type of support that they are receiving.

Finally, the burden of coordinating health and social care services for someone approaching the end of life, often falls onto carers. Similarly to the other groups discussed in this section so far, carers

report not knowing what services are available and find identifying the various sources of support and navigating their access routes to be challenging. Existing methods of collating and sharing methods of support with carers are therefore in need of review.

Support for staff working in End of Life care

The roles of staff in end of life care are diverse, and as it was drawn from a self-selecting sample, caution must be taken when interpreting the results of the local survey that was undertaken due to the risk of responder bias. Across work areas however, responders were generally happy with the resources and equipment that they received to help them undertake their role. Differences were seen though in terms of the training received, when considering the person's job description. Those whose primary role is not delivering end of life care, reported feeling that they had insufficient training to adequately support people towards the end of life. As we are faced with an ageing and increasingly co-morbid population which interacts with multiple health services and specialities, staff will increasingly work with patients who are approaching the end of life even if that is not the focus of their role. This is therefore likely to be a growing problem, and it is important that those within the health and social care system feel adequately supported in this area.

Recommendations

This JSNA chapter has identified the local needs and current gaps in service provision relating to end of life care and support. The following recommendations have been produced on the basis of these findings, to support improved outcomes for the people in Rutland.

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 as discussed in Section 3.5.2.
- 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 (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.
- Consider the need for a paediatric palliative care consultant and the need for community paediatric and nursing support that responds to the rising numbers of children and young people on end of life pathways with increasing complexity.

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.

Next Steps

This JSNA chapter will be used to inform a refreshed end of life strategy which is being developed across Leicester, Leicestershire and Rutland by the Integrated Care Board.

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1. Introduction

Adults are usually considered to be approaching the end of life when they are likely to die within the next 12 months (8). This is often difficult to predict though and even when someone has a chronic or life-limiting condition, they may not be identified as approaching the end of life until their final weeks or days. The aim of end of life care is to help people to live as well as possible during this period, and to support them in achieving a dignified death (8). It is the responsibility of all to support the delivery of this, with health and social care staff from all settings and specialties having a role.

Palliative care is closely related to end of life care and relates to the management of symptoms and caring for someone with a terminal illness. In addition to clinical management, it involves providing psychological, social and spiritual support for the individual, their family, and carers (8). Whilst end of life care is usually delivered during someone's last 12 months of life, palliative care is available from when someone is first diagnosed with a life-limiting condition. People may therefore receive palliative care for longer than end of life care and may be in receipt of it whilst simultaneously receiving active treatments and therapies for their condition.

For Children and Young People, End of life care is generally considered to be the last few weeks or days as the condition changes and deteriorates. Children and young people can fluctuate in and out of the end of life phase as they can be vulnerable when experiencing infections or other illnesses. Palliative care for children and young people with life-limiting or life-threatening conditions is an active and total approach to care, from the point of diagnosis or recognition throughout the child's life and death.

The death of a loved one, along with the time both leading up to the event and following it, are significant and traumatic periods in people's lives. It affects not just individuals, but also family and social networks, and local communities. End of life care therefore also seeks to support the individual's family, carers and those who are important to them.

2. Who is at risk?

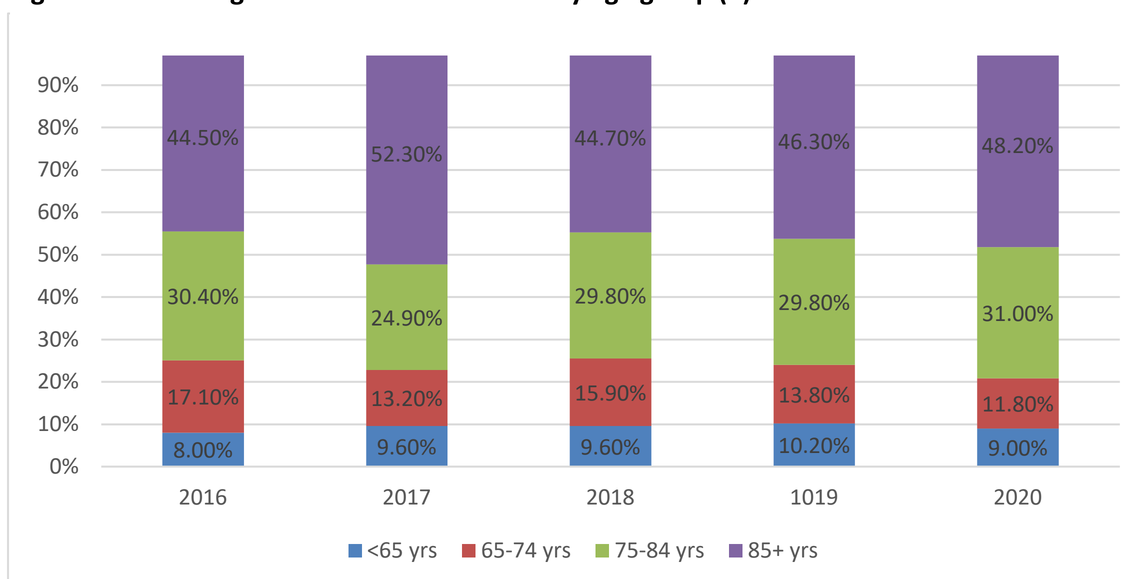
2.1. Groups at risk of negative end of life outcomes

Everybody is affected by death, both directly and indirectly through the loss of loved ones. How someone interacts with this life event varies, however. It depends for example on the age at which a person dies, and whether the death follows a prolonged illness or has taken place suddenly. The experience someone has of end of life and palliative care, and bereavement support, can similarly be affected by a range of demographic and diagnostic characteristics. Here, we discuss those groups at increased risk of negative outcomes and those which are more likely to face challenges.

2.1.1. Increasing Age

In 2020, the life expectancy at birth of people in Rutland was significantly greater than that of England. This was 83.3 years for men (78.5 in England) and 84.9 years for women (82.3 in England) (11). Rutland has a growing population, with older age groups representing the greatest cumulative change (12). Between 2016 and 2039, the over 65 population is predicted to grow from 9,400 to 14,000 people, whilst the population of those aged 90 years or older is predicted to increase by 1,200. Most deaths occur in these older age groups, with 204 deaths in Rutland in 2020 attributed to people aged 85+ years, accounting for 48.2% of all deaths (Figure 1) (2). In Rutland, a significantly lower proportion of deaths occurred in 2020 in those aged <65 and 65-74 years, and a significantly higher proportion ain those aged 85+ years, compared to England (2). Whilst England has experienced a significant increase since 2016 in the percentage of deaths at ages 75-84 and a decrease in those at 65-74 and <65 years, Rutland has seen no significant change (2).

Figure 1: Percentage of all deaths in Rutland by age group (2)



Source: OHID Fingertips, Palliative and End of Life Care Profiles

Older age and frailty are associated with an increased need for social care which often requires at least partial self-funding. This can serve as a barrier for access to services and result in a heavy reliance on family members as carers (13). There is also evidence that those aged over 85 years less likely to access palliative care than are those below 85, with those who do access it also on average receiving a shorter duration of palliative care prior to death (13, 14). Despite representing nearly 40% of all deaths nationally, only 16.4% of people aged 85 or older gain access to specialist palliative care services (15). Emerging evidence indicates however, that access to hospice care for this group is improving (16).

There is some evidence that older adults receive less adequate pain relief and receive more unwanted treatment decisions, than do people from younger age groups (14). Between 2014 and 2018, 69.6% of people in England who had 3 or more emergency admissions to hospital in the last 3 months of life were aged 70 or older (17).

2.1.2. Children and Young People

The national prevalence of life limiting conditions in children (aged 0-19 years) in England was 63.2 per 10,000 in 2017/18 (18). Based on these figures, there are approximately 1,000 children in Leicestershire living with such conditions. In 2021, the Child Death Overview Panel were notified of 96 child deaths in Leicester, Leicestershire and Rutland, including 42 neonatal deaths.

Nationally, the prevalence of life limiting conditions was highest in the under 1 year age group at 226.5 per 10,000 in 2017/18 (18). Congenital abnormalities were the most common life limiting conditions, followed by neurological disorders. Life limiting conditions were highest amongst children of Pakistani origin (103.9 per 10,000) and lowest among children of Chinese origin (32.0 per 10,000). More children with a life limiting condition lived in areas of higher deprivation (13% most deprived versus 8% in least deprived). The future prevalence of children aged 0-19 years with a life limiting condition in England is estimated to be between 67.0 and 84.2 per 10,000. There are increasing numbers of children with a life limiting condition who have a hospital stay of greater than 28 days each year, rising from 2482 in 2001/2 to 3538 in 2017/18.

There are several differences to the end of life and palliative care needs of children compared to adults. Life-limiting and life-threatening conditions are terms which are used to describe the population of children who may benefit from input from paediatric palliative care services. This is something that lasts longer than the 12 months prior to death. For Children and Young People end of life care is generally considered to be the last few weeks or days as the condition changes and deteriorates. Children and young people can fluctuate in and out of the end of life phase as they can be vulnerable when experiencing infections or other illnesses. Palliative care for children and young people with life-limiting or life-threatening conditions is an active and total approach to care, from the point of diagnosis or recognition throughout the child's life and death.

Palliative care for children is often provided over a longer period than for adults, with services often involved from the time of diagnosis (19, 20). During the time children are cared for, they

will therefore continue to develop physically, emotionally, and cognitively, and so their individual understanding and needs will also change (19). Local services advise that children would usually be constantly meeting milestones throughout their lives. Hence, a life limiting condition has implications for the family as the child can appear to be improving when a milestone is reached even though the child still has a life limiting condition. This is seen more in non-neurological conditions. Care is needed when advising parents of prognosis as child as gaining milestones can cause confusion for families when they feel that their child appears to be doing better than expected.

A large part of paediatric palliative care is providing support for the affected family, in addition to the child (21). Indeed, in most cases the direct family are the primary carers for the child, and may also have other children affected by the same condition (19). This can be a particularly difficult time for parents and can result in placing pressure on relationships within the family (21).

Other challenges faced by families of children with a life limiting condition the feeling that there is a failure to include both parents or other significant family members in discussions about the child's care (22). Furthermore, there has been shown to often be a lack of family privacy, and also a lack of support in managing parental anxiety (22).

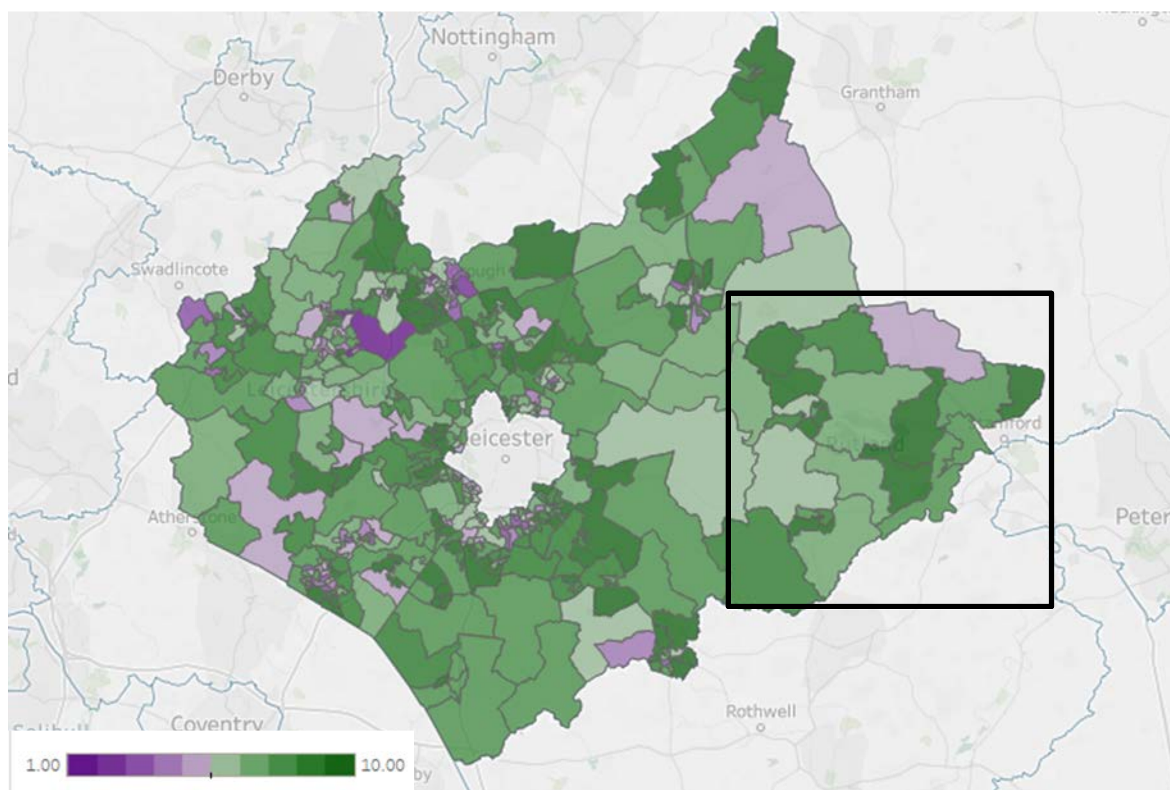
Advance care planning is important with parallel planning often undertaken locally, using advanced care planning and anticipatory care planning approaches. These should consider all possible outcomes and ensure that families are offered choices in care options throughout their journey. In Leicester, Leicestershire and Rutland, Diana staff will advocate for all children and young people with a life limiting condition to have an advanced care plan. Children who are felt to be end of life will also have a ReSPECT form completed. Families are asked where their preferred place of death for their child/ young person is, and this is rechecked regularly.

Finally, children often receive more aggressive treatments than adults, and so are more often in a hospital when receiving palliative care (23). Interaction with palliative care services however, can result in reduced hospital admissions, reduced risk of Intensive Care admission, reduced length of hospital stay, and being more likely to die at home rather than in a medical setting (24).

2.1.3. Deprivation

Rutland is overall one of the least deprived upper tier local authorities in England, being in the top decile when ranked using the Index of Multiple Deprivation 2019 (Figure 2) (25). It is important to recognise however, that variation does still exist within the county.

Figure 2: Leicestershire and Rutland (boxed area) LSOA map of Index of Multiple Deprivation 2019



Source: IMD 2019

People living in more deprived areas have shorter life expectancies than do comparable individuals living in more affluent areas. In England, this gap was as large as 9.5 years in men and 7.7 years in women in 2016-18 (26). There is also a strong association between the incidence of many chronic diseases including frailty and cognitive function, and deprivation (27). Furthermore, people of lower socio-economic status experience a shorter time period between diagnosis of a life-limiting illness and death, and therefore require more complex end of life care needs (27).

Increased social needs associated with deprivation relate to a range of factors including social isolation, increased caring responsibilities, and housing concerns (27). Whilst the majority of people would prefer to die at home over other settings, these concerns and in particular that of substandard housing, can be obstacles for those in poverty to achieve this. Indeed, in England the more deprived an area a person is from, the more likely they are to die in hospital. It is not clear however if this is due to choice or a lack thereof.

Deprivation impacts on multiple end of life related outcomes. Work by Macmillan Cancer Support has shown that patients with cancer in the most deprived areas are more likely to die in hospital, have a higher number of emergency hospital admissions in their last 12 months of life, and to report receiving either poor or fair quality of care (28). The National Survey of Bereaved People (VOICES) has similarly shown that those from the most deprived

quintile are more likely to report receiving either fair or poor care in the last 3 months of life than are those in the least deprived quintile (29), whilst work by PHE has shown that they are more likely to have 3 or more emergency hospital admissions in the last 3 months of life (17). It has been suggested this is due to their being able to access fewer information sources to help navigate end of life care, finding it difficult to ask for information, and to be more likely to misunderstand the role of services (30).

People experiencing poverty have higher rates of poor mental health than the general population, and there is emerging evidence that this may translate into increased anxiety and depression amongst people receiving palliative care (27). It is also documented that family caregivers of lower socio-economic status are more likely to experience moderate to severe depression when caring for someone with palliative care needs, and that grief and vulnerability following bereavement is heightened for this population (27).

2.1.4. Homeless People

The term homelessness includes those who are rough sleepers, in temporary accommodation and 'sofa surfing'. People who are homeless are more likely to be exposed to death, especially premature, violent, and traumatic deaths (13). Across England and Wales, the most common cause of death in this group is drug related poisoning (38.5%) (31). This is also the most common cause seen for the general population aged 20-49 but at higher rates, with accidental poisoning at 11.1% (31). In 2020, the mean age at death among men and women who were homeless was just 45.9 and 41.6 years respectively (31), whilst age adjusted death rates are up to four times higher than for the housed population (32). Furthermore, it appears that the crude death rate for this population is increasing, having more than doubled in the East Midlands since 2013, to approximately 14 per million people in 2020 (31).

Factors that contribute to these poor outcomes include barriers to accessing healthcare that are direct (such as requiring an address) or indirect (due to rigid models of care that do not accommodate the uncertainty that homelessness creates) (13). This results in treatment often being crisis-led, and so a greater likelihood of having emergency admissions to hospital than the general population (33). Furthermore, people experiencing homelessness often fear discrimination from, and negative interactions with, health professionals which can reduce the likelihood with which they will seek help (13, 33). Small, but strong social networks amongst individuals of this population allow for negative news to spread quickly which may make institutional trust slow to re-build and quick to break (13).

Once these barriers are overcome and people who are homeless do interact with services, healthcare professionals can then find it difficult to know whether they would benefit from palliative services. This can be due to their having less regular interaction with health professionals, having more complex needs, conditions with uncertain prognosis (such as drug or alcohol related liver disease), and being of a younger age than most who are referred for end of life care (33). People experiencing homelessness are also less likely to receive support from family members and friends in managing their practical, financial, physical, and emotional needs (33). As a result of these multiple complexities, advance care planning rarely happens.

Higher rates of alcohol and drug dependence can also make it difficult for people who are homeless to stay in hospital and hospice settings for prolonged periods, and lead to them self-discharging (especially if services hold zero tolerance policies towards illicit substances) (32, 33). Having a history of addiction and tolerance to certain medications can also complicate the delivery of pain relief, requiring combined input from both palliative care teams and substance misuse teams (33). Providing care in the community is also a challenge, with a potentially high level of responsibility on hostel staff to try and support people with complex health and social care needs with little specialist training (32, 33).

2.1.1. Imprisoned People

In December 2017, HMP Stocken had a prison population of 841 males, against an operational capacity of 842 (12). Across England and Wales, people aged 50 and over made up 16% of the total prisoner population in 2020 with this value predicted to increase further in future years (34). Indeed, over the last 20 years the number of people in prison aged over 60 has more than tripled (13). Furthermore, someone experiencing long-term imprisonment is considered to have the equivalent health status of someone 10 years older in the general population (34). Resulting from these implications, deaths in prisons across England from natural causes have increased by 77% over the last decade, and the palliative care needs of this population are expected to rise (13).

It is recognised that people in prison should have access to palliative care services equitable to those available outside prison, and in 2018, HMPPS launched the Dying Well in Custody Charter to set out standards and guidelines for palliative and end of life care (35). Whilst prisoners suffering from terminal conditions can apply for early release, not all will be eligible. Some may also choose to remain in prison, particularly if they have served long sentences and no longer have social connections in the community (36). Thus, there is a requirement for prisons to be able to offer quality end of life care and support in-house.

2.1.2. LGBT People

An estimated 2.7% of the UK population aged 16 years and over identified as lesbian, gay or bisexual (LGB) in 2019, with an increasing trend being seen in the recent years up to this point (37). Based on this figure, it would be estimated that there are approximately 900 people in Rutland who identify as LGB. There is a lack of robust data to indicate what proportion of the population identify as transgender however.

Today's LGBT older adults belong to a generation that experienced criminalisation and pervasive negative social attitudes, and who's sexual orientation or gender identity was considered to be deviant (38). Even today, LGBT people face ongoing challenges when interacting with healthcare services. A national survey of LGBT people by the Government in 2017 found that at least 16% who accessed or tried to access public health services had a negative experience because of their sexual orientation, and that at least 38% had a negative experience because of their gender identity (13). Discrimination is not always

overt, but can instead exist in more subtle forms such as a heteronormative bias and a lack of LGBT representation in service promotion leaflets or assumptions that patients are heterosexual unless stated otherwise (39). LGBT people have been shown to have grater all-cause mortality than heterosexual people, and to be more likely to present with more advanced disease (38). It has been suggested that this is due to their having higher levels of smoking, drug and alcohol misuse, and mental ill health leading to increased risks of cancer, coronary heart disease, and suicide (40).

With many LGBT people experiencing discrimination in their everyday lives, some delay accessing end of life care or palliative services for fear of further negative experiences, particularly if a service is linked to a church or religion (39, 41). Older adults in particular may be less open to disclosing their sexual orientation than younger LBGT people, especially when in a vulnerable position (38). This can be a particular challenge in care homes, where other older residents may retain negative views towards LGBT people (42). Such concerns extend to worry about how partners may be received with some feeling unable to show each other affection in front of staff, leading to increased loneliness and isolation at the end of life (41, 42).

Delivering care at home for LBGT people can also present challenges, as they are more likely to live alone than are their heterosexual counterparts, which has practical impacts on the levels of informal care and support available to them at home (38). Issues of lack of support and loneliness are further exacerbated as older LGBT people are less likely to have children, and more likely to be estranged from family members than are heterosexual individuals (39).

Barriers also exist for same sex partners of people at the end of life, as they are not always included in care planning and provision in the same way as heterosexual partners (42). This can stem from a failure to recognise those who are important to the patient. It has also been noted that the pain of bereavement of LGBT partners can be exacerbated by a lack of social recognition and validation that they have suffered a significant loss (13, 41).

Bisexual and Trans people face different kinds of prejudice and discrimination from gay men and lesbian women (13). As many as 2 in 5 trans people have reported that healthcare staff lack understanding of specific trans health needs (13), and concerns include areas such as what will happen after they die such as not being buried as their correct gender (39, 41).

It is important to recognise that the LGBT community represents a diverse population, and whilst some experiences will be common to the majority, others will not. There is emerging evidence to show that people of different sexualities approach end of life care planning differently. One study for example showed that gay men are more likely to have considered advance care planning than bisexual men, and that lesbian women were more likely to have done so than bisexual women (38).

2.1.3. People with learning disabilities

As many as 1 in 50 people in the UK have a learning disability (43), and this population are three times as likely to die early than are the general population (44). Based on 2018-19 data, life expectancy for a man with a learning disability is 14 years lower than for males in the general population at 66 years. The life expectancy for women with a learning disability is 17 years lower than for women in the general population at 67 years (45). The median age of death of this population is increasing however, and so aspects of ageing common to the general population such as frailty are likely to become more apparent, adding a further level of complexity to end of life care provision (44). This group are also at increased risk of developing dementia as they age. People with learning disabilities are also more likely to have high levels of unmet physical and mental health needs, and were found by the CQC in 2016 to generally receive poorer quality end of life care due to a failure to understand or fully consider their needs (44). This included being less likely to have access to specialist palliative care services and opioid analgesia, at least in part because of difficulty in reporting and describing pain (44, 46).

One barrier to accessing end of life care is that people with learning disabilities are more likely than the general population to have an unidentified health issue, which often results in late identification of those nearing the end of life (46). In the absence of advance care planning, this can lead to problems in coordinating end of life care for the individual and their family. Indeed, people with learning disabilities are sometimes excluded from advance care planning conversations, through the belief that they need to be protected from such topics, but it is vital that they are empowered to contribute to these discussions (13, 43, 44, 46). Even if they do not have the mental capacity to fully participate or have difficulty in communicating their wishes, it is important that they are supported to identify and share their choices about care (43, 44).

Transferring to a hospital or hospice can be a source of anxiety for many, but being in unfamiliar environments can be particularly distressing for those with a learning disability and thus negatively impact on their end of life care experience. Having honest and open conversations to help prepare individuals for what to expect can help to ease this (44). This is particularly important given that rates of poor mental health are already higher in this population than for the general population (44).

People with learning disabilities may also need additional support in processing a bereavement of a loved one, with grief responses possibly delayed or expressed in unconventional ways (44). This may include the need for multiple open and honest conversations to help individuals to fully understand and accept what has happened (43, 44).

2.1.4. Ethnic minority groups

The majority of the Rutland population (97.1%) belong to White ethnic groups, including White British and White Irish (12). This is higher than the figure for the East Midlands (89%) and England (85%) (12, 25). The next largest ethnic group is Asian (1%) and Mixed or

Multiple Ethnic Group (1%), followed by Black ethnic groups (0.7%) and Other Ethnic Group (0.2%) (25).

People from Black and minority ethnic (BME) groups have been shown to be less likely to rate overall care as outstanding or excellent, particularly if they spent time in a care home or hospice (47). This may be because some groups report being unaware of the aims and role of palliative and end of life care, including what roles care homes and hospices have in delivering this (47, 48). Indeed, historically there has been reduced uptake of palliative and end of life care services by people in BME groups (48).

It has been reported that there is often a lack of sensitivity to cultural and religious issues in health and social care delivery, contributing to a poor understanding of people's needs (48). During the COVID-19 pandemic for example, restrictions have been in place limiting the number of visitors allowed to patients in health and social care settings. Evidence indicates that this has had a disproportionate negative impact on ethnic groups that would traditionally have large numbers of family members involved in providing care and support near the end of life (49). Services in England have also reported difficulty in fulfilling religious and culturally prescribed responsibilities under these circumstances (49). Such needs may include the need for access to female members of staff, and the timely release of the deceased person's body and death certificate to enable funeral arrangements to be made within required timeframes (47).

Members of ethnic minority groups are also more likely to experience communication challenges when English is not their first language (47, 49). The absence of a professional translator can result in a reliance on family members and friends to help communicate wishes. In such situations, it can be difficult to be confident that the dying person has been able to make genuine and independent choices about their care (47, 48). Even when organisations have systems in place for accessing professional translators, it may be difficult to do so in a timely manner and particularly out of hours. It is important to remember however that in some cultures, patients want to be protected from hearing about diagnoses and prognoses and that these conversations are actually expected to be had with family members (48). This underlines the importance of early conversations to explore the wishes of individuals.

Overall, people from BME groups are less likely to undertake advance care planning and are more likely to advocate for life-sustaining and aggressive treatments such as artificial nutrition and cardiopulmonary resuscitation (48). Contributing to this are higher levels of mistrust towards healthcare services, particularly when discussing ceilings of treatment with such planning potentially being seen as 'an excuse to limit treatment' (47-49).

2.1.5. Non-cancer diagnoses

In 2019, 71.5% of all deaths in England and Wales were from conditions other than cancer and yet these only accounted for 15.3% of deaths occurring in hospices (16) despite having comparable symptom burdens and palliative care needs (50). This issue of reduced access is also generally true for generalist care, including being in receipt of district nursing and care

from a GP (50). There is evidence however that access to hospices is increasing for people with non-malignant conditions (16).

Studies have shown that people with non-cancer diagnoses may benefit from palliative care interventions, including through fewer emergency hospital attendances, and lower symptom burden (51). Despite this, people with a non-cancer diagnosis tend to have less access to supportive and palliative care, and also to have a poorer experience of care towards the end of life than people with cancer (52). It is often reported that it is more difficult to identify when someone without cancer is approaching the end of life. With clinical courses often less predictable (50), clinicians often report a fear of 'getting it wrong' (52). Failure to have these conversations can result in patients and their loved ones feeling uninformed and unsure of what to expect in the last months of life (52). It is therefore important to normalise and encourage having discussions relating to advance care plans early, to ensure that they are not left until more terminal and less beneficial time points.

Some of the difference in quality of end of life care for patients appears to be linked to where they are looked after. The National Survey of Bereaved People in England found that people with cancer who die at home are more likely to experience 'outstanding' or 'excellent' care in their last 3 months of life (62.8%), than are those with cardiovascular disease (46.2%) and other diagnoses (36.9%) (50). These differences were not replicated in other settings, including hospital and care homes.

Healthcare professionals have also described documents, guidelines and services relating to end of life care to be developed with cancer patients in mind, and to be less applicable to people with other diagnoses (50).

2.1.6. Dementia

Affecting an estimated 1 in 14 people aged over 65 and 1 in 6 people aged over 80, dementia is a condition which increases in prevalence with age (53). In view of predicted population growth in older age groups in Rutland, the burden from this condition is expected to increase. It is also important to acknowledge that dementia is not only associated with older ages but is itself life-shortening (54, 55). It has consistently been reported as the leading cause of death in England and Wales by the Office for National Statistics (56).

Dementia is a progressive condition and is likely to impact a person's abilities including memory, communication, and ability to undertake everyday activities as they approach the end of life (57). As such, people with dementia are likely to have additional care and support needs as they near the end of life, compared to the general population including higher levels of emotional distress that require management (58). Transferring people with dementia to unfamiliar environments such as hospitals and hospices, away from people they are used to, can exacerbate this (57). Admission to hospital for example can result in rapid physical deconditioning, distress, and delirium (55).

People with dementia require high levels of carer support, to help manage common symptoms such as incontinence and wandering (55). Despite this, compared to those without dementia, they are less likely to be referred to specialist end of life care services, are prescribed fewer palliative care medications and are less frequently referred or considered for hospice care (13). They are also more likely to experience invasive interventions such as blood tests, intravenous treatments, and feeding tubes.

Part of the reason for this is the person's reduced capacity to communicate verbally as the condition progresses, which can make it particularly difficult for them to relay to carers when they are in pain. They may instead cry out or become restless, which can sometimes be dismissed by staff as an element of the dementia or purely as 'challenging behaviour', leading to poor quality care and inadequate symptom relief (54, 55, 57). A further challenge with communication is that people whose first language is not English may revert to their mother tongue, thus introducing an additional language barrier (44)

Advance care planning is an important step in ensuring that people are able to receive the care and support that they would like. For people with dementia it is important that these conversations are initiated early, while it is possible for them to contribute and make shared decisions (58, 59). This is particularly important as it can be difficult to know when a person with dementia is coming to the end of their life due to often unpredictable clinical courses (54, 55, 57).

2.1.7. Sudden and Unexpected Deaths

The causes of a sudden or unexpected death range from medical (including stroke, myocardial infarction, acute aortic aneurysm), trauma (arising from road traffic accidents, natural disasters, or violent attacks), and taking one's own life (60). When a death occurs suddenly, loved ones have no opportunity to prepare and feelings of grief, shock and confusion can be intensified (60). Furthermore, if they are not present when their loved one dies suddenly, they may experience guilt or anger. Alternatively, if they are present, they may find themselves affected by additional trauma if they were responsible for calling for help or delivering first aid (60). The unexpected death of a loved one is associated with depression and anxiety, substance misuse, and a heightened risk for prolonged grief reactions (61).

2.2. Informal Carers

It is estimated that informal carers provide as much as 75-90% of homebased care for people who are near the end of life (62) and it is predicted that the reliance on carers is likely to increase over the coming years. During the course of the COVID-19 pandemic, the number of deaths in private homes increased placing an additional burden on carers (63). The caring role does not end when the cared for person is admitted to a place of care though, with loved ones often visiting frequently and being responsible for bringing in their personal effects (64). It can however be difficult to identify and clearly define this group, as

many who are caring do not recognise themselves as a carer but instead consider themselves to be doing what needs doing for their loved one (65).

In addition to a sense of fulfilment and wish to provide for a loved one, there are multiple negative impacts that may arise from doing so, with one of these being a high financial burden. Costs that are faced may be direct (such as transport, food, medication) and indirect (including changes to employment status through taking unpaid leave, reducing working hours, or changing to a lower paid but more flexible job) (62, 66). Such financial costs often impact those from lower socio-economic groups the most (62). Informal carers also face non-monetary costs such as time cost and potential negative health impacts. Indeed, as time is dedicated towards caring for a loved one, major life changes may be needed including moving house, delaying education, and taking time off work which may impact on future job opportunities and earning potential (62).

Informal carers are more likely to experience higher levels of anxiety, depression, and social isolation than are formal or non-caregivers (66). Studies from other countries have shown that they often experience sleep deprivation and fatigue as a result of caregiving, which can exacerbate poor mental health. The needs of carers can be divided into those which support the carer in looking after their loved one, and the distinct needs of the carer themselves (64). With a common theme among informal caregivers being that they often put the needs of their loved ones first whilst neglecting their own, there is sometimes a risk that this latter is overlooked (64, 66).

Carers also face challenges in undertaking their role, with a lack of information and knowledge about the end of life shown to be one key issue (67). Studies have shown that carers often feel that they have either received insufficient information about their loved one's illness or their care needs and how to seek help, have received information at too late a timepoint, or failed to receive it in a written format (68). A lack of information can be a particular challenge given that end of life care is often delivered in a multidisciplinary manner, with input from multiple services. Carers have reported that there is at times a lack of a clear action plan, with poor understanding amongst organisations regarding who is responsible for delivering aspects of care. In these cases it often falls on the carer to navigate and coordinate services which can place additional pressure and stress on them (69).

Upon the death of their loved one, carers may feel a mix of emotions in addition to bereavement. This may include a sense of relief, which can in turn cause guilt (64). These feelings are not distinct from the caring role, but may also be experienced whilst the loved one is still alive, with many experiencing an 'anticipation of loss' (65). Carers can also experience a secondary loss which compounds the bereavement, through the abrupt withdrawal of professional support from health and social care services. It has been reported that this can leave carers feeling abandoned and invisible (65).

Informal carers comprise a diverse population, and experiences are not uniform across this group. There is considerable evidence that women are more likely to be caregivers to family members than are men (62, 66), and so are more likely to be affected by the challenges associated with this role. The relationship between health impacts and other carer demographics is complex though. For example, younger carers have been shown to mainly

suffer greater psychological impacts whilst older carers have worse physical health, and spouses appear to suffer greater overall health impacts than other carers (63). A certain level of physical fitness is needed to be able to deliver some practical aspects of care, which can be increasingly challenging with an increasingly ageing population taking up caring responsibilities (64).

2.3. Staff working in end of life and palliative care roles

Whilst a large amount of research has been undertaken to investigate the challenges faced by informal carers in providing end of life care, there is little in the literature considering the impacts on staff in this area. Those who work in end of life and palliative care roles face numerous emotional demands which may negatively impact their mental health and psychological wellbeing, including recurrent exposure to death and patient suffering, breaking bad news, and the absorption of negative emotional responses (70). Practical considerations including limited time and resources have also been cited as further sources of stress in this area (71).

Persistent work-related stress can lead to burnout, which consists of emotional exhaustion, depersonalisation, and feelings of reduced personal accomplishment (72, 73). Due to differences in how it is measured, prevalence estimates vary and range from 3% to 66% (72). In addition to directly affecting the wellbeing of staff, burnout can result in reduced quality of patient care, increased risk of mistakes being made, and impact healthcare organisations through time off work and staff leaving (72).

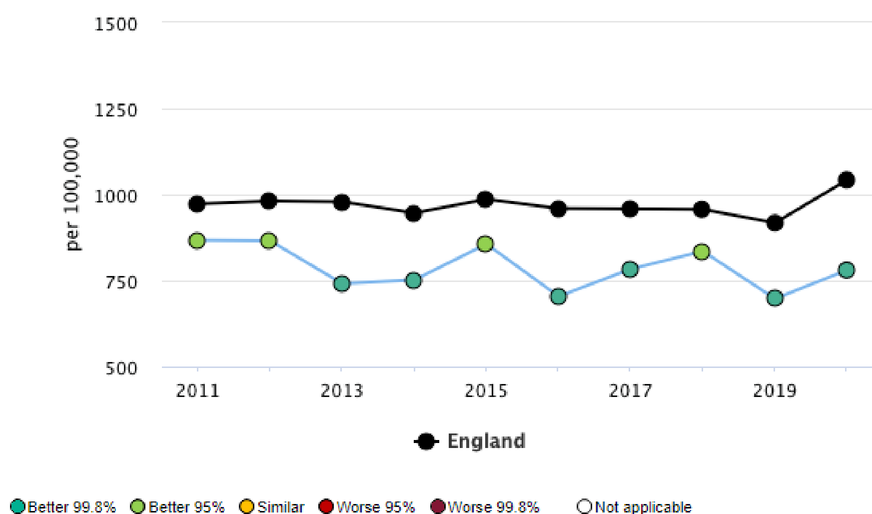
Work undertaken by the British Medical Association (BMA) has shown that significant numbers of junior doctors have also highlighted a lack of confidence when managing end of life situations stemming at least in part from a lack of exposure, with complex conversations often left to more senior colleagues (74). Even doctors at more senior levels of training felt that they had received little training in discussing sensitive issues with patients. Areas of particular difficulty included the administration of pain relief, and challenges in predicting how long a patient has to live.

3. Level of need in Rutland

3.1. Mortality Rate

The mortality rate for all ages in Rutland was 780 per 100,000 population in 2020, with no significant change in trend over the preceding 5 years. This is significantly better than the rate for England, which in 2020 was 1,042 per 100,000 (Figure 3) (2). When considering mortality rates in Rutland by age group, those in groups <65 years, 65-74, 75-84 and 85+ years all have significantly better mortality than England (2).

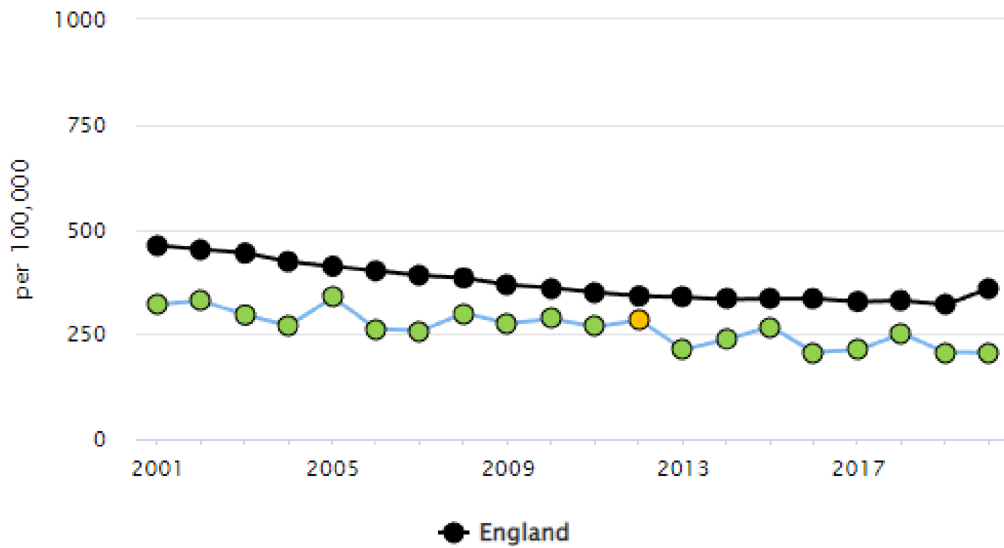
Figure 3: Mortality in England and Rutland (all ages) (2)



Source: OHID Fingertips, Palliative and End of Life Care Profiles

Premature mortality is defined as deaths under age 75 for all years. In Rutland, the under 75 mortality from all causes was 205.8 per 100,000 in 2020 (Figure 4). This is significantly lower than both the East Midlands (362.5 per 100,000) and England which was 358.5 per 100,000 (75).

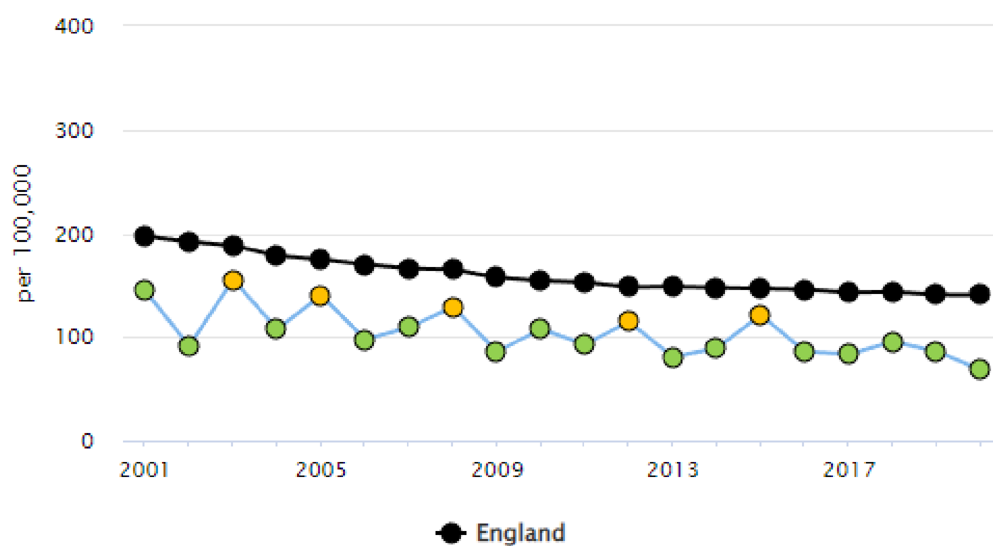
Figure 4: Under 75 mortality rate from all causes in Rutland and England



Source: OHID Fingertips, Palliative and End of Life Care Profiles

Some causes of death are considered preventable. These are causes where all or most deaths could potentially be prevented by public health interventions. In Rutland, the under 75 mortality rate from causes considered preventable was 68.2 per 100,000 in 2020 (Figure 5). This is significantly lower than both the East Midlands (142.1 per 100,000) and England (140.5 per 100,000) (76).

Figure 5: Under 75 mortality rate from causes considered preventable in Eutland and England



Source: OHID Fingertips, Palliative and End of Life Care Profiles

3.2. End of Life Preferences

National Data

If severely ill, the majority of people would prioritise their quality of life over the length of time remaining to them. In one survey commissioned by Marie Curie, 77% of people either agreed or strongly with the statement “If I was severely ill with no hope of recovery, my quality of life would be more important than the length of my life”, whilst only 6.7% either disagreed or strongly disagreed (10). This proportion is similar for those identified as being in their last years of life (79%), carers of people with terminal illness (76%) and bereaved carers (81%).

This same survey also asked members of the general population to select the three priorities that would be most important to them in their final days of life (10). The highest ranked priority was being free of pain and other symptoms, selected by 46.5% of respondents. This was followed by being in the company of loved ones (43%) and being able to maintain personal dignity and self-respect (35%). Being at home was the fourth ranked priority, selected by 26% of respondents. Being at home was a greater priority for those who self-identified as being at the end of life, than for members of the general population. For these individuals, being at home became the second highest ranked priority, replacing being in the company of loved ones (Table 1).

Table 1: Most selected personal priorities for individuals during the last years of life (10)

	Top priority	Second Priority	Third Priority
General Population	Being free of pain & other symptoms	The company of loved ones	Being able to maintain personal dignity & self-respect
Individuals in the last years of life	Being free of pain & other symptoms	Being at home	Being able to maintain personal dignity & self-respect

Source: Public attitudes to death and dying in the UK, Marie Curie, 2021

Other research has shown that key themes important to the general public when considering good end of life care include being treated as a person, the timely provision of medical services, the location of services, and provision of information (74). The concept of being seen as a person, encompasses the recognition that they remain an individual with particular needs, wishes and goals. It was recognised as being important to have care tailored to the person themselves, rather than being placed on a generic plan which could be applicable to anyone with their condition (74). This includes having choice with regards to what treatments they do or do not receive and being able to change one’s mind. This

reinforces the importance of robust and timely advance care planning, to support the delivery of tailored care.

Local Insights

UHL collate feedback collected through their bereavement service (see section 6.2) to create 'End of Life' themes. Both positive and negative feedback is received, and so these themes can give an indication of what is considered important to the loved ones of those receiving end of life care in hospital. The theme of 'communication' is by far the largest of these, with subthemes including communication around the topics of imminence of death, DNACPR, prognosis, results, management, and care planning. This links with national the national findings discussed previously, that people value being included in decision making and being treated as an autonomous individual.

3.3. Advance Care Planning

National Data for adults

Advance care planning provides people with the opportunity to plan their future care and support, whilst they have capacity to do so (77). It should be personalised to the individual and emphasises personal reflection and choice (77). Whilst not everyone may wish to make an advance care plan, it may be particularly relevant to those who are at risk of losing mental capacity through a progressive illness such as dementia. Such plans can take place either through informal conversations with loved ones, or through formal routes such as the completion of advance statements, lasting power of attorney, and advance decisions (77). Although these are not legally enforcing, planning in this way does make it more likely that a person's wishes will be understood and followed (78). Evidence indicates that timely advance care planning is strongly associated with lower rates of hospital deaths, and greater odds of being cared for and dying at home (79, 80). It allows for a more proactive approach to delivering care and support, in place of a reactive one. This also has the benefit of supporting friends and family in being better prepared (10).

Despite the important role of advance care planning, only 15% of those participating in a national survey by Marie Curie reported having already talked to someone about their end of life care wishes (10). Slightly more (20%) had made financial arrangements for their funeral. These figures remain low, even amongst those who are in their last years of life (13% reported having made advance plans). This is in line with results from other studies, such as The National Audit of Care at the End of Life which found that only 9.7% of people had an advance care plan before their final hospital admission in 2019 (though this was an increase from 4.5% in 2015) (9). With approximately half of all participating adults reporting that they intend to have these conversations, there appears to be an intention-action gap in this area (10). Some topics appear to be easier to discuss however, with 40% saying that they had talked to someone about whether they want their body to be buried, cremated, or donated. It also appears that there is a reluctance by individuals to discuss their own

preferences about end of life care, but also to discuss those of others. As little as 16% of respondents reported asking a family member/friend whether they had made a living will, and 15% had asked what type of care support they would want at the end of their lives.

Barriers to initiating these conversations from a carer's perspective include a fear of causing further pain or upset. Furthermore, acknowledging the need to discuss these topics can be seen as 'giving in' and abandoning hope of recovery by the individual (81). One way to build effective communication and create trust is through having one-to-one relationships with a health or care professional (1). This is particularly important for those who may have negative past experiences of healthcare services, such as those who are homeless or Gypsies and Travellers.

It is also important to consider when conversations take place. Although it may feel easier to have these discussions when either yourself or a loved one are nearing the end of life, cognitive capacity can be compromised in the later stages of some terminal conditions (such as dementia) and so make these conversations less meaningful (1, 13, 81). Beginning these conversations earlier suggests better control, making it easier to plan for the practicalities of death such as wills and finances. The CQC acknowledge that there ought to be a shift towards having conversations about wishes and preferences at an earlier stage in the care pathway, even if diagnoses and prognoses are less clear (1).

Multiple factors may explain these low figures. Being able to talk about death is vital to facilitating advance care planning, and yet the majority of people feel we do not talk enough about death and dying (10). Some feel that the COVID-19 pandemic has highlighted the importance of talking about death and dying, and that the amount we now discuss this subject as a society has increased as a result. Despite the belief that death and dying are not discussed enough, 65% of people responding to a survey by Marie curie reported feeling either comfortable or very comfortable discussing these topics (10). This was even higher for people in the last years of life, carers and bereaved carers, of whom 80% reported feeling comfortable discussing these topics with family and friends. An exception to this, was seen in relation to discussing the arrangement of virtual possessions such as social medial accounts with only 45% reporting feeling comfortable.

A further barrier to advance care planning appears to be a lack of knowledge and understanding of the types of services available, and of terms commonly used in end of life care. Amongst the general population, as many as 78% are unaware of the term "Advance Care Plan", whilst 88% are unaware of the term "Advance Directive" (10). The most recognised terms in this survey were "Palliative Care" and "Hospice Care", although 31.3% and 31.6% were respectively unaware of these. Furthermore, 55% of those in the last years of life reported not knowing where to find information on how to plan in advance for care at the end of life.

There also appears to be a low level of understanding as to who can access end of life care. This same survey found that 45% of respondents either did not agree, or did not know, that people thought to be approaching the end of life are themselves able to access end of life care facilities. Those who have actively made advance plans around their end of life preferences however, appear to have a far greater understanding on this issue. This same

survey found that between 55% and 76% of those who had made advance plans agreed that those approaching the end of life are able to access end of life care facilities.

Local Insights

One challenge with ensuring advance care plans are followed locally, is in initially identifying that the person actually has one. Known as Integrated Care Plans in the community, these are completed by GPs and recorded electronically on SystemOne whilst the patient is provided with a paper copy. Hospital teams, however, do not have access to SystemOne and so are reliant on the patient brining their physical copy with them, should they be admitted. Similarly, GPs do not have access to hospital records and if an advance care plan is completed during an inpatient stay, they are reliant either on this being clearly documented in the discharge letter or on the patient bringing them a physical copy. This failure of systems to communicate results in confusion, duplication of work, and the risk of going against a patients' clearly identified wishes.

An audit of 36 patients in the Leicester Royal Infirmary over the space of 2 weeks in April and 2 weeks in May 2021 who died in hospital identified 85% had a ReSPECT form completed in hospital, identifying their clinical care and treatment recommendations for an emergency (this includes forms that were re-written during their stay) (82).

Where plans are in place and held by the patient at the time of admission, the quality can sometimes cause problems when patients wishes aren't clear or use statements that are ambiguous.

Children and Young People
Advanced Care planning is used more frequently with children and young people than with adults in Leicester, Leicestershire and Rutland. Local teams advocate for a combined CYPACP (Child and Young Person's Advanced Care Plan) with ReSPECT embedded and ensure that families are offered choices in care options throughout their journey. A much higher percentage of children and young people die with this combined document in place wherever death has been anticipated due to the child having a life limiting and/or life threatening condition. Figures from the Diana service for 2021 identify over 57% of children that died in this period having a CYPACP and/or ReSPECT in place. The majority of those without plans were due to the unexpected or rapid death of the child.

3.4. Delivery of End of Life Care and Support

National Data

There is evidence that end of life care is often not well coordinated, and that having multiple people involved in delivering care can be confusing and result in inconsistent quality of care (1). This can have a particular impact on carers, who must subsequently spend time coordinating services. This can also be challenging for staff working in the sector, with a lack of clarity over whose responsibility aspects of care falls under. Evidence suggests

that poor coordination of care is particularly an issue for hospital services attempting to coordinate with services outside the hospital such as General Practice, compared to community based services working together (9).

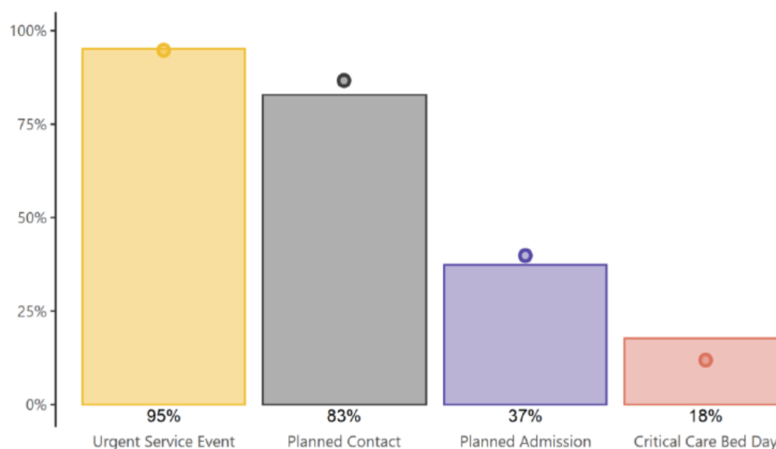
It has been identified nationally that many inappropriate hospital admissions amongst end of life patients occur because the patient and/or family are concerned over a sudden deterioration in health and do not know who to contact. They therefore call an ambulance, whose staff do not know the patient's full medical history and so transfer to hospital where the emergency team similarly lack information about decisions that have previously been made about the patient's care. This leads to admission to a ward. It is important to have timely discussions with patients and families, and to signpost who to contact in such situations (74).

Local Insights

In the two years before they die, most people access some form of healthcare (4), but it is the nature of the services with which they interact which is important. Compared to the Midlands as a whole, a lower proportion of people in Leicester, Leicestershire and Rutland access planned admissions whilst a greater proportion access critical care beds (Figure 6). Data shows that those dying from cancer are likely to have more planned contacts and planned bed days than people from other death groups. Part of this is due to their undergoing cancer treatment regimens.

A review undertaken of deaths that took place in UHL or LPT, or within 30 days of discharge from UHL, found that elderly patients in particular are often admitted to hospital out of necessity due to deterioration in their condition. They felt however, that this necessity could be mitigated by placing a greater emphasis on preventative measures in the community. These may include providing greater clinical solutions in community hospitals and nursing homes, and providing more focussed support for informal carers (83).

Figure 6: Proportion of people who in the last two years of life accessed healthcare services. Leicester, Leicestershire and Rutland indicated by bars (with percentages) and Midlands region indicated by dots (4)



Source: Health Service use in the last two years of life. Leicester, Leicestershire and Rutland STP, Midlands and Lancashire Commissioning Support Unit, 2020

To enhance our understanding of the needs and experiences of local people, an online survey was conducted by Leicestershire County Council. Of those who responded, 9 people had both undergone a bereavement within the last 3 years following the expected death of a loved one, and identified Rutland as the primary location to which their experiences related. These individuals were asked to reflect on the care that their loved ones received as they approached the end of life, with the results outlined in figures 7-13 (note that this was a self-selected sample, and so may not be representative of experiences across the county).

Figure 7: There was a sufficient range of services to meet my loved one's physical needs.

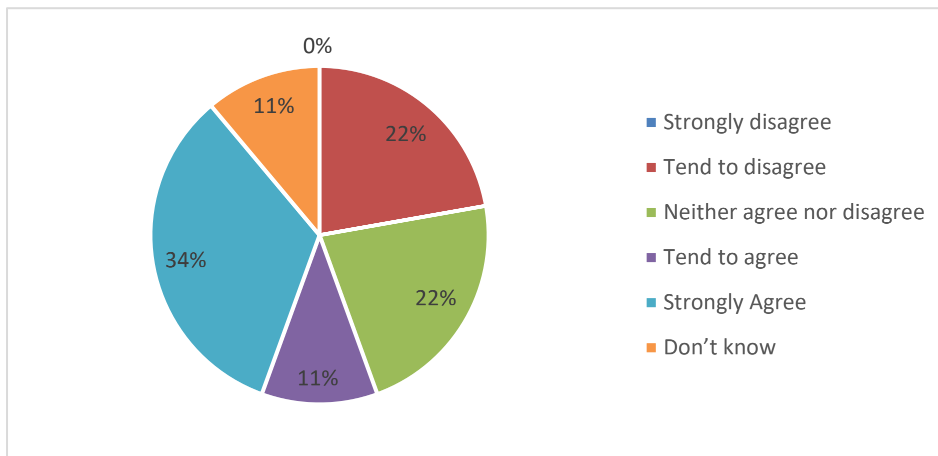


Figure 8: There was a sufficient range of services to meet my loved one's mental health needs.

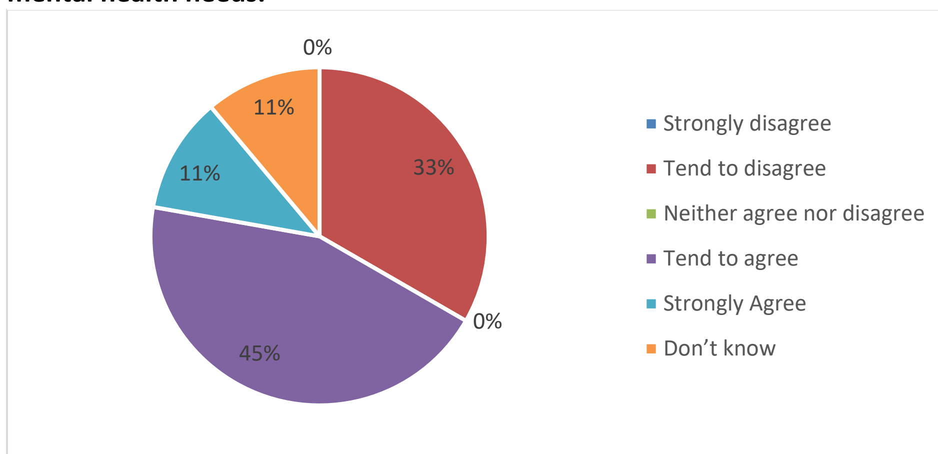


Figure 9: There was a sufficient range of services to meet my loved one's financial needs.

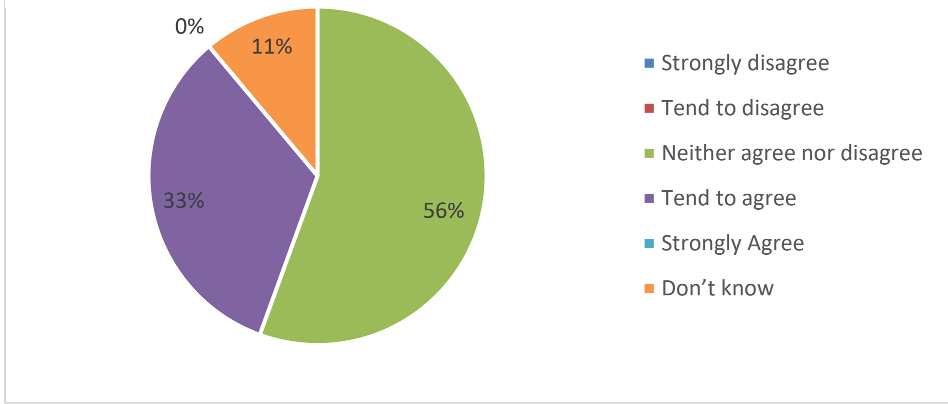


Figure 10: There was a sufficient range of services to meet my loved one's cultural needs.

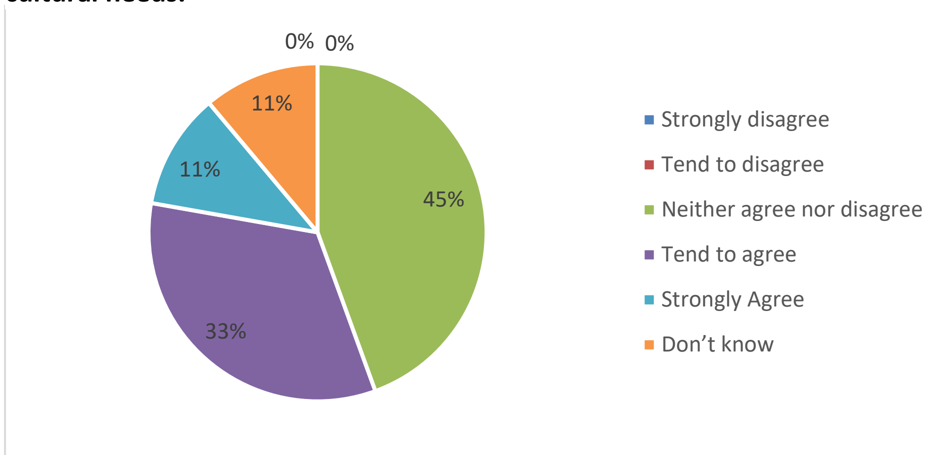


Figure 11: It was easy to access support services for my loved one.

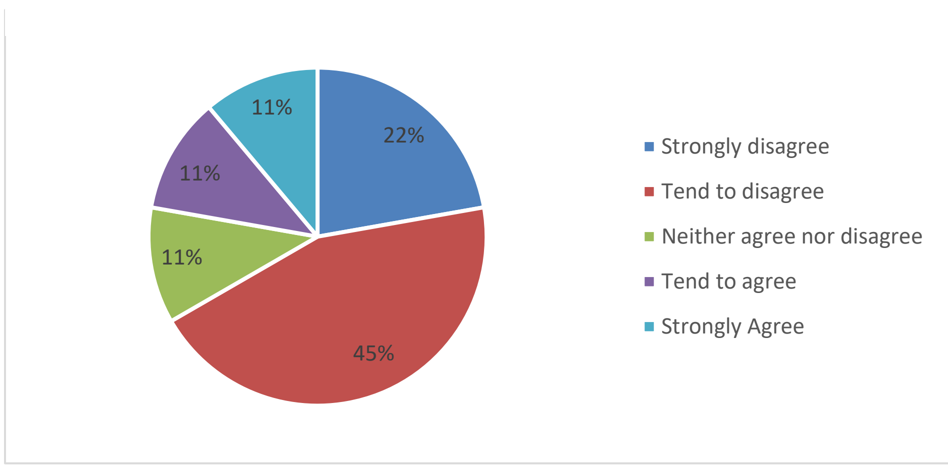


Figure 12: My loved one received the equipment (such as medical devices and mobility aids) that they needed in a timely manner.

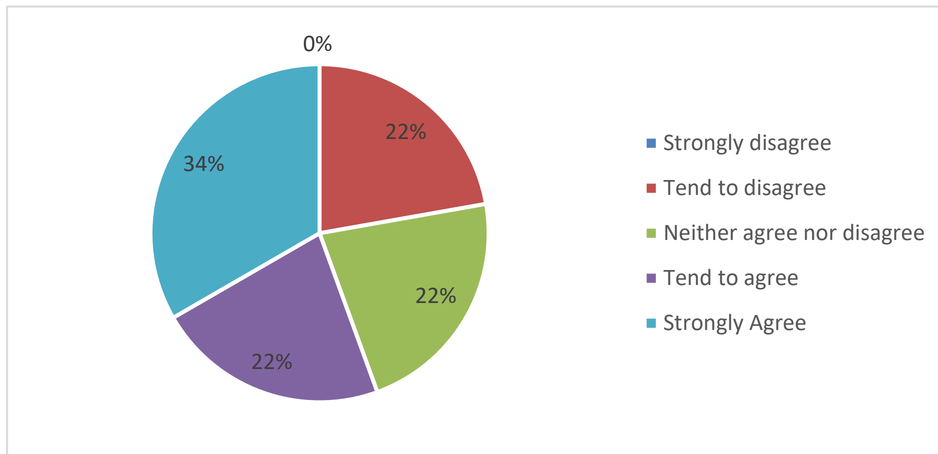
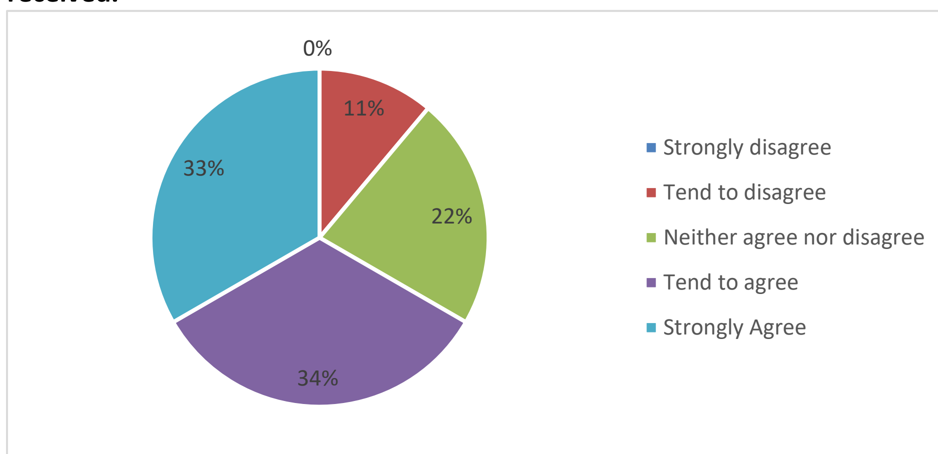


Figure 13: Overall, I was happy with the care and support that my loved one received.



Respondents were also asked what aspects of the care and support received by their loved one worked well, and which require strengthening and developing further. Health and social care staff delivering care were spoken highly of, particularly in relation to their caring nature. Several reported however, that they would have benefited from additional support at home and in the community, particularly out of hours. People also found that the burden of identifying and coordinating services fell upon themselves and their loved one, leading to additional stress during an already difficult time. Poor communication between primary and secondary care was mentioned specifically by one respondent.

This poor coordination of services and disjointed care was also highlighted at a workshop attended by local stakeholders in the delivery of end of life care, which was held in January 2022 to contribute towards the shaping of the Rutland Place Based Delivery Plan. This session also highlighted that there is a lack of continuity of care, particularly in primary care. The absence of a named GP taking ownership over a patient's care was felt to contribute

towards late identification of someone approaching the end of life, and so later implementation of support packages.

Finally, whilst 56% of people agreed that equipment arrived in a timely manner (Figure 12), one respondent commented on delays in having this collected following the death of their loved one. Having the equipment kept in the house was a source of additional distress.

Quotes provided by respondents:

"Excellent advice from the Doctors for myself and family in order to inform plans. We opted for palliative care only. All were fully involved in the decision and aware of the outcomes and timescales in order to prepare for death. The hospital were able to provide a side room for our use for the final 10 days. The whole process was excellent in preparing for death and recovery afterwards ie knowing that everything had been so well done."

"We asked for support on numerous occasions - via our GP and PCH. and was told we would receive support from MacMillan, but none was received. 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"*

"All care was arranged and paid for by the family. Had to wait 2 weeks for GP to attend to ensure end off life medical care which was two days before death."

"[My parent] was discharged to die at my house, as per [their] wish. no one actually asked me though. We did have issues around string driver medication running out, leading to a very distressing few hours on a Saturday night."

"The equipment that filled up my house, was unable to be collected for a week. That was distressing as had the bed and all equipment and couldn't get my house back"

3.5. Place of Death

3.5.1. Preferred Place of Death

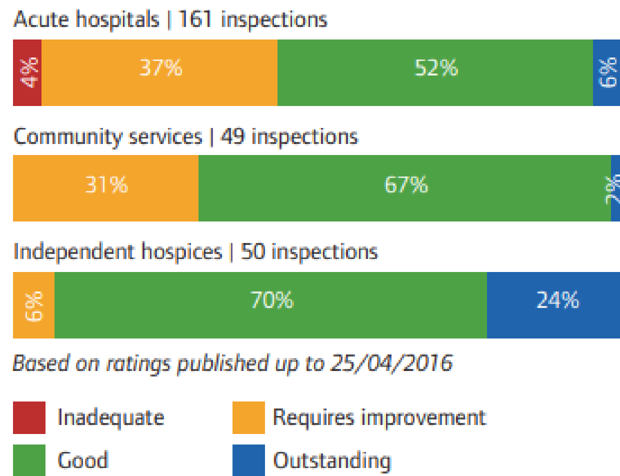
It is estimated that for 81% of people in England, home is the preferred place of death (29). This is followed by hospice (8%), care home (7%), hospital (3%) and other (1%). Caution ought to be taken however when considering these figures however. Indeed, in many studies a large proportion of respondents indicate that they have no preference, and there is also often a shift in preferences away from home and towards hospital as age increases or illness progresses (84). Furthermore, the term 'home' can be poorly defined and conflated with concepts of comfort, familiarity and the presence of loved ones which can exist in other settings (84). Practical considerations also need to be thought of when reflecting on preferred place of death, and yet many surveys do not ask respondents to consider aspects such as access to clinical support when considering their preferred end-of-life location (84). Given that being free of pain and other symptoms is often a top priority for people in their final days (10), it is possible that this may influence decision making.

There are also personal reasons why although dying at home may be the aspiration, it may not be a practical option for a given individual. In deprived areas for example, housing is often of poorer quality, and those in temporary and rented accommodation may also experience housing insecurity (13). In such situations, home may not represent the ideals of comfort and familiarity in the same way it does for others. Additionally, as outlined in Section 2.1, a considerable workload is taken on by families and loved ones when caring for someone nearing the end of life at home. Those with low socioeconomic status may also be less able to take time off work to care for loved ones, whilst those from other groups such as older LGBT adults are more likely to live alone and so not have as robust a support network. Thus, dying at home may not mean the same to everyone, and dying well at home may not be possible for all thus driving inequalities in end of life care.

Whilst hospitals are often considered the least preferred place of death, some suggest that they might be the most appropriate place for some, particularly for those with pain, which can potentially be better managed in hospital settings (74). Evidence suggests however that this isn't the case, with the National Survey of Bereaved People (VOICES) finding that complete pain relief was achieved all of the time during the last 3 months of life in only 39.7% of those in hospital (29). This compares to 63.5% of those in a hospice, and 42.7% in care homes. These results also reflect overall end of life CQC inspection ratings, with hospices being the sector to receive the highest proportion of good or outstanding ratings (Figure 14) (1).

Finally, although large gaps exist between preferred and actual place of death, the majority of bereaved people believe that their loved one died in the right place (29). Based on results from the latest VOICES survey, 94% of those who died in a hospice were believed to have died in the right place for them, 93% of those at home, and 74% of those in hospital.

Figure 14: Overall End of Life CQC inspection ratings by sector (1)



Source: A different ending. Addressing inequalities in end of life care. Overview Report, CQC, 2016

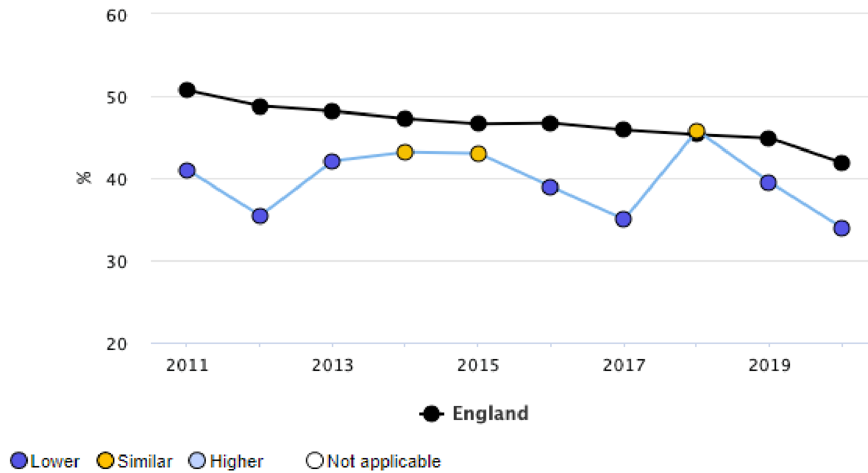
3.5.2. Actual Places of Death in Rutland

Hospital

In 2020, 33.9% of all deaths in Rutland occurred in hospitals. This is significantly lower than the England value of 41.9% (Figure 15) and is driven by a particularly low proportion of deaths occurring in hospital amongst those aged 65-74 years (all other age groups have similar proportions to England) (3). Whilst there has been a decreasing trend in the percentage of people of all ages in England dying in hospitals from 2016 onwards, there has been no significant change in Rutland.

Based on data collected by the UHL Bereavement Support Service (see section 6.2), 63% of contacted bereaved family members who were willing to provide feedback in Quarter 4 of 2021/22 rated the quality of End of Life care received by their loved one in hospital as good or excellent. This compares to 32% who felt it was satisfactory, and 6% who felt it was poor or very poor.

Figure 15: Proportion of deaths that occur in hospital in England and Rutland (all ages) (3)

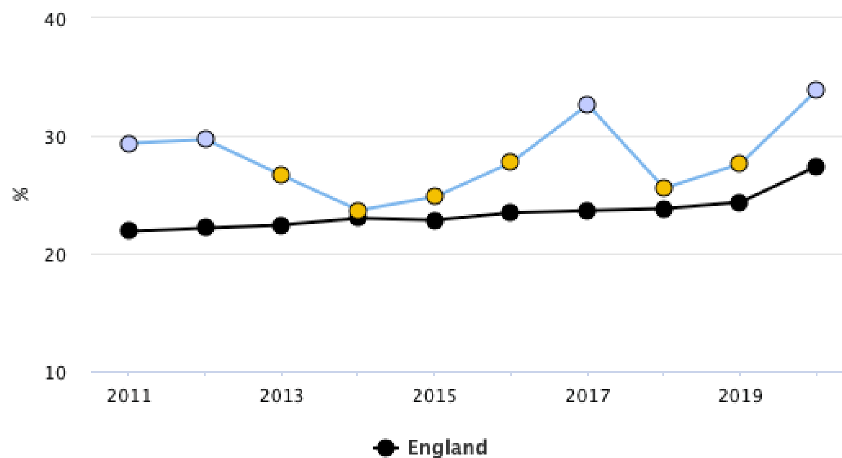


Source: OHID Fingertips, Palliative and End of Life Care Profiles

Home

In 2020, 33.9% of all deaths in Rutland were at home. This is the highest proportion of any local authority in England and is significantly higher than the England value of 27.4% (Figure 16). The percentage of deaths occurring at home for those aged 75-84 and 65-74 were significantly higher in Rutland than England, whilst those for ages <65 and 85+ years were similar to the England value. There has been an increasing trend in the percentage of deaths in England occurring at home over the past decade, but no change in Rutland.

Figure 16: Percentage of deaths that occur at home in England and Rutland (all ages) (3)

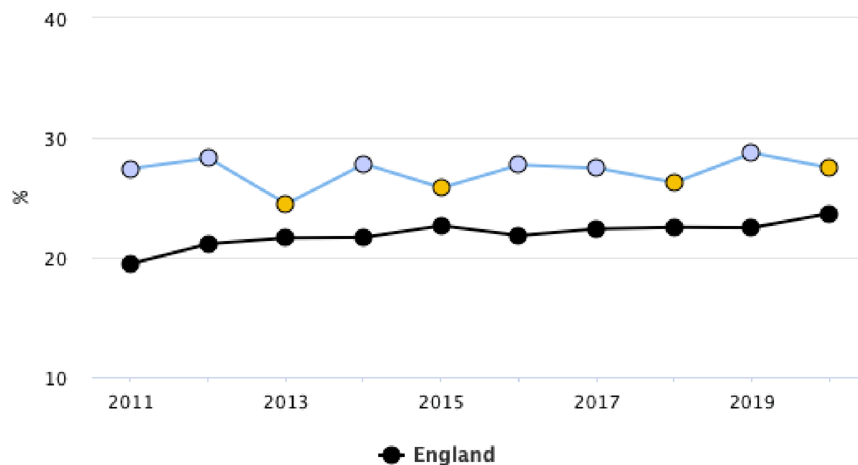


Source: OHID Fingertips, Palliative and End of Life Care Profiles

Care Home

In 2020, 27.5% of deaths in Rutland were in care homes. This is similar to the England value of 23.7% (Figure 17) (3). There has been an increasing trend in England for the percentage of deaths to occur in care homes from 2016 onwards, but there has been no significant change in Rutland.

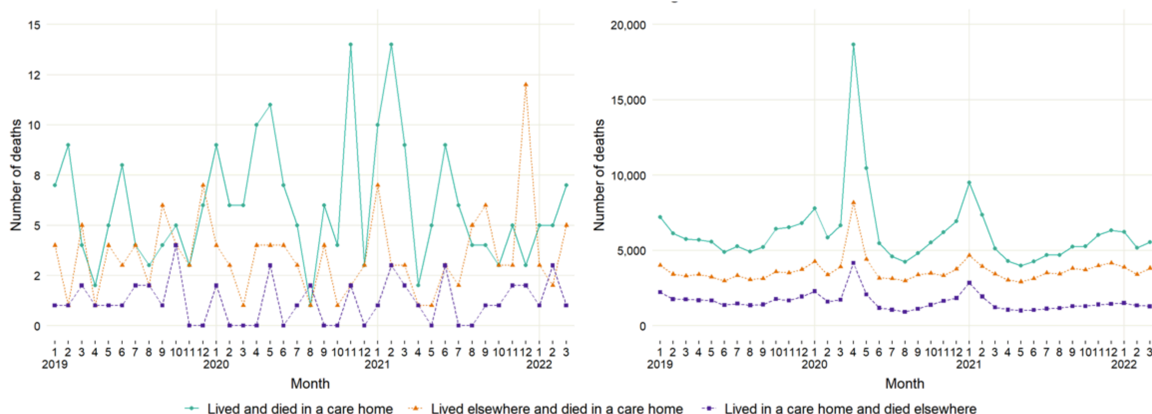
Figure 17: Percentage of deaths that occur in care homes in England and Rutland (all ages) (3)



Source: OHID Fingertips, Palliative and End of Life Care Profiles

One difficulty when considering care homes as place of death, is that for many older adults in particular this will represent their place of normal residence. A breakdown of the number of deaths occurring in care homes in those who lived in a care home and those who lived elsewhere, is shown in Figure 18 (6). There is a high degree of month-to-month variability due to low numbers of deaths in care homes, but proportion of those who lived and died in a care home compared to those who lived elsewhere beforehand, is broadly similar to that of England.

Figure 18: Number of deaths by care home-related place of death (all ages): Rutland and England (2019 to 2022) (6)

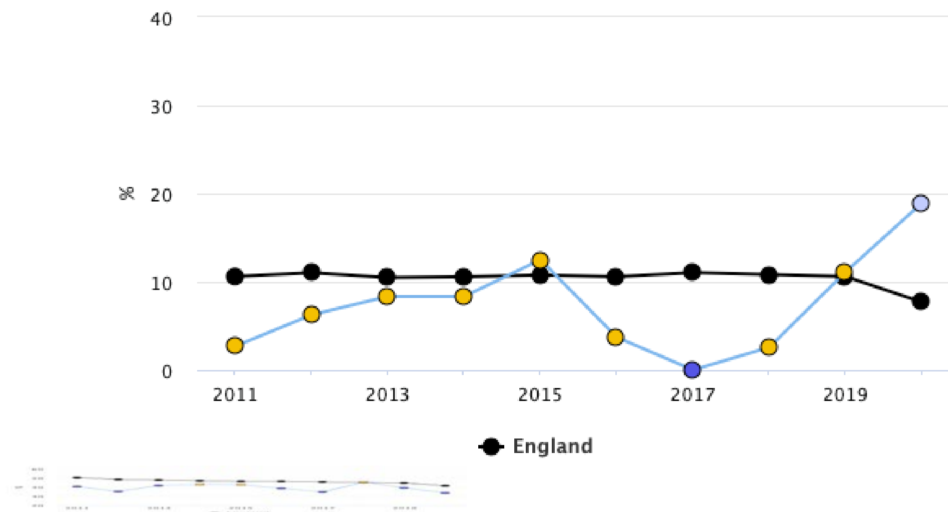


Source: OHID Fingertips, Palliative and End of Life Care Profiles

Hospice

There has been no significant change in the percentage of deaths in England or Rutland occurring in a hospice, from 2016 onwards. In 2020, 3.1% of deaths in Rutland occurred in a hospice. This is similar to the England value of 4.5% (figure 19) (3).

Figure 19: Percentage of deaths that occur in hospice in England and Rutland (all ages) (3)



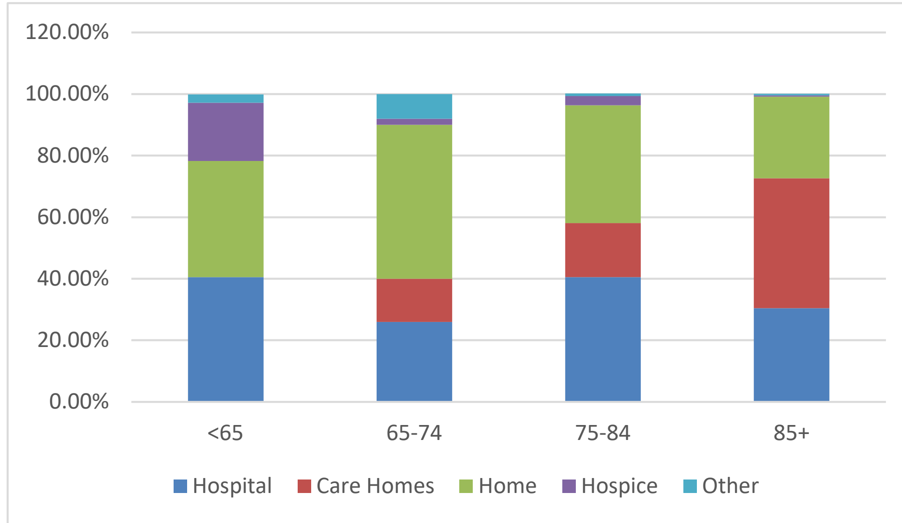
Source: OHID Fingertips, Palliative and End of Life Care Profiles

3.5.3. Factors influencing place of death

Age

The proportion of deaths in Rutland occurring at different locations varies by age. As age increases, the percentage who die in hospital or at home generally decreases, whilst the percentage dying in a care home increases (Figure 20) (3).

Figure 20: Percentage of deaths by age group in Rutland that occur in different locations (2022) (3)

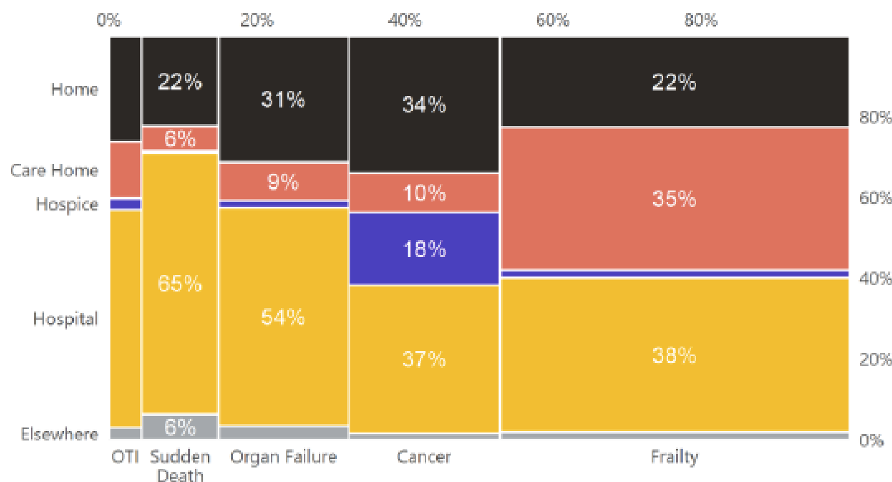


Source: OHID Fingertips, Palliative and End of Life Care Profiles

Diagnosis

Cause of death also influences someone's likely place of death. In keeping with what is seen nationally for example, those diagnosed with cancer in Leicester, Leicestershire and Rutland are far more likely to die in a hospice than are people with other diagnoses (Figure 21). Meanwhile, those whose cause of death is classed as frailty are far more likely to die in care homes.

Figure 21: Proportion of deaths by cause and place - Leicester, Leicestershire and Rutland STP (4)

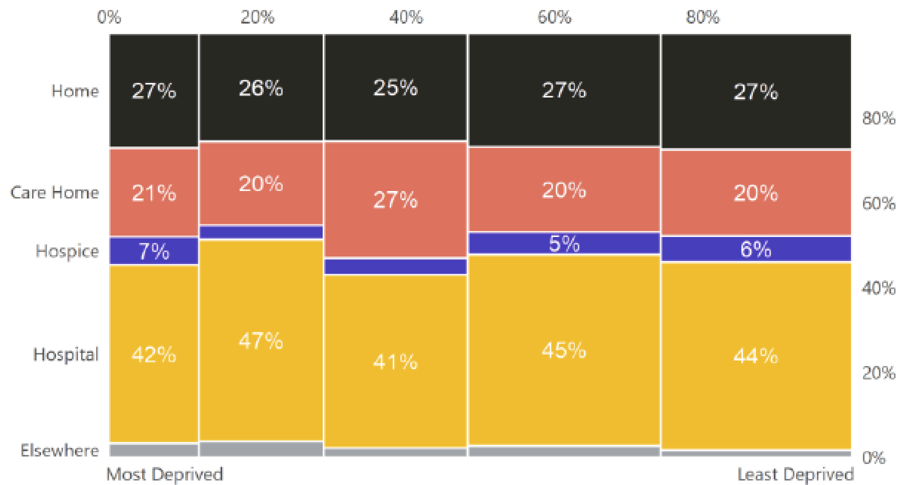


Source: Health Service use in the last two years of life. Leicester, Leicestershire and Rutland STP, Midlands and Lancashire Commissioning Support Unit, 2020

Deprivation

In Leicester, Leicestershire and Rutland, there is a mixed picture for place of death by deprivation level (Figure 22) (4). This is in contrast to the Midlands, which saw the highest proportion of deaths in hospital for those in the most deprived areas.

Figure 22: Proportion of deaths by deprivation quintile and place - Leicester, Leicestershire and Rutland STP (4)



Source: Health Service use in the last two years of life. Leicester, Leicestershire and Rutland STP, Midlands and Lancashire Commissioning Support Unit, 2020

3.6. Cause of Death

The leading causes of death in the UK differs by sex (7). For men, whilst the number of deaths from ischaemic heart diseases have decreased over time, this remains the leading cause of death (Figure 23). For women, the number of deaths caused by dementia and Alzheimer disease has increased since 2001 and has been the leading cause of death since 2011 (Figure 24).

Leading cause of death also varies based on age (7). In 2018 (the most recent year for which ONS data is available), the leading causes of death for different age groups in the UK were as follows:

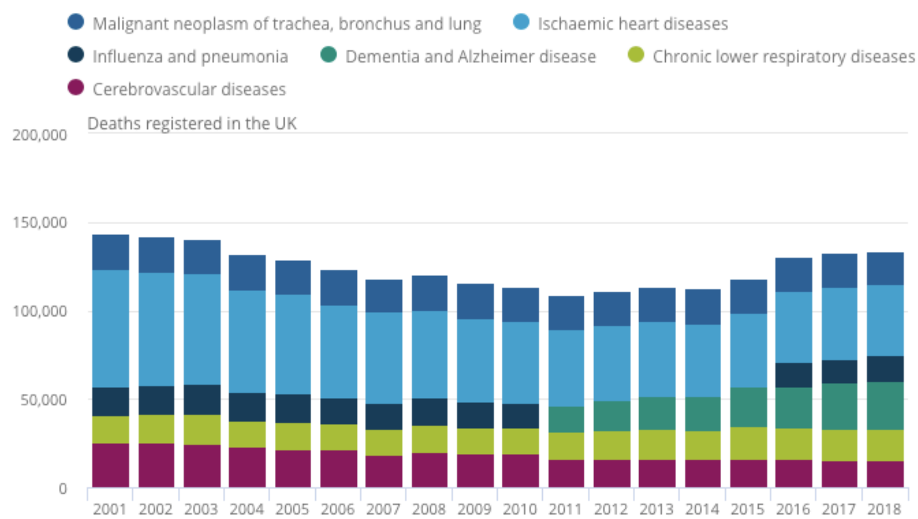
- 20-34 Years - suicide and injury or poisoning of undetermined intent for both males and females (27.1% and 16.7% respectively).
- 35-49 Years – accidental poisoning for both males and females
- 50-64 Years – for males, the leading cause of death was ischaemic heart disease (17.2%). For females, the leading cause was cancer of the trachea, bronchus and lung (10.1%).

- <u>65-79 Years</u> – for males, the leading cause of death was ischaemic heart disease (14.8%) despite a decrease since 2001. For females, the leading cause was cancer of the trachea, bronchus and lung (10.4%).

- <u>80+ Years</u> – dementia and Alzheimer disease for both males and females

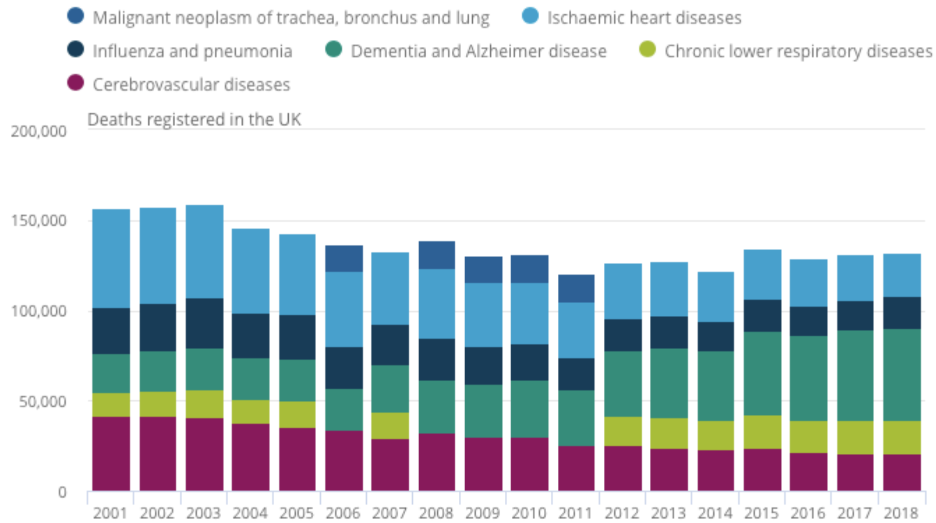
Local data is only available for the conditions of cancer, respiratory disease, and cardiovascular disease, as discussed in the following sections.

Figure 23: Deaths registered in the UK by leading causes of death, males, all ages, 2001 to 2018 (7)



Source: Leading causes of death UK: 2001 to 2018, ONS, 2020

Figure 24: Deaths registered in the UK by leading causes of death, females, all ages, 2001 to 2018 (7)

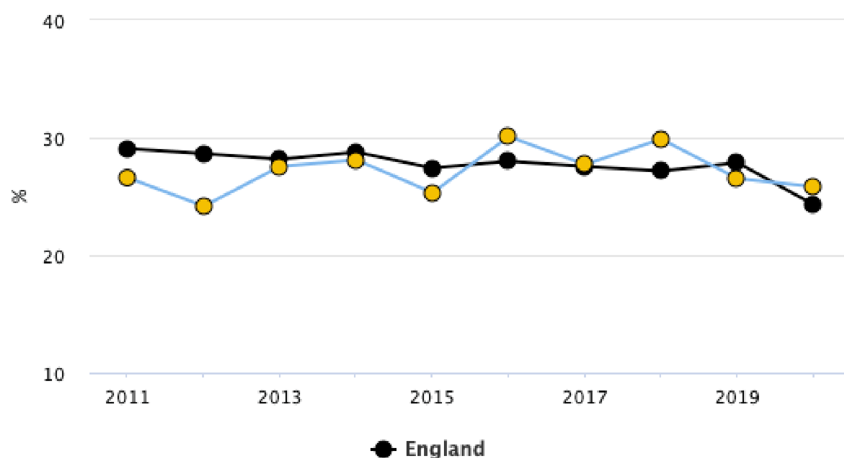


Source: Leading causes of death UK: 2001 to 2018, ONS, 2020

3.6.1. Cancer

In 2020, 25.8% of deaths across all ages in Rutland occurred with cancer as the underlying cause (5). This is similar to the England value of 24.3% as shown by Figure 25. There has been no significant change in this figure in Rutland since 2016, whilst a decreasing trend has been experienced in England.

Figure 25: Percentage of deaths with underlying cause cancer in Rutland (all ages) (5)

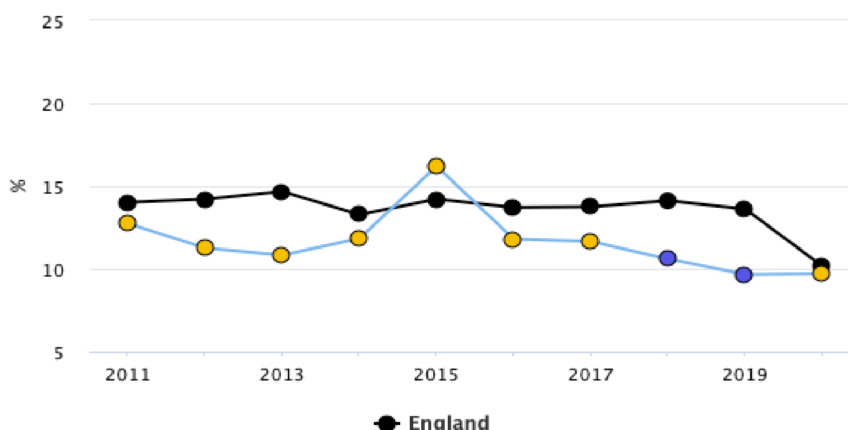


Source: OHID Fingertips, Palliative and End of Life Care Profiles

3.6.2. Respiratory Disease

In 2020, 9.7% of deaths in Rutland occurred with respiratory disease as the underlying cause (5). This is similar to the England value of 10.2% as shown by Figure 26. There has been no significant change in trend in either England or Rutland for the percentage of deaths with respiratory disease as the underlying cause from 2016 onwards.

Figure 26: Percentage of deaths with underlying cause respiratory disease in Rutland (all ages) (5)

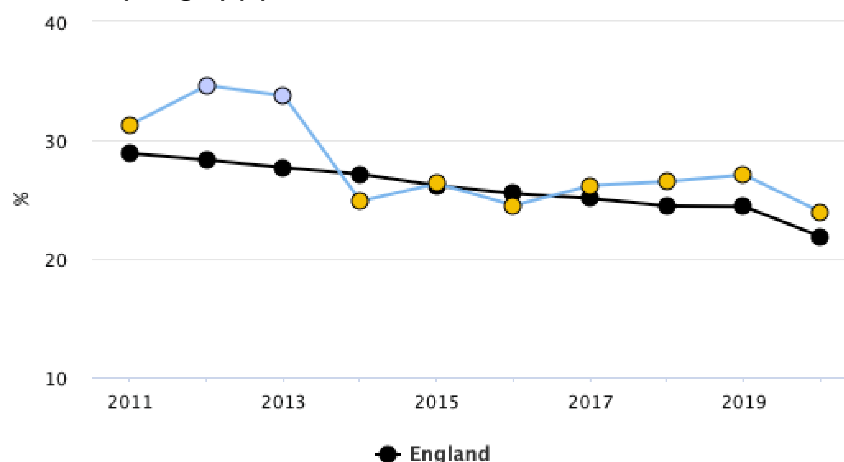


Source: OHID Fingertips, Palliative and End of Life Care Profiles

3.6.3. Circulatory Disease

In 2020, 23.9% of deaths in Rutland occurred with circulatory disease as the underlying cause (5). This is similar to the England value of 21.8% as shown by Figure 27. England has shown a decreasing trend in the percentage of deaths with underlying cause circulatory disease from 2016 onwards, whilst there has been no trend in Rutland.

Figure 27: Percentage of deaths with underlying cause circulatory disease in Rutland (all ages) (5)



Source: OHID Fingertips, Palliative and End of Life Care Profiles

3.7. Bereavement support

To enhance our understanding of the needs and experiences of local people, an online survey was conducted by Leicestershire County Council. Of those who responded, 13 people had both undergone a bereavement within the last 3 years and identified Rutland as the primary location to which their experiences related. These individuals were asked to reflect on the bereavement support that they had received, with the results outlined below in figures 28-35 (note that this was a self-selected sample, and so may not be representative of experiences across the county).

Figure 28: To what extent are you satisfied with the formal emotional support that you may have received?

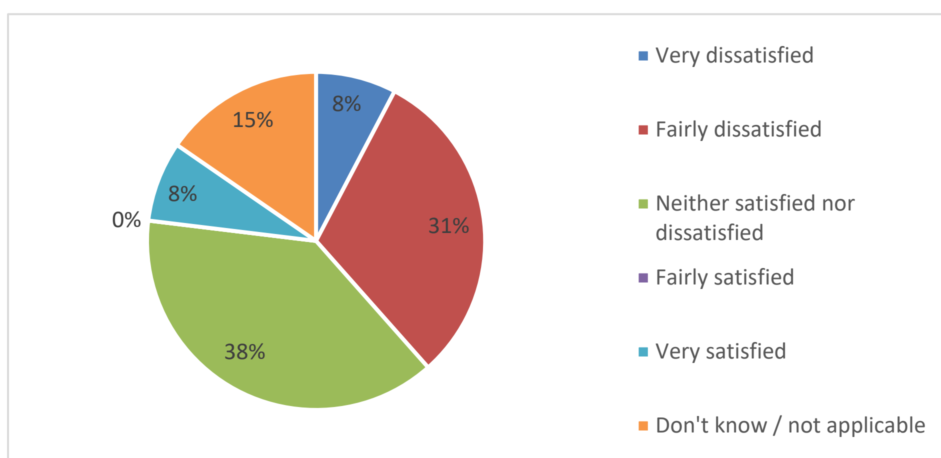


Figure 29: To what extent are you satisfied with the formal financial support that you may have received?

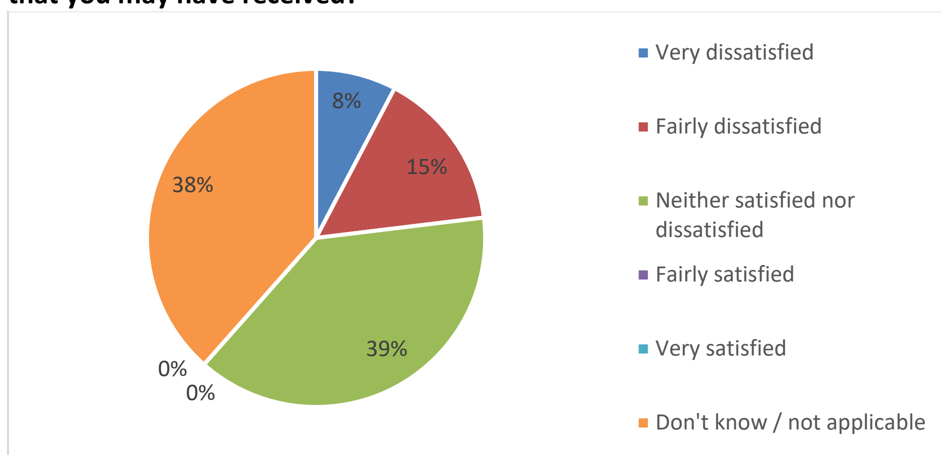


Figure 30: To what extent are you satisfied with the formal social support that you may have received?

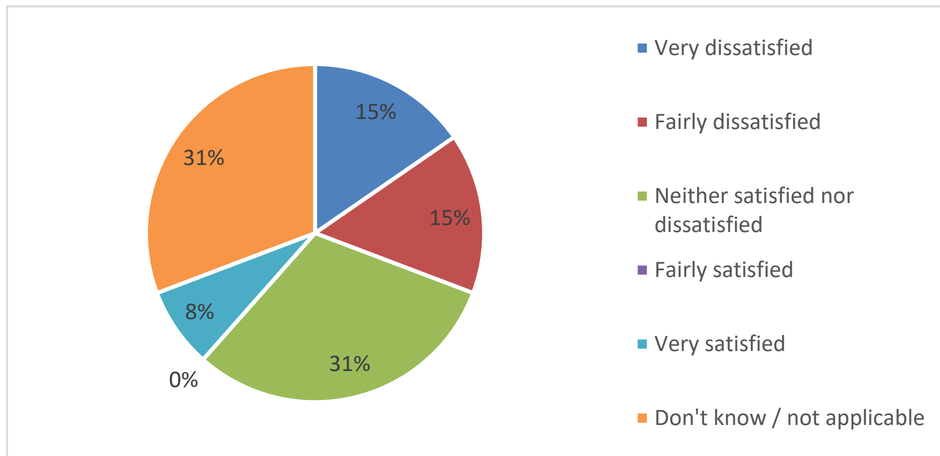


Figure 31: To what extent are you satisfied with the formal practical support that you may have received?

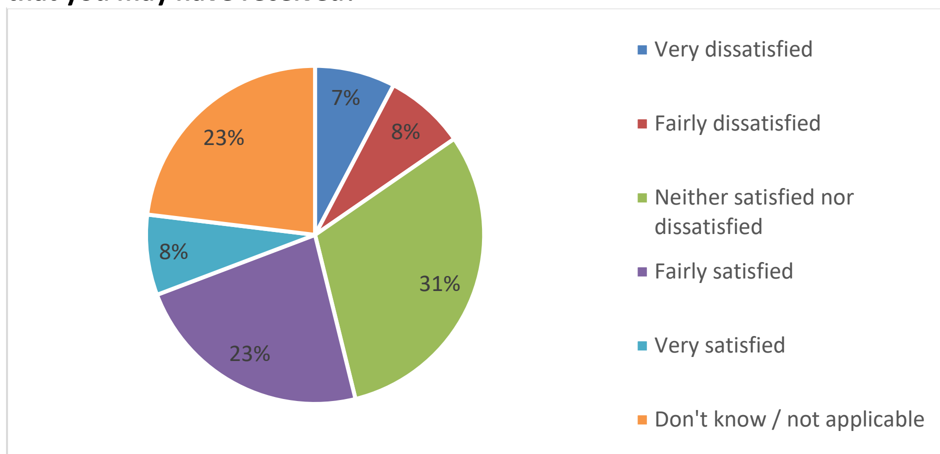


Figure 32: I am happy with the overall level of support that I received prior to my loss. (asked of the 9 whose loved one experienced an expected death)

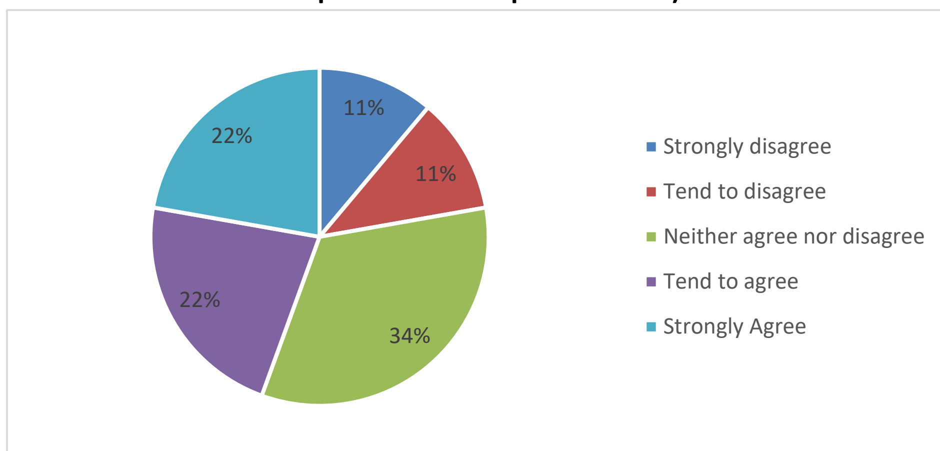


Figure 33: I am happy with the overall level of support that I received following my loss.

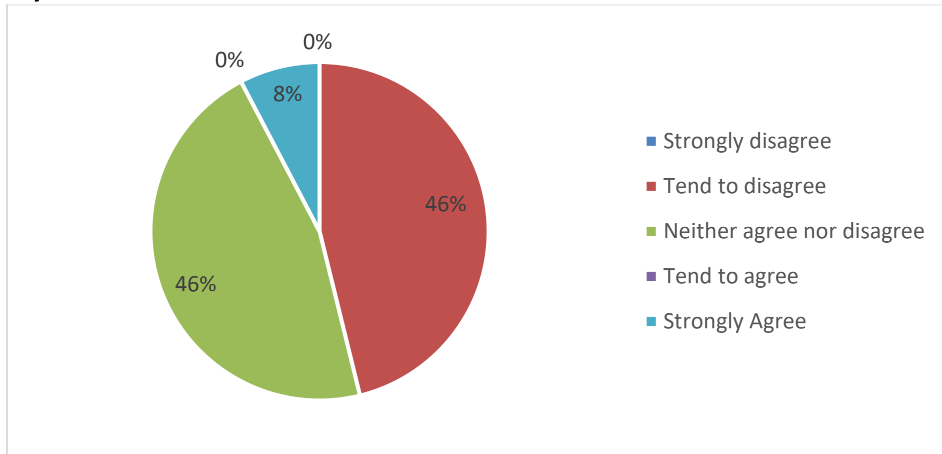


Figure 34: I had a good understanding of the support services available to me.

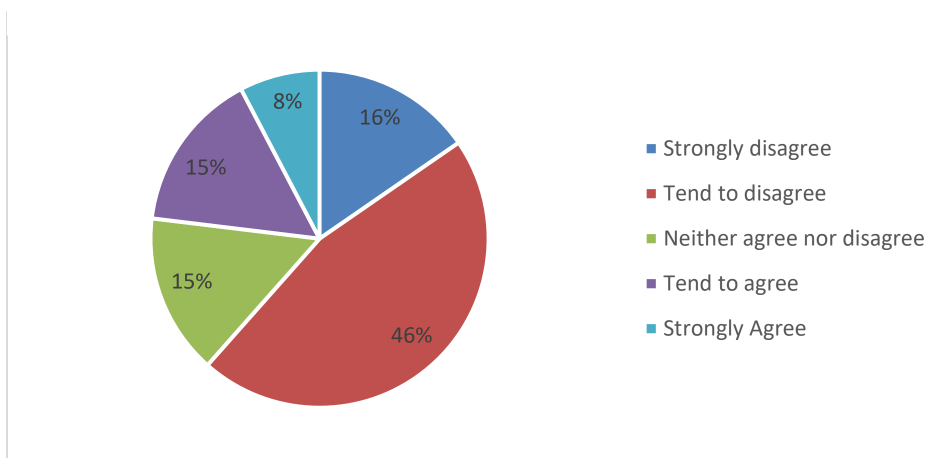
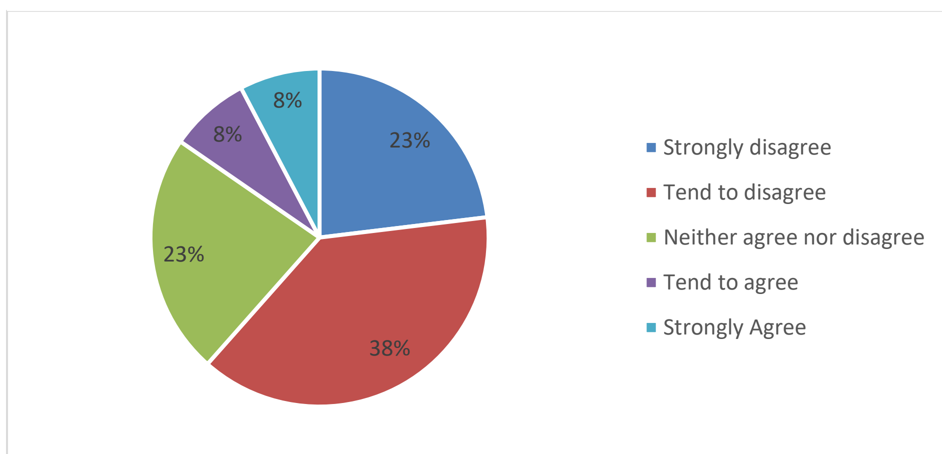


Figure 35: It was clear how I could access support services



Respondents were also asked what aspects of the support they received worked well, and which require strengthening and developing further. Unfortunately, several reported not receiving any bereavement support beyond that given by loved ones and existing social networks. Barriers cited included a lack of local services, insufficient information about what type of support is available elsewhere, and a lack of support in accessing it.

Those who did access services and receive support, spoke highly of them. One person reported appreciating receiving a phone call from their GP in the weeks following the death of their loved one, whilst another spoke positively of the support received by the care company looking after their loved one and the district nursing team. It was suggested though that some services could be improved upon, with one person who received bereavement counselling during COVID related restrictions suggesting that video rather than phone consultations would have helped alleviate loneliness.

Quotes provided by respondents:

“I received Carers Allowance for a short time when I was sole Carer. Had to find out about it myself and claim. No emotional or other support received during [their] last years.”

“As someone with a strong faith was wonderfully supported by our clergy and the hospital chaplains”

“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 fund8ng’. We were not made aware of any end of life care or bereavement services outside of the care we were paying for privately.”

“Some one to one help and advice / support would have been appreciated particularly as to how to navigate "the system" . I was unable to visit my [parent] for approx. a year due to Covid restrictions - which was the very worse thing for [their] (and my) mental health. When I did eventually get to see [them] it was briefly as [they were] taken on trolley into ambulance for hospital, one visit a day later as [they were] at "end of life" . No "emotional support" from any staff. After [they] died I was told that I had to travel back to the hospital (80 mile round trip) to collect [their] effects.”

“The counselling received was not what it would normally be, due to Covid. Maybe a video call, rather than phone call would have been more supportive. I was living alone after my partner died, and was very isolated.”

3.8. Informal carers

A review of deaths that either occurred in UHL or PLT, or within 30 days of discharge from UHL, found that a common theme was of families and carers struggling to cope with the care of their relative (83). To enhance our understanding of the needs and experiences of local people, an online survey was conducted by Leicestershire County Council. Of those who responded, 7 people have experience being a carer for a loved one nearing the end of life, and identified Rutland as the primary location to which their experiences related. These individuals were asked to reflect on the carer support that they had received, with the results outlined in figures 36-39 (note that this was a self-selected sample, and so may not be representative of experiences across the county).

Figure 36: I received sufficient support / training, such that I felt/feel well equipped to support someone near the end of life.

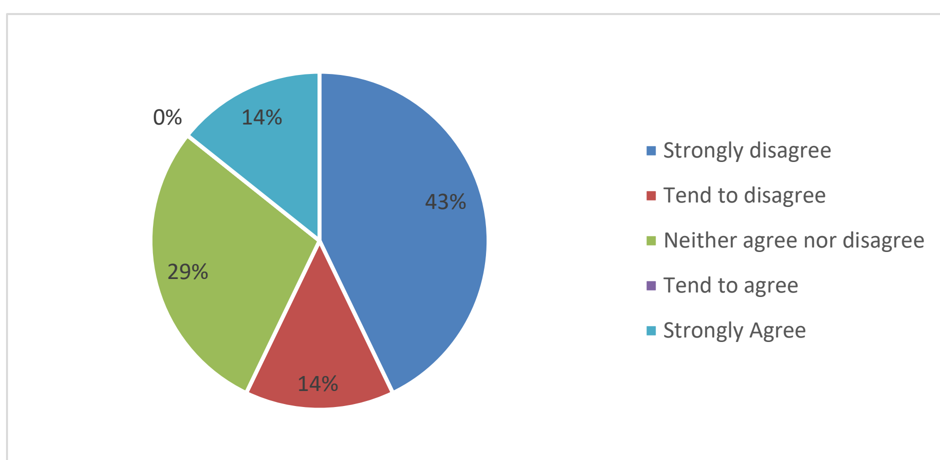


Figure 37: I received sufficient financial support to meet additional costs of being a carer.

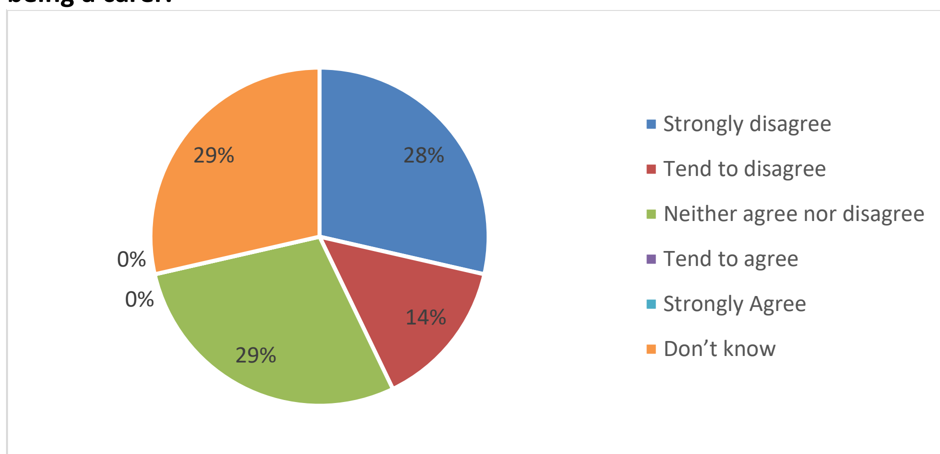


Figure 38: I received sufficient support to be able to take respite care.

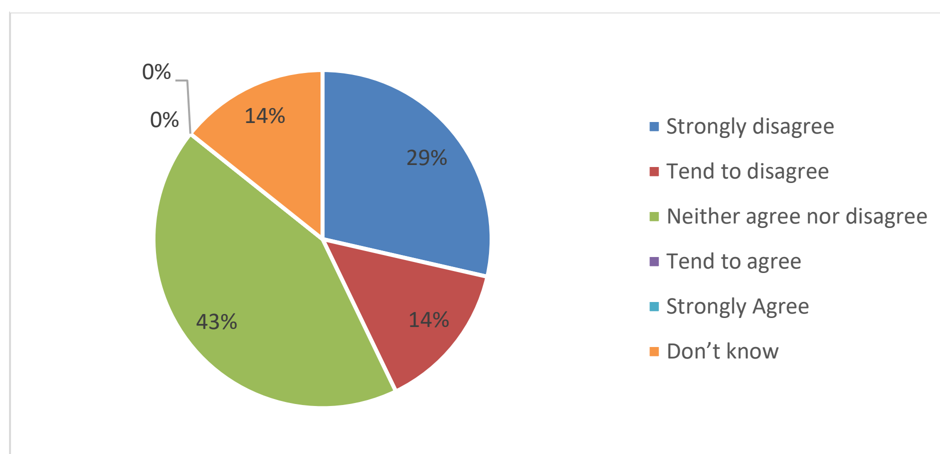
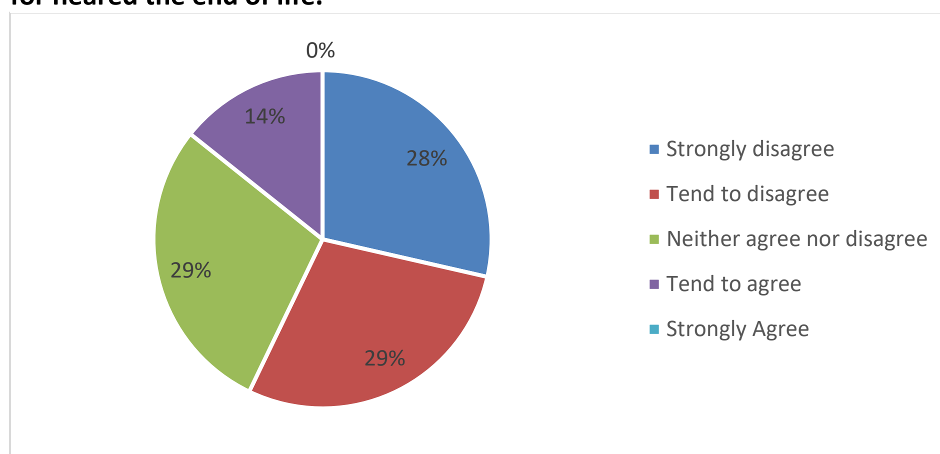


Figure 39: I have a good understanding of what to expect as the person I cared for neared the end of life.



Respondents were also asked what aspects of the support they received worked well, and which require strengthening and developing further. People once again commented on the need for better coordination between end of life services, and for greater need of out of hour support services. One respondent informed us of the difficulties they faced balancing caring responsibilities with work, because of limited opening hours for extra support services. It was also commented on that as carers, it was felt they needed more advice from health and social care staff with regards to what to expect as their loved one approaches the end of life. Issues of additional training needed for carers, and of the daunting nature of attempting to coordinate services were also highlighted at a workshop attended by local stakeholders in the delivery of end of life care, which was held in January 2022 to contribute towards the shaping of the Rutland Place Based Delivery Plan.

Quotes provided by respondents:

"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 was supporting my partner alone, and taking [them] to all [their] medical appointments. The only way you could receive additional support from PCH, was if you were not working, as the opening hours for extra support were very limiting. I was having to work around my partner's appointments, and as such, was only getting paid for hours worked. This meant if we were at hospital for 2/3 hours in the morning, I was having to work until 7pm or later at night. I was exhausted and felt really let down. Nobody seemed to care."

3.9. Staff working in end of life and palliative care roles

To enhance our understanding of the needs and experiences of local people, an online survey was conducted by Leicestershire County Council. Of those who responded, 36 people work to deliver health and social care in Leicester, Leicestershire, and Rutland. Respondents' roles were varied, including working in different sectors and with different age groups. These individuals were asked to reflect on the support that they receive to undertake their role, with the results outlined in figures 40-44 (note that this was a self-selected sample, and so may not be representative of experiences across the county).

Figure 40: I receive sufficient support and training, such that I feel well equipped to support someone near the end of life.

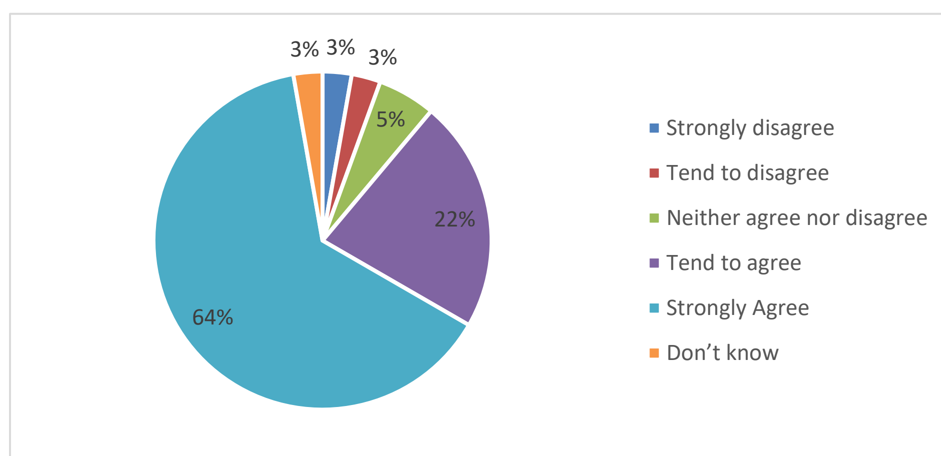


Figure 41: I have access to the resources and equipment necessary to be able to deliver high quality and effective care.

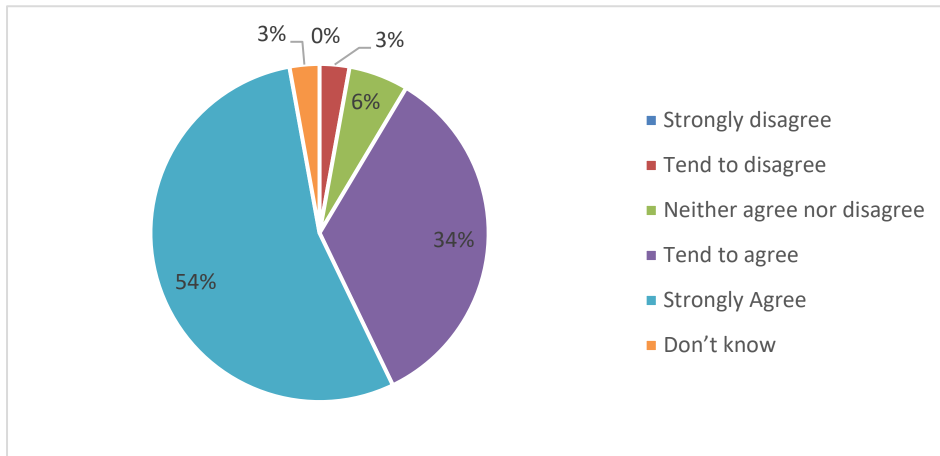


Figure 42: I have enough time with each person in the end of life stage, to be able to provide them with the care they need.

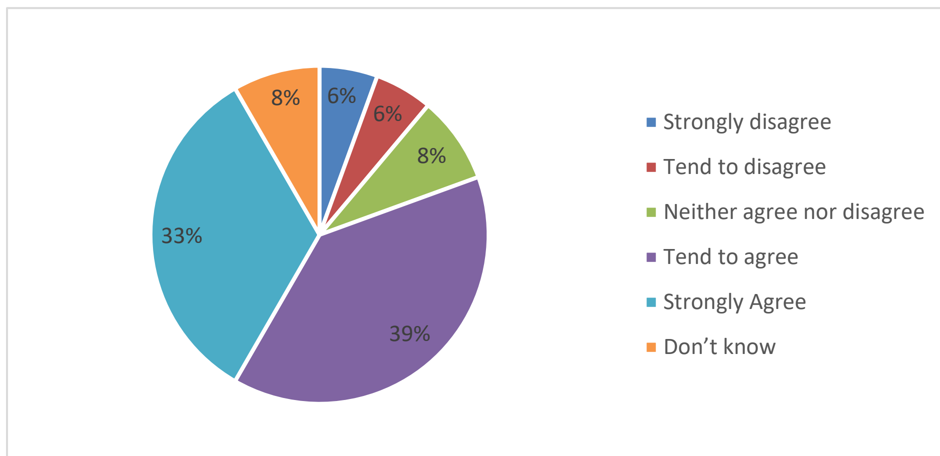


Figure 43: I have a good understanding of what to expect as the people I care for approach the end of life.

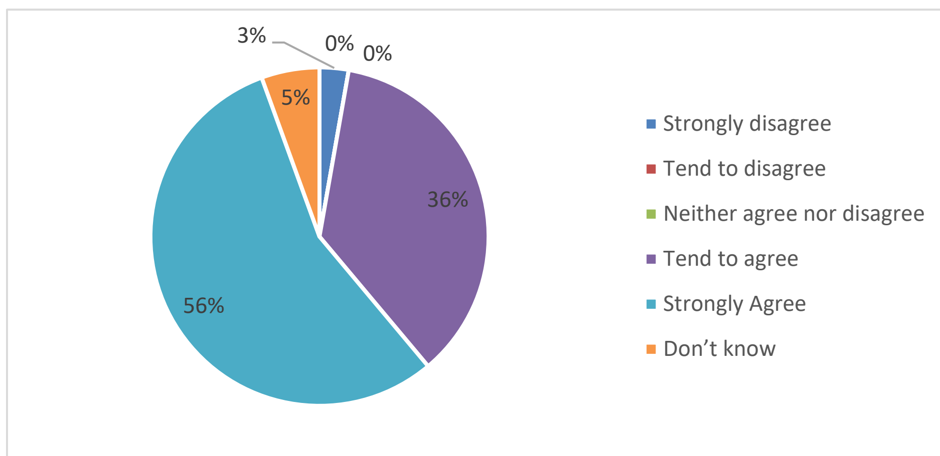
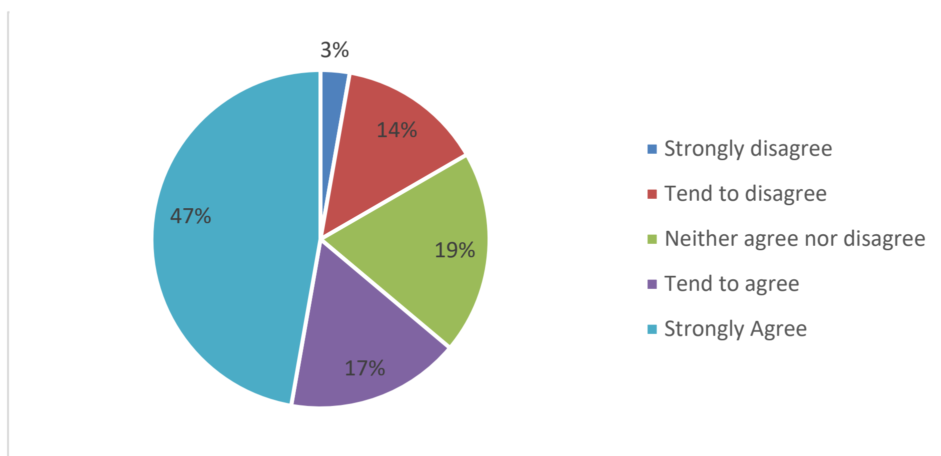


Figure 44: I am happy with the amount of emotional support that I receive.



Respondents were also asked which aspects of their role they felt currently worked well to support them in delivering the best care possible, and which need to be strengthened and developed further. Replies were positive overall, with many praising the teams they work with in providing support. This, combined with having access to the necessary equipment, being able to deliver person-centred care, and working closely with other services were cited as further strengths of existing services by staff.

Many also felt that they received adequate training to support them in caring for those near the end of life, but this wasn't universally accepted. Those whose primary role is in a specialty other than delivering palliative care in particular felt that they would benefit from additional training and support.

A further challenge cited was a large and increasing caseload of patients. It was felt by several that current staffing does not provide enough capacity to allow sufficient time with each patient, and that the workforce would benefit from expanding. Out of hours services were also specifically mentioned in this context.

Quotes provided by respondents:

"I am supported by a friendly, helpful team that I can call upon at any time should I need support."

"Sometimes not enough time to reflect due to workload."

"Carers need time to both support the individual person and time to process the loss as individuals themselves."

"Obviously COVID has reduced training opportunities and the whole ethos of the [work setting] as far as visiting is concerned. Due to current concerns about increasing COVID numbers it is understandable that restrictions are still required. However as soon as it

is safe to do so the services and flexible arrangements for those receiving end of life care needs to return to those pre 2020"

"Outreach, although I see folk from all ethnicities I do wonder if more work can be done to get into ethnic minority communities, I'd expect the see more folk based on the percentages in Leicester."

"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"

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4. How does this impact?

4.1. Impact on the individual

When palliative care is delivered well, it is associated with improved patient outcomes including pain and symptom management, improved communication, higher satisfaction with care, improved quality of life, and reduced healthcare costs (85). Many of these features are closely intertwined through pathways such as reduced emergency hospital admissions and length of hospital stays (85). An important component in achieving these outcomes is the enabling of timely communication of what is important to the individuals so that they can make meaningful decisions about the care they receive. This helps ensure that people's priorities are recognised and met where possible.

4.2. Impact on family and friends

The loss of a loved one is a traumatic event. Between 6-20% of adults experiencing a loss develop complicated grief symptoms, described as painful and persistent reactions associated with impaired psychological, social and daily functioning (86). Receiving bereavement support can result in improved quality of life measures, reduced anxiety and depression symptoms, and improved social connections (86).

4.3. Impact on Carers

Carers play an important role in supporting patients at the end of life, allowing care to be delivered at home, and preventing hospital admissions. This is a resource intensive role, that places physical, emotional, and social burdens on the individual. They therefore require support in two areas:

1. As carers providing support to patients – this includes ensuring they have the knowledge, skills and equipment necessary to fulfil their caring role.
2. As individuals whose own health and wellbeing need to be protected.

4.4. Impact on health and social care

A large share of healthcare expenditure occurs in the last months of life, and so an understanding of the costs and benefits of care that is delivered during this period is beneficial (85). In the last two years of life, around £121 million is spent on hospital services for decedents in Leicester, Leicestershire and Rutland. Urgent service events account for around two-thirds of this (4). Spend per decedent on hospital services was around £15,000, which is significantly lower than the Midlands average of £15,800 (4). The strongest evidence of cost-effectiveness relates to home-based interventions. Home-based services may reduce resource use and costs, and improve pain management and increase death outside of hospital (85).

5. Policy and Guidance

This chapter provides an overview of key policies and guidelines relating to End of Life Care.

5.1. Ambitions for Palliative and End of Life Care: A national framework for local action 2021-226 (87)

The aim of this document is to provide a framework with which to improve palliative and end of life care. It was produced by the National Palliative and End of Life Care Partnership, which comprises of national organisations that have experience of, and responsibility for, end of life care. The framework sets out six ambitions for palliative and end of life care, which are:

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help

To compliment this framework, the NHS England & NHS Improvement Palliative and End of Life Care team have worked to develop a self-assessment tool that was initially created by the Cheshire & Merseyside Palliative & End of Life Care Clinical Network. This tool provides a self-assessment framework which supports localities to determine their current level of delivery against the six ambitions for Palliative and End of Life Care.

5.2. Treatment and care towards the end of life: good practice in decision making (88)

This guidance document was written by the General Medical Council (GMC) and is primarily addressed to doctors. It is however recommended that it may benefit other staff working to deliver end of life care, and also patients and the public by supporting them in understanding what to expect of their doctors. It provides a framework to support staff in meeting the needs of their patient towards the end of life, through advice on a range of topics. These include supporting patients who lack capacity, advance care planning, understanding the role of relatives and those close to the patient, and care after death. The framework also contains a section that focuses on aspects of care as they relate specifically to neonates, children, and young people.

5.3. NICE Guidelines

NICE guidelines are evidence-based recommendations for health and care in England. They seek to support health and social care professionals to prevent ill health, promote and protect good health, improve the quality of care and services, and to adapt and provide health and social care services (89). Guidelines with a focus on end of life and palliative care include:

5.3.1. End of life care for adults; NICE Quality Standard (90)

This quality standard covers care for those aged 18 and over who are approaching the end of life. It includes people who are likely to die within the next twelve months, people with advanced, progressive, incurable conditions, and people with life-threatening acute conditions. Topics covered in the standard include the identification of those nearing the end of life, advance care planning, coordinated care, and out-of-hours care. It also covers support for their families and carers.

5.3.2. Care of dying adults in the last days of life; NICE Guideline (91)

This guideline covers the clinical care of those aged 18 and over who are in the last two or three days of life. It seeks to improve end of life care for people by emphasising the importance of communication and including patients and their loved ones in decision making, and of maintaining comfort and dignity. It also covers how to manage common symptoms without causing unacceptable side effects. The guideline is specifically aimed at those who do not have specialist level training in end of life care.

5.3.3. End of life care for adults: service delivery; NICE Guideline (92)

This guideline covers the topic of organising and delivering end of life care services, with the aim of ensuring that people have access to the care they want and need in all settings. It advises on service models for care in acute settings by disease-specific specialists and their supportive services, and in community settings by primary care or specialists in palliative care. It is intended that this guideline is used alongside the NICE guideline on care of dying adults in the last days of life (section 5.4).

5.3.4. End of life care for infants, children and young people with life-limiting conditions: planning and management; NICE Guideline (20)

This guideline covers the planning and management of end of life and palliative care for infants, children, and young people (aged 0 to 1 7 years) with life limiting conditions. It aims to involve young people and their families in decisions about their care and improve the support that is available to them throughout their lives.

5.4. Inspection framework: NHS acute hospitals and independent health; CQC (93)

The CQC are responsible for monitoring, inspecting, and regulating all care providers in the UK. They inspect and regulate services to make sure that quality and safety standards are met, and publish their findings. This framework is used by inspectors to explore key lines of enquiry when assessing services in NHS and independent hospitals.

6. Current Services

6.1. Delivering care at the end of life

6.1.1. Adult Services

Integrated Community Specialist Palliative Care Service

The Integrated Community Specialist Palliative Care service is a team comprising of nurses and healthcare assistants (HCAs) from LPT and LOROS. They care for those with life-limiting illnesses who have complex palliative care needs (especially pain and symptom management). They may become involved in the care of an individual when an appropriate intervention has failed to control symptoms, when symptoms are escalating, when patients or families require psychological and spiritual care, or if there are other problems that other healthcare professionals are unable to manage. Support is delivered via multiple formats, including telephone advice, one-off assessments, and ongoing management and personal care. Access to this service is via referral by a healthcare or social care professional, and patients or carers can re-refer back into the service via the Single Point of Access (94).

Community Nursing Services

The Leicestershire Partnership Trust (LPT) core Community Nursing Service are an integrated and diverse, skilled team of professionals central in the management and care of patients with advanced progressive illness, requiring palliative and end of life care in the home environment. Care is provided throughout the city and county with teams working out of 8 Community Nursing Hubs. The service is available 8am-10pm every day, with care outside of these hours delivered by the "Out of Hours Community Nursing Service" described below.

Palliative and end of life care is an intrinsic part of community nursing and in addition to the practical and clinical delivery of care, the community team offer psychosocial, spiritual support and guidance to patients, families and carers. In 2021/2022, there were 3,729 accepted palliative care/ care in the last days of life referrals into the service (this does not include the referrals for complex, specialist palliative care as patients with specialist needs are seen by the Integrated Community Specialist Palliative Care Team).

Most end of life and palliative care is routinely planned within the nursing caseloads. However, patients and carers also contact the service for unplanned support, particularly in relation to symptom management. These referrals are recorded separately and are additional to the number above. The nationally agreed target for an urgent community response (UCR) is 2 hours and the target for patients to be seen within this timeframe set nationally at 70%. In April 2022 the core community nursing team received 119 urgent referrals for end-of-life care and achieved an overall compliance rate of 73.4%.

The Community Nursing Service have access to five palliative suites for patients at the end of life. These are located in Loughborough, St Lukes, Coalville, Hinckley & Bosworth and Melton Community Hospitals. If these are not available, then an inpatient bed located in a general side-room is used where possible.

Out of Hours Community Nursing Service

During the hours of 10pm and 8am, community nursing is provided by Derbyshire Health United. This is not a dedicated end of life service, but covers all queries. There is one roaming nurse covering Leicester, Leicestershire, and Rutland, predominantly managing pain relief and catheter related issues.

University Hospitals of Leicester Palliative Care Service

The Hospital Specialist Palliative Care Team consists of a hospital-based team at the Royal Infirmary, General and Glenfield hospitals (95). They deliver care to adults with palliative care needs within the hospital and also in the outpatient setting. Referrals are taken for patients with difficult symptoms, psychological distress, and those who are dying. These are usually made by the hospital ward team, who will remain responsible for the person's overall care.

Leicestershire and Rutland Hospice (LOROS)

LOROS is a local Leicester, Leicestershire and Rutland charity who primarily provides specialist palliative care for those over 18yrs, with complex problems who are suffering from a terminal illness when cure is no longer possible.

LOROS offers a consultant-led multi-disciplinary service, providing symptom management, psychological support and co-ordination of care for adults with complex palliative care needs that cannot be adequately managed by their usual community/acute healthcare professionals.

In addition, LOROS also provides a range of palliative and supportive care services which helps the patient and their family to cope with their condition through their illness or death and into bereavement.

Referrals are generally made by a GP, hospital consultant or hospital palliative care team, or are facilitated by a community nurse specialist, with the exception of Day Therapy drop in. Patients must be registered with a GP within Leicester, Leicestershire or Rutland.

The Hospice is based at Groby Road Leicester and provides care for over 2,500+ people each year.

There are 31 inpatient beds, of which 19 are single rooms. Short-term specialist care is provided for patients with complex issues (pain and symptom control) and care in the last days of life. Based on need, patients can be admitted both in and out of normal working hours, including weekends and bank holidays. Patients identified with 'urgent needs' will be admitted within 48hrs (dependent on bed availability).

Day Therapy is provided 9.30am to 3.30pm, 4 days a week at Groby Road Hospice. The service is provided by qualified practitioners, support staff and a diverse team of volunteers. There is also access to medical, enablement and chaplaincy support.

Additional services include:

- Outreach support in the patient's home - Clinical Nurse Specialist and Compassionate Neighbours
- Outpatient Clinics at the Hospice
- Palliative Consultant Domiciliary Home Visits (based on patient need)
- Complementary Therapy
- Counselling & Bereavement Support at the Hospice and in the Community

LOROS contributes to the education and training of its own and other health and social care professionals and of volunteers. The charity is also committed to research in order to improve the understanding and practice of palliative care.

Dove Cottage Day Hospice

Dove Cottage is a day care hospice located in Stathern, Melton, to which guests usually go for one day a week (96). It is open three days a week, and provides approximately 3,700 day care places each year. Referrals can be made by health professionals, guests or their families. Guests must be well enough to attend day care and travel to and from the hospice, and places are not routinely offered to people in residential care, with a primary diagnosis of dementia, learning disability or acute mental illness.

Guests can participate in games, crafts and wellbeing activities, and also have access to skilled nurses, chaplaincy support and complementary therapies. Help is also offered to families and carers such as bereavement support, a Family Support Group, and regular groups for those living with dementia.

Palliative Care Consultants Advice Line, Domiciliary Medical Home Visits and Community Support

There is a dedicated daily advice line (Monday-Friday) for nurse specialists and other community staff including GPs to call for medical advice and support. LOROS consultants and SpRs can undertake home visits for those too unwell to come to clinic who need a specialist medical assessment.

6.1.2. Paediatric Services

Diana Service

Provided by the Leicestershire Partnership Trust, the Diana service provides a comprehensive community care provision by a multi disciplinary team consisting registered nurses, health care workers, respiratory specialists, physiotherapists, a trained play specialist, pre and post bereavement and counselling skills, and registered Macmillan

nurses. This service supports children and young people aged 0-18 with health care needs and their families. For a child or young person at end of life, a 24/7 on-call in the community will be commenced. The Diana service is delivered by a small team in LLR, and due to the complex and time consuming nature of providing end of life care and support, they have capacity to accept a maximum of two children or young people for 24/7 on-call provision.

The service provides planned face to face visits and telephone support, visiting when a child's symptoms change and offer support to the family when a child dies. Although the Diana Service is a nurse led service, the Diana Palliative Care Lead Nurse works alongside a Community Pediatrician for 4 hours each week to manage a discreet caseload of children and young people requiring palliative care to parallel plan, develop and maintain CYPACP, completion and updates of ReSPECT and liaison with other professionals to ensure care is planned to enable changes in care requirements.

Pre and post bereavement support is provided by the child and family support service in Diana for children and young people with life limiting and/or life threatening conditions as well as their siblings and close family members.

Rainbows

Rainbows Hospice for Children and Young People in Loughborough provides end of life care, symptom management and short breaks from birth to 25 years of age. They offer care at home, in the hospice or in hospital for children who are life limited or life threatened and also those who have long term ventilation. Care and support are also offered for all the family.

The hospice consists of a large multidisciplinary palliative care team including family support, complementary and music therapy as well as experienced nurses and carers. They can also offer 'step down' care between hospital and home.

Bodies Hodges

Bodies Hodges supports families bereaved of a child across Leicester, Leicestershire and Rutland by providing a range of services including early therapeutic support to newly bereaved families in their own home and work with siblings. The service also raises awareness of the facts about organ donation and runs an organ donation education program for schools and businesses.

Laura Centre

The Laura Centre provides bereavement support for parents and children on an individual basis as well as offering group work and access to alternative therapies. The service also

offers a range of training courses aimed at professionals that may come into contact with families or children facing bereavement.

6.1.3. Condition Specific Services

<u>*Dementia Services*</u>

There are services covering Leicester, Leicestershire and Rutland which seek to support both those with dementia as their condition progresses and they approach the end of life, and their loved ones.

- Mental Health Services for Older People (MHSOP) in Patient Assessment – This aims to enable people to remain at home, or their usual place of residence, for as long as this is their preferred place of care. The service supports the reduction in admissions and readmissions to specialist inpatient care.

- MHSOP Community Team - Provides multi-disciplinary assessment (with input from medics, nursing staff and allied health professionals, dependent on the patient's need) and interventions for patients with moderate to complex mental health needs requiring medium to long term interventions.

- MHSOP Care Homes - The service provides intensive multidisciplinary assessment and intervention for patients within care homes who have Dementia who are demonstrating behavioural and psychological symptoms that may lead to breakdown of placement leading to admission to hospital.

- Admiral Nurses - Support family carers to gain the necessary skills to assist with dementia care, promoting positive approaches in living well with dementia and improving the quality of life for everyone involved.

- Community Support Age UK – Provide one to one support to maintain social contacts, pursue hobbies. Provide day breaks at day centres, provide activities and classes suitable for dementia patients, trips and outings. provide specialist classes to help improve mood and memory such as, singing for the brain, dance for dementia, art for dementia, seated exercise, and memory cafés.

- Dementia carers Support Age UK - Dementia advisors support friends and family of those with dementia with information and advice about navigating local services and applying for benefits.

<u>*Sue Young Cancer Support*</u>

Offers counselling, befriending services, disease specific support groups and complimentary therapies to anyone affected by cancer in Leicestershire and Rutland. This includes people with a diagnosis, their family members, and carers. Individuals can self-refer or be referred by a GP (97, 98).

6.2. Bereavement Support

UHL Bereavement Support Service

The bereavement support service seeks to contact the bereaved next of kin of all those who die in a UHL Hospital. This is a multistep process, beginning with medical examiners (MEs) who (unless the death is due to be taken for investigation by the Coroner) phone the bereaved to ask if they understand the cause of death and if they have any questions about care. In 2021/22, 96% of bereaved relatives were spoken to by the ME in this way.

The second stage involves the bereavement support nurses attempting to make verbal contact with bereaved relatives within 8 weeks of the death. In 2021/22, 73% of relatives were spoken to in this way. The purpose of these calls is to identify any unmet bereavement needs and to provide relatives with an opportunity to raise questions or concerns. Where unable to contact verbally, a letter is sent to the relative instead.

Bereavement Help Points

The Bereavement help points in Rutland are a drop-in service that aims to provide bereaved people with a place where they can access information support where they can talk to others and share their emotions with the flexibility of it being locally based and accessible to people who feel they need support. It is open to all irrespective of if your bereavement was days weeks months or years ago. The Bereavement Help Point is a volunteer led initiative supported by local organisations which currently operates in Ketton and Uppingham.

National Bereavement Support Groups

A selection of the organisations and services available to support individuals following a bereavement are outlined in Table 2, with further information available at the Dying Matters website (**www.dyingmattersleicestershireandrutland.com**) (99):

Table 2: National Bereavement Support Groups

Organisation / Group Name	Description
The Compassionate Friends	Bereaved Parents provide support for other parents and siblings after the death of a child.
Marie Curie	A free national listening support service for people who have been bereaved due to terminal illness. Callers can be

	matched with a trained volunteer to have regular bereavement support sessions over the phone.
Cruse Bereavement Care	Offers free one-to-one counselling sessions.
Hope Again: Young People Living After Loss	An online space for young people to learn from other young people how to cope with grief. A youth website which is part of Cruse Bereavement Care.
The Loss Foundation	National charity providing free bereavement support after the loss of a loved one.
Leicester Counselling Centre	A charity that provides counselling to people in Leicester, Leicestershire and Rutland for a nominal charge.
Way Up	Online self-help group providing mutual emotional and practical advice and support to those who have been widowed primarily but not exclusively in their 50s and 60s.
SSAFA	Bereavement support for the military, providing helpline and group support.
The Good Grief Trust	Charity providing reassurance and support to the bereaved, run by the bereaved.

Source: Dying Matters Leicester, Leicestershire and Rutland

6.3. Support for Informal Carers

6.3.1. Practical, social and emotional support

Table 3: Support groups for informal carers

Organisation / Group Name	Description
Rutland Carers Support Group	Hosted by Age UK, this group allows for carers of older people suffering chronic illness a chance to meet and mutually support one another. The group meets once a month in Oakham, hosting a variety of speakers and outings to provide respite from care (100).
Providing Care	A Leicester, Leicestershire and Rutland resource for carers that includes information about available courses and training (101).

The Carers Centre	The Carers Centre supports people looking after a relative, friend or neighbour with care needs across Leicester, Leicestershire and Rutland. They host a range of online social events, training and support groups (102).
Rutland Health Primary Care Network	Website which provides information on sources of support available to carers.
Age UK Leicestershire & Rutland	A service which provides information and advice for carers and hosts a Rutland carers support group
Rutland County Council	Source of advice on carer's allowance, carers assessments, and other types of advice for carers.

Source: Dying Matters Leicester, Leicestershire and Rutland

6.3.2. Respite Care

Local day activities may also be an option for some, including attending Dove Cottage Day Hospice (see section 6.1.1). Carers may also be eligible for receiving respite care, following the completion of a carers assessment by the Rutland Carers Team, with the level of care provided (if found to be eligible) dependent on the cared for person's circumstances. Organisations including Age UK Leicestershire & Rutland can also provide respite care at home, though at cost. Alternatively, short term care may be arranged by self-funding a place at a residential home (respite care in this form may be significantly more expensive than long term permanent care) (103).

6.4. Support for Staff

AMICA

Confidential emotional support and counselling for those employed by UHL, LCC, LPT, and LOROS. Employees can discuss any difficulties that they are faced with, including workplace stressors and personal issues. Support is delivered over the phone, with lines open 8.30am – 8.30pm every day (97, 104).

6.5. Information Services

Dying Matters in Leicester, Leicestershire and Rutland

The website **www.dyingmattersleicestershireandrutland.com** is dedicated to improving end-of-life experiences for people of all ages, their families and loved ones. It was initiated and is led by Dr Sarah Furness, Her Majesty's Lord-Lieutenant of Rutland.

The website offers detailed information on important topics surrounding dying, death and bereavement, including; end of life planning, caring for a loved one, living well with a long term health condition, what to do in an emergency, how to arrange a funeral and support with bereavement. The website also provides comprehensive lists of local health and care support contacts.

The website aims to serve as a sign-post and does not recommend any support providers or rate their service.

End of Life Care Task Force and Co-production in palliative and end of life care

The End of Life Care Task Force is a group comprising of commissioners, providers of health and social care, and voluntary service members. It seeks to define and plan to deliver a longer term End of Life Care pathway across the health and care system. One such piece of work that is being developed is a hub and spoke approach to take forward co-production in palliative and end of life care. This will aim to utilise existing groups and touch points (such as medical examiners and information centres) to build on current knowledge and expertise within end of life care. By delivering feedback from those with lived experience and existing data sources to one place in the system, a greater understanding of arising issues can be gained, and co-production projects identified and taken forward. This will also support a two-way flow of information. Such an approach will also allow organisations or individuals to join over time, or withdraw should they no longer wish to contribute.

7. Unmet needs/Gaps

This section outlines the areas for improvement in current End of Life care and support provision in Rutland, based on the findings discussed thus far in this JSNA chapter. Whilst this section has been divided into different components of End of Life care and support, many of the themes and issues discussed are common to many if not all.

7.1. Advance Care Planning and ReSPECT

The importance of undertaking advance care planning early has been a recurring theme throughout this JSNA chapter. It has been shown that having conversations with those who are themselves approaching the end of life and their loved ones in a timely manner, makes it more likely that a person's wishes will be understood and followed. This in turn contributes to improved quality of care for individuals and those important to them. Despite this, as few as 9.7% of people have an advance care plan in place prior to their final hospital admission (9). Different factors are thought to contribute towards this low uptake. The ReSPECT form is a summary of the management for someone at the end of life, referring specifically to the wishes of the person in a medical emergency. It is often completed in addition to the advance care plan.

As was highlighted in Section 2, it is often difficult to predict the course and length of the end of life stage. Non-cancer diagnoses for example often have more variable prognoses. Some populations meanwhile have less frequent interactions with healthcare staff, which leads to disease often progressing further before it is identified. It is also important not to overlook deaths that occur suddenly. In each of these instances, waiting until there is certainty about the person's condition before discussing their end of life preferences is too late. In many cases, patients are unlikely to be able to contribute meaningfully to these conversations as a result of their own poor health and distress, and services are unable to act in a proactive manner to support the wishes and decisions arising from these. More must therefore be done to not only support early identification of those approaching the end of life, but to also support these conversations taking place whilst individuals are healthy and well.

Evidence also suggests that whilst people report feeling comfortable talking about topics relating to the end of life, there is poor understanding of the options and services available. Indeed, in one survey, as many as 55% of those in the last years of life reported not knowing where to find information on how to plan in advance for care at the end of life (10). Whilst these resources do exist, it seems that there is a gap in terms of connecting people to them. Only with adequate access to high quality information, can people make informed decisions about their end of life care.

Finally, we have heard anecdotally of concerns from some individuals that the wishes documented in advance care plan are not always considered as fully as they ought to be, resulting in inappropriate treatments and interventions. Whilst this may in part be due to health and social care staff being unaware of the patient having an advance care plan in

place (due to difficulties in linking primary and secondary care records as discussed in Section 3.3), further work is needed to explore how these are practically being utilised.

7.2. Utilisation and delivery of End of Life and Palliative Care Services

End of Life and palliative care often involves receiving input from multiple organisations and services. Whilst the quality of support received from these services once in receipt of care from them is generally rated highly, a common complaint is that they are difficult to access in the first place. We have again heard that people are unaware of the services which are available to them. As such, they are often unable to seek help from as early a time point as they could otherwise benefit from. This may then be exacerbated by long waiting lists, leading to their only receiving input for a short time towards the very end of their life.

It has also been frequently reported both nationally and locally, that services coordinate poorly with one another. The challenge here is twofold and appears to be a particular issue when patients move from primary to secondary care or vice versa. Firstly, an inability to access patient records from other services means that staff must often work with incomplete information. We have discussed for example how being unable to access an already completed Advance Care Plan can lead to inappropriate transfer to hospital by ambulance crews, and subsequent admission to a ward by the Emergency Department team. This not only results in negative experiences and outcomes for the affected individual and their loved ones, but also places additional pressures on staff delivering care.

The second challenge resulting from a lack of coordination is not having anyone with a complete overview and understanding of the persons' needs. This risks services focusing solely on their own role and remit, and thus overlooking any needs of the patient which fall outside of this. Patients and their loved ones can again be uncertain as to who they should seek help from, must take time to navigate multiple services to find that which is most appropriate, and then again face lengthy waiting lists. It is therefore helpful if a named individual takes overall responsibility of the patients' care, so that responsibility for coordinating services in this way doesn't fall upon the patient and their loved ones during what is already a difficult and distressing period. Thus, in addition to coordination of care, continuity of care is also important. Improving the coordination of services in both these ways will support them in transitioning towards a more proactive rather than reactive approach to care, increasing the chance that the preferences of those nearing the end of life can be realised.

For children and young people, the challenges include nationally rising numbers of children and young people on end of life pathways with increasing complexity. Locally, this will require an evolution of wrap-around community services to keep up with demand. In Leicester, Leicestershire and Rutland, there is currently not a paediatric palliative care consultant which forms a minimum requirement in NICE guidance (20).

We have also heard of a lack of local services for the people of Rutland, with the need to often travel long distances and to neighbouring areas to access support. Lengthy travel times can impact on carers' ability to work whilst simultaneously supporting their loved on

in attending appointments, lead to isolation from your local community, and also be painful and distressing for those who are unwell.

Finally, have heard of challenges in accessing support out-of-hours. This is not only a matter of service users being unsure of how to access it, but also includes a lack of available services. Between the hours of 10pm and 8am for example, community nursing is currently limited to just one nurse covering the whole of Leicester, Leicestershire, and Rutland. When faced with uncertainty such as new onset of symptoms whilst unable to access advice and support, people are likely to present to hospital. Whilst this will be appropriate for some, others could be supported to stay at their place of residence if they were to receive timely input from community services. For children and young people, the existing out of hours service relies on nurses that are often due to be working the next day, impacting on service provision the following day if they are called out.

7.3. Support for those who are bereaved

Those who are bereaved have rated the level of support that they received poorly, particularly that in relation to their emotional, social, and practical needs. Once again, service users appear to be happy with the quality of care they receive once they are in receipt of it, but often find themselves unsure of what is available, facing uncertain referral routes, and made to join lengthy waiting lists. More therefore needs to be done to provide residents with complete and accurate information, and to facilitate the process of connecting them to sources of help and support.

People who have experienced a bereavement have also reported feeling abandoned by health and social care staff following the death of a loved one, due to a lack of routine follow up. Local people have informed us that they would have benefited from someone such as their GP contacting them following their loss, to check-in. Instead, residents must often actively seek support, which can be challenging during such a difficult time.

7.4. Support for informal carers

The support that carers require can be divided into two broad categories. The first of these is support to undertake their caring role, including through adequate training and the provision of sufficient equipment. The second, is support for them as an individual who is experiencing a traumatic life event as their loved one is unwell. Both forms of support are required if they are to help their loved one and remain well themselves. Sadly, local people report being unhappy with the levels of either type of support that they are receiving.

Strikingly, only 14% of respondents to a survey undertaken to support this JSNA chapter reported that they agreed with the statement “I received sufficient carer related support / training, such that I felt well equipped to support someone near the end of life”. Whilst it is important to note that the survey used a self-selected sample and so is subject to responder bias, this remains a notable statistic. Local people have reported feeling to care for their

loved one without sufficient knowledge and skills. Not only does this negatively impact on the quality and experience of end of life care received, but it is distressing for both the carer and their loved one. Furthermore, carers may be left feeling guilty following the death of their loved one for not being able to provide as high a level of care as they would have liked, and feeling as if they had in some way let that person down.

Finally, the burden of coordinating health and social care services for someone approaching the end of life, often falls onto carers. Similarly to the other groups discussed in this section so far, carers report not knowing what services are available and find identifying the various sources of support and navigating their access routes to be challenging. Existing methods of collating and sharing methods of support with carers are therefore in need of review.

7.5. Support for staff working in End of Life care

The roles of staff in end of life care are diverse, and as it was drawn from a self-selecting sample, caution must be taken when interpreting the results of the local survey that was undertaken due to the risk of responder bias. Across work areas however, responders were generally happy with the resources and equipment that they received to help them undertake their role. Differences were seen though in terms of the training received, when considering the person's job description. Those whose primary role is not delivering end of life care reported feeling that they had insufficient training to adequately support people towards the end of life. As we are faced with an ageing and increasingly co-morbid population which interacts with multiple health services and specialities, staff will increasingly work with patients who are approaching the end of life even if that is not the focus of their role. This is therefore likely to be a growing problem, and it is important that those within the health and social care system feel adequately supported in this area.

8. Recommendations

This JSNA chapter has identified the local needs and current gaps in service provision relating to end of life care and support. The following recommendations have been produced on the basis of these findings, to support improved outcomes for the people in Rutland.

8.1. 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 as discussed in Section 3.5.2.
- 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.

8.2. 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 (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.

8.3. 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.

8.4. 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.
- Consider the need for a paediatric palliative care consultant and the need for community paediatric and nursing support that responds to the rising numbers of children and young people on end of life pathways with increasing complexity.

8.5. 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.

GLOSSARY OF TERMS

CCG	Clinical Commissioning Group
ELRCCG	East Leicestershire and Rutland Clinical Commissioning Group
GP	General Practitioner
HWB	Health and Wellbeing Board
IDACI	Income Deprivation Affecting Children
IDAOPI	Income Deprivation Affecting Older People
IMD	Index of Multiple Deprivation
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LLR	Leicester, Leicestershire and Rutland
LPT	Leicestershire Partnership Trust
LSOA	Lower Super Output Area
MSOA	Middle Super Output Area
NHS	National Health Service
ONS	Office of National Statistics
PHE	Public Health England
WLCCG	West Leicestershire Clinical Commissioning Group

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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.

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
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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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Agenda Item 8c

Report No: 18/2023
PUBLIC REPORT

HEALTH AND WELLBEING BOARD

24 January 2023

DRAFT OF ORAL HEALTH JSNA 2022

Report of the Director of Public Health

Strategic Aim:	Healthy and Well	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Sam Harvey: Portfolio Holder for Health, Wellbeing and Adult Care	
Contact Officer(s):	Hanna Blackledge, Business Intelligence, Lead Public Health Analyst	hanna.blackledge@leics.gov.uk
	Mike Sandys, Director of Public Health	Telephone – 0116 3054239 email: mike@sandys@leics.gov.uk
Ward Councillors	N/A	

DECISION RECOMMENDATIONS

That the Committee:

1. Approves publication of the Oral Health Needs Assessment for the Rutland JSNA.
2. Endorses the Needs Assessment recommendations for the Integrated Delivery Group to consider and progress as required.

1. PURPOSE OF THE REPORT

1.1 The purpose of the report is to present the findings and the recommendations of the recent Oral Health Needs Assessment (OHNA) for Rutland (part of the JSNA process) and to seek approval for its final submission and publication.

2. BACKGROUND

2.1 The purpose of a health needs assessment (HNA) is to inform commissioning and planning of services through identifying unmet health and healthcare needs of the population and recommend appropriate actions to meet these unmet needs. It involves epidemiological, comparative and qualitative methods to define health inequalities, gaps in services and priorities for consideration.

2.2 Oral health is one of the key indicators of overall health and wellbeing and is necessary for important daily functions, such as eating, speaking and smiling.

2.3 Poor oral health is a major public health problem, owing to its high prevalence and incidence. The burden of oral diseases, such as tooth decay, gum disease, oral cancer, and facial and dental injuries, falls unequally upon disadvantaged and/or vulnerable populations.

2.5 However, these conditions are highly preventable. Simple measures, such as improved oral hygiene, healthy diet, access to fluoride and regular dental check-ups play a major role in their prevention and early treatment.

2.6 Oral health of Rutland population was last assessed, as part of the Joint Strategic Needs Assessment process, in 2018 (reports accessed here: https://www.rutland.gov.uk/my-services/health-and-family/health-and-nhs/joint-strategic-needs-assessment/)

2.6 The issues of access to the NHS Dental Services in Rutland, provision and recovery plans post-pandemic were reported to the Scrutiny Committee in September 2022 (see: https://rutlandcounty.moderngov.co.uk/documents/s24017/Report%20No.%20145-2022%20-%20Access%20to%20NHS%20Dental%20Services%20within%20Rutland.pdf).

2.7 The COVID-19 pandemic impacted substantially on how dental services were provided, with priority for urgent care, those at higher risk or vulnerable individuals, such as children. Capacity issues were reported by many practices during and in the aftermath of the pandemic.

3. MAIN FINDINGS

3.1 Census 2021 figures show higher than national average overall proportion and population growth in the older age groups, particularly among the over 65s, with relatively less working age adults and children. The total population of Rutland has increased by 10% since 2011 and is projected to increase further by 7% in the next decade.

3.2 There is a well-documented link between **socio-economic deprivation** and poor oral health. Although the overall measures of deprivation are better than national average for Rutland there are specific issues linked to rural deprivation, such as social isolation and barriers to housing and to services. Almost two-thirds of Rutland population live in a rural setting.

3.3 Several **population groups are at higher risk** of poor oral health including:

- children with special educational needs and children looked after
- vulnerable elderly
- people with disabilities
- prison populations
- military personnel and their families
- refugees and asylum seekers

3.2 The level of **oral health in children** is assessed regularly through national surveys.

- The results emerging form the most recent survey of the **3-year-old children**, albeit based on a small sample size, seems to suggest the level of oral health need, measured as level of dental decay, similar to the national average. However, higher level of dental decay of incisor teeth specifically in this age group could indicate poor infant feeding practices such as consuming sugar-sweetened drinks.

- Similarly, for the **5-year-olds** the overall level of dental decay is similar to the national and regional (East Midlands) average, and significantly lower than in Leicester but borderline higher than for Leicestershire County.

In addition:
- Rate of hospital tooth extraction in children and young adults (0-19) is another potential indicator of high level of dental decay. In Rutland these figures are generally low and the regional rates are also much lower than the national average.
- The rate of dental checks for the looked after children is similar to other areas, however it fell substantially between 2019-21, when compared to previous years.

3.3 The 2018 Oral Health Survey for **adults** has shown level of functional dentition similar to other areas and active decal lower, indicating relatively good level of oral health in Rutland. Nationally, **oral cancer** rates have been increasing steadily since 2007. Oral cancer can be detected at dental check-up. In Rutland there were 25 new cases between 2017 and 2019 (latest published registration figures), and this rate is statistically similar to the national average, although longer-term trends for Rutland are difficult to assess due to small numbers.

3.4 **NHS dental services** include primary dental care service ('hight street' surgeries), community dental services, specialist dental services (Intermediate Minor Oral Surgery – IMOS), secondary care (NHS Hospital Trusts) and dental services in secure settings. The commissioning responsibilities for these services will transfer on the 1st of April 2023 from the NHSE to the Integrated Care Board (ICB).
During the COVID-19 pandemic, dental services were prioritising urgent care, care for vulnerable (including children) and high-risk patients.
Ongoing issues, such as falling levels of dental access in primary care, staff shortages, increasing pressure on service (private patients re-patriating to the NHS) and low orthodontic capacity have been highlighted nationally.

Issues of **access to services** highlighted in the report include the following:

- With regards to access by new patients to primary NHS dental care – of all practices contacted through survey within 16-mile radius (including six practices within Rutland and 44 cross-border providers), the majority either did not accept any new NHS patient or accepted only referrals. A small proportion (10%) accepted only children.
- Almost half of Rutland population is more than 15 min walk from a nearest dental care provider and a third have more than 30 min travel by public transport. Both these findings are correlated to rurality rather than deprivation in Rutland.
- One of the measures of access is the proportion of population **'seen by a dentist in the past 12 or 24 months**.' Because of the timing of COVID-19 pandemic and limited services during that time, the conclusions are nuanced, but the following was found:

    - In the pre-pandemic year over 60% of children would have been seen by a dentist in previous 12 months; this proportion halved by March 2021 and partially recovered to 53% by March 2022 (better than England average of 45% at that time).
    - For adults, the percentage of those seen in the 24 months prior, were generally lower pre-pandemic (in the ballpark of 40%) and continued to fall through the pandemic to less than 30% and without any recovery. Access is lowest for the over 65s and significantly lower than the national average (26% compared to the 37% for England). Highest rates for adults were in the eastern localities

  (Ketton, Ryhall and Luffenham), although there was no correlation to deprivation measures.
  - Men (particularly of working age) were much less likely to access dental services than women (by 15%).

- Other proxy indicators of access, such as rates of dentists per head of population or those reported through GP Patient Survey show rates similar or better than the national average.
- Activity data for period January 2019 to June 2022 further suggest that:

  - access rate for children has been rising since 2020, from the low of 13% to 42% in 2022, which is still below the pre-pandemic level,
  - rates for adults are generally low (lower than many comparators) and have not recovered post-pandemic, at least by the summer of 2022

- As a measure of **patient satisfaction**, the percentage of people describing a 'very good' or 'fairly good' experience of NHS dental services in Rutland dropped from over 80% across previous years to less than 75% in 2020/21.

3.6 A number of **oral health improvement** measures are underpinned by strong evidence of effectiveness and are estimated to have high return on investment. They include breastfeeding, toothbrushing, use of fluoridated toothpaste, reduction of consumption of sugary food and drinks, application of fluoride varnish in children or water fluoridation. Water fluoridation has the highest return on investment estimate (£22 per £1 after 10 years).

- In 2021/22, Rutland had a significantly lower rate of fluoride varnish application for children 0-17, compared to Leicestershire average – 48.2% against 57.4%
- Rutland currently do not have an oral health promotion service or a supervised tooth brushing programme. Health visitors provide oral health advice, but do not distribute toothbrushes or toothpaste.
- There is an Oral Health Promotion Partnership Board across Leicester, Leicestershire and Rutland (LLR) and Public Health represent Rutland on this board.

4. RECOMMENDATIONS

4.1 Dental access issues should be monitored, and steps taken to improve access where necessary. Focus on the elderly, working-age men and vulnerable groups, such as families of military personnel.

4.2 Provide up-to-date information on available NHS dentistry and investigate current pattern of service use, particularly cross-border flows and the use of private dentistry.

4.3 Consider targeted oral health promotion for the youngest children and the elderly.

4.4 Consider increasing fluoridation programmes across Rutland, including promotion of fluoride varnish and toothpaste and the feasibility of water fluoridation in Rutland, aligned to any upcoming changes to the Health and Care Act 2022 regarding fluoridation responsibilities for local areas.

4.5 Commission health promotion service or supervised toothbrushing to Early Years Settings in Rutland.

5. CONSULTATION

5.1 A range of stakeholders in the health and care system have been consulted over the development of the JSNA, including NHS commissioning (NHSE).

6. ALTERNATIVE OPTIONS

6.1 The production of a JSNA is a statutory requirement. However, alternative options over the overall scale, size, structure and timing of production of different elements of this and other JSNA chapters are being considered.

7. FINANCIAL IMPLICATIONS

7.1 The small business intelligence (BI) team supports the analytical work for both Leicestershire and Rutland Public Health for all JSNA chapters. Any requirements over the existing team capacity may have resource implications.

8. LEGAL AND GOVERNANCE CONSIDERATIONS

8.1 From the 1st of April 2023 the commissioning responsibility, including any funding allocation, for the NHS dental service will be delegated to the LLR ICB, previously held by NHS England.

9. DATA PROTECTION IMPLICATIONS

9.1 A Data Protection Impact Assessments (DPIA) has not been as there are no personal identifiable data contained within the report.

10. EQUALITY IMPACT ASSESSMENT

10.1 An Equality Impact Assessment (EqIA) has not been completed however, equity of access to NHS dental service forms a major part of this JSNA.

11. COMMUNITY SAFETY IMPLICATIONS

11.1 None have been identified.

12. HEALTH AND WELLBEING IMPLICATIONS

12.1 Several initiatives aimed at recovery of access to NHS dental care and oral health improvement activities, backed by substantial financial investment, are already in place across Leicester, Leicestershire and Rutland.

13. ORGANISATIONAL IMPLICATIONS (OPTIONAL DETERMINED BY SUBJECT)

13.1 Environmental Implications

13.1.1 None were identified

13.2 Human Resource Implications

13.2.1 No HR implications identified

13.3 Procurement Implications

13.3.1 There are no procurement implications

14. CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

14.1 The Oral Health Needs Assessment comes at a time when access to dental services is challenging across the country and commissioning responsibilities for Rutland transfer from NHS England to LLR ICB. The findings inform a set of recommendations around improving access, targeting support to those most in need and developing oral health promotion activity. Whilst the more acute issue of dentistry access is prominent, preventative measures must also be considered.

15. BACKGROUND PAPERS

15.1 There are no additional background papers.

16. APPENDICES

16.1 Appendix A - Rutland Joint Strategic Needs Assessment 2022: Oral Health.

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

Rutland

Joint Strategic Needs Assessment

ORAL HEALTH

December 2022

Business Intelligence Service

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

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Executive Summary

Poor oral health is a major public health problem, owing to its high prevalence and incidence worldwide. Oral health diseases include tooth decay, erosion, gum disease, oral cancer, and facial and dental injuries; their burden falls unequally upon disadvantaged and vulnerable populations. However, these conditions are highly preventable with simple measures such as improved oral hygiene and/or diet, access to fluoride and regular dental check-ups playing a major role in prevention of, and early treatment of disease.

Although Rutland's population has, on average, lower levels of socio-economic disadvantage or general ill-health, there are pockets of rural deprivation, expressed as problems with access to services, barriers to housing and mental health issues and social isolation. Demographically, Rutland has a substantial, and rising, proportion of elderly population, many of whom are living in rural settings. Other vulnerable groups include children in need, looked after children, disabled, prisoners and families of military personnel stationed in Rutland.

Because of the relatively small size of Rutland's population, national indicators, including survey results, may be difficult to interpret and follow over time.

The latest dental surveys among the 5-year-olds and other indicators of oral health suggest average or better than average oral health in this group, however, among the 3-year-olds there was an indication of potentially poor infant feeding practices, which may need further exploration. The rates of access to NHS dental services for children in Rutland is also better than for adults, and higher than England's average, although very few practices accept new patients under 18.

For Rutland's adults, oral health also seems average or better than average. The rates of oral cancer are similar to elsewhere and the mortality rate is low; the levels functional dentition is within national average, while levels of active decay are lower. However, there are significant problems with access to dental care, with dental practices, even those outside of the County, not accepting new adult patients. It is very likely that access issues affect the vulnerable groups disproportionately. Compared to the national average, the rate of access to NHS dentistry for those 65 and over was particularly low in 2021/22 (26% vs 37%). Men of working age access the services less commonly than women. There is some indication of patient flows to dental practices outside the County (Stamford and Melton in particular) but it is difficult to quantify where patients access their treatment.

The COVID-19 pandemic had a significant impact on rates of treatment which, by June 2022, was still below the pre-pandemic levels, particularly for adults.

There was a fall in patient experience of NHS dentistry when compared to previous years, more pronounced than the national decline. In 2020/21 less than 75% of patients described their experience as good or fairly good, historically this indicator was over 80%.

Rutland currently does not have an oral health promotion service or a supervised tooth brushing programme; health visitors provide oral health advice.

1 Introduction and Overview

Oral health is one of the key indicators of overall health and wellbeing and is necessary for important daily functions, such as eating, speaking and smiling.

Oral diseases include a range of chronic clinical conditions such as dental caries (tooth decay), periodontal (gum) disease, and oral cancers. While tooth decay affects population of all ages, gum disease is more prevalent in older people. Oral conditions can a have substantial effects, causing pain, sepsis, impacting the quality of life and work productivity. Although largely preventable, oral diseases are highly prevalent, with dental caries estimated as the most common disease globally (35% of world's population having untreated tooth decay) and periodontal disease affecting almost 11% of people world-wide[1].

Consistently across studies and settings, oral diseases were shown to be closely linked to socioeconomic status and the broader social determinants of health, sharing common risk factors with other non-communicable diseases, such as overweight and obesity, high sugar consumption, tobacco use, and harmful alcohol use. Their distribution and severity vary between populations, with more vulnerable, disadvantaged and socially excluded groups experiencing more oral health problems.

Tooth decay can be prevented by reducing the amount and frequency of consumption of sugary foods and drinks and optimising exposure to fluoride. Likewise, gum disease can be prevented by good oral hygiene and stopping smoking; and the risk of oral cancer may be reduced by stopping smoking, drinking alcohol within recommended safe limits and eating a healthy diet.

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2 The Population of Rutland

2.1 Demography

The recent Census 2021 population figures show that there is relatively more elderly and less children in Rutland when compared to other areas (Table 1). This includes over a quarter (25.4%) of those over the age of 65, compared to 18.5% across England. The ratio of those over 65 to 15-64 age group is nearly 43, compared to 29 for England as a whole ('old age dependency ratio').

Table 1. Broad age group population comparison between Rutland, national, regional and Leicestershire structure (Census 2021 - thousands) (Source: ONS 2022)

Area	0-14		15-64		65-79		80+		Total
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	
England	9,839	**17.4**	36,250	**32.0**	7,603	**13.5**	2,798	**5.0**	**56,490**
East Midlands	827	**16.9**	3,102	**31.2**	706	**14.5**	246	**5.0**	**4,880**
Leicestershire	117.0	**16.4**	447.3	**62.8**	109.3	**15.3**	38.8	**5.4**	**712.4**
Rutland	6.2	**15.2**	24.3	**59.4**	7.5	**18.3**	2.9	**7.1**	**40.9**

Rutland had proportionately more residents in older age groups (above the age of 50), particularly women, when compared to England (Figure 1). Conversely, there are less children and younger adults, again particularly for females.

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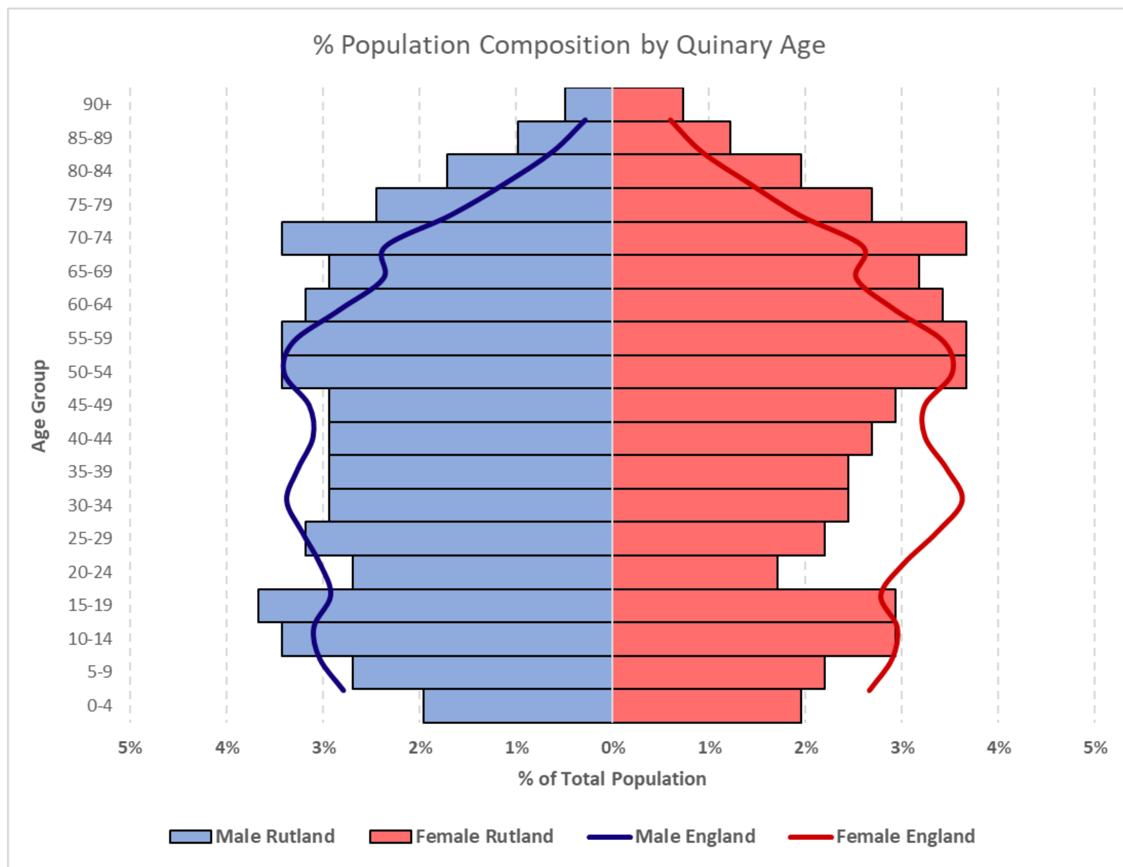
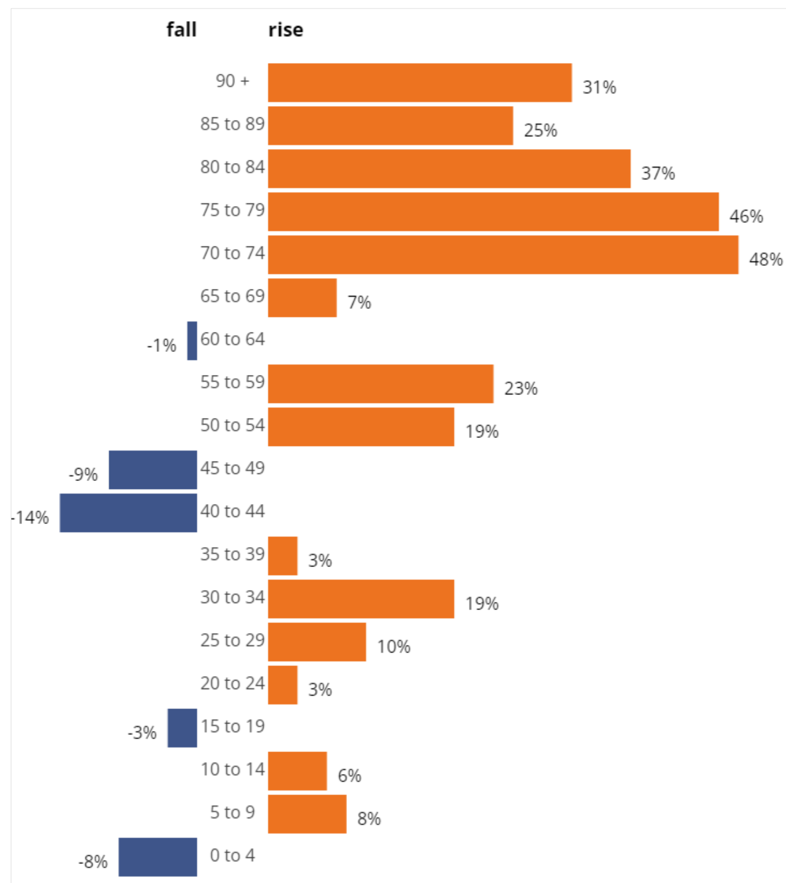
Figure 1. Age structure of Rutland population - Census 2021 (Source: ONS 2022)



There has been an increase of 31.2% in people aged 65 years and over between 2011 and 2021 (Figure 2), particularly for people in their seventies (46-48%), with a decrease of 2.4% in children aged under 15 years.

Figure 2. Population change (%) between 2011 and 2021 in Rutland, by age group (Office for National Statistics 2022)



2.2 Socio-Economic Deprivation

The average levels of deprivation in Rutland measured by the Index of Deprivation (IoD)[2] are not high when compared to the national figures, with only one area classified as just above the national average of deprivation (in the fifth national decile - Figure 3) and 80% of the population living in the 40% least deprived areas nationally (Office for National Statistics).

Although a useful measure at a larger scale, IoD is known to be biased towards urban type of deprivation. As Rutland is predominantly rural, it has specific issues expressed better through the Barriers to Housing and Services domain of the IoD. Within this domain, six out of the 23 Rutland LSOA's are classified in the most deprived 10% nationally (Figure 4).
More detail on deprivation of specific groups have been identified through the *Rutland Health Inequalities JSNA* [3] including:

- Potential issues of childhood poverty - when housing costs are factored-in, the proportion of children in relative low-income families is this proportion is estimated to be over 17%, with significant variation between areas.
- Levels of benefit support have increased substantially since 2020, with significant geographical variation
- Fuel poverty remains a significant issue in six of the Rutland LSOAs.

Based on these and a number of other indicators, the report identified three Rutland LSOAs of particular concern – Cottesmore, Oakham North West and Greetham.

2.2.1 Deprivation and Oral Health

The clear and persistent link between socioeconomic status and oral health has been well documented through research and routine surveillance and is exemplified in the national oral health indicators for children and adults.

Thus, the prevalence of tooth decay in *3-year-old children* (NDEP Survey[4]) shows a three-fold variation between the most (nearly 17% of surveyed children) and the least deprived (6%) areas of the country. Tooth extractions rates for children 0-19 (Hospital Episode Statistics, HES, for 2020/21) also show a three-fold variation, with nearly 180/100,000 in the most deprived areas, compared to less than 60/100,000 (Figure 5). Trend data show that, while the overall extraction rate has decreased in the recent years, these inequalities persist. Some further details on tooth extraction in children in the Child Dental Access chapter.

The *Health Survey for England* (2019)[5] has shown that, despite overall falling rates of adults without natural teeth, the rates of functional dentition (defined as 20 or more natural teeth) are significantly lower in the most deprived quintile of deprivation (75% and 76% for men and women, respectively) than in the least disadvantaged (90% and 88%, respectively).

Figure 3. Socio-economic deprivation by lower super-output area (LSOA) in Rutland.

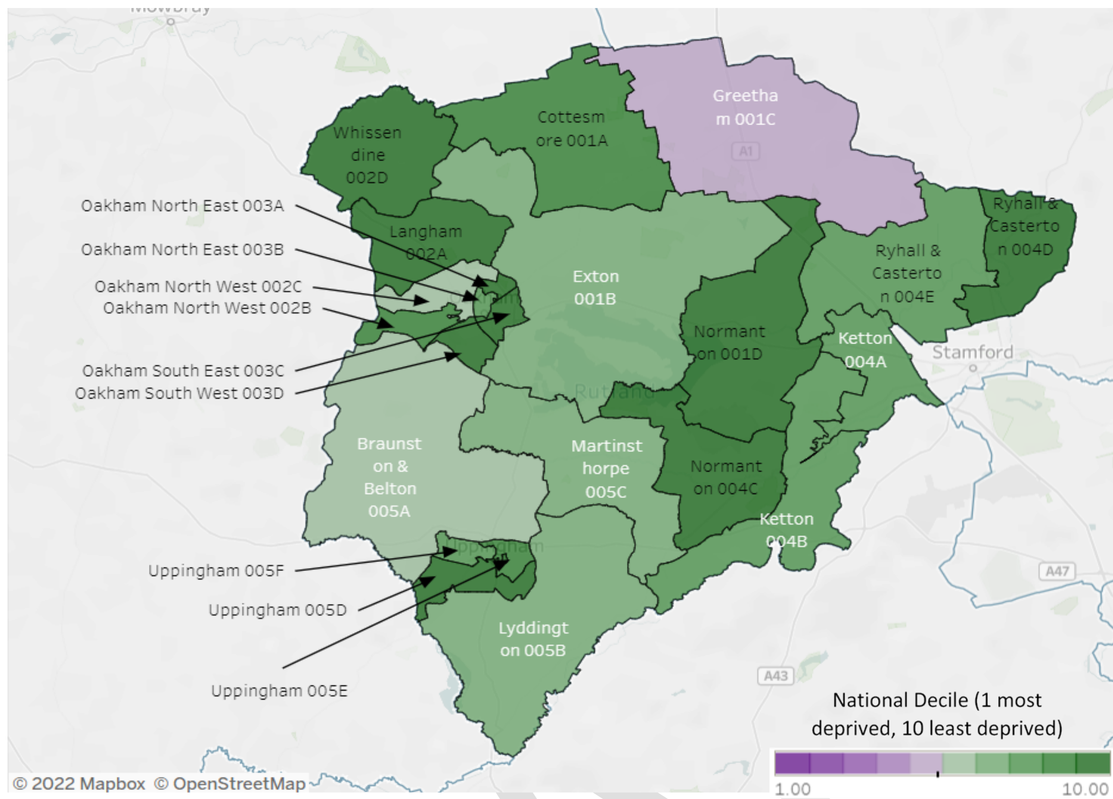


Figure 4. Barriers to Housing and Services domain of the IoD in Rutland.

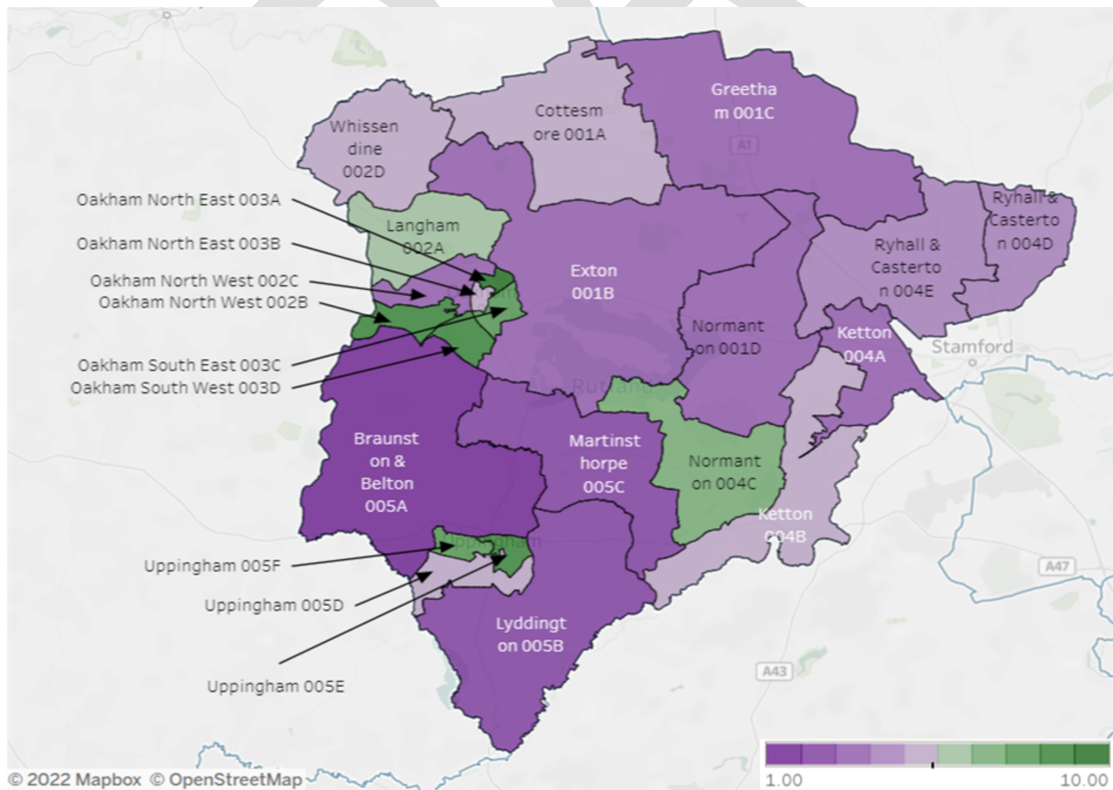
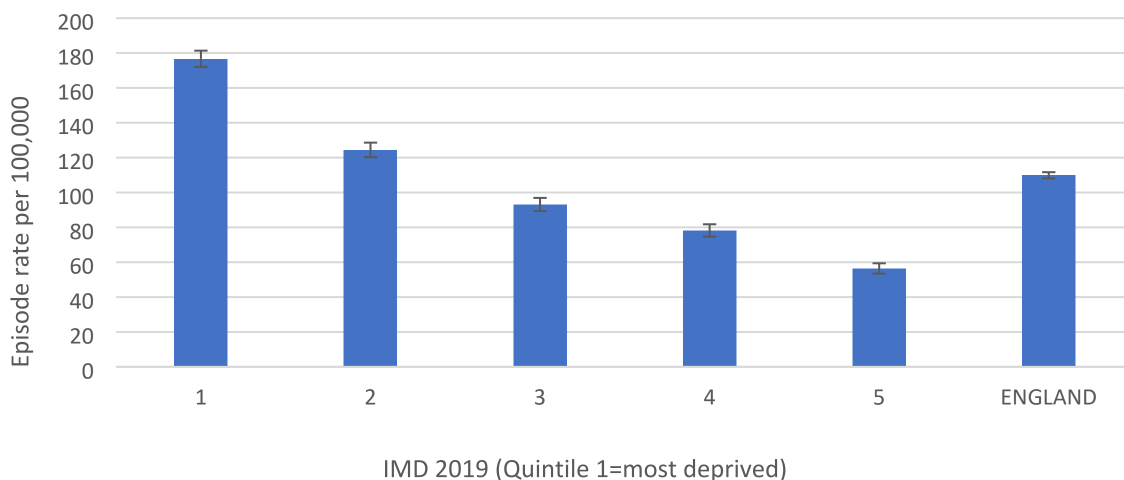


Figure 5. Episode rate per 100,000 IMD quintile population of tooth caries-related tooth extractions in hospital 0-19Y for 2020-21 (n=14,645) (Source: OHID, December 2021)



2.3 Ethnicity

Although the relationship between ethnicity and oral health outcomes is complex and can be confounded by other factors, there is strong evidence that those of non-white backgrounds have lower use of dental services[6]. The recent surveys have also shown that children from Chinese and Eastern European backgrounds have higher prevalence, severity and extent of dental decay than other ethnic groups.

In 2021 the largest proportion (94.8%, N=38,909) of Rutland population was of white[i] ethnic background which is significantly more than the average for England (81%). The total number in other ethnic groups was 2,141, with highest numbers classified as 'mixed and other', followed by Asian[ii], black[iii] and other population groups (Figure 6). In the decade since 2011 the size of ethnic minority population of Rutland had doubled to 5% of the total in 2021 (Figure 7). However, of the total 10% population increase in Rutland (from 3.7 thousand in

[i] Includes the following categories – white English/Welsh/Scottish/Northern Irish/British, Irish and other white

[ii] Includes Asian or Asian British groups – Bangladeshi, Chinese, Indian, Pakistani or other

[iii] Includes black and black British, African, Caribbean and other black groups

2011 to over 41 thousand in 2021) the highest increase in numbers was in white population (by over 2.6 thousand).

Figure 6. Ethnic profile of Rutland's population (Source: ONS Census 2021)

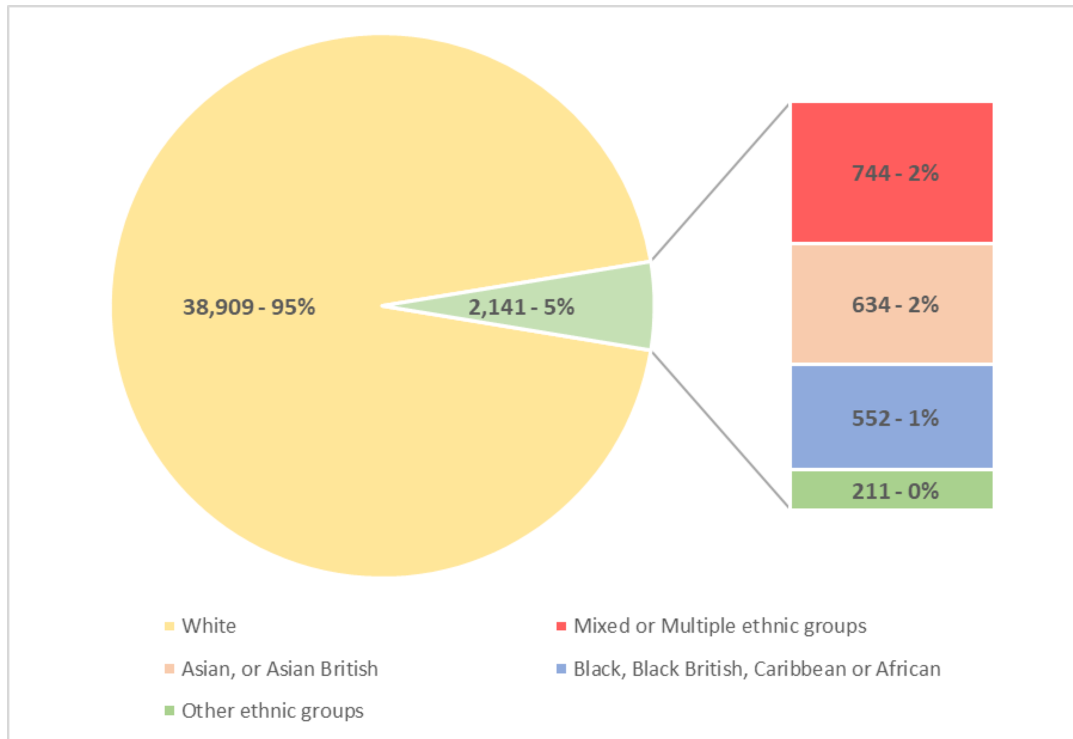
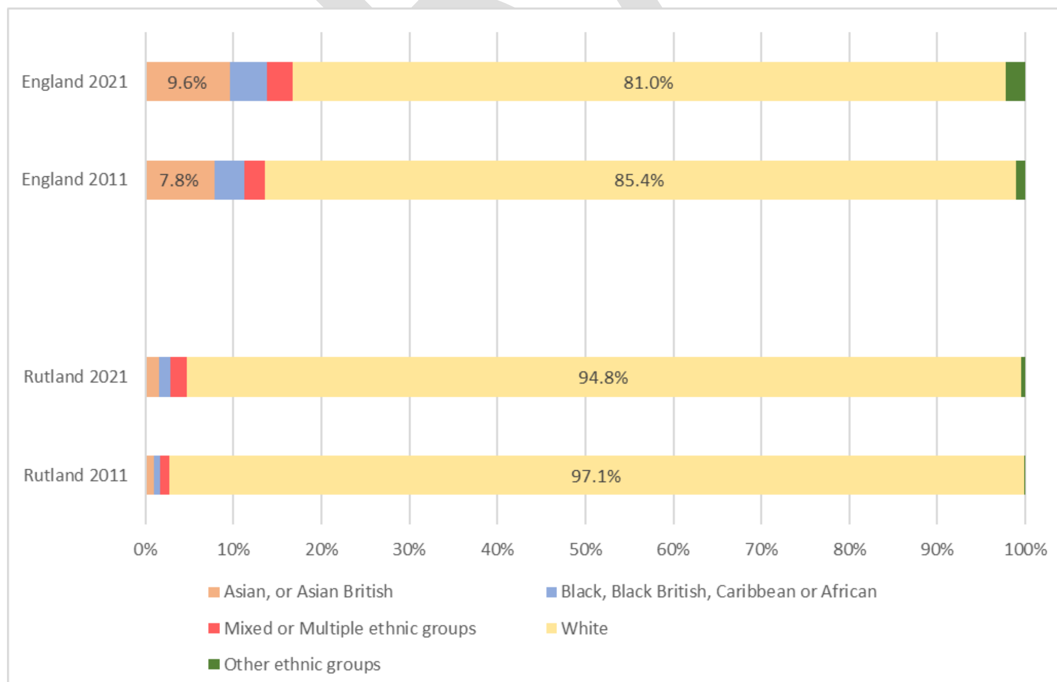


Figure 7. Percent change between 2001 and 2011 Census (Source: ONS)



2.4 Urban-rural Classification

According to data from the latest population Census (2021), Rutland is the fourth least densely populated local authority area in the East Midlands[7].

More than a third of Rutland population live in areas classified as rural (37%), a third in 'urban city and town' and the remaining 30% as 'rural town and fringe' (Figure 8).

Geographically, only a small proportion of areas, around Oakham, are classified as urban with the remainder described as rural, either 'town or fringe' in character (Uppingham and eastern-most areas) or 'rural dispersed' (Figure 9).

There are several issues affecting the health and wellbeing of rural communities, including low-paid work, unemployment of young people, high costs of housing and fuel poverty. Access to health services is also of concern, as dental as well as general practices, and other services are further away than in urban areas. In addition, rural areas often lack public transport, while poor broadband and mobile phone network availability hinders communication and access to online health services, banking, and shopping.

Figure 8. Population by rural-urban classification (Census 2011 data)

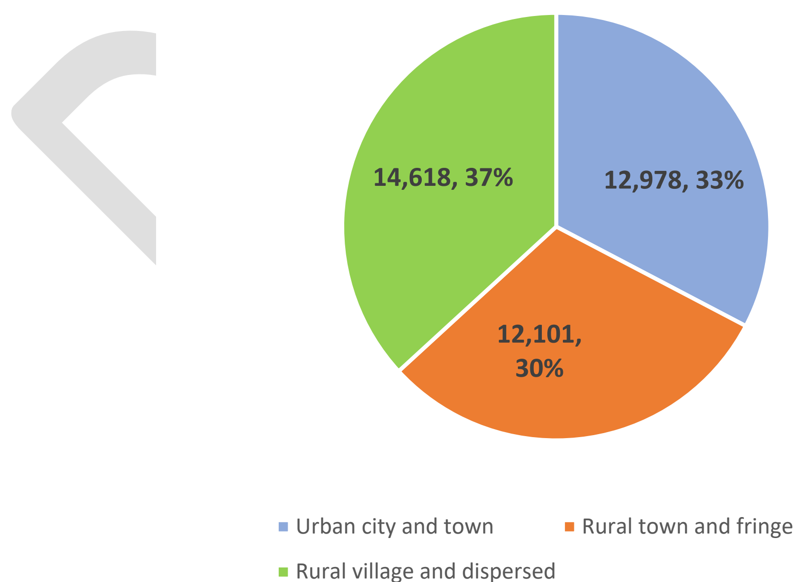
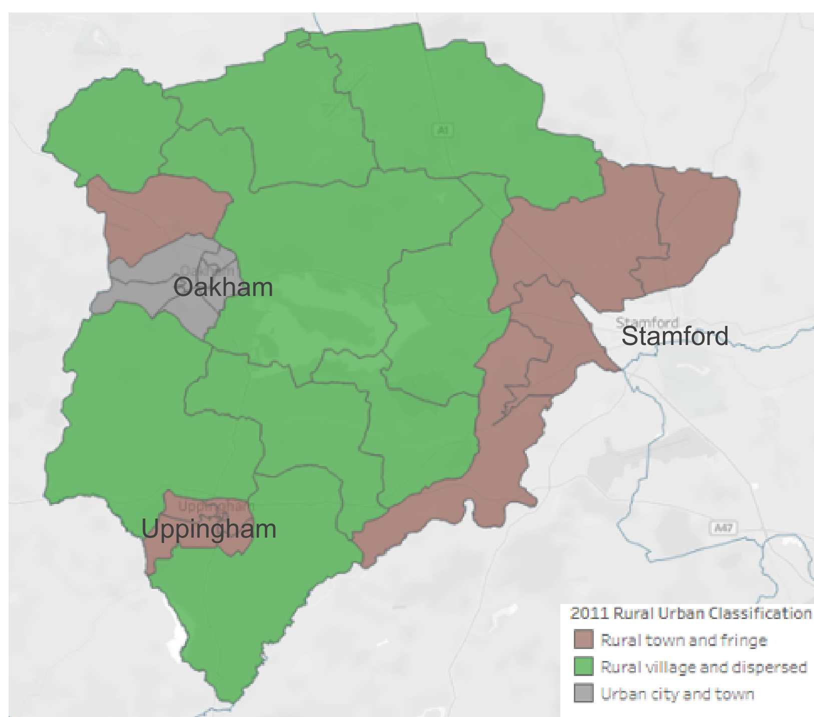


Figure 9. Rural-urban classification of Rutland LSOAs (Source: ONS Census 2011)



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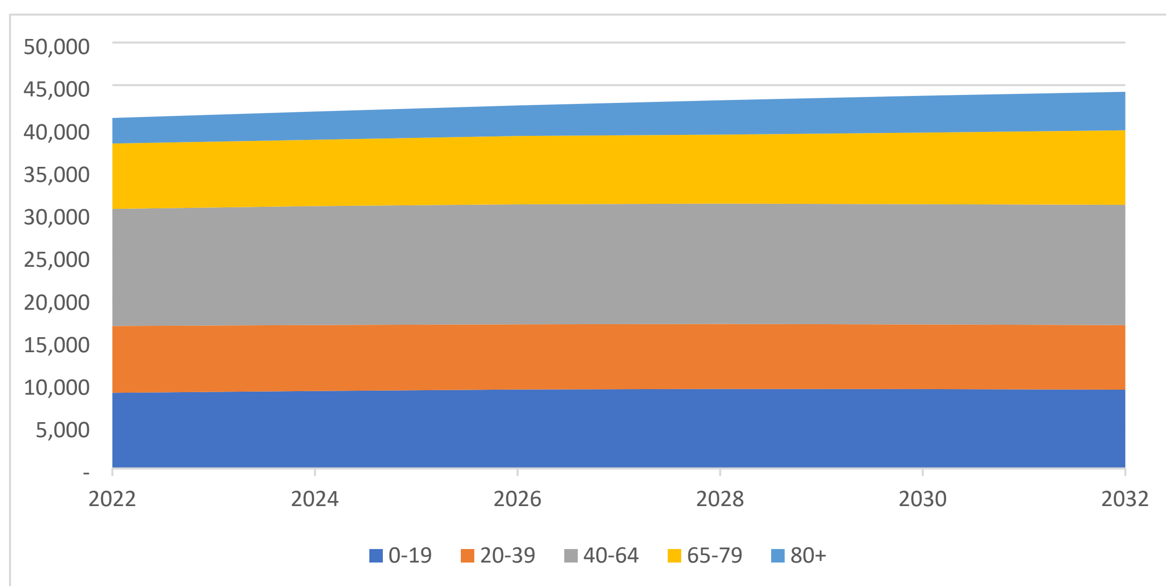
2.5 Projected Population Growth

Currently available projections are based on 2018 population estimates published by the ONS[8], which in turn are based on Census 2011 population figures. These projections are likely to be rebased by the ONS later in 2022 using Census 2021 results.

With this caveat in mind the following is expected by 2032 [9] **(**Figure 10):

- The population of Rutland is projected to increase by over 7% to circa 45,250 in the next decade, an increase of over 3,000 people. This is a higher rate of increase than that for England (4%) and East Midlands (6%).
- The greatest change is expected in the oldest population group (80 and above), accounting for over 1,500 additional elderly people in Rutland.
- There is also a projected significant increase in the numbers of residents aged 65 to 79 - by over a thousand in the next ten years.

Figure 10. Rutland population projections 2022-32 (source: ONS 2022)



Age	2022	2024	2026	2028	2030	2032	Change 2022-32	
0-19	8,878	9,088	9,266	9,326	9,310	9,245	367	4%
20-39	7,851	7,748	7,649	7,629	7,592	7,582	269	-3%
40-64	13,740	13,964	14,092	14,137	14,122	14,121	381	3%
65-79	7,679	7,790	8,025	8,099	8,405	8,757	1,078	14%
80+	3,000	3,312	3,584	4,034	4,327	4,516	1,516	51%
Total	43,169	43,926	44,642	45,252	45,786	46,251	3,082	7%

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3 Who is at Risk and Why?

Most of chronic ill-health in the population is characterised by complex and multi-factorial risks, often determined by social, physical or political environment.

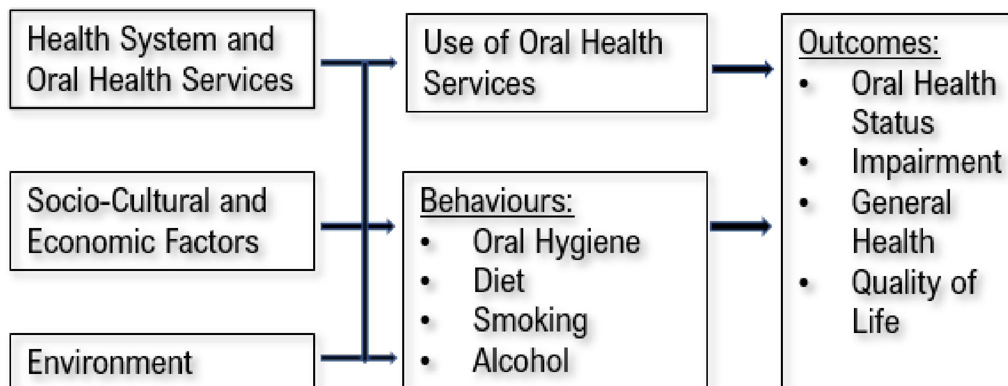
In the context of oral health, several models[10] [11] link behavioural and environmental risk factors, such as diet, smoking, alcohol consumption, exercise or levels of stress, to oral disease and other conditions (Figure 11).

The risk factors particularly important in the context or oral health include:

- poor oral hygiene - the main cause of gum disease, also implicated in dental decay
- diets high in sugar and fat – linked to dental decay as well as coronary heart disease, stroke, obesity, diabetes, and cancers

- smoking - implicated in gum disease and other diseases of the soft tissues of the mouth, as well as cancers of the lung, throat and mouth, coronary heart disease and diabetes
- excessive alcohol consumption - linked to high blood pressure, liver disease, coronary heart disease and cancers of the mouth, as well as being a cause of many social problems, violence, and injuries.

Figure 11 Common risk factor approach for oral health (after Petersen 2003[7])



3.1 Population Groups at Risk

Several population groups are at higher risk of poor oral health[12], including those experiencing socio-economic deprivation, children looked after (CLA), military personnel and their families, pregnant women, people with disabilities, the elderly (particularly dementia sufferers, people with long-term conditions and care home residents), some ethnic groups and several marginalised groups – the homeless, travellers, refugees and asylum seekers.

This section describes population groups in Rutland likely to experience poorer oral health.

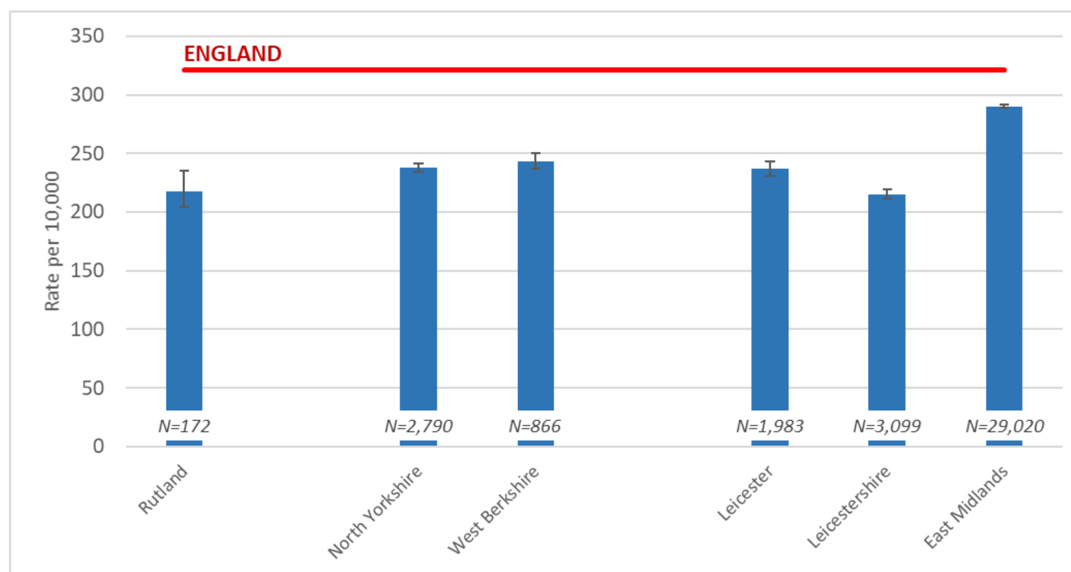
3.1.1 Children with Special Educational Needs, Children in Need and Children Looked After

As of the spring school census 2021 in Rutland there were 778 children (13.2%) with identified special educational needs or disabilities (SEND). 56% of children with SEND were aged 0-11 years (primary) and 44% 12-17 years; 698 (89.7%) of children with SEND are white British. The next biggest category is 'white other' (3.08%) then black African (1.15%), which is broadly reflective of Rutland's ethnicity[13].

The overall rate of *children in need (CIN)* in Rutland in 2021 was 218/10,000 (estimated number 172), significantly lower than the average for England (321/10,000) and the East

Midland (290). The rate is somewhat lower than its statistical neighbours[iv] and similar to Leicestershire (Figure 12).

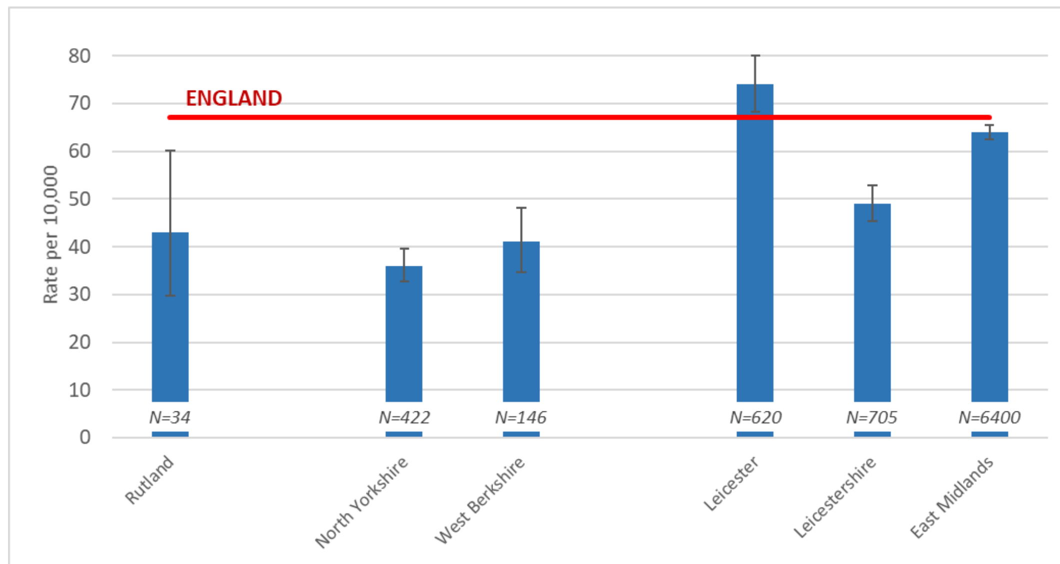
Figure 12. Children in need (rate per 10,000 of population under 18) in Rutland and comparator areas (Source: LAIT 2022)



Children looked after (CLA) are generally in the poorer state of health when they enter the care system, they could also experience more issues with provision of dental care, when compared to other children. Qualitative research indicates that foster carers may have more problems with enforcing health-related behaviours, including those underpinning oral health[14]. The number of looked after children in Rutland is relatively low (N=34 in 2021[15]) and, expressed as rate per all under 18s in the population, consistently lower than the national or regional average, while being similar to its 'statistical neighbours' (Figure 13).

[iv] North Yorkshire and West Berkshire are the closest area statistical comparators for Rutland, specifically for children – Children's Services Statistical Neighbour Benchmarking Tool

Figure 13. Looked after children (rate per 10,000 of population under 18) in Rutland and comparator areas (Source: LAIT 2022)



3.1.2 Vulnerable Elderly

Older people are at much higher risk of suffering from long-term physical and mental conditions, increasing their risk oral ill health. Risk factors include poor nutrition, impaired manual dexterity, poor oral hygiene. Previous dental disease is the cause of lack of functional dentition on many of the elderly population. Added to this are issues with access to dental services, particularly for those residing in care homes[16] as well as residents of remote rural areas.

3.1.3 People with Disabilities

Both physical, mental, including learning disabilities, can lead to poor oral health outcomes, through poor diet, lack of oral hygiene, potentially higher rates of smoking and alcohol consumption. This groups.

As of the spring school census 2021 13.2% (778 children) of the school population have identified Special Educational Needs or Difficulties (SEND), with a quarter of those (25%) with moderate or severe learning difficulties[17].

3.1.4 Prison Populations

Many studies have shown poor oral health among prisoners, with over 8-fold higher rates of untreated caries in some reports[18]. Surveys conducted in the UK show the general health of people in prison is poorer than the general population, with higher dependency on tobacco and recreational drugs, and higher rates of alcohol misuse. Prison populations generally have

poor oral health, with reports of periodontal disease and dental decay levels as much as four times higher than the general population. People in prisons are more likely to have come from socially excluded or disadvantaged backgrounds, suffering from lower educational attainment which may relate to learning difficulties. Oral health needs on admission to prison are high, with significant levels of unmet dental treatment need. Research in North West England showed the decayed, missing and filled (DMFT) scores of people entering prison are around twice as high as those of the general population[19].

As reported by the Ministry of Justice[20], there is one prison in Rutland, category C men's prison in Stocken, near Oakham, with a population of 1,026; this prison has an operational capacity of 1,059[21].

NHS England commissions Time for Teeth[v] to provide NHS dental services for the prison population in Rutland.

3.1.5 Military Personnel

Armed Forces personnel and their families are recognised as a vulnerable group in the population, whose health needs are often higher than that of the general population, and can be caused by

- social isolation, separation, interruption of training and education
- poor access to dental service for the families, particularly if relocating often
- maintaining continuity of treatment, including orthodontic treatment
- higher that average rates of smoking and alcohol consumption.

The UK Armed Forces have a distinct age, sex and sociodemographic profile. In 2019 just under a quarter were under 25 years of age, with the average age of an officer 37 and average of 30 years for other ranks; by gender, 11% were female[22]. Research has shown that 63% of non-officer UKAF personnel were recruited from the most deprived quintiles (1 and 2)[23]. Social inequalities could explain the higher levels of active caries found in non-officer recruits, with 2.0 decayed teeth per recruit compared with 0.9 in the similarly aged UK general population[24].

Currently most of military population are stationed in Kendrew Barracks, nr Cottesmore and St George's Barracks, nr Luffenham. As of October 2021, there were 2,160 Armed Forces

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[v] https://www.timeforteeth.co.uk/where-we-work.php

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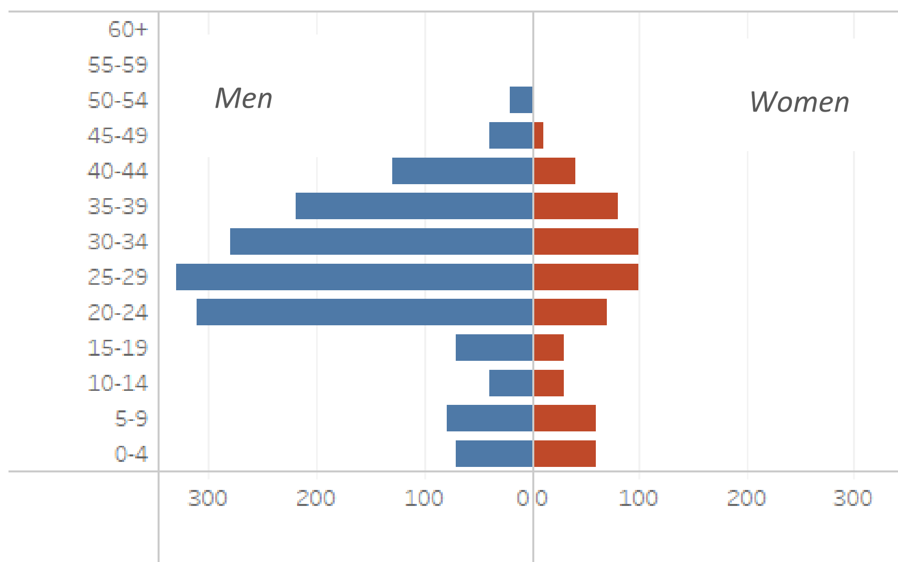
personnel and entitled civilian personnel with a Defence Medical Services registration in Rutland (over 5% of the estimated total resident population), 53% were for male personnel aged 20-39 and 27% were female personnel (Figure 14), which is higher than the national average. In addition, using the 1.7 multiplier, there could be over 3,670 family members (or 9% of Rutland's population).

Figure 14. Age structure of military population in Rutland, October 2021[25] (MoD 2022)



Defence Primary Healthcare (Dental) are responsible for providing primary dental care for the service personnel; it has the further capability of a consultant-led managed clinical network which manages complex needs of service personnel within the military. This includes Tier 2 practitioners across clinical dentistry specialisms including oral surgery. This means that very few service personnel require NHS secondary care input.

Unlike military personnel themselves, their families need to access primary dental care provided locally, and on re-location need to find a practice accepting new NHS patients. Wider health needs of army personnel and their families were assessed in 2019 (available here: https://www.rutland.gov.uk/my-services/health-and-family/health-and-nhs/joint-strategic-needs-assessment/).

3.1.6 Refugees and Asylum Seekers

A combination of socio-economic circumstances lies behind the observed poor oral health outcomes in this group. Poor literacy level and language barriers are important factors why refugees and asylum seekers are much less likely to access dental care or health improvement services[26]. The risk factors include higher rates of smoking, alcohol consumption and diet hight in sugar and fat.

3.1.7 Overweight and obese

Overweight and obese people are in the high-risk category for a number of lifestyle and clinical reasons, such as higher likelihood of consuming sugary food and drink with corresponding high level of tooth decay or comorbidities, for example diabetes, increasing their risk of periodontal disease.

Just over 17% of adults are obese in Rutland, which is significantly lower than the national average and below rates recorded across all Rutland's statistical neighbours. Although the rate of adult obesity is relatively low, it indicates as much as 7,000 people across Rutland could be at increased risk. The combined rate of adult overweight and obesity is 59.5%, which similar to the national average.

Similarly to the adult rate, obesity in children aged 10-11 (Year 6) are significantly lower than national and statistical comparator rates, with 12.5% with BMI indicating obesity, with a quarter of those children severely obese (3%). The corresponding rates for England are 21% and 4.7%. The rate of obesity among 4–5-year-olds is 7.7%, compared to 9.9% for England. Although these rates are comparatively low, a substantial number of children is at an increased risk.

4 Oral Health Needs - Children

The *National Dental Epidemiology Programme (NDEP)* includes examination of oral health in a random sample of children attending government funded academies and LA maintained schools. The aim is to measure prevalence and severity of dental caries in children to inform policy makers, and to evaluate health inequalities across the country and over time.

The most recent surveys concerned children aged 3 (2020) and the 5-year-olds (2019).

4.1 Oral Health of 3-year-old Children

Dental caries (tooth decay) and periodontal (gum) disease are the most common dental pathologies in the UK. Tooth decay has become less common over the past two decades but is still a significant health and social problem. It results in destruction of the crowns of teeth and frequently leads to pain and infection. Dental disease is more common in deprived communities than those that are more affluent. The indicator is a good direct measure of dental health and an indirect, proxy measure of child health and diet.

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The latest published results for the 3-year-olds are the 2019-20 data, the second survey for this age group[27]. Data collection was curtailed by the COVID-19 pandemic in early 2020.

Nationally, of the 3-year-olds participating in the survey, 10.7% already had experience of dental decay. Among children with experience of dental decay, each had on average 3 affected teeth (CI 2.81-3.03); at age 3-years, children normally have all 20 primary teeth. At the regional level, the highest experience of dental decay in 2020 was in northern England. As an example, 3-year-old children living in Yorkshire and The Humber were more than twice as likely to have experience of dental decay (14.7%) than children living in the East of England (6.7%).

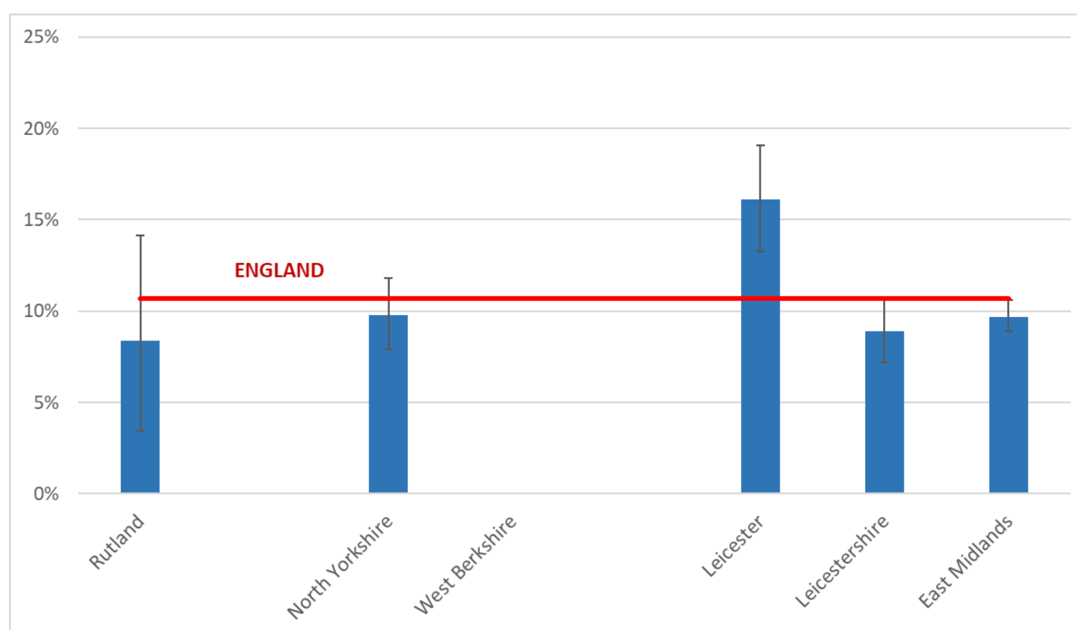
There is a strong link between rates of dental decay and deprivation. The survey has shown that children living in the most deprived areas of the country re almost 3 times as likely to have experience of dental decay (16.6%) as those living in the least deprived areas (5.9%).

There is also variation in prevalence of experience of dental decay by ethnic group and this was significantly higher children classified as 'other' ethnic group (20.9%) or as Asian/Asian British (18.4%).

Only 39 children (10% of total) were examined in Rutland, thus results have to be treated with caution. With the small sample caveat in mind, the experience of dental decay in this group of children in Rutland was 8.4%, similar to the national and regional average, as well as national (North Yorkshire/West Berkshire[vi]) and local (Leicestershire) comparators. The rate was almost half of that for Leicester (16%), but the difference is not statistically significant (Figure 15).

[vi] North Yorkshire and West Berkshire are the closest area statistical comparators for Rutland for children – Children's Services Statistical Neighbour Benchmarking Tool

Figure 15. Prevalence of experience of dental decay among three-year-old children (NDEP 2020)



Source: PHE 2021 (no data for West Berkshire – no children examined)

Further comparative data for Rutland on the dental health of the 3-year-old children are given in Appendix Table 1. While the examined population of children had similar mean numbers of teeth with experience of decay or untreated decay, it appears that all children with experience of decay (8.4%) also had incisor teeth affected (8.4%, 95% CI: 3.0-21.2%), a proportion significantly higher than the East Midlands, Leicestershire or north Yorkshire.

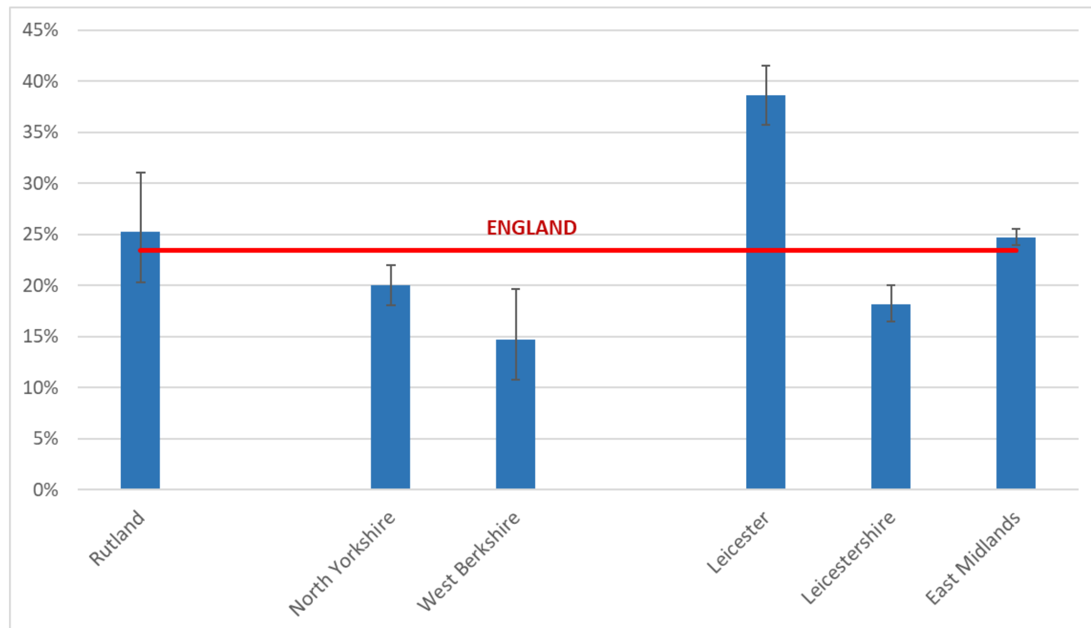
Experience of dental decay of incisor teeth in this age group is associated with infant feeding practices such as consuming sugar-sweetened drinks from a feeding bottle, especially when these are given overnight or for long periods of the day.

4.2 Oral Health of the 5-year-old Children

Across England, less than a quarter (23.4%) of 5-year-old children had experience of dental decay in the latest survey which is comparable to the 2017 results (23.3%). Among all 5-year-olds, 0.8 teeth had dental decay of which 75% (0.6) were untreated.

The prevalence of experience of dental decay in Rutland was 23.5% (Figure 16). This is similar to the national or regional average, significantly lower than Leicester, but borderline higher than Leicestershire (Rutland's regional 'statistical neighbour') or West Berkshire (a close-matching national 'statistical neighbour'). The rate in North Yorkshire (another statistical comparator) was similar to that in Rutland.

Figure 16. Prevalence of experience of dental decay among five-year-old children (Source: NDEP 2019)



Further details for this age group are given in Appendix Table 2. As measures of severity, mean numbers of teeth with active decay or experience of dental decay were lower or comparable to other areas. Although it appears that the proportion of 5-year-olds with active decay (24.6%, 95% CI: 19.7-30.2%) was higher than Leicestershire (15.7%) or statistical comparators, it was broadly in line with the national and regional average. Figure 17 below presents additional comparator data (a set of CIPFA 'statistical neighbours') for the prevalence of decay among 5-year-olds in Rutland.

Figure 17. Percentage of dental decay among 5-year-old children in 2019 - Rutland and its CIPFA nearest neighbours, compared to England average (PHE 2022)

Percentage of 5 year olds with experience of visually obvious dental decay 2018/19 — Proportion - %

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	23.4	23.1	23.7
Neighbours average	–	-	-	-	-	-
Rutland	–	-	-	25.3	20.3	31.0
Herefordshire	–	1	-	31.9	28.1	36.1
Wiltshire	–	2	-	13.1	9.4	18.0
Central Bedfordshire	–	3	-	14.5	10.8	19.2
Shropshire	–	4	-	23.8	18.1	30.6
North Somerset	–	5	-	13.9	8.4	22.1
Cheshire East	–	6	-	*	-	-
Bath and North East Somerset	–	7	-	20.8	16.1	26.5
West Berkshire	–	8	-	14.7	10.8	19.7
East Riding of Yorkshire	–	9	-	*	-	-
Cornwall	–	10	-	*	-	-
South Gloucestershire	–	11	-	14.3	9.8	20.2
Solihull	–	12	-	14.5	10.4	19.8
Cheshire West and Chester	–	13	-	22.7	17.9	28.3
Isle of Wight	–	14	-	*	-	-
Bedford	–	15	-	24.7	19.7	30.4

4.2.1 Variation in Children's Oral Health

Across England, the survey has shown a wide variation in prevalence and severity of dental decay - by geographical area (five-fold between local authority areas), deprivation (more two-fold between the least and the most deprived areas) and ethnicity. Time trends have also shown that the gaps have not improved since 2015.

The numbers of the surveyed children are too low to robustly detect inequality gaps locally (252 or 75% of all 5-year-olds in Rutland), but one can expect specific issues rural access disadvantage in parts of Rutland.

4.3 Hospital Tooth Extraction Rates (Children and Young Adults)

Most of hospital tooth extractions in children and young adults are as result of dental decay and the rates are closely correlated to socio-economic deprivation, which a t a national level was illustrated earlier (see Figure 5 in the section on Deprivation and Oral Health).

In England there was a steady reduction (17%) in the number of such episodes since 2014/15. There was a more significant fall in 2020/21, however this is most likely a reflection of service changes due to the COVID-19 pandemic than representative of longer-term trend.

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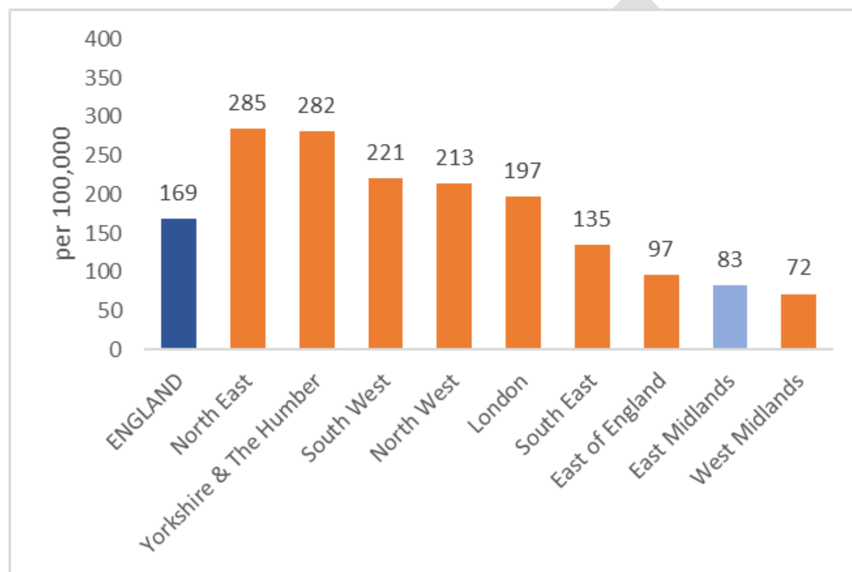
Among all regions in England (Figure 18), the East Midlands had the second lowest rate in 2020/21 – just over 83 FCEs per 100,000 population, compared to nearly 170/100,000 nationally.

For Rutland (as well as for four Leicestershire districts) numbers were generally low (under 8) and were suppressed. Thus, the local rates are low, but may be subject to annual variation.

Figure 18. Rates of hospital episodes including tooth extraction in 2020/21 (0-19 year olds) in the English regions (Source: OHID 2022)

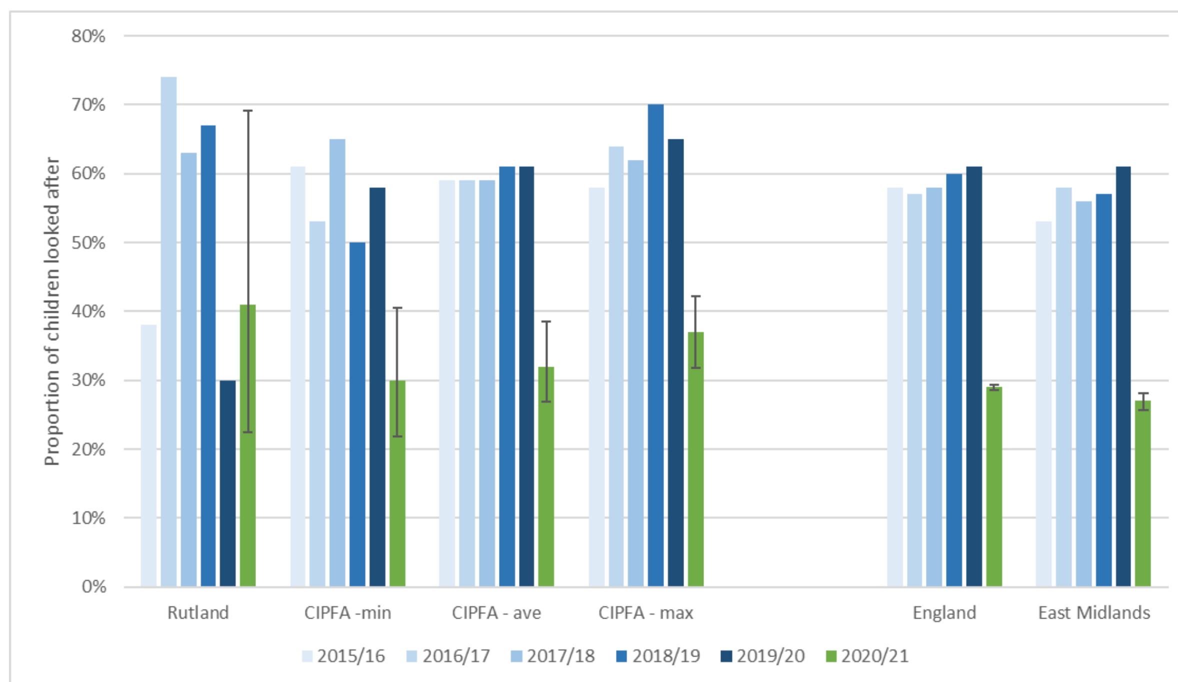


4.4 Looked After Children

The Department for Education (DfE) provides the local authorities with a set of indicators (the *LAIT Tool*), which include the proportion of the proportion of looked after children who had their teeth checked by a dentist in the last 12 months. Across all areas, this proportion halved in 2020/21 when compared to the previous years, which is most likely the effect of service changes due to the COVID-19 pandemic.

In March 2021, there were 34 looked after children in Rutland and 14 (41.2%) had their teeth checked by a dentist the last 12 months (DfE[28]). Although this proportion appears higher than the national and regional average, and higher than all rates in all Rutland CIPFA comparators, it is not statistically significant because of small numbers (Figure 19**).**

Figure 19. Percentage of looked after children who had their teeth checked by a dentist (Source: DfE 2022)



5 Oral Health Needs - Adults

5.1 Oral Cancer

Mouth (oral) cancer is preventable, with tobacco and alcohol use as its main avoidable risk factors (conveying 15 times greater risk). HPV infections also increase the risk. Oral cancer can be diagnosed early at dental check-up, leading to a much better prognosis. Incidence has been rising nationally, although, this cancer is relatively less common (2% of all cancers) in England than in the rest of the world.

Nationally, survival rates for oral cancer are almost 80% for 1-year survival, 65% for 5-year survival and 60% for 10-year survival (based on data for 2009-2012)[29].

Annually in Rutland, there are less than 10 new cases per year and a relatively small number of deaths, so it would be difficult to present robust comparative analysis, unless using figures combined over a number of years. From routine monitoring, presented below, it appears that the population of Rutland doesn't have excessive morbidity or mortality from oral cancer.

In the three years between 2017 and 2019, there were 25 new cases of oral (individuals registered with this diagnosis) in Rutland, which corresponds to an average of 8 new cases

per year. With the low numbers of cases, the rate appears higher than that for England or Leicestershire, however, the difference is not statistically significant (Table 2).

Registration rate for Rutland is also comparable to the five closest 'statistical neighbours' (CIPFA model) and the East Midlands (Figure 20).

Table 2. Rates of oral cancer in Rutland, Leicestershire and England 2017-19 (Source: PHE 2022, Fingertips)

AREA	**Number**	**Rate (95% CI)**
ENGLAND	24,115	15.4 (15.2-15.6)
Rutland	25	19.6 (12.6-29.0)
LEICESTERSHIRE	284	13.4 (11.9-15.1)

Figure 20. Comparative oral cancer registration rates in 2017-19 for Rutland (per 100,000)

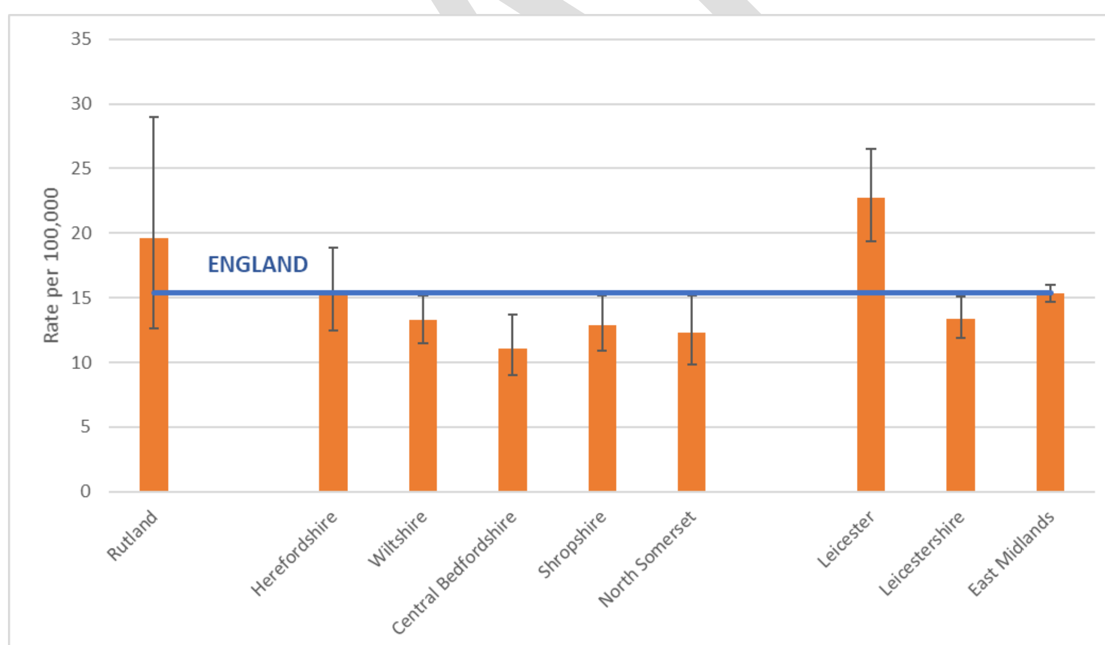
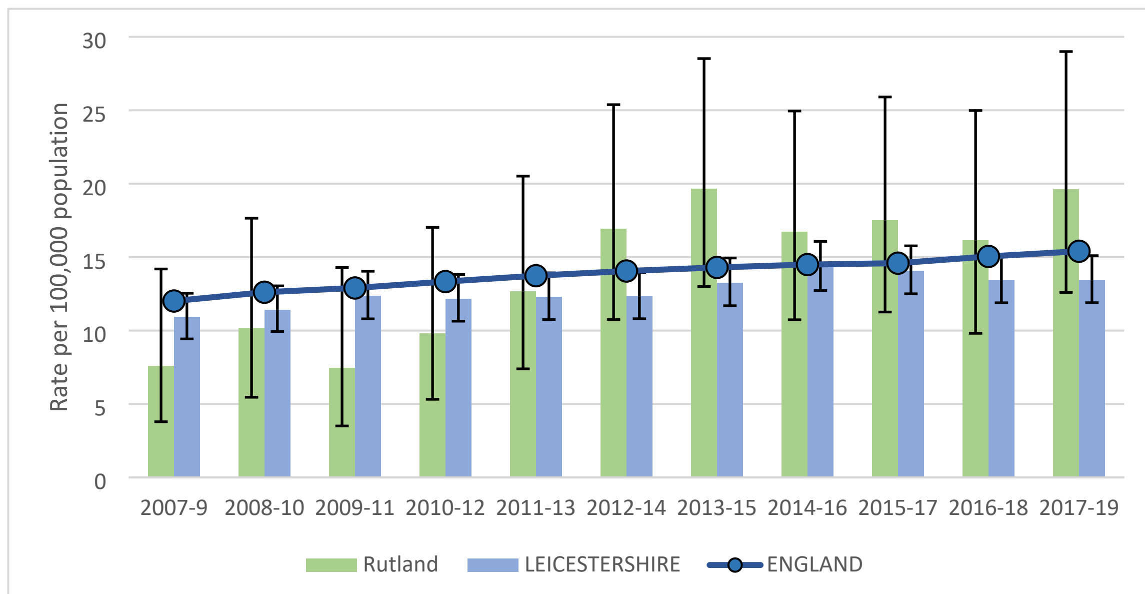


Figure 21 below shows longer time trends in oral cancer registration data for Leicestershire and Rutland, compared to the national average.

Nationally, the rates of oral cancer have increased steadily from 12/100,000 in 2007-9 to over 15/100,000 in 2017-19 (a 28% increase). Because of the small numbers involved, the apparent increase in Rutland is not statistically significant.

Figure 21. Trends in oral cancer registration rates - 2007 to 2019 (3-year averages) (Source: PHE 2022 (Fingertips)



Because of small numbers involved, *mortality* rates for Rutland have not been published[30].

5.2 Adult Oral Health Survey 2018

The data collected in 2018 through the Oral Health Survey of patients attending general dental practices[31] show that the proportion of adults with functional dentition in Rutland is similar to the national and regional average, as well to other comparator areas (Figure 22).

The total number of completed questionnaires with a clinical examination for Rutland was just 54 (survey sample size), so the results have to be treated with caution.

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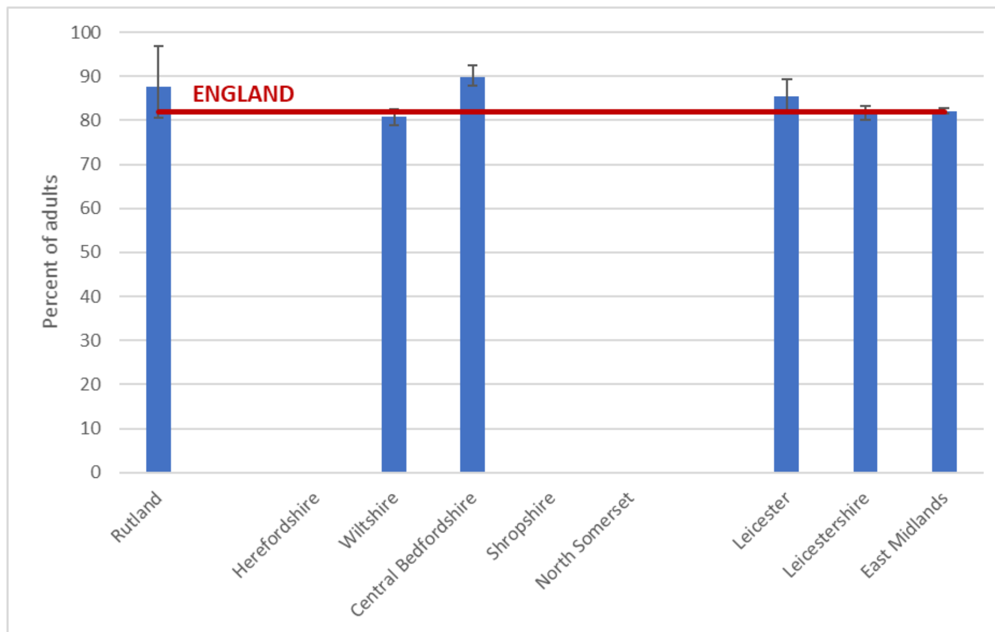
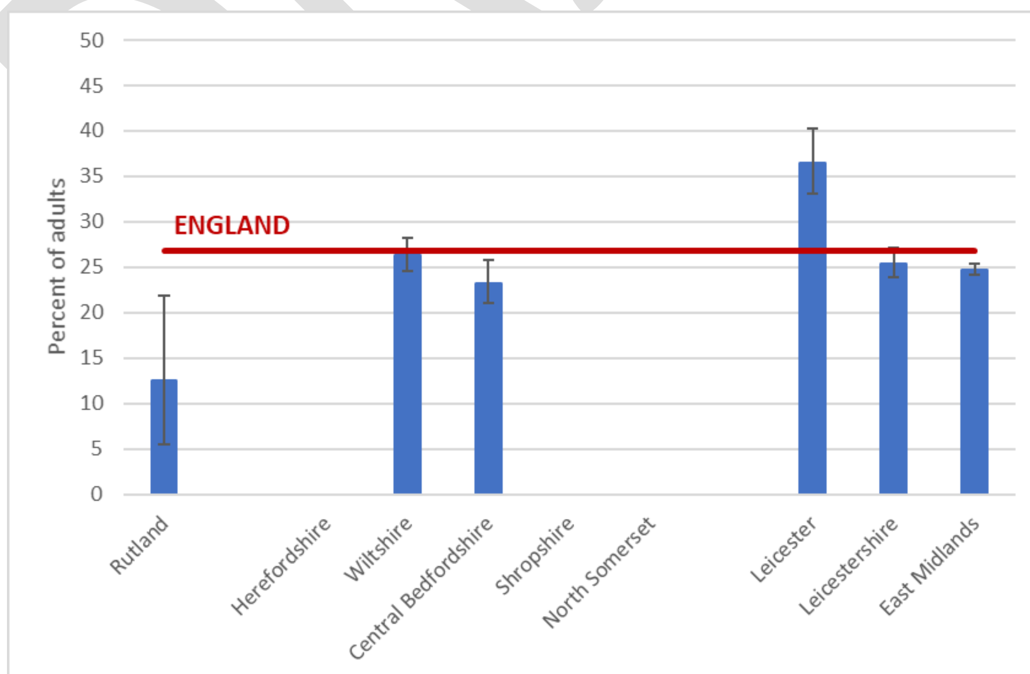
Figure 22. Percentage of adults with functional dentition (21 or more natural teeth) in 2018. No data for some comparator areas (Source: PHE 2020).



The Survey has also shown that 13% of adults in Rutland are likely to have one or more obvious untreated decayed teeth (DT>0), which significantly lower than the national or regional (East Midlands) average, as well as below local (Leicester and Leicestershire) and national (Wiltshire, Central Bedfordshire) comparators (Figure 23).

Figure 23. Proportion of adults with active decay in 2018. No data for some comparator areas (Source: PHE 2020).



6 Current Services

6.1 Outline of NHS Dental Services

This section presents a brief outline of the dental services commissioned by the NHS. Under the current arrangement (2006) NHS England (NHSE) is responsible for commissioning all NHS dental services, including:

- primary dental care service ('hight street' surgeries)
- community dental services
- specialist dental services (Intermediate Minor Oral Surgery – IMOS)
- services provided by NHS Hospital Trusts
- dental services in secure settings

6.1.1 Primary Care Dental Services

The main point of contact for residents that choose NHS dental care. Services are provided by independent providers (individuals, partnerships or corporate providers, usually high street dental practices) and commissioned in accordance with national regulations. The commissioning responsibility for the NHS dental service lies with the NHS England and NHS Improvement (Midlands) and there are no limitations based on patient residence. Generally, patients are not registered with a practice, but regular attendance may be informally regarded as such.

Primary dental care includes routine assessments and urgent appointments, preventative care (advice and, where appropriate, the application of fluoride varnish or fissure sealants), treatments including fillings, extractions and root canal treatment, treatment of wider oral health matters such as gum disease, referral for specialist consultation where appropriate and restorative treatment such as crowns, bridges, partial or complete dentures.

For purpose of renumeration, treatment is assigned to one of three treatment bands or as urgent care. Treatment bands include the following:

- band 1 covers an examination, diagnosis, advice, scale and polish if needed and preventative treatment such as application of fluoride varnish or fissure sealant;
- band 2 covers, in addition to the above, any further treatment such as fillings, root canal work or removal of teeth;
- band 3 covers everything listed in two bands above, plus restorative treatment, such as crowns, dentures or bridges;
- the fourth category covers all urgent and emergency dental care.

Fee-paying patients (adults) contribute a fixed amount according to the charge band, treatment for children (all 0-17 years of age) is free, as is for adults who are exempt for a specific reason. Orthodontic treatment may be provided under the NHS where it is clinically necessary.

Dental services activity is monitored by the NHS Business Services Authority (NHS BSA) and reported as courses of treatment for patients resident in a given area, wherever this activity took place. Value given to courses of treatment is defined as Units of Dental Activity (UDAs). These give weight to the complexity of a course of treatment, for example, while there is one UDA for examination only, there could be 12 UDAs for a course of treatment including laboratory work[32].

6.1.2 Community Dental Services (CDS)

This is a dental care referral service for children and adults, enabling the improvement of oral health for individuals and groups at risk (particularly any impairment or disability). Care provided to patients who have a need beyond the skill set and facilities of a general dental practitioner.

Community Dental Services include dental treatment under general anaesthetic (GA pathway)[vii] in secondary care sites (e.g. children who require multiple tooth extractions), children with complex health needs and who require restorative treatment, and for adults with special needs that may impact upon their ability to co-operate. Community Dental Services also provide additional services, for example oral health promotion, epidemiology for Local Authorities, and outreach projects for vulnerable groups.

6.1.3 Intermediate Minor Oral Surgery (IMOS)

Oral Surgery care that deals with the diagnosis and management of pathology of mouth and jaws that requires surgical intervention. Requires enhanced clinical skills and experience; can be provided in primary or secondary care setting. Commissioned under a PDA agreement. Monitored by the NHS BSA.

6.1.4 Secondary Care Dental Services

The majority are specialist services at Level 3, provided in the secondary or tertiary care setting. Commissioned under the NHS Standard Contract, subject to national and local service specifications.

[vii] GA pathway is commissioned under a shared care arrangement.

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6.1.5 Commissioning of NHS Dental Services

Dental practices are commissioned on the basis of UDAs, which are annually allocated to each practice and cannot be changed without an agreement by both parties. It has been recognised that changes in commissioned UDAs have not always followed trends in demand or need for services. From the 1st of April 2023, the commissioning responsibility will transfer to the Integrated Care Board (ICB).

As indicated in the previous section, there is no system patient registration, patients can choose any practice convenient for them. While a practice is responsible for patients undergoing treatment, once a treatment is completed the practice has no ongoing responsibility for a patient. However, many surgeries have patient lists and may be taking on new NHS patients, if there is capacity.

During the COVID-19 pandemic, practices were prioritising urgent care, vulnerable patients (including children) and high-risk patients.

The recent Midlands regional commissioning strategy[33] highlighted a number of current issues including falling levels of dental access in primary care (particularly for vulnerable groups), staff shortages (lower recruitment and poor retention), increasing pressure on service by private patients re-patriating to the NHS, low orthodontic capacity and poor throughput of patients. Community Services are also suffering from problems with access, workforce issues and list backlogs. Long waiting lists and significant capacity issues are also quoted for IMOS and secondary dental care.

6.2 Access to NHS Dental Service in Rutland

This section looks at access to primary care dental service in Rutland exploring the following measures:

- numbers and location of dental practices, including proportion of practices accepting new NHS patients;
- access to these practices - by walking, public transport or car drive time;
- proportions of residents accessing services in previous 24 (adults) or 12 (children) months;
- numbers of dentists per population;
- GP Patient Survey

6.2.1 Dental Practices in Rutland and Surrounding Areas

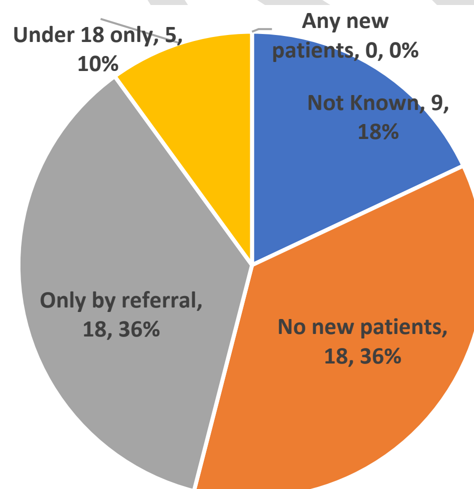
There are six NHS dental practices within Rutland, including four in Oakham and two in Uppingham. One of the NHS dental practices in Uppingham also provides NHS orthodontic services, there is one specialist NHS Orthodontic practice in Oakham and one NHS

Orthodontic Pathway contract in Oakham. Extended hours and out of hours care is provided by 8-8 practice in Oakham (8am to 8pm every day of the year).
Only urgent dental care is provided out of hours. This is triaged into:

- routine dental problems (with a timeline for access to appropriate service of 7 days);
- urgent dental conditions (patient to be treated within 24 hours);
- dental emergencies (requiring a contact with a clinician within 60 minutes) - patients can attend any NHS dental service at any locality.

As of the end of July 2022, of the 50 closest (Rutland and cross-border) practices recommended for Rutland residents by the NHS 'Find a dentist' online service none of practices were accepting new adult NHS patients, 18 (36%) accepted referrals only and 5 (10%) accepted children. The remaining 18 (36%) were not currently accepting any new NHS patients (Figure 24). Checks were made with practices who had not recently given an update, although not all details were available. Many of these 50 practices are outside of Rutland (up to 16 miles from Oakham), including some Leicester practices, Stamford or Corby.

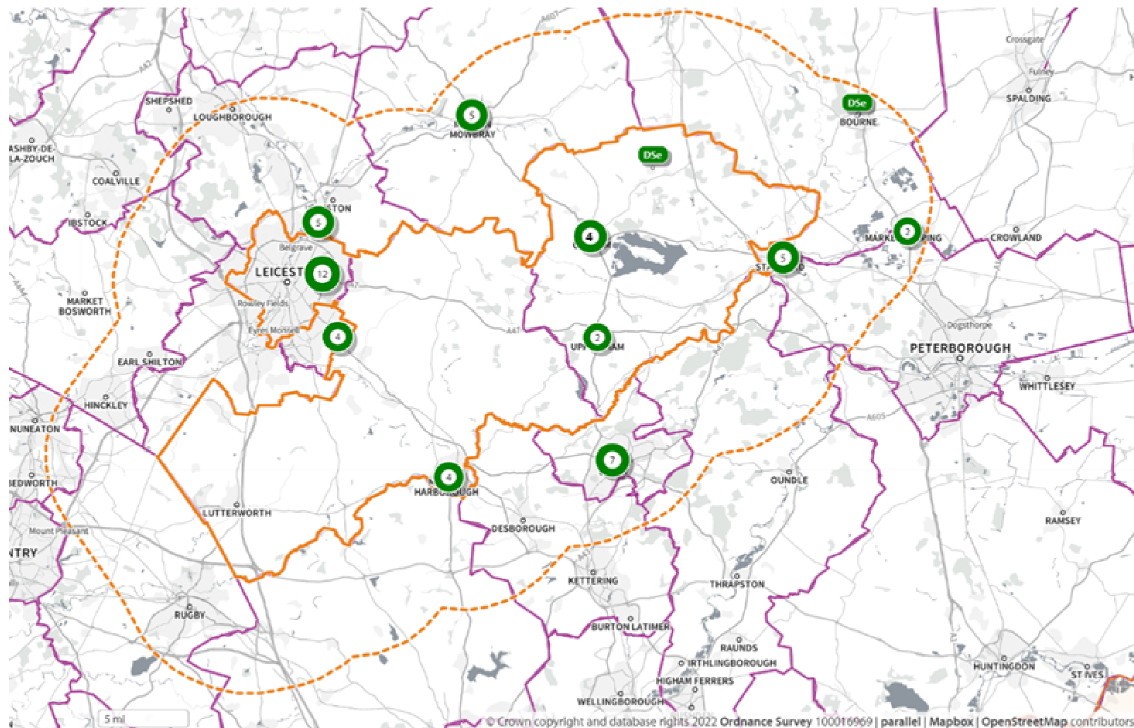
Figure 24. Practices within 16 miles accepting new patients (Source: NHS)



There is likely to be a cross-boundary flow of patients. In addition to the six practices within Rutland there are 19 NHS dental practices near the Rutland borders, including four in Melton Mowbray (1 orthodontic), six in Market Harborough (1 pathway contract), three in Stamford and six in Corby (1 mixed). Orthodontic services near the Rutland borders include one specialist NHS Orthodontic practice in Melton Mowbray, one in Market Harborough (NHS Orthodontic Pathway contract), and one of the practices in Corby also providing NHS orthodontic services.

Figure 25 presents geographical locations of dental practices.

Figure 25. Map of practices in and around Rutland, identified by the NHS search in July 2022.



6.2.2 Access: Walk, Public Transport and Drive Time

Nearly a half of Rutland’s population (19,662) have more than 15-minute walk to a nearest dental practice. Of those, the majority (63%) reside in the areas classified as ‘rural village and dispersed’ and the rest (37%) in 'rural town and fringe' (Table 3, Figure 26).

Table 3. Walking time to dental practice by rurality and deprivation (SHAPE 2022)

Walking time > 15 min	**Number**	**%**
Rural village and dispersed	12,368	62.9%
Rural town and fringe	7,294	37.1%
Urban city and town	0	0.0%
Quintile 3 (most deprived)	4,833	24.6%
Quintile 4	6,956	35.4%
Quintile 5 (least deprived)	7,873	40.0%
Rutland >15 min	**19,662**	**48.6%**
Rutland <= 15 min	**20,814**	**51.4%**

Just under a third of Rutland's population (12,797) have more than 30 min travel by public transport to a nearest dentist, with most of those excluded from rural village or rural town and fringe areas (54% and 46%, respectively) and no discernible pattern of deprivation (Table 4, Figure 27).

Table 4. Public transport time by rurality and deprivation (SHAPE 2022)

Public Transport > 30 min	**Number**	**%**
Rural village and dispersed	6,950	54.3%
Rural town and fringe	5,847	45.7%
Urban city and town	0	0.0%
Quintile 3 (most deprived)	3,754	29.3%
Quintile 4	5,593	43.7%
Quintile 5 (least deprived)	3,450	27.0%
Rutland > 30 min	**12,797**	**31.6%**
Rutland <= 30 min	**27,679**	**68.4%**

No residents of Rutland are outside of the 30-minute drive from a dental practice (Figure 28).

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Figure 26. Walking times (up to 15 min) to dental practice in Rutland (Source: SHAPE 2022)

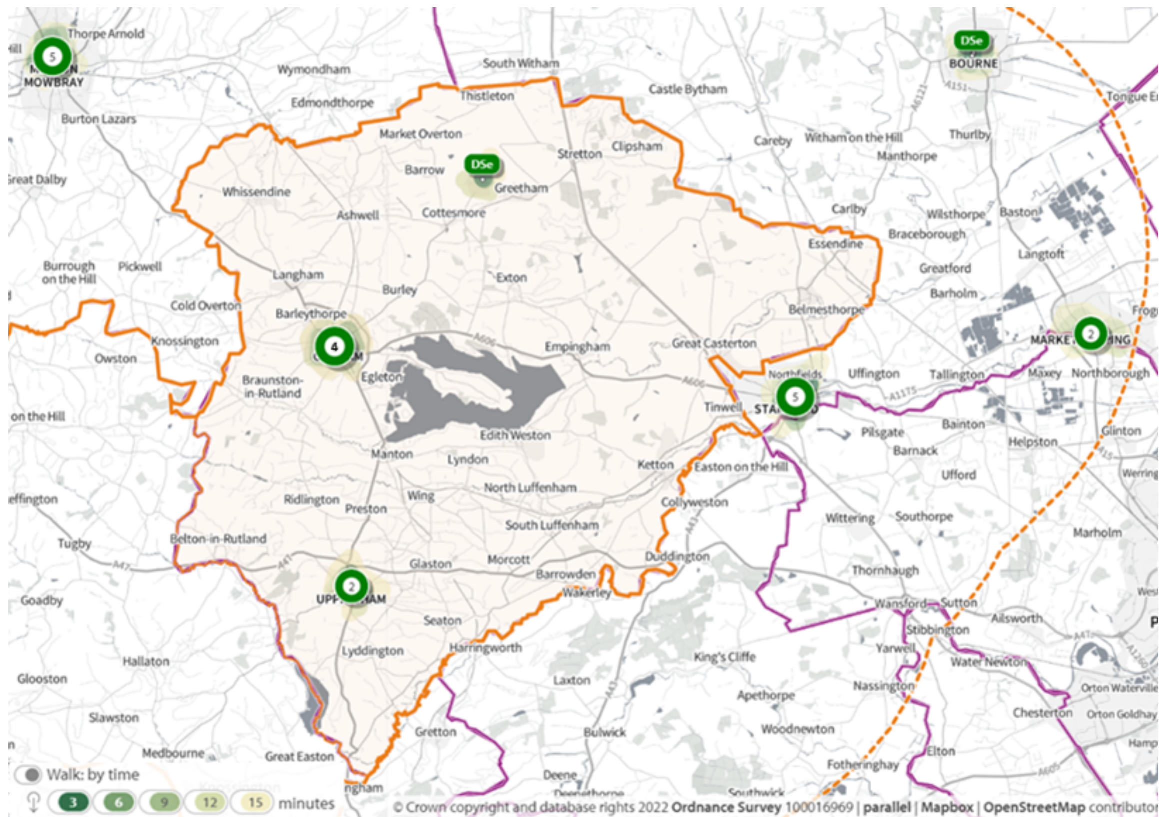


Figure 27. Public transport access times (up to 30 min, on weekday) in Rutland (Source: SHAPE 2022)

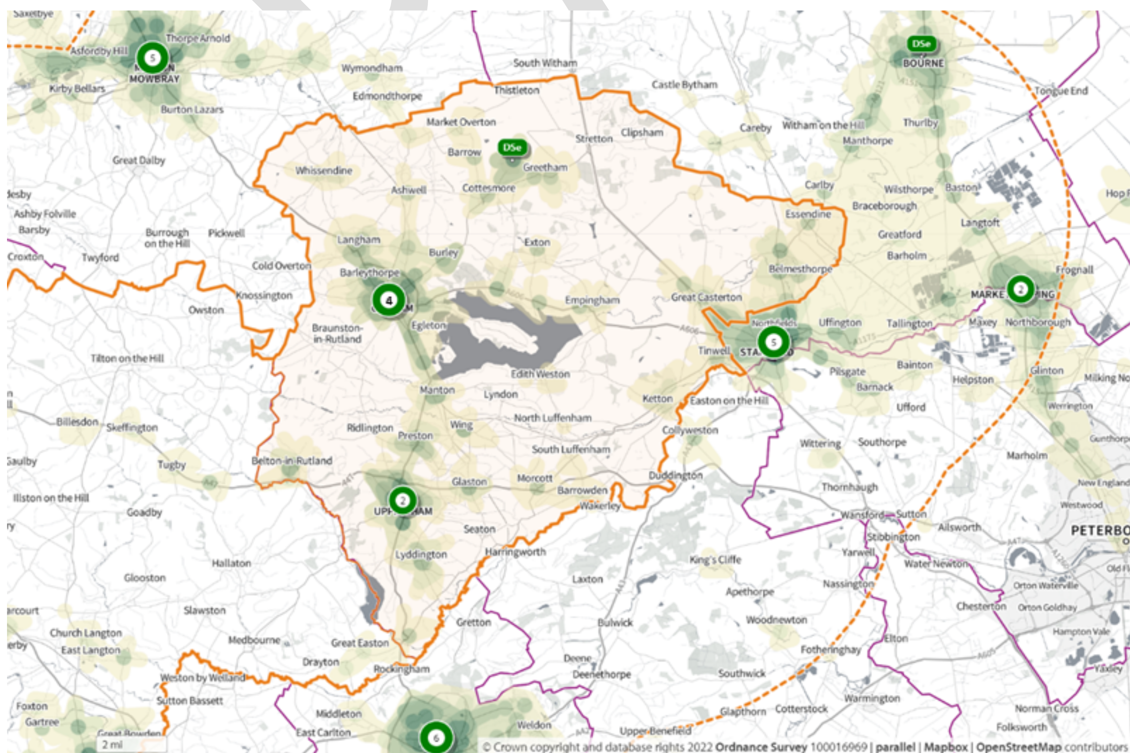
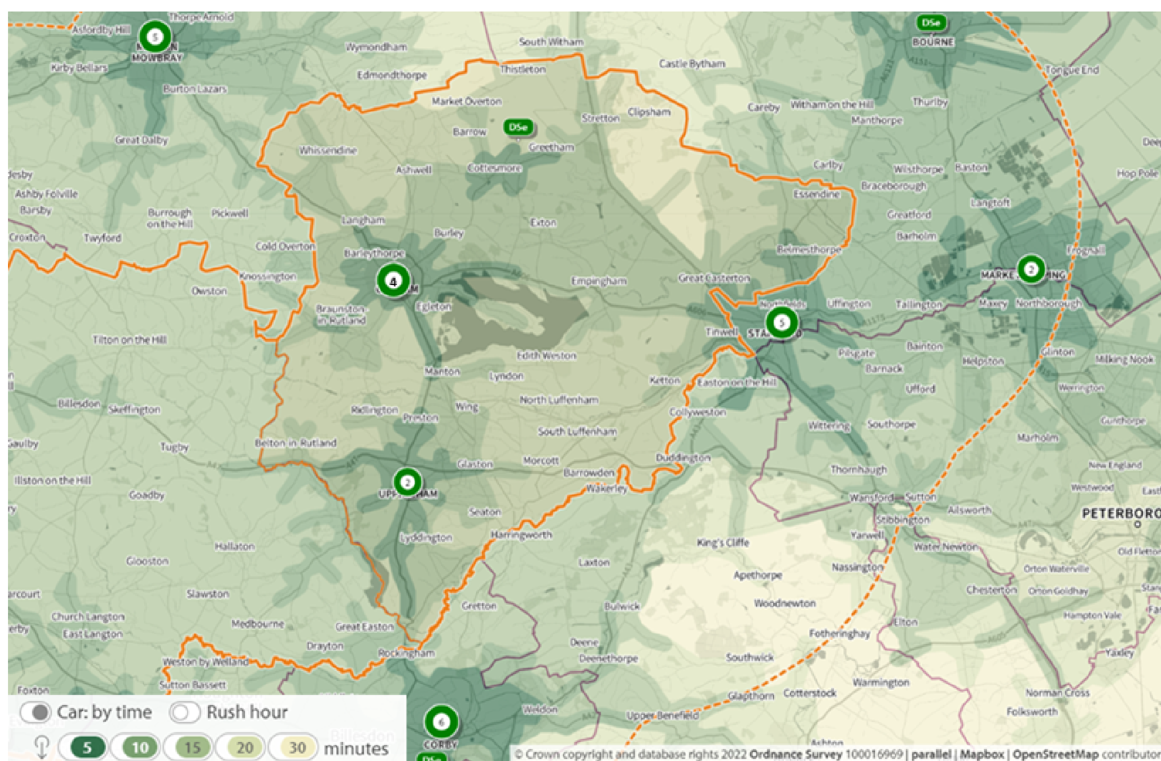


Figure 28. Drive times to a nearest dental surgery (up to 30 min) in Rutland (Source: SHAPE 2022)



6.2.3 Patients Seen by a Dentist in 24 or 12 months

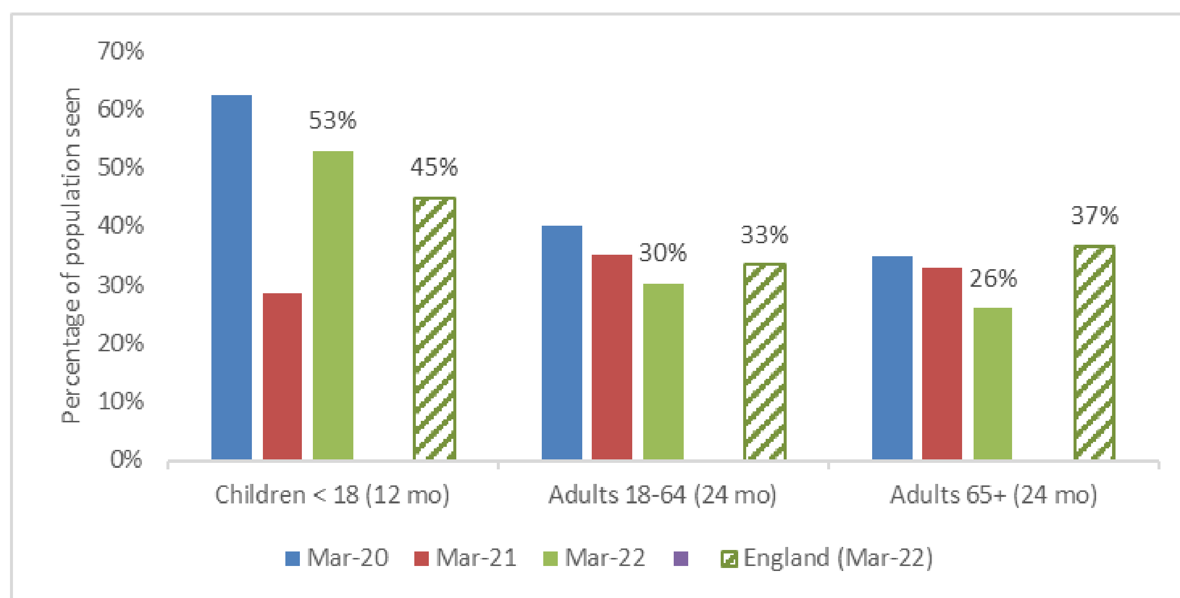
This indicator shows what proportion (%) of the estimated resident population has been seen by a dentist in the previous 24 months (for adults) or 12 months (for children). This is measured in the last day (31st of March) of each financial year.

It is important to stress that, as a result of COVID-19 restrictions (from the 25 March 2020 all routine, non-urgent dental care, including orthodontics, was cancelled or deferred), any measures of access to NHS dental service in the last three years are inevitably distorted. Further details of the effect of COVID-19 pandemic are presented in *The Impact of the COVID-19* Pandemic chapter below (page 44).

Figure 29 shows the rates of access in the last three years for main population age groups, compared to the average for England. There was a significant drop in coverage for children in Leicestershire and Rutland in 2020/21 (from well over 60% to below 30%), with subsequent partial recovery in 2021/22. Rates for both adult groups were lower and, against the national trend, without recovery in the last year. The lowest coverage is for residents 65 or above –

only over a quarter (26%) in Rutland accessed NHS dentistry, much lower than the national average of 37%, with working-age adults' rate also below the England's figure. However, access rate was higher than the national average for children (53% vs 45%).

Figure 29. Rates of access to NHS dental services for Rutland residents in the last three years, with England average for comparison (Source: NHS BSA 2022).



Access varied across areas in Rutland (Table 5), nearly two-fold for children (Figure 30), although comparatively Leicestershire showed more significant gaps, over 4-fold for adults of working age, for example.

The highest access rates for adults are in the east of Rutland (Figure 31 and Figure 32).

There was no correlation between rates of access and deprivation in Rutland at a small (LSOA) geographical level – graphs are presented din the Appendix (see Appendix Figure 1 and Appendix Figure 2).

Table 5. Range of variation in access, by MSOA, for broad age groups (NHS BSA 2022)

AREA	Children 0-17	Adults 18-64	Adults 65+
Rutland	37% - 75%	23% - 39%	21% - 33%
Leicestershire	33% - 62%	13% - 50%	24% - 48%

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Figure 30. Access to NHS dental service for children (0-17) in Rutland

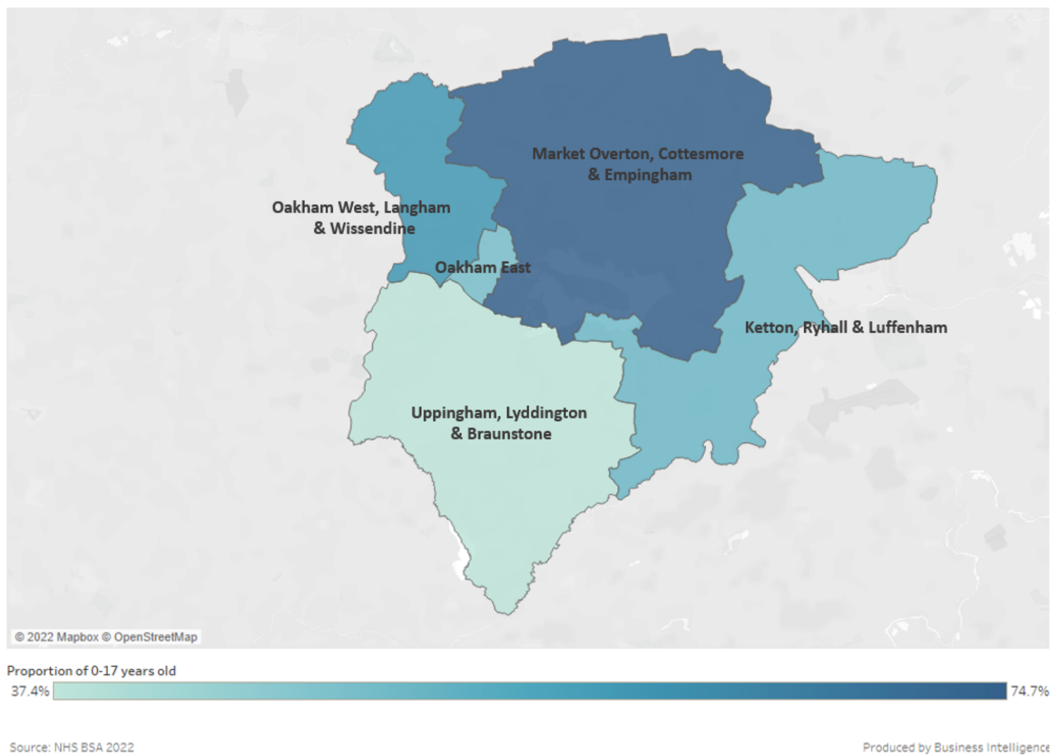


Figure 31. Access to NHS dental service for adults 18-64 in Rutland

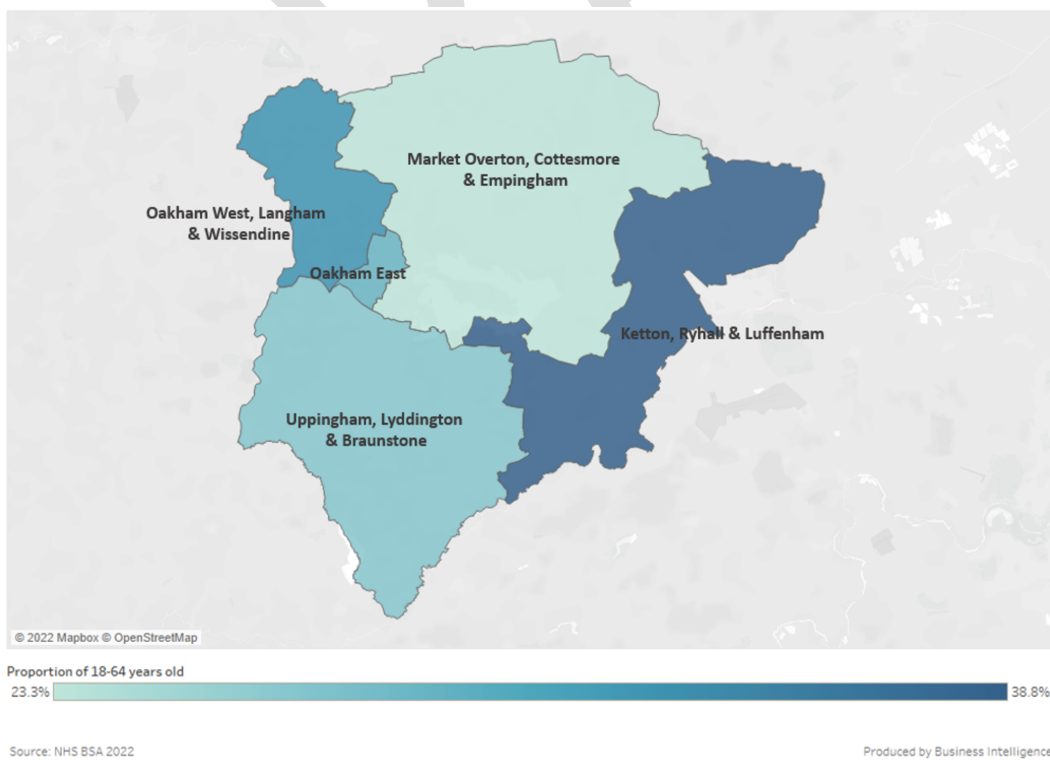
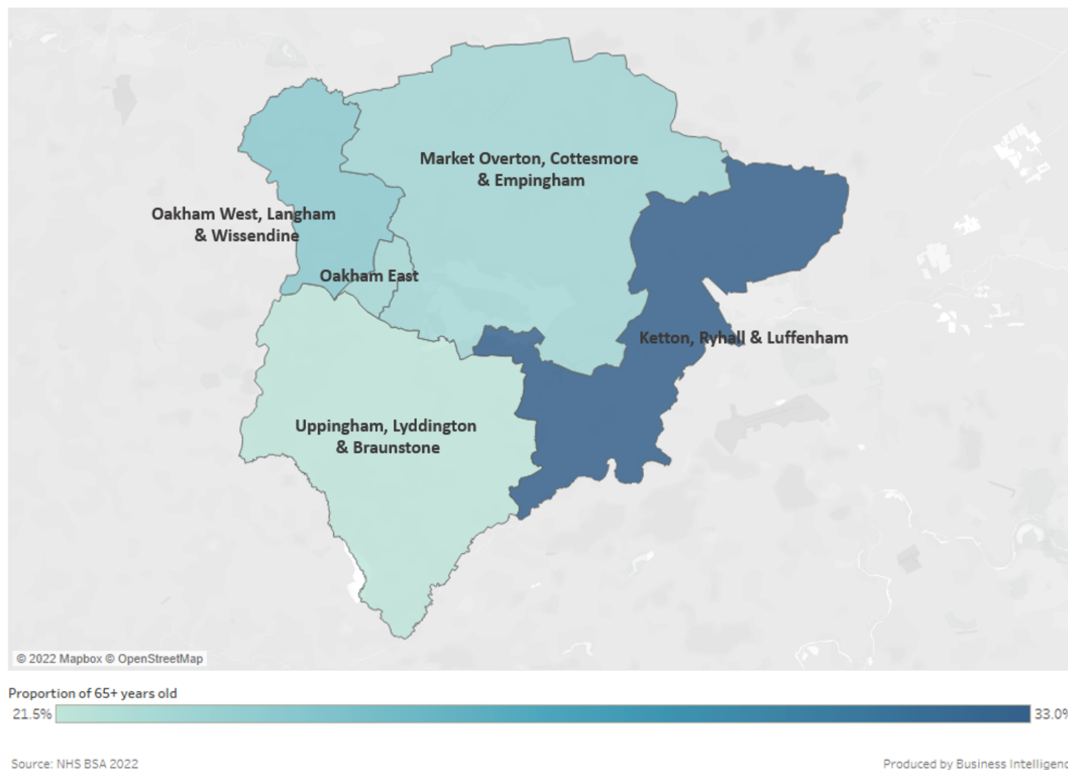


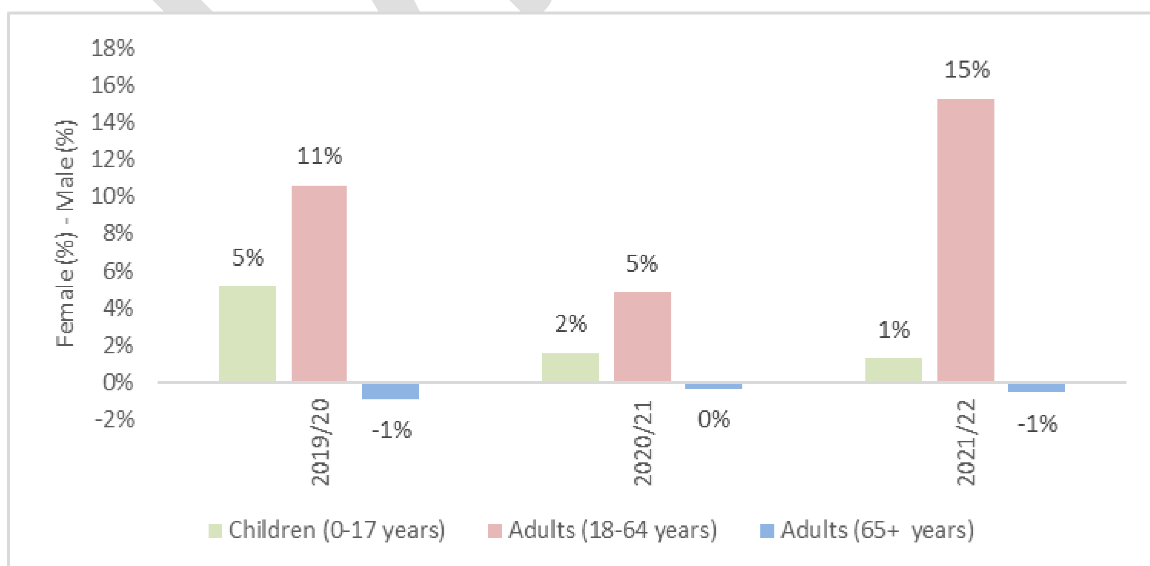
Figure 32. Access to NHS dental service for adults 65+ in Rutland



6.2.4 Equity of access – Sex and Ethnicity

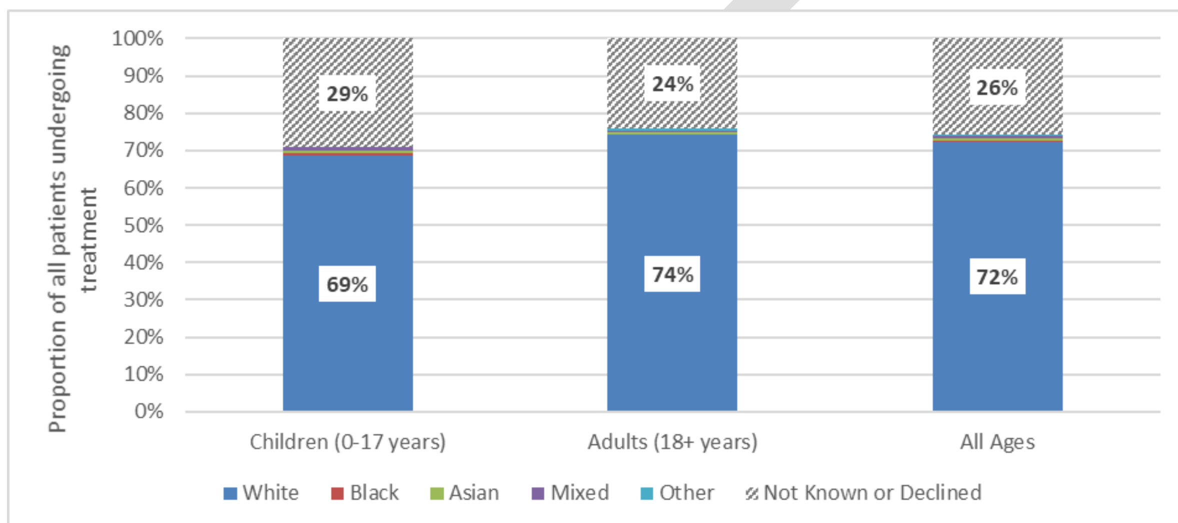
Using counts of unique patients accessing services between April 2019 and March 2022, proportionately more women of working age were accessing the dental service, compared to men in this age group (up to 15% more in 2021/22 - Figure 33), with a small excess in the under-18 group (1-5%) and very similar rates in the over-65s.

Figure 33. Sex differentials NHS dental activity in Rutland (Source: NHS BSA 2022)



The ethnicity of patients undergoing dental treatment is generally poorly recorded, with 26% overall (29% for children) not known or marked as declined (Figure 34). Only 2% of patients treated in Rutland are recorded as group other than white. In Census 2021, nearly 5% of Rutland population declared themselves in groups other than white, however with such high number of unclassified records it is difficult to judge whether ethnic minority patients truly have lower access to dental care.

Figure 34. Recorded ethnicity for patients undergoing NHS dental treatment (Source: NHS BSA 2022)



6.2.5 Number of Dentists per Population

This indicator is a high-level proxy of access to NHS dental service. At the time of writing, it is available at the CCG level, up to 2020/21.

Both Leicestershire Clinical Commissioning Group (CCG) populations had higher than national average access to NHS dentists in the last two years, although there were significant reductions in the number of such dentists between 2019/20 and 2020/21.

This is particularly noticeable for the NHS West Leicestershire CCG with nearly 16% reduction in the rate of access and 39 dentists less in the last covered year.

East Leicestershire and Rutland CCG experienced less of change (2% - half the national figure - with only 4 dentists less in the last year). The crude rate of access to NHS dentists still remains higher for both local CCGs (51-54/100,000) than the national or regional average of 42.2/100,000 (Table 6).

Table 6. Access to dentist with NHS activity in two most recent years - comparative rates (Source: HSCIC 2022)

AREA	2019/20			2020/21			Difference	
	Total dentists	**Population per dentist**	**Dentists per 100,000 population**	**Total dentists**	**Population per dentist**	**Dentists per 100,000 population**	**Dentists (number)**	**Change (%)**
England	24,684	2,280	43.9	23,733	2,372	42.2	-951	-3.9
Midlands	4,549	2,331	42.9	4,341	2,442	40.9	-208	-4.6
NHS East Leicestershire & Rutland CCG	188	1,801	55.5	184	1,840	54.3	-4	-2.1
NHS West Leicestershire CCG	245	1,663	60.1	206	1,978	50.6	-39	-15.9

6.2.6 Access to a Dental Appointment - GP Patient Survey

Figure 35 shows the comparator figures for access to NHS dental appointments in 2020/21 reported through the GP Patient Survey. The 77.7% rate in Rutland is statistically similar to the national average as well as to most of its 'statistical neighbours'[34]. The data also indicate that, similarly to North Somerset, Bedford and Central Bedfordshire there was no fall in access, compared to previous year. Of note is the relatively small response sample for Rutland (N=187).

Figure 35. Successfully obtained an NHS dental appointment in 2020/21 (Source: PHE Fingertips 2022)

Area	Recent Trend	Neighbour Rank	Count	Value
England	↓	-	322,641	77.0
Neighbours average	–	-	-	-
North Somerset	→	5	1,436	85.4
Central Bedfordshire	→	3	1,848	81.8
Bedford	→	15	1,084	80.2
Solihull	↓	12	1,381	79.4
Cheshire West and Chester	↓	13	2,276	78.3
West Berkshire	↓	8	781	77.7
Rutland	→	-	187	77.7
Shropshire	↓	4	1,757	77.6
Cheshire East	↓	6	2,359	77.5
Bath and North East Somerset	↓	7	1,046	74.4
Wiltshire	↓	2	2,686	74.4
South Gloucestershire	↓	11	1,886	74.1
East Riding of Yorkshire	↓	9	2,006	72.9
Herefordshire	↓	1	943	71.3
Isle of Wight	↓	14	756	70.3
Cornwall	↓	10	2,789	65.0

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6.3 Dental Activity

This section presents data on NHS dental activity in the last three years, the impact of COVID-19 pandemic, activity by patient type, treatment bands, preventive clinical treatments and hospital extraction rates for children.

6.3.1 The Impact of the COVID-19 Pandemic on Access to NHS Dental Services

In response to the COVID-19 pandemic, from the 25 March 2020 all routine, non-urgent dental care including orthodontics was cancelled or deferred, with no data available for January to June 2020.

This section presents comparative trends in dental activity for the period between January 2019 and June 2022.

Figure 36 shows the time trends in the all-age rates of access to dental NHS services (numbers of people accessing per population), comparing pre-pandemic year (2019) and the most recent period. The pre-pandemic all-age rates in Rutland were 29% and lower (by circa 5%) than regional, LLR, Leicestershire or its statistical neighbour average, while being comparable to England and Leicester rates. By the latter half of 2020, the rates fell down to about 7% with some recovery since then (22% in 2022). However, in the first half of 2022, Rutland rates were still below the pre-pandemic coverage and remaining below the comparator areas.

Rutland rates seem to be comparatively higher for children and younger age groups (under 18s, Figure 37). Pre-pandemic rate for children in Rutland was 49%, above the national average and other comparators, except for Leicestershire. Rate for children has been rising since 2020, from the low of 13% to 42% in 2022, which is still below the pre-pandemic level. These trends seem to be in line with Leicestershire and Leicester rates, and above the national, regional or statistical neighbour averages.

The rates for adults (Figure 38) seems significantly lower, 24% in 2019, below the national and other comparators, except for Leicester. Rate for adults has been rising since 2020, from 6% to 18% in 2022, still below the pre-pandemic level. These trends seem to be in line with the comparators, however Rutland rates are generally lower, and recovery seems slower than elsewhere.

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Figure 36. The percentage of Rutland population (all ages) accessing NHS primary care dental services from 2019 to 2022, compared to national average and other areas (Source: NHS BSA July 2022).

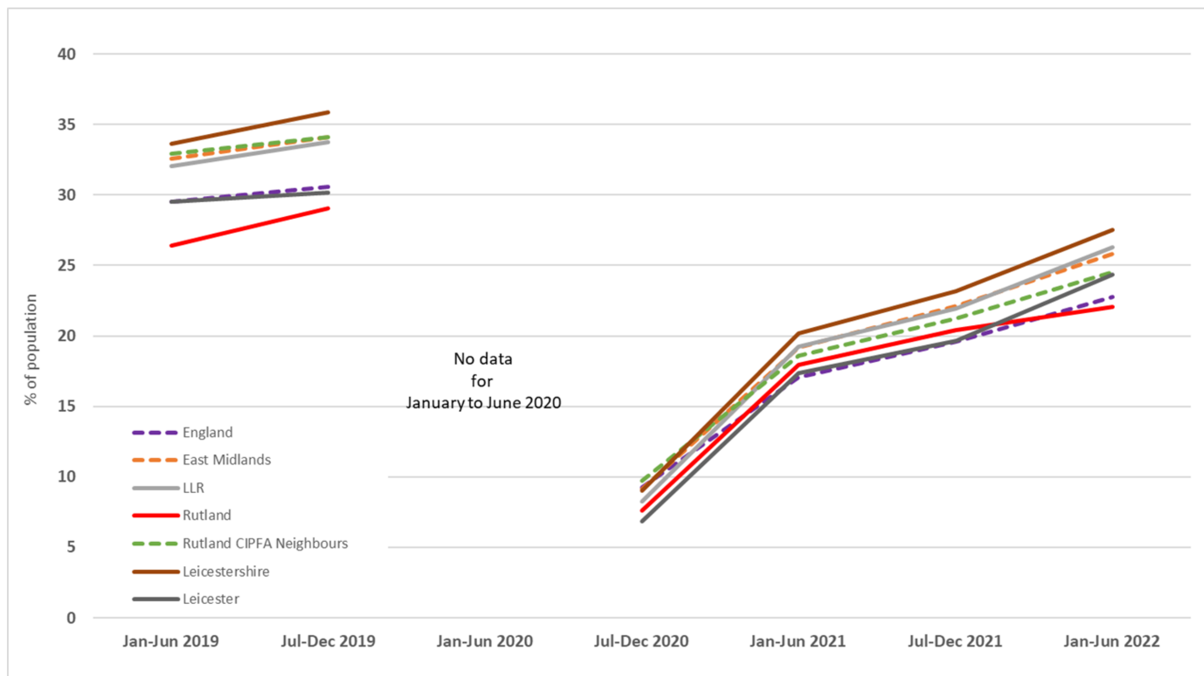


Figure 37. The percentage of 0-17 population of Rutland accessing NHS primary care dental services from 2019 to 2022, compared to national average and other areas (Source: NHS BSA July 2022).

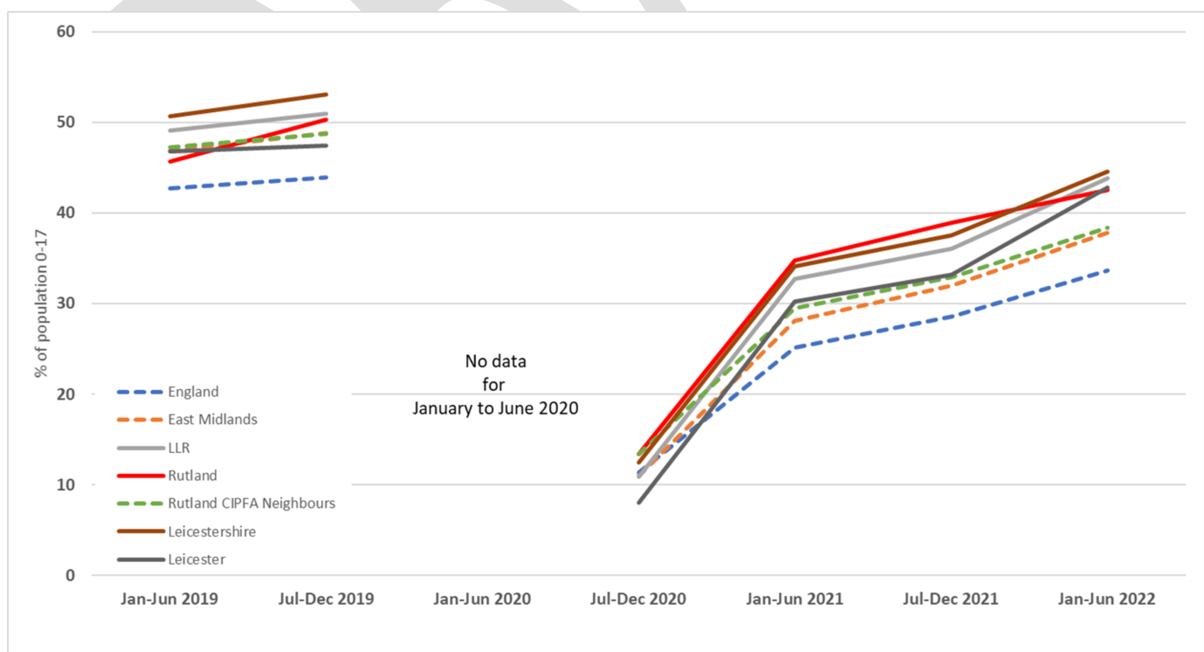
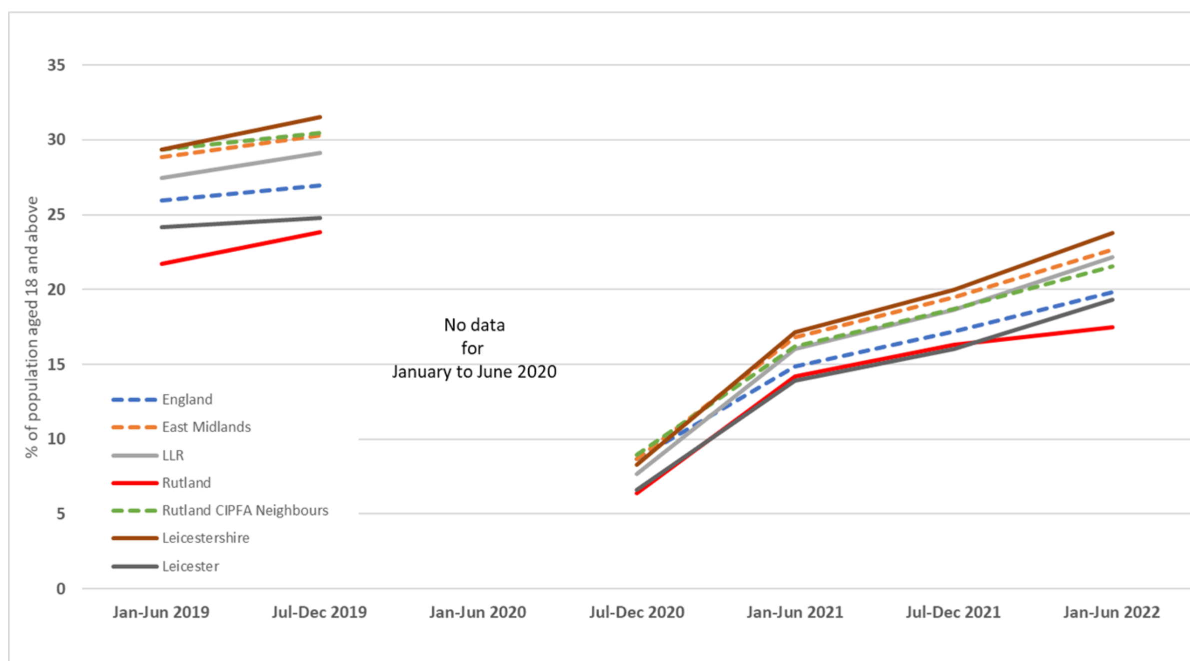


Figure 38. The percentage of adult population of Rutland accessing NHS primary care dental services from 2019 to 2022, compared to national average and other areas (Source: NHS BSA July 2022).



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6.3.1.1 Estimated gap in access to pre-pandemic period

It can be estimated that, to achieve the same rates of access in Rutland as were experienced pre-pandemic (July – December 2019), an additional 600 children and 2,100 adults would have to be treated. This calculation adjusts for changing population estimates.

6.3.2 Patient Type

Patients undergoing treatment are classified according to age and exemption status:

- paying adults - pay a charge to the full cost of the treatment
- non-paying adults - exempt or remitted from paying a charge to the full cost of the treatment
- children – free NHS treatment for all 0–17-year-olds

Common reasons for exemption for adults are:

- in full-time education
- pregnant or mother of a baby in the year before treatment starts
- NHS inpatient (treatment by a hospital dentist) or outpatient

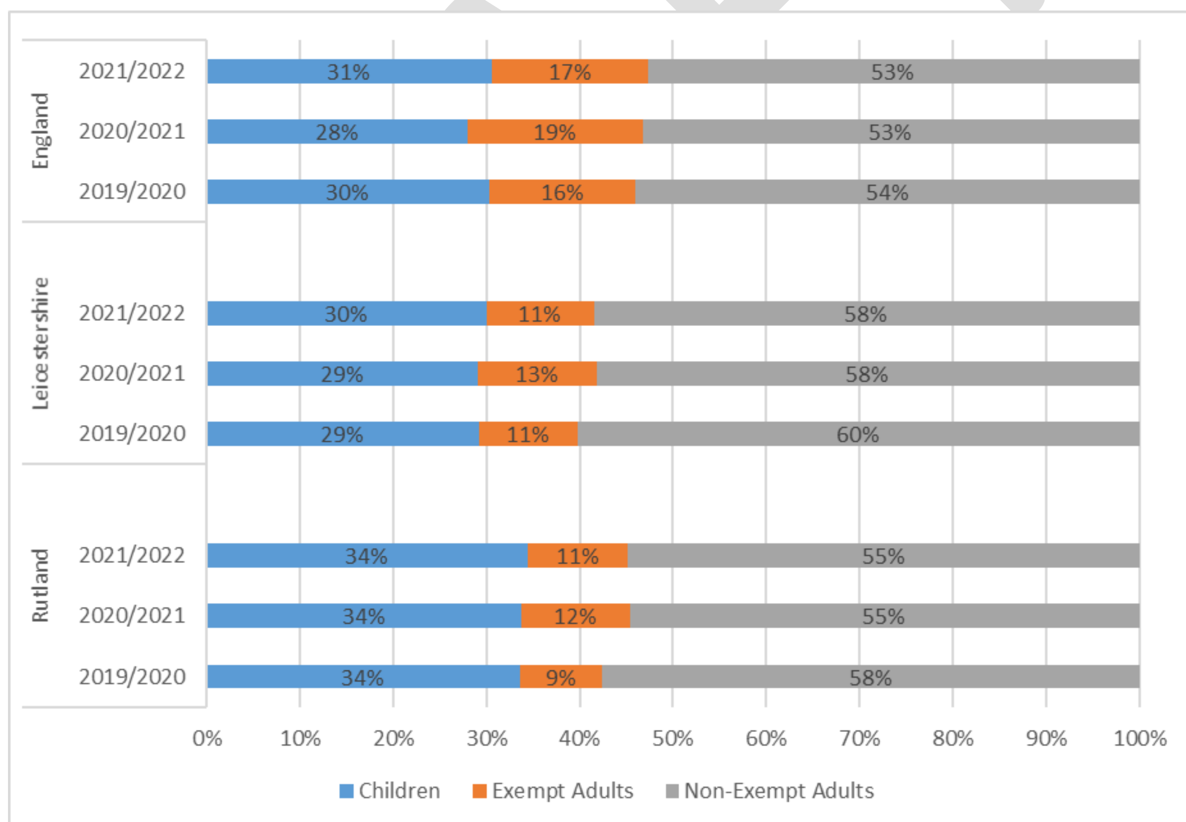
- on income support, pension credit or other financial support schemes

Compared to the national average, there were proportionately more courses of treatment for children in Rutland (e.g., 34% vs 31% for England in 2021/22), and less for non-paying (exempt) adults (11% vs 17% for England), with these differentials less pronounced for Leicestershire as comparison (Figure 39).

These findings are undoubtedly affected by the COVID-19 pandemic, with the numbers of treatments significantly lower in 2020/21 across all categories of patients, and a small proportional increase in treatment of children in that year (details in Appendix Table 3).

For the commissioning area (LLR East – 03W), in the last quarter of 2021/22 (March 2022), the proportions were 30.8% children, 10% exempt adults and 59.2% fee-paying adults, comparable to Leicestershire.

Figure 39. NHS dental treatment for Rutland residents by patient type in the last 3 financial years (Source: NHS BSA)

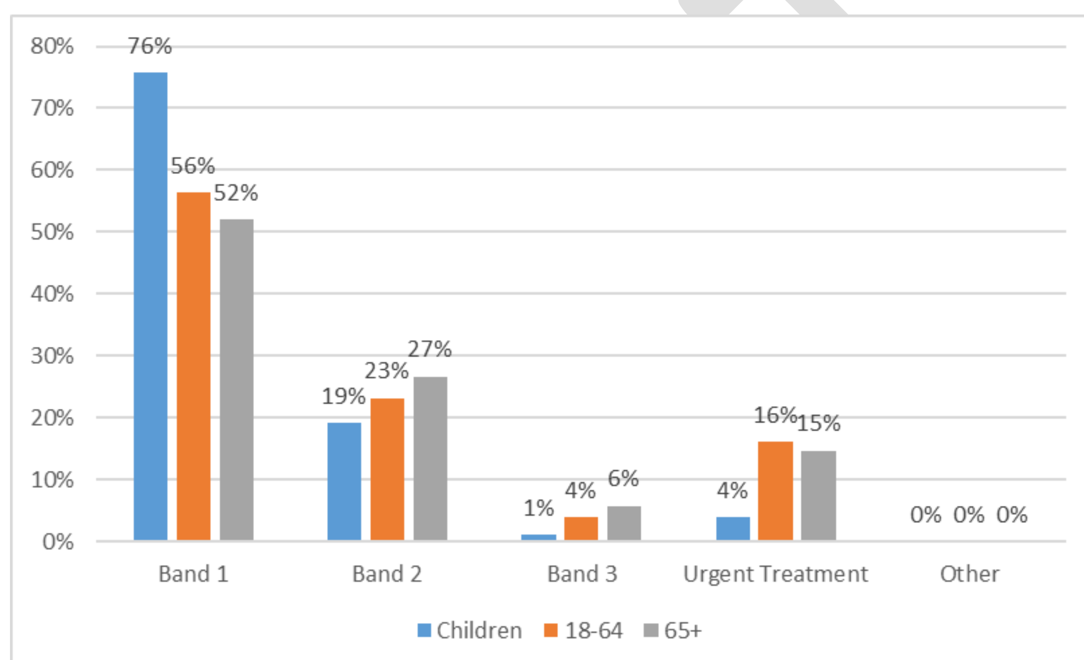


6.3.3 Treatment Bands

Over three quarters (76%) of treatments for Rutland's children are band 1 (e.g., examination, advice or preventative treatment, such as fluoride varnish or fissure sealant), while 19% were band 2 treatments, and only 4% activity was urgent (Figure 40).

For comparison, the national (England) proportions for children in 2021/22 were 70% in band 1, 22% in band 2 and 6% urgent, thus Rutland has relatively more band 1 activity and less band 2 or urgent treatments.

Figure 40. Courses of treatment for Rutland residents in 2021/22 by treatment band (% claims in age group) (Source: NHS BSA).



6.3.4 Urgent Treatment

In the last three years, children had 5% of urgent treatment, working age adults 16% and older adults 14% (Table 7). There was little variation between the MSOAs, and no obvious relationship with deprivation in MSOAs, although the deprivation gradient in Rutland, as defined by the IMD 2019, is generally not wide enough to show such differences reliably.

Table 7. Rates of urgent dental treatment in main age groups in Rutland in the three years from 2019/20 to 2021/22 (Source: NHS BSA 2022)

MSOA	IMD score	0-17 No	0-17 %	18-64 No	18-64 %	65+ No	65+ %
Market Overton, Cottesmore & Empingham	10	140	4%	708	19%	257	14%
Oakham West, Langham & Whissendine	8.9	174	4%	766	15%	209	11%
Oakham East	5.7	171	5%	633	15%	289	13%
Ketton, Ryhall & Luffenham	7.6	148	4%	813	14%	512	16%
Uppingham, Lyddington & Braunston	9.8	171	5%	739	17%	370	16%
RUTLAND TOTAL		**17,662**	**5%**	**3,659**	**16%**	**1,637**	**14%**

6.3.5 Treatments including fluoride varnish

Both fluoride varnish (FV) and fissure sealants are primary preventative measures. The first involves fluoride preparation applied to the teeth surface, the second application of sealant material to the pit and fissure systems. FV treatment is an effective treatment in children under the age of 17.

In 2021/22, fluoride varnish treatment was part of a 56% of claims for children, 4% and 5% for adults. For children, the proportion of FV was lower than in Leicestershire (67%) but higher than the average for England (53.8%). For all adults (ages 18 +), 4.4% of treatments were FV in Rutland, which is higher than in Leicestershire (2.8%) and higher than England (2.6%) (Figure 41).

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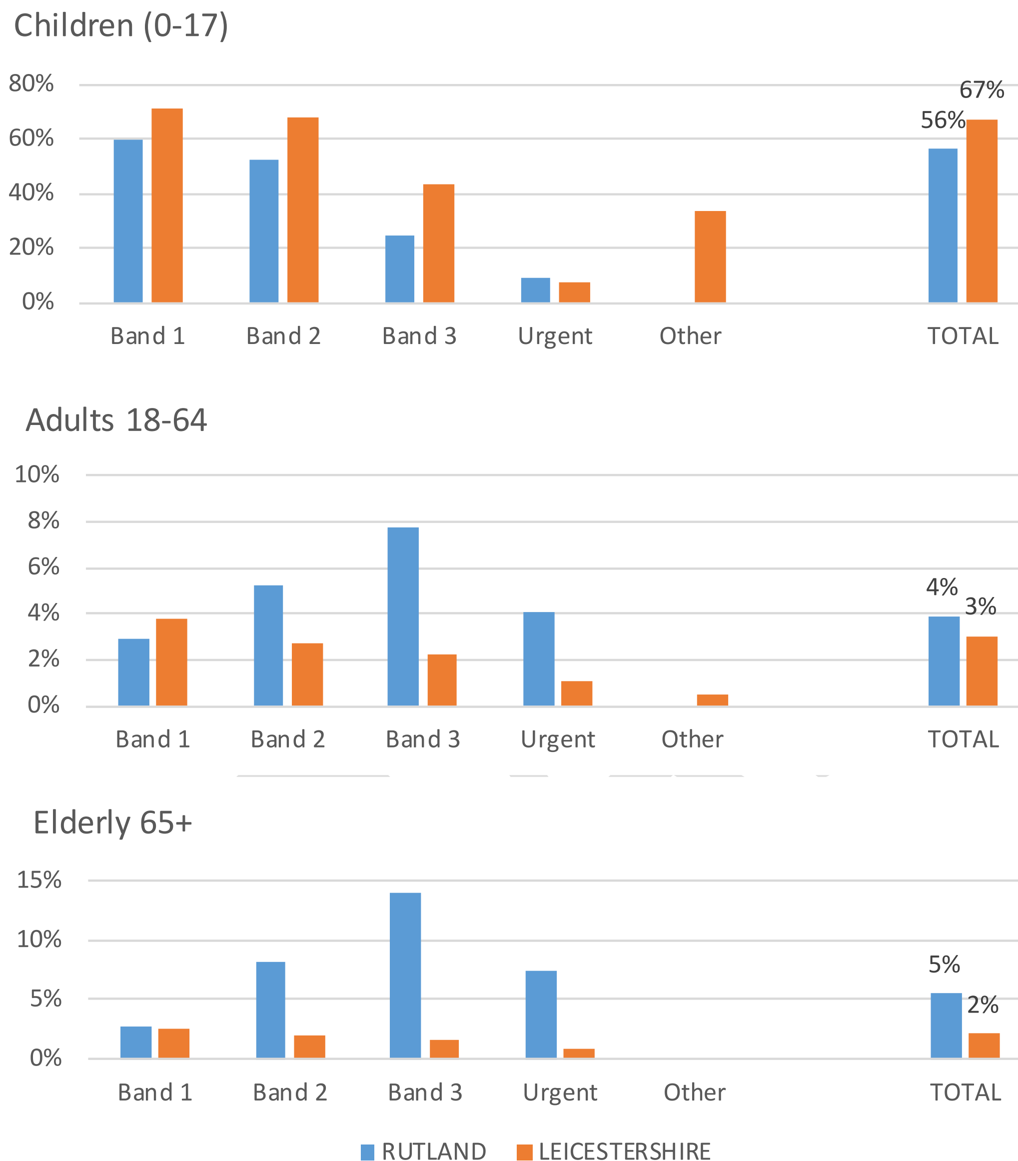
Figure 41. Fluoride Varnish Claims as percentage of all claims by treatment band and age group for Rutland and Leicestershire in 2021/22) (Source: NHS BSA 2022)



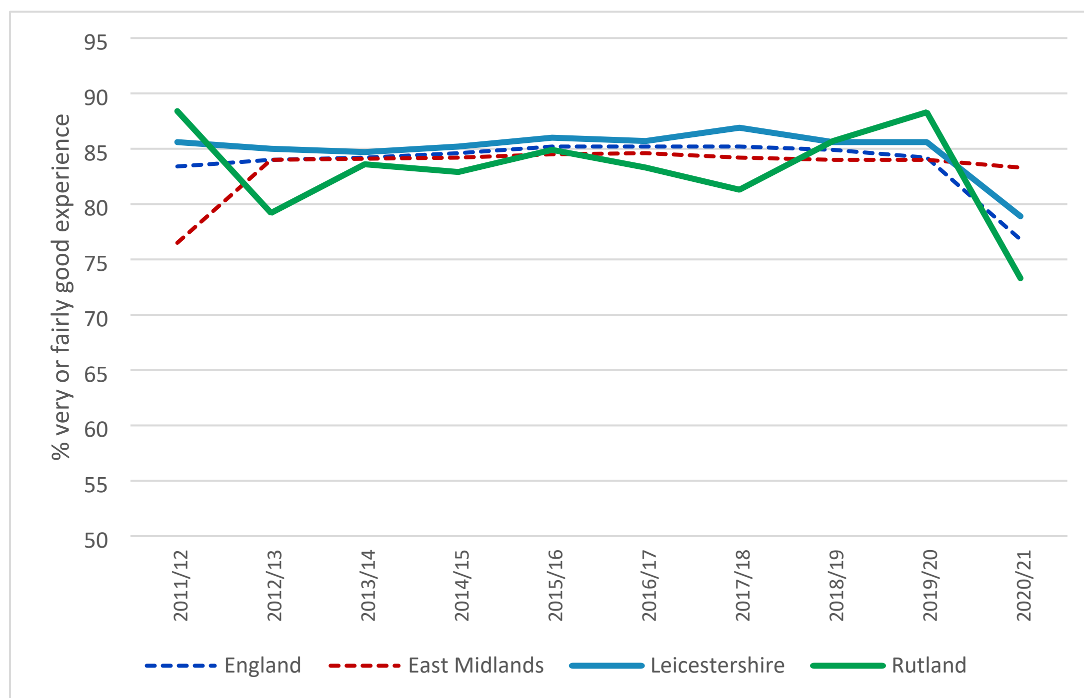
6.4 Patient Experience

Patient experience of the NHS dental services are published nationally as part the NHS Outcomes Framework (indicator 4a.iii) [35]. The latest publication (2022) reported on data for the period 2011/12 to 2020/21. Data collected through the GP Patient Survey.

The Framework reports the percentage of people describing a 'very good' or 'fairly good' experience of NHS dental services, weighted for design and non-response, with breakdown into several population groups.

In line with the national (but not the East Midlands') trend, there was a fall in good/fairly good patient experience in 2020/01 (from about 85% in previous years to 78%), more pronounced in Rutland (dropped below 75%) than in Leicestershire (Figure 42 below).

Figure 42. Trends in patient experience (Source: NHS Digital 2022)



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7 Oral Health Improvement

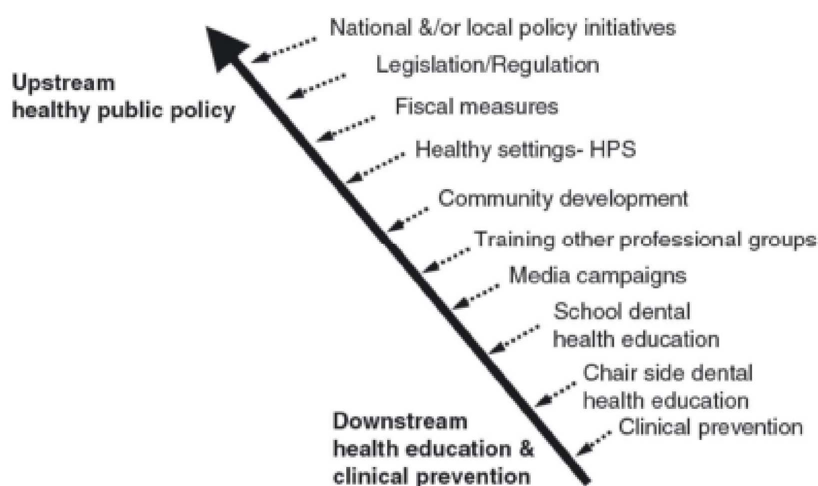
Local authorities (LAs) have a statutory responsibility for oral health improvement as part of their overall responsibility for public health. LAs role includes undertaking health needs assessment and the commissioning of health improvement programmes, as appropriate to local needs. LAs also have a collaborative role in evidence-based planning and evaluation of services, and assessment of oral health inequalities. Dental public health consultants, working for OHID (Office for Health Improvement & Disparities), provide expert advice to local authorities, NHSE, Healthwatch and other partners.

7.1 Evidence for Public Health Interventions

Guidance on what works in oral health promotion is provided by Commissioning Better Oral Health for Children and Young People[36] and Oral Health Improvement for Local Authority and Partners[37]. Generally, the guidance recommends a population approach with advice and actions for all, with additional interventions aimed at those at higher risk of developing

disease, with many different approaches and options available. A range of possible approaches are summarised in the upstream/downstream model (Figure 43) of oral health promotion[38]. Clinical intervention and individual dental health education are the lowest level, with community level interventions in the middle, and large-scale, regional or national, measures at the top.

Figure 43. Upstream/downstream model of oral health promotion



Source: Watt (2007)

Because oral diseases share many risk factors with other common conditions, including cancer and cardiovascular disease, as described in Chapter 3 (Who is at Risk and Why?), a common risk factor approach can be very effective for health improvement.

Delivering Better Oral Health: An Evidence-Based Toolkit for Prevention[39] provides detailed evidence-based, age-specific guidance for oral health care providers and commissioners.

Universal measures, underpinned by strong evidence include:

- Breastfeeding - supporting mothers to breastfeed exclusively for the first 6 months of a baby's life.
- Children - brushing or supervised toothbrushing by parents/carers
- Brushing all tooth surfaces twice daily with a fluoridated toothpaste (manual or powered toothbrush) and as soon as children are able, spit out after brushing rather than rinse
- For children aged 0-3 years: Use a smear of fluoridated toothpaste containing no less than 1,000 ppm fluoride; for children aged 3+ years: use a pea-sized amount of fluoridated toothpaste containing more than 1,000 ppm fluoride

- Application of fluoride varnish in a clinical setting from age 3 years and applied twice yearly
- For children aged 7+ and adults: fluoridated toothpaste (1,350 – 1,500 ppm fluoride)
- Reduction in the frequency and amount of sugary food and drinks
- Tobacco and alcohol - very brief advice (Ask, Advise, Act).
- Fluoridation of public water supplies

Targeted, evidenced measures include:

- Shortened recall interval based on dental caries risk
- For children aged 0-6 years at high risk of dental decay:
    - using toothpaste containing 1,350-1,500 ppm fluoride
    - application of fluoride varnish to teeth two or more times a year
- For children aged 7+ years and adults at high risk of dental decay:
    - using a fluoride mouth rinse daily at a different time to brushing
    - resin sealant application to permanent teeth on eruption
    - fluoride varnish application to teeth two or more times a year
- For those 10+ years with high risk of dental decay:
    - using 2,800 ppm fluoride toothpaste
- For those 16+ years with high risk of dental decay:
    - using either 2,800 ppm or 5,000 ppm fluoride toothpaste
    - daily fluoride rinse
- For all children and adults with high risk of dental decay:
    - dietary advice and assistance in adopting good dietary practice
    - supporting toothbrushing, where required
- For adults with high risk of dental decay – application of fluoride varnish to teeth two times a year
- For those who smoke - a combination of behavioural support and medication, as appropriate
- Community-based fluoride varnish programmes
- Supervised tooth brushing in targeted childhood settings
- Distribution of toothbrushes and toothpaste (i.e. postal or through health visitors)

7.1.1 Return on Investment (ROI)

Water fluoridation gives highest return on investment (£22 per £1 after 10 years, Figure 44), followed by targeted provision of toothbrushes and toothpaste by health visitors (£7.4), with other measures relatively less effective at population level. Except for targeted fluoride varnish programme (NHSE), all these interventions are part of oral health promotion for 0-19s.

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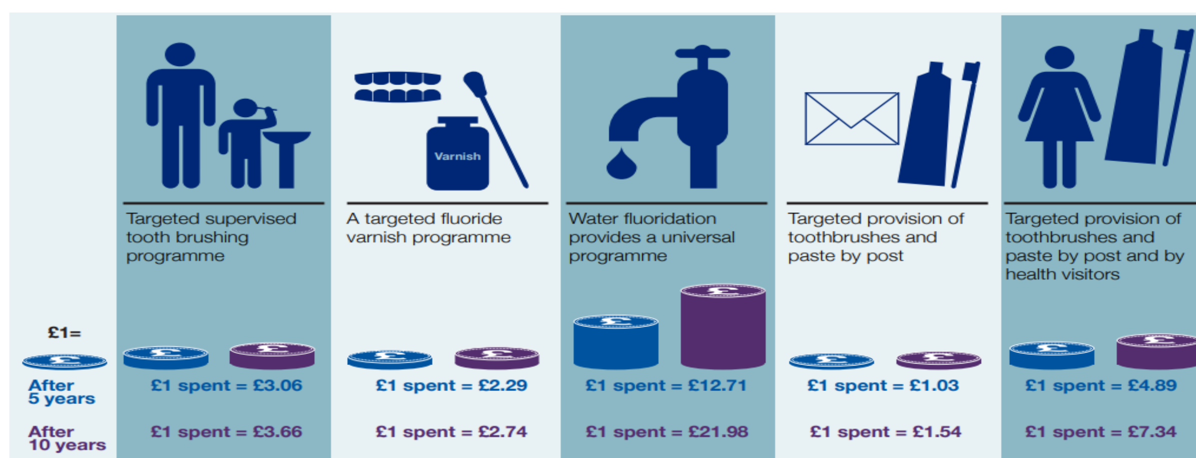
Figure 44 Public health interventions - return on investment



Fluoridated water is currently supplied to 10% of England's population; Rutland is not included. The new Health and Care Act 2022 is expected to centralise the responsibility for water fluoridisation decisions (currently within LA remit) with a view to level up the existing oral health inequalities.

Fluoride varnish application is recommended twice a year for all children above the age of three, more often in those at increased risk of decay (see above). It offers an increased level of protection from decay, in addition to regular toothbrushing and is a free NHS service to all children. In 2021/22, Rutland had a significantly lower rate of fluoride varnish for children 0-17, compared to Leicestershire average – 48.2% against 57.4% (Figure 41), this is despite a similar overall level of access for children (measured as all FP17 claims - 85.8% and 85.3%, respectively).

7.2 Oral Health Promotion in Rutland – Current and Future Initiatives

Up to 31st August 2022 oral health promotion was a part of the 0-19 Healthy Child Programme provided by Leicestershire partnerships trust (LPT). Currently, the programme is separated into 0-11 and 11+ services, the former of which is still provided by LPT. Oral health is a priority of the health visiting programme of the 0-11 service where health visitors are able to give advice, information and sign posting for parents.

There is an *Oral Health Promotion Partnership Board* across Leicester, Leicestershire and Rutland (LLR). Public Health represent Rutland on this board. Non-recurrent monies from NHS England were made available for the area and this is held by Leicester City on behalf of

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all three local authority areas. The Partnership Board make the decisions about the spend of the money and are currently looking at the following initiatives across LLR:

- £150K (recurrent for two years) to support oral health improvement initiatives and activities;
- £40K (non-recurrent) to support purchase and distribution of toothbrushing packs to food banks and other venues;
- £10K (non-recurrent) to enable each local authority's oral health promotion service to expand and improve their resources;
- £10K (non-recurrent) to provide each child with a toothbrushing pack as part of the dental epidemiology survey;
- They are looking at using resources to support care homes in formulating what the minimum oral health promotion offer should be in their establishments and would require links into dentistry.
- There is an intention to recruit to two posts, one of which will cover Leicestershire and Rutland to embed Oral Health promotion into policies and link into the Make Every Contact Count programme.

Public health is responsible for commissioning the annual *Dental Epidemiology Fieldwork survey* which is a statutory function. The fieldwork survey focuses on the dental health of five-year-olds every other year with the intervening year being another selected age group. This could be another children's age group or working aged adults. In the conducting of the dental examinations for the survey the provider will recommend whether dental treatment is required and the urgency of such treatment. The provider is able to fast track into the community special care dental services as they also provide that service.

Rutland currently do not have an oral health promotion service or a supervised tooth brushing programme. Health visitors provide oral health advice, but do not distribute toothbrushes or toothpaste. However, public health for Leicestershire and Rutland is working with other LLR partners to determine such a programme through additional joint funding. This would mean extending the offer for oral health promotion that is provided by the Health Improvement Team of Leicestershire to cover Rutland as well and will offer the following components:

1. Supervised toothbrushing programmes in Early Years Settings in Rutland
2. Oral Health training for professionals
3. Oral Health campaigns

8 Identified Gaps and Recommendations

This assessment demonstrated that, although on average oral health of Rutland's population appears to be relatively good when compared to the national average or comparator local authority areas, there are some specific concerns for individual population subgroups and there are substantial problems with access to NHS dental services.

Demographic findings point at a higher than average, and rising, proportion of elderly population. Many of these older residents live in rural areas, which predominate in Rutland, experiencing isolation and poor access to services. Although on average, deprivation in the county is relatively low, there are strong indications of poor access to services, including health services, and detectable barriers to housing. These factors need to be taken into consideration when commissioning new services and health promotion programmes.

Among the youngest children (according to the 2020 dental survey of the 3-year-olds) there was a higher-than-expected rate of decay in incisor teeth in which could indicate poor infant feeding practices, particularly excessive consumption of sugary drinks. Although statistically significant, this finding is based on a very small survey sample size and has to be treated with caution. However, a further investigation and a targeted health promotion programme may be indicated for the youngest children.

Currently, there is no oral health promotion service or a supervised tooth brushing programme in Rutland; the health visitors provide oral health advice, but do not distribute toothbrushes or toothpaste.

There are substantial problems with access to dental care. At the time of this investigation, none within the 16-mile radius (whether local to Rutland or cross-border) was accepting new adult patients and only one in ten (5 out of 50) were accepting new patients under 18. It is very likely that access issues affect some groups disproportionately and populations such as families of military personnel stationed in Rutland, vulnerable elderly or disabled, may have particular difficulties. Emerging barriers to accessing NHS dental service are not unique to Rutland - list backlogs and staff shortages have been highlighted regionally as growing issues in NHS dental service.

The patterns of 'access rates' within Rutland would indicate significant cross-border flows of patients, but details on where the care is provided are unknown. Access rates in the first part of 2022 were lagging behind the national rates for the adult patients, with some indication than adult men accessed services less often than women.

Measured through the GP Patient Survey, the levels of satisfaction with NHS dental service have dropped in 2020/21 to below 75%, 10% below the regional average.

There are some important caveats and limitations relating to available data on oral health. For many routinely collected oral health indicators, the samples and numbers of observations are relatively small in Rutland. Thus, any observations or conclusions must be treated with caution, as they are subject to statistical uncertainty and/or temporal fluctuation. For the same reason, it is very difficult to detect any variation (or correlation with known health determinants) within Rutland. It is also important to note that many of the collected oral health indicators are subject to a substantial time lag, they are usually published with one or two-year delay. In addition, this investigation covers the time of the COVID-19 pandemic which makes any interpretation of longer-term health needs (and outcomes) difficult and may affect our understanding of patterns of service use, urgent.

Based on the findings of this assessment the following recommendations are suggested for the commissioners of NHS Dental Services and Local Authority:

- Dental access issues should be investigated further, and steps taken to improve access locally, with focus on:
    - the elderly, particularly those living alone and in residential homes
    - men of working age
    - vulnerable groups, including families of military personnel
- Provide up-to-date information on available NHS Dentistry
- Investigate current pattern of service use, particularly cross-border flows and the use of private dentistry
- Consider targeted health promotion for the elderly
- Consider a targeted health promotion for youngest children (0 to 3-year-olds)
- Consider increasing level of fluoridation programmes across Rutland, including promotion of fluoride varnish and toothpaste.
- Consider the feasibility of water fluoridation in Rutland, aligned to any upcoming changes to the Health and Care Act 2022 regarding fluoridation responsibilities for local areas.
- Commission health promotion service or supervised toothbrushing to Early Years Settings in Rutland

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GLOSSARY OF TERMS

BMI = Body Mass Index

BSA: Business Services Authority

CCG: Clinical Commissioning Group

CDS = Community Dental Service

CI = Confidence Interval

CIN = Children in Need

CIPFA = Chartered Institute of Public Finance and Accountancy

CLA = Children Looked After

DfE = Department for Education

FV = Fluoride Varnish

HES = Hospital Episodes Statistics

HSCIC = Health and Social Care Information Centre

ICB = Integrated Commissioning Board

IMOS = Intermediate Minor Oral Surgery

IoD = Index of Deprivation

LA = Local Authority

LAIT = Local Authority Interactive Tool

LLR = Leicester, Leicestershire and Rutland

LSOA = Lower Super Output Area

MoD = Ministry of Defence

MSOA = Middle Super Output Area

NDEP = National Dental Epidemiology Programme

NHS BSA = NHS Business Services Authority

NHSE = NHS England

OHID = Office for Health Improvement and Disparities

ONS: Office for National Statistics

PHE = Public Health England

SEND = Special Educational Needs and Disabilities

SHAPE = Strategic Health Asset Planning and Evaluation

UDAs = Units of Dental Activity

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APPENDIX

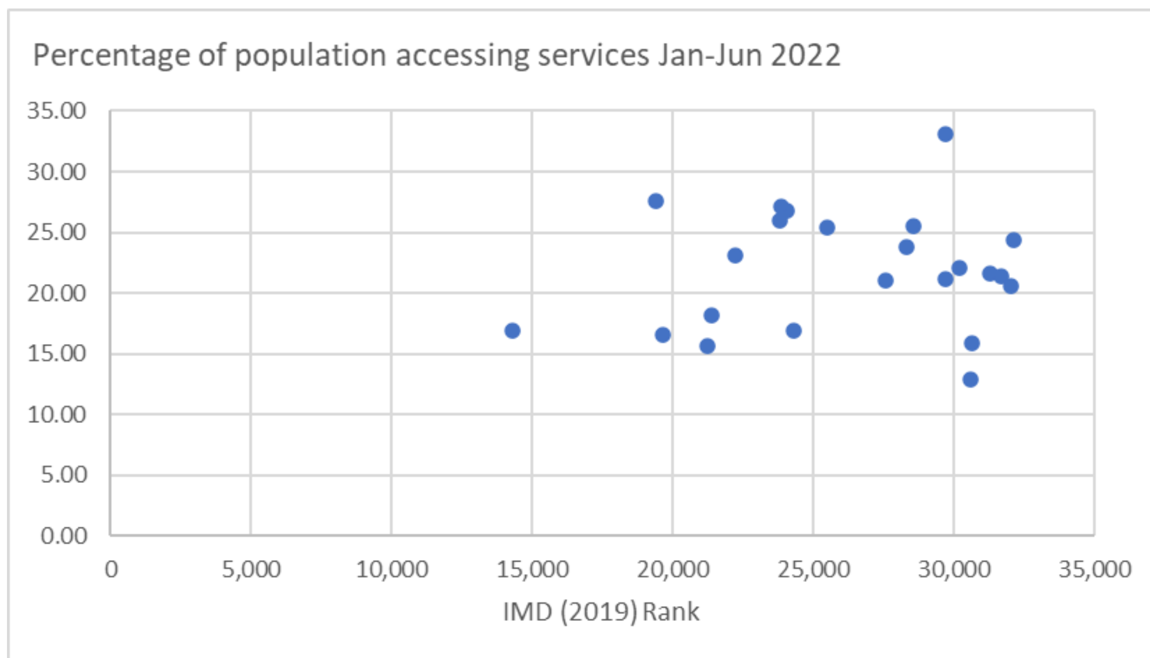
Appendix Table 1 Measures of oral health among 3-year-old children - Rutland, its statistical (*) l and local neighbours (**), as well as England and the East Midlands (Source: NDEP 2020)

	Rutland	North Yorkshire*	West Berkshire*	Leicester	Leicestershire**	East Midlands	England
Mean number of teeth with experience of dental decay in those examined	0.3	0.2	nk	0.5	0.2	0.3	0.3
Mean number of untreated dental decay in those examined	0.3	0.1	nk	0.4	0.2	0.2	0.3
Prevalence (%) of experience of dental decay	8.4	9.8	nk	16.1	8.5	9.7	10.7
Mean number of teeth with experience of dental decay in those with decay experience	nk	1.8	nk	3	2.7	2.8	2.9
Mean number of teeth with untreated dental decay in those with decay experience	nk	1.5	nk	2.8	2.3	2.4	2.6
Mean number of teeth missing due to decay in those with decay experience	nk	0.1	nk	0.1	0.2	0.3	0.2
% of 3-year-old with experience of dental decay affecting incisor teeth	8.4	0.8	nk	7.2	2.4	2.8	3.4
% of 3-year-old children with substantial amount of plaque visible	0	0.5	nk	1.2	0.5	0.6	1.9
% of 3-year-old children with pufa	0	1.5	nk	0.5	0.3	0.3	0.4

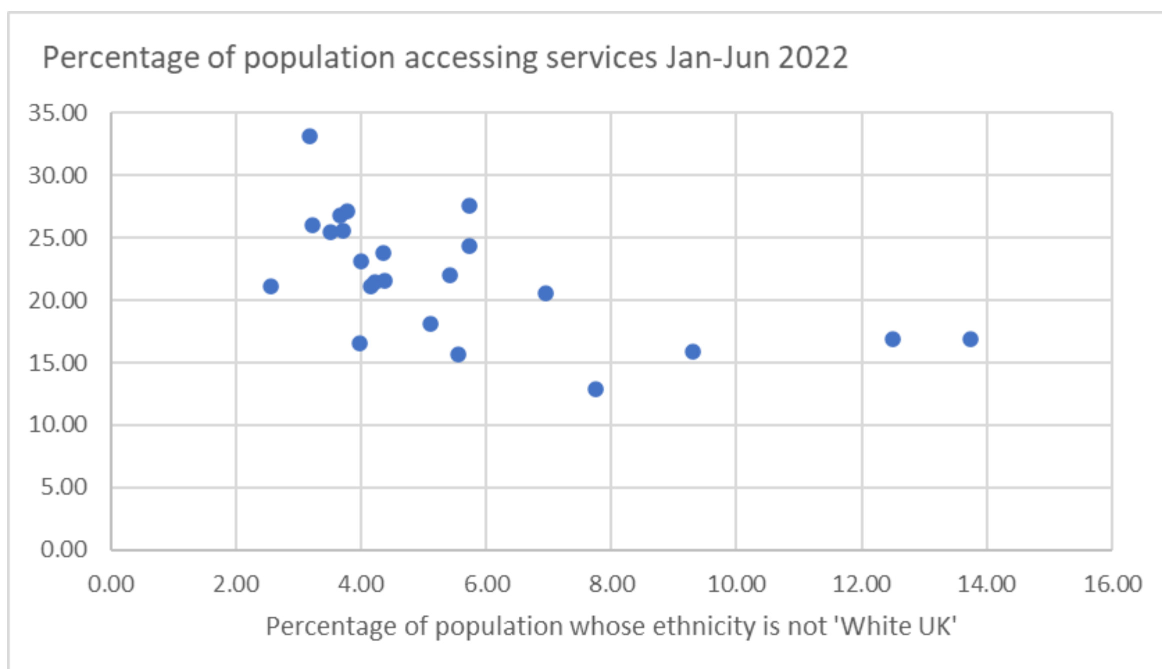
Appendix Table 2 Measures of oral health among 5-year-old children - Rutland, its statistical (*) l and local neighbours (**), as well as England and the East Midlands (Source: NDEP 2019)

	Rutland	North Yorkshire*	West Berkshire*	Leicester	Leicestershire**	East Midlands	England
Prevalence of experience of dental decay	25.3%	20.0%	14.7	38.60%	18.2%	24.7%	23.4%
Mean number of teeth with experience of dental decay	0.7	0.6	0.5	1.6	0.5	0.8	0.8
Mean number of teeth with experience of decay in those with experience of dental decay	2.8	2.8	2.8	4.1	2.8	3.4	3.4
Mean number of decayed teeth in those with experience of dental decay	2.5	2.1	3	3.3	2.3	2.7	2.7
Proportion with active decay	24.6%	17.6%	12.3%	34.7%	15.7%	21.7%	20.4%
Proportion with experience of tooth extraction	0.8%	1.7%	0.4%	3.3%	1.0%	1.8%	2.2%
Proportion with dental abscess	0.8%	0.5%	2.5%	2.9%	1.2%	1.6%	1.0%
Proportion with teeth decayed into pulp	1.9%	2.1%	3.1%	8.5%	2.2%	4.1%	3.3%
Proportion with decay affecting incisorsiii	2.0%	3.6%	5.1%	11.4%	3.0%	4.6%	5.2%
Proportion with high levels of plaque present on upper front teeth	0.9%	0.3%	4.4%	0.9%	0.5%	0.4%	1.2%

Appendix Figure 1 Correlation between deprivation and access to NHS service across Rutland LSOAs



Appendix Figure 2 Correlation between ethnicity and access to NHS service across Rutland LSOAs



Appendix Table 3 Courses of treatment by patient type in Rutland Leicestershire and England, over the course of the last three years (NHS BSA 2022)

	Year	Children (0-17)		Exempt Adults		Non-Exempt Adults	
		Number	%	Number	%	Number	%
Rutland	2019/2020	5,173	33.2%	1,430	9.2%	9,212	59.1%
	2020/2021	2,306	34.8%	734	11.1%	3,623	54.7%
	2021/2022	4,341	34.6%	1,328	10.6%	7,018	55.9%
Leicestershire	2019/2020	97,545	28.3%	36,459	10.6%	210,440	61.1%
	2020/2021	38,791	29.6%	15,322	11.7%	77,009	58.7%
	2021/2022	77,783	29.6%	28,714	10.9%	155,934	59.4%
England	2019/2020	11,628,279	30.3%	6,027,299	15.7%	20,725,595	54.0%
	2020/2021	3,345,347	27.9%	2,260,561	18.9%	6,378,744	53.2%
	2021/2022	8,070,100	30.6%	4,390,201	16.7%	13,902,459	52.7%

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Report No: 20/2023
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

24 January 2023

JOINT HEALTH AND WELLBEING STRATEGY UPDATE

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

Strategic Aim:	Protecting the vulnerable	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor 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
Ward Councillors	n/a	

DECISION RECOMMENDATIONS
That the Board: 1. Notes the further development of the JHWS Delivery Plan 2. Notes the latest Rutland Outcomes Report

1 PURPOSE OF THE REPORT

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 progress of the JHWS Delivery Plan.

1.3 The report also highlights elements of the Rutland Outcomes Report for consideration

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The overall aim of the joint strategy is 'people living 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.

2.2 Appendix A provides a **high-level summary of progress across the JHWS's priorities**. This includes activities to achieve all elements of the strategy, the lead, the timescale, how success will be measured and also importantly also risks, mitigations and issues for escalation and discussion. The leads also use coloured rating to show whether or not progress is on target and where activity is yet to start and where outcomes have been achieved and the action can be closed.

2.3 The structure of the **JHWS delivery plan** has been updated to incorporate SMART (Specific, Measurable, Achievable, Relevant, Timebound) objectives. This has assisted the reporting leads to focus on the scope of the deliverables and target the timescales for completion. Highlight reports are being completed on a monthly basis. Reporting Officers report on 6 areas: Key objectives and deliverables, Key achievements and progress, Next steps, Risks, Mitigations and Points for discussion or escalation. There has been good progress in moving towards measurable outcomes which sit beside longer- term aspirational outcomes. There is opportunity to develop the measurement of deliverables further. Work is also now required to identify what can be achieved by end of the first 12 months of the strategy delivery and which will contribute to the first annual report.

2.4 The following are highlights from the progress reported:

- The Children's Centre has been identified as Rutland's first Family Hub. Communications and promotions plan is underway. This supports health child development from conception to two years old (Priority 1). An Active Referral Programme has been designed which supports people taking an active role in their community (Priority 2). Funding has been secured for a Co-ordinator in the Active Rutland Team whose role enables exercise referrals to promote personalised activity levels. Promotes health ageing and falls prevention (Priority 3). Routine Partnership meetings are now in place with cross border ICB Lincolnshire which promotes shared learning. This supports planning for the future infrastructure; cross border health impacts are understood (Priority 5). Enhanced access to GPs is now in place offering appointments from 6.30 to 8pm Monday to Friday and 9am to 5pm on Saturdays. This supports improving access to primary and community health (Priority 6). The first Staying Healthy Partnership session will take place in January 2023 which supports Reducing Health Inequalities (Priority 7 Cross Cutting Theme).

- There are also challenges and risks to progress. These include engagement from partners in some areas. The x-ray machine at Rutland Memorial Hospital is not operational impacting on access to this health assessment provision. LPT and the Integration and Transformation Manager are already working together to resolve this. The Rutland Prehab project is currently on hold due to system pressure. All risks to progress are being discussed at the IDG forum to identify resolution.

2.5 Appendix B is an **Outcomes Summary Report** which provides additional context by setting out the most recent Public Health data available for indicators relevant to each of the Strategy's priorities. It highlights whether Rutland rates are below, similar to or above either national rates or the rates in a group of 16 similar areas of

the country, offering greatest detail on indicators of concern. These data are released with a time lag, so the impact of the early work undertaken to deliver the strategy will not initially be reflected here. The reports will be used ongoing by priority teams in their targeting and prioritisation.

- The report highlights many areas where Rutland performs well in comparison to other similar areas. Highest ranked areas within Priority 1 include A&E attendances for 0 to 4 years, Year 6 prevalence of overweight, hospital injuries caused by unintentional and deliberate injuries in both age categories of 0 to 4 years and 0 to 14 years. Within Priorities 2 and 3 respectively, Rutland performs well in Cancer screening for bowel cancer and for Emergency hospital admissions due to falls in people over 65 years. Within Cross Cutting Themes, Mental Health, Rutland Performs well for Admissions for alcohol related harm and Emergency admissions for intentional self-harm.

- The report also shows that there are areas which are achieving poor performance rates compared to other similar areas of the country. Within Priority 1, Children in care immunisations and Proportion of children receiving a 12 month review, are areas where Rutland's performance is 16th out of 16. Cancer screening coverage for breast cancer and Population vaccination coverage for shingles – 71 years are both poor performance categories within Priority 2. Within Priority 3, Excess Winter Deaths performs poorly within Rutland and Priority 4 highlights an issue with a reduction in access to an NHS dentist. Within Priority 6, the percentage of deaths that occur at home, Rutland performs 16th out of 16. It is important to note that the large number of amber indicators is the result of Rutland's small population affecting statistical significance, and so should not be considered alongside red indicators as poor performing.

2.6 Next steps: consider how JHWS leads can work with partners to make improvements in areas of poor performance highlighted in the report and maintain areas which are performing well.

3 ALTERNATIVE OPTIONS

3.1 The JHWS is a statutory responsibility and has been consulted on publicly.

4 FINANCIAL IMPLICATIONS

4.1 In common with previous JHWS, the strategy brings together and influences the spending plans of its constituent partners or programmes (including the Better Care Fund), and will enhance the ability to bid for national, regional or ICS funding to drive forward change.

5 LEGAL AND GOVERNANCE CONSIDERATIONS

5.1 The JHWS meets the HWB's statutory duty to produce a JHWS, and the ICS duty for there to be a Place Led Plan for the local population.

5.2 JHWS actions will be delivered on behalf of the HWB via the CYPP and IDG.

6 DATA PROTECTION IMPLICATIONS

6.1 Data Protection Impact Assessments (DPIA) will be undertaken for individual projects as and when required to ensure that any risks to the rights and freedoms

of natural persons through proposed changes to the processing of personal data are appropriately managed and mitigated.

7 EQUALITY IMPACT ASSESSMENT

7.1 Equality and human rights are key themes in embedding an equitable approach to the development and implementation of the Plan. An RCC high level Equality Impact Assessment (EqIA) has been completed and approved.

7.2 The initial Equality Impact Assessment sets out how the Strategy, successfully implemented, could help to reduce a wide range of inequalities. It is acknowledged that the strategy and delivery plan are high level and therefore additional equality impact assessments will be completed as appropriate as services are redesigned or recommissioned within the life of the strategy.

8 COMMUNITY SAFETY IMPLICATIONS

8.1 Having a safe and resilient environment has a positive impact on health and wellbeing. National evidence has also shown that more equal societies experience less crime and higher levels of feeing safe than unequal communities. The JHWS has no specific community safety implications but will work to build relationships across the Community Safety Partnership and to build strong resilient communities across Rutland.

9 HEALTH AND WELLBEING IMPLICATIONS

9.1 The JHWS is a central tool in supporting local partners to work together effectively with the Rutland population to enhance and maintain health and wellbeing.

10 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

10.1 The JHWS provides a clear, single vision for health and care with purpose of driving change and improving health and wellbeing outcomes for Rutland residents and patients. The progress against the plan set out in this paper supports the HWB in tracking and steering delivery.

11 BACKGROUND PAPERS

11.1 There are no additional background papers.

12 APPENDICES

12.1 Appendices are as follows:

A. JHWS Delivery Plan December 2022

B. JHWS Outcomes Summary Report January 2023

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

Priority 1: The Best Start for Life

Senior Responsible Officer (on HWB) **Dawn Godfrey**

Responsible Officer (on IDG) **Bernadette Caffrey**

GREEN = On Track
AMBER = Off track but mitigations in place top recover
RED = Off track and at risk
GREY = Not Started
BLUE = Complete

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for December 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
1.1	**Healthy child development in the 1,001 critical days (conception to 2 years old)**									
1.1.1		Clear 'Start for Life' offer for parents. The Family Hub programmes will be critical to bring activity together and ensuring an integrated offer across the 0 to 19 (25) years pathway. Information sharing agreements to be agreed. Watch - Family Hub programme receiving oversight from the Rutland CYP Partnership.	RCC/PH /Mina Bhavsar (ICB commissioning officer). Sham Mahmood. Public Health.	2022-24	Place and system	Family Hub operating 0 to 19, (25 yrs. SEND), clear, accessible , seamless and integrated services for families in place and achieving positve outcomes for children and young people. Quantative, qualitative feedback from parents on feeling supported through 1,001 critical days.NHS provider meeting KPis in 0 to 11 years Healthy Child contract and offer.	1001 Critical days launched across LLR with an agreed vision of 1001 Critical Days. Maternity Transformational Programme in place with key objectives. Family Hub Project plan and Steering Group established.	Engagement		
1.1.2		Healthy lifestyle information and advice for pregnant women or those planning to conceive, including: a) implementation of MECC+ healthy conversations across prevention services b) Targeted communication campaigns c) Increase awareness of postnatal depression and social isolation through midwifery and 0-10 children's public health service d) Immunisations in pregnancy (flu/covid) e) Ensuring women are also reached who have chosen to give birth out of area. Link to 2.1.1 Communications 2.2.3 Healthy conversations 7.1.1 Perinatal mental health support.	LPT/UHL	2022-23	Place and system	* Women healthier during pregnancy: reduction in overweight/obese or smoking. * Improved rates of immunisation for mothers (notably flu/Covid). * Women aware of the risk of Post Natal Depression and isolation. Better able to prevent and seek support where required. * Wherever women give birth, they have access to information about health in pregnancy and access to support.	LLR Strategic Healthy Baby Group led by Rob Howard. Focus to deliver health diet advice, healthy food boxes, reduce maternal obesity. Safer sleep campaign happening. ICON programme in place.Yes Stork campaign,to support parents with bonding and confidence in caring for their premature babies in neonatal unit and at home.	Lackof capacity and increased demand in key partner agencies		
1.1.3		Local implementation of the Maternity Transformation Programme considering: Improving quality and safety for mother and babies. Improving quality of pathway Implementing neonatal critical care review, improving access to perinatal health services. Link to above actions. LLR LMS Transformation Funding	LPT/UHL	2023-24	Place and System and Neighbourood. Working toward 6% perinatal access to increase access from 6% to to 10% by March 2023	Mothers in Rutland are happy with the services available to them. Positive change in longer term trends around low birth weights and infant Mortality. .Maternity service patient satisfaction surveys · Qualitative feedback re maternity service access, including cross border · Location of Rutland births · Low birth weight for term babies · Infant mortality	Delivering all key requirements of the Transformation programme. Submitted a checkpoint equity assessment.			

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for December 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
1.1.4		Implementation of 0-19 Healthy Child Programme, to support Rutland's Family Hub Programme. Including: 0-10year mandated child development checks (including 3-4month and 3.5year checks), a digital offer, evidence-based interventions for children (antenatal, breastfeeding, dental care and peer support for developing active, resilient children, awareness around shaking and head trauma (ICON)), and safeguarding. Consideration of accessibility of related health health services, including dental. Specific consideration for military population.11plus Public Health Teen Health contract and Offer for young people in Rutland	Public Health Rutland	From Sept 2022	Place and system	Positive development of children 1-10, in areas covered by the dashboard metrics .New Born Visits within 14 days • Breast milk is baby's first feed • Breastfeeding initiation and continuation rates • 2.5 year development checks (fine, gross and motor skills) • Healthy Together 2.5 year development checks (communication, fine and gross motor skills) • Early Years Foundation Stage Progress Check between 2-3 years of age, including communication and language, physical development and personal, social and emotional development • Attainment of a Good Level of Development (GLD) at the end of reception year, taking into consideration children eligible for Free School Meals (FSM) • Immunisation rates in under 2years • School readiness at the end of foundation year (especially those receiving Free School Meals)	New contract in place from September2022			
1.1.5		Further investigation into -High proportion of low birth weights at term in Rutland. -Children and Young People's dental care in Rutland, including dental education and access to services.	Rutland Public Health	2022-23	Place	Better understanding of the factors contributing to these patterns. Stronger evidence base for next steps to tackle these issues. Oral Health JSNA chapter · .Low birth weight for term babies · Infant mortality • Children with visibly obvious tooth decay at age 5years	Not yet underway			
1.2	Confident families and young people									
1.2.1		Implementation of 0-19 Healthy Child Programme, 11-19year element, which supports the Rutland Family Hub programme - including face to face offer for families, a digital offer, health promotion campaigns including via schools, health behaviours survey, safeguarding, evidence-based interventions for healthy, active resilient children and young people who are able to transition effectively into adulthood. Specific work on transitions for children with LD (up to the age of 25years.) Integrated offer that include a whole family approach,(fathers/grandparents), and is supported by local and vountary groups and communities. 1.4 for vaccinations 2.1 communication campaigns 4.4.1 Digital inclusion 7.1.3 Children and Young People's mental health needs	Rutland County Council	From Sept 2022	Place and system	Happy and successful young people 11-19, receiving support and interventions early and when and where they need it. Provider meeting the KPIs. * Immunisation uptake (Covid, HPV, school leavers booster especially for those in care) * Proportion of children at a healthy weight (NCMP data at reception and year 6) * Under 18year conceptions * Health behaviour survey results indicating positive lifestyle choices and access to a trusted adult * A&E attendance for under 18years * Rate of hospital admissions caused by unintentional and deliberate injuries (Children aged 0-14yrs) * Educational attainment * Proportion of young people not in education, employment or training * Specific split of data from those with LD including qualitative feedback on transition from CYP service to Adult Services for those with additional needs	The 0-11 service commenced on 01/09/22 with LPT as the provider. Contract management has commenced. LPT has indicated that they have recruited to vacancies but it will be early next year before the benefits are realised. For the 11+ in house service the new staff have now started, links are being made and two mapping events are arranged for early December programme. Steering Group in place to drive the Rutland family Hub programme.	Capacity within key partner organisaitons to engage in and deliver programme.		

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for December 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
1.2.2		Targeted, coordinated support for Rutland's most disadvantaged or vulnerable children, representative of Rutland's demograpic, to access their Early Years and Inclusion Offer and provision. Reduce the impact of Adverse Childhood Experiences on children and their families by embedding a 'trauma informed approach' to the workforce. Integrated Early Help, SEND, Health and Social Care offer	RCC,	2022-23	Place	Families who are disadvantaged or with additional needs have their needs identified early, and feel supported, and less likely to need specialist services.Adverse Childhood Experiences have less impact on children and families - through prevention and support to manage/recover. * 0-5 year development indicators specifically for target groups * Healthy lifestyle indicators reviewed for specific groups including immunisation uptake for SEND in over 14years * Proportion of annual Looked After Child Reviews carried out by Looked after Children Nurses * Proportion of Strengths and Difficulties Questionnaires (SDQ) undertaken for Looked After Children * Proportion of Education and Health Care Plans completed	As above for Family Hub. Supporting Families Programme (formerly Troubled Families) in place and meeting targets. Reducing Parental Conflict programme secured and in place.			
1.3	**Access to health services**									
1.3.1		Increase health checks for SEND children aged 14years and over ensuring that status is built into the education and health provision set in a Child's Education and Health Care Plan. Funding RCC - DSG HNF. CHC CCG	ICB /LPT	2022-23	Place	Children with SEND are having their health checks in a timely fashion. This is helping those working with them to do this more successfully. * Immunisation uptake especially in SEND over 14s * Proportion of SEND Health check completed	Undertaken generally in Q3 and Q4.			
1.3.2		Increase immunisation take-up for children and young people where this is low, including identifying sub-groups where take-up is lower and understanding why.	ICB/ LPT	2022-23	Place and system	It is clear where immunisation take-up is lower than average (including among which demographics), and changes to delivery help to increase take-up to match or exceed comparator averages. * Review into immunisation uptake across Rutland * Immunisation uptake rates (Covid, HPV, school leavers' booster especially for those in care)	Uptake in Rutland is good,some dip during Covid. PCN Health and Wellbeing Coach developing advisory role for families around vaccinations.			

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for December 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
1.3.3		Coordinated services for children and young people with long term conditions (LTCs) and SEND. Long term condition support for children and young people with asthma, diabetes and obesity including access to appropriate medication, care planning and information to self-manage their conditions, and to relevant support services. To include learning from the Leicester City CYP asthma review and take-up of Tier 3 weight management services. 3.2 Integrated care for LTCs 7.1 Integrated Neighbourhood Team development ND Pathway programnme, and Key Worker programme. To explore early planning for ASD/ADHD families	LPT	2022-24	Place and system	* Report with review of Leicester City Evaluation in context of Rutland needs	Iniital work complete. Further areas to develop.			

Priority 2: Staying Healthy and Independent: Prevention

Senior Responsible Officer (on HWB) **Mike Sandys**
Responsible Officer (on IDG) **Adrian Allen**

GREEN = On Track
AMBER = Off track but mitigations in place top recover
RED = Off track and at risk
GREY = Not Started
BLUE = Complete

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How will Success Be Measured?	Key Identified Risks	Mitigations	Key points for Discussion or Escalation	November 2022 Project RAG Status
2.1	**Supporting people to take an active part in their communities**									
2.1.1	Ensure residents are fully aware of the community and health and well-being offer in Rutland and understand how to access it.	Communication of Rutland's community and health and wellbeing offer including; a) Develop and implement a multi-channel communication plan to enhance information for signposters and for the public, including distinctive groups. This will also align with the work of the HWB and cater for those that are digitally excluded or use cross border services. b) To include enhancing the reach and scope of the Rutland Information Service (RIS) via multiple channels (web, social media, print). c) Updating the RIS online platform to meet accessibility standards and be more usable on mobile devices as this is how most users access it. d) Enhancement of online functionality for clearer routes into preventative services.	RCC-Public Health (RIS)	Jun-23	Place	* Completed Health and Wellbeing Communication plan aligned with the HWB * Reach of communication campaigns including social media followers, posts and shares * RIS monthly visitor figures * Qualitative feedback on awareness of and access to service across Rutland				GREEN
2.1.2	Working in collaboration with the VCF sector to further strengthen relationships across the sector.	a) The VCF forum coordinated by Citizens Advice Rutland (CAR), also working with wider bodies and services e.g. Parish Councils, and statutory and commissioned services. Sharing intelligence, skills and resources; mutual aid; joint responses to community needs and funding opportunities. b) VCF groupings with a shared focus e.g. deprivation, armed forces. c) Community development encouraging the formation and confident operation of new groups in Rutland for shared interests. d) Mapping of the Rutland voluntary and community sector to understand its strengths and areas for development. e) Collaboration, with statutory and commissioned services, around sustainable improvement for households with multiple and/or complex needs impacting health and wellbeing.	CAR, RCC	Jun-23	Place	* VCF forum participants * Collaborations including events, shared resources, joint services, grants obtained * Mapping of Rutland voluntary and community sector				GREEN
2.1.3	Increase the level of volunteering across the county.	Working through the Citizens Advice Rutland (CAR) volunteering marketplace, making sure we are building on positive experiences in the pandemic.	CAR	Sep-23	Place	* Number of volunteers registered * Number of matches made * Number of hours of volunteering committed				GREEN
2.1.4	Building Community Conversations	Explore the potential application of innovative models to empower individuals and communities, including: the Healthier Fleetwood model in which facilitated conversation spaces enable communities/groups with a common interest to meet informally to discuss opportunities and issues and progress improvements; and Camerados, an approach designed around people looking out for each other.	CAR	Mar-24	Place	* Feasibility study on implementation of potential community models in Rutland * Qualitative feedback that community conversations are taking place * Number of participants in the model				GREY
2.2	**Looking after yourself and staying well in mind and body**									

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2.2.1	Supporting residents to live more active lives	a) Increasing exercise on referral and promotion of active opportunities – helping people to increase activity positively in ways that work for them - personalised approach building on strengths. Also targeting groups such as patients on waiting lists, with mental ill health or living with dementia or cancer, people isolated or unable to travel. b) Local progress of the LLR Active Together strategy, including engaging organisations including businesses, care homes and schools in facilitating active lives. c) Secure funding for the active referral scheme following leisure contract review. Consider feasibility of subsidised participation for people on lower incomes. d) Secure funding via PCN to develop a wider offer e.g. hip, knee and back school.	Active Rutland, Active Together, PCN RISE	Mar-24	Place	* Exercise referrals made * Exercise referral service user numbers * Reduction in the proportion of adults overweight or obese * Increased proportion of physically active adults * Increased proportion of adults engaging in active travel (cycling or walking) at least 3 days a week * Proportion of health checks completed				GREEN
2.2.2	Supporting residents in health awareness and ensuring they can self-care where appropriate.	a) Providing information to increase awareness of changing health needs, and confidence to self-care. b) Clear prevention 'front doors' for additional support (See 2.2.4 Social Prescribing). c) Increase uptake of Weight Management Rutland service for adults, and family-focused support programmes, including Holiday Activities and Food Programme. Encourage take-up of NHS health checks and ongoing blood pressure monitoring for early diagnosis of cardio vascular risk. d) Review Chlamydia screening across Rutland to identify reasons for low level of Chlamydia detection and screening.	RCC (incl RIS, RISE, libraries), Public Health, PCN, VCF sector	Mar-24	Place	* Communication measures on Health awareness campaigns and RIS webpages (reach, shares, posts etc.) * Uptake of prevention services * Uptake of NHS health checks and numbers of referrals to prevention services * No. of blood pressure checks in the community * Improvement in Chlamydia screening rate and understanding of detection rate				GREEN
2.2.3	Ensure our workforce are trained and empowered to have healthy conversations	a) Implement Healthy Conversations training (Making Every Contact Count Plus – MECC+) to empower Rutland's diverse front line staff to discuss health and wellbeing with service users and signpost them. b) To include professionals working with housebound and digitally excluded people, and those who struggle to travel. c) Accessible signposting resources.	RCC, PH, LPT	Jun-23	Place and System	* Numbers trained in MECC+, train the trainers and super trainers in Rutland * Data on source of referrals to prevention services * Reach of RIS website * Qualitative feedback and evaluation of MECC+ training package				GREEN
2.2.4	Increase and enhance social prescribing for wellbeing, focussing on personalised, strengths-based care assessment and planning via the joint RCC and PCN 'RISE team' and other local providers.	a) Promote clear routes for wellbeing enquiries/ requests for support through Rise front door and RIS.Link to' prevention front door.' b) Enhance social prescribing tools by developing: * Consistent assessment frameworks for use across agencies. * Social prescribing signposting network. * Service maps for consistent referral. * Social prescribing platform managed by RISE, aiding referral between agencies and monitoring of pathways and outcomes.	RCC (RISE), PCN	Jun-23	Place	* Increased social prescribing referrals * Social prescribing platform users and activity * Development of signposting network * Number of groups/activities referred to by RISE team * Patient changes to ONS4 scores (a 4 element self-assessed measure of wellbeing) * Evaluation of the impact on social prescribing including understanding the impact on GP practices by service users				GREEN
2.3	**Encourage and enable take up of preventative health services**									

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2.3.1	Increase uptake of immunisation and screening programmes.	a) Completion of a health equity audits on immunisation and screening programme uptake across Rutland. (Including childhood immunisations.) See 1.1 and 1.2. b) Targeted communications campaigns using behavioural science to support increasing uptake. (See 2.1) c) Use the Health and Wellbeing Coach, healthy conversations (MECC+), Core20Plus5 and other routes to increase cancer screening uptake including mammograms, bowel scope screening and cervical screening [see 2.2] d) Considering how services could be delivered closer to home (for example breast and bowel scope screening) See 4.2.	PH/ PCN/ NHS England	Mar-23	Place and System	* Health Equity audits completed on areas of concern. Results/ recommendations reported to HWB and LLR Health Protection Board. * Uptake of specific immunisation and screening programmes. Specifically reviewing vulnerable or under-served groups. * Including offer/ uptake of health checks (including those for LD), uptake of screening programmes (including breast and bowel scope screening), uptake of screening programmes closer to home.				**GREEN**
2.4	**Maintaining and developing the environmental, economic and social conditions to encourage healthy living for all**									
2.4.1	To have a focus on health and equity in all policies.	Focus will include the economic, social and environmental contributions to health (wider determinants of health). a) Aiming for an overall commitment of relevant organisations in Rutland to building in consideration of health and equity in all that they do. b) Health Impact Assessments (HIA) or Integrated Assessments for decision making and policy development. Health Impact Assessment (HIA) of individual policies/investments, considering social value. c) Produce a wider determinants review with partners for Rutland. The review will explore existing work across Rutland, identifying any gaps to consider additional action across partners. Focus will include the built environment; open and green spaces; active travel; fuel poverty; air quality; and healthy housing.	RCC PH	Mar-24	Place	* Organisations committed to a Health and Equity in all Policies approach. * Evidence that organisations have embedded a process to systematically consider health, wellbeing and equity in everything they do. * Evidence of enhanced designs/decisions from HIAs * Development of wider determinants review.				**GREEN**

Priority 3: Living Well with Long Term Conditions and Healthy Ageing

Senior Responsible Officer (on HWB) **John Morley**

Responsible Officer (on IDG) **Emma Jane Perkins**

GREEN = On Track

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3.1	**Healthy ageing, including living well with long-term health conditions, and reducing frailty and over 65s falls**										
3.1.1	Empower people towards self care	1. Development of new digital front door	PH/rcc	22/23	p	Number of people accessing front door	initial scoping meeitng to be held 5/12/22		funds to progress this project buy in from across partners		
		2. Full use of the Joy social prescribing platform as the referal route to Rise	pcn/rise	22/23	p	number of rise referals against target for year of 507 from PCN	245 referals to rise from PCN to end Oct 2022 - a rise of nearly 50% seen from some surgeries following introduction of Joy	321 referals received to end of Dec 2022			
		3. Rutland prehab pilot	icb/pcn/active rutland/vol sector	22/23	p	number of residents engaging in prehab activites prior to below the waist operations	intial meeitng held 14th Sept - await numbers from UHL	onhold due to pressures in secondary care			
	also in health plan	4. Recruit dedicated Digital Inclusion and Communications resources to support development, access, and navigation of e.g., Patient Online System/NHS App services/remote consultations/ practice websites (22/23)	pcn	22/23	p	number of patients accessing ppintment online	Linking in with the work of the stakeholder and communications group to ascertain local needs and work with partner organisations so as not to create duplication. Consideration giving to local sessions on how to use the NHS app and patient online services. Linkages to the pilot model in the city.				
3.1.2	Anticipatory care	**1 Monitoring deterioration in a persons health using:-**									
	also in health plan	**1. Whzan – NEWS2/Restore Mini**	Pcn/rcc	22/23	p	number of people admitted to acute from a care home	care home admissions 20/21 = 162 21/22 = 149 22/223 = 32 9 care homes signed up to whzan pilot - pilot starting 1/11/22	pilot started in Rutland care homes			
	also in health plan	**2. Population health management anticipatory care project - pre dementia** **Embed operational and anticipatory care/ population health management approach through Multi-Disciplinary Teams to jointly manage frail, complex and high-risk patients (Jan 23)**	Pcn/rcc	22/23	p	number of MDTs from neighbourhood facilitator number of people engaged with pilot/project"PCN MDT meetings taking place at agreed intervals Increase in identification of patient cohorts identified by the Anticipatory Care regional team • Increase in care planning for above cohorts	new neighbourhood facilitator started 21/11/22" • Target cohort for anticipatory care agreed by end of November 2023 Rutland is one of 7 Anticipatory Care Early Adopter sites across LLR. The Rutland project will focus on holistic assessment and action planning for patients with memory/cognitive issues but no formal dementia diagnosis. Project planning underway, with expected go live in January 2023. Finalise project planning (December 2022), with delivery to commence in January 2023.	project plan agreed - intial stakeholder meeting planned for Jan 2023			
	also in health plan	3. Increase the number of Blood Pressure monitors available for Hypertensive patients to self-monitor (Blood Pressure @ Home) (22/23)	pcn	22/23	p	Rutland Health PCN to increase the number of BP monitors to support Hypertensive patients to self monitor at home. Monitor the use of the BP machines and average waiting times for patients Monitor the use of the BP machines and average waiting times for patients	The PCN now has a total of 180 BP monitors for use across the four practices.				
	also in health plan	4. Implement a proactive framework for identifying and managing frailty, using care coordinators to target support for Housebound and/or frail patients in collaboration with RISE team (22/23) action from strat health plan We aim to implement a proactive framework for identifying and managing frailty, using care coordinators to ensure that all patients are offered 1.Shingles vaccination 2.Screening for dementia 3.Structured Medication Review 4.Referral to integrated care coordinator 5.Falls prevention advice and referral 6.Proactive management of long term conditions and care planning	pcn	22/23	p	Review and evaluate based on: Reduced rate of hip fractures. Increase number of patients with frailty flag using the electronic frailty index. Increased uptake of shingles vaccination. Number of completed structured medication reviews. Number of completed care plans including RESPECT where appropriate. Number of patients referred to Steady Steps and falls prevention services.	PCN DES Inequalities plan targeted at Housebound patients and patients with frailty. Care coordinators are actively identifying selected cohort and proactively contacting patients, identifying those who are experiencing digital exclusion to offer interventions. Integrated care coordinators, working as part of Rutland's RISE social prescribing team provide a comprehensive social assessment, whilst the frailty coordinator ensures that all the health interventions are complete and long term conditions optimised. Plan underway in support for RISE team and WHZAN project.				
		5.. EHCH - Frailty assessment	pcn/ccs	22/23	p	number of care home residents with a frailty assessment/score					
	also in health plan	6.Implement Proactive Care at Home frameworks for managing Cardiovascular Disease Long Term Conditions, using risk stratification to prioritise patient condition reviews (22/23) To deliver the Network Contract DES including the requirements for the delivery of a cardiovascular disease (CVD) prevention and diagnosis service by primary care networks (PCNs).	pcn	22/23	p	Recruitment of 7 clinical pharmacists as a part of the ARRS 2022/23 programme who will help to improve access for CVS risk management.					

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	also in health plan	7. PCN to Increase frailty identification and assessment on collaboration with RISE team by 25% (Oct 22)	pcn								
	also in health plan	8. Increase uptake of community eye scheme provided by local optometrists (22/23) Completion of a business case for consideration by the Strategic Estates Team that demonstrates the utilisation of ringfenced S106 funds that complies with criteria outlined by Rutland County Council. Agreement of S106 funding for re-purposing of a waiting room at Oakham Medical Practice in to additional clinical rooms.	icb?	22/23	p	numbers accessing	??				
	also in health plan	9. All vulnerable patients (including end of life) have quality care plans in place by Oct 22 (22/23)	pcn	22/23	p	number with a quality care plan					
3.1.3	prevention of falls	1. Exercise referral and promotion of active opportunities makes it easier for people to increase their activity levels in a way that works for them.	Active rutland /pcn/dhu/rcc therapy	22/23	p	Living with ill health	paper on future of exercise referal programme to be presented to PH board - Mitch Harper	agreed funding secured for new coordinator poat in Active Rutland Team	funding request not supported by PH		
		2. DHU urgent falls response car		22/23	p	Number of responses by DHU car	Rutland area. Of these 6 were referred into hospital services either via ED or admission pathways and the utilization of urgent transport rather than 999. project extended to march 2023				
		3. Personalised falls prevention programme - Therapy project for support to care homes to prevent falls	LHis	22/23	p	Period No of reported Hip Fractures in Care/Residential Homes July – October 2021 12 July – October 2022 1 Number of care homes engaged in falls project and resulting reduction in number of falls	Four care homes have now enrolled onto the personalised falls prevention programme. Our Falls OT is working collaboratively with the Clinical Care Home Coordinator to ensure accurate reporting of falls from all care and residential homes in Rutland, not just those enrolled onto the programme. Data analysis has started to look at the impact of the programme, initial figures are positive. Falling amongst our most vulnerable cannot be fully eradicated, however this programme is demonstrating a reduction in the impact/severity of falls.	RCC Therapy and Quality Assurance are continuing to work with the 5 Care Homes enrolled onto the personalised falls prevention programme. An integrated approach between Therapy and the Primary Care Network is addressing the inclusion of Chater Lodge. As a cross border surgery this enables streamlined work, avoiding duplication and benefiting from regional best practice. Falling can never be fully eradicated, however this programme is continuing to be demonstrate significant benefit to minimising the impact of a fall. There has been 1 hip fracture reported in the last two months (Oct/Nov) in the care homes enrolled.	Staff Capacity: Currently 1 Full time OT dedicated to falls prevention, as the programme expands capacity would need to be considered. Demand – the programme has created a huge demand on therapy services increasing the falls reporting to unmanageable levels. The programme is constantly evolving, and process is being revised in line with the demand that has been created. This will be seen in the 2023 rollout for the next homes and changes for those enrolled.		
		4. Care homes digital falls monitoring		23/24	p	Reduction in admissions to acute from care homes due to falls	project being led by Lhis - intiial scoping being undertaken of digital access of falls equipment from care homes	Phil Eagle from Lhis assessing number of care homes with digital care records			
	also in health plan	5. Pilot of Falls Crisis Response Service in Rutland (22/23)	Charlie Summers/ Kerry Kaur								
3.2	**Integrating services to support people living with long-term health conditions**										
3.2.1	MDT/collaborative neighbourhood working	1. Weekly care home MDTs EHCH	Rise/pcn/vol/lpt	22/23	**p**	Number of care home weekly board round. Strutured medication review (SMR) residents with a care plan	mdt = 49 for sept 100% rutland homes have a weekly MDT/ward round 100% residents have a SMR tbc care plans in place	MDT = 41 for Nov			
		2. Monthly Rise /asc/pcn in each of the 4 Gp practices			**p**	Number of cases discussed at weekly MDT					
		3. Full use of the Joy social prescribing platform			**p**	number of partners using Joy Outcomes of individuals – ONS4 + qualitative		321 referals up to Dec 2023			
		4. Weekly DN board rounds			**p**						
	also in health plan	5. Neighbourhood monthly meetings			p	Professional experience of MDT working	51 partners/professionals on monthly	meeting held			
		6. expansion of housing MOT to support people with digital access	longhurst/rcc	22/23	p	number accessing servcies digitally	In addition to the launch of the Digital Mot pilot				
		7. fire servce home safety checks	rutland and	22/23	p	target of 650 oakham 50 upingham home	24 warm packs availble for people identified				
3.2.2	MDT access to resident records/information	1. Case management taking place on Joy platform and informing asc LL & PCN S1	Rise	22/23	p	Number of cases on joy platform		rise fully case managing on the joy platform			

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	also in health plan	2. Use of LLR electronic shared care record when available	lhis	22/23	p	number of professionals using the LLR shared care record " • Ensuring all pilot users can access the LLRCR and any issues are investigated, resolved and documented. • Analysis and report of feedback gained throughout pilot • Pilot users are able to successfully navigate the LLRCR and use it routinely. • Information visible aids efficiency and works towards realising benefits. • Successful connectivity • Evaluation of data set provided, Inc. feedback on any additional fields needed for efficiency • Feedback from pilots team on implementation process, incl training and support. •Staff satisfaction of interface and usability "	The Rutland discharge team will imminently be going live as the first team in LLR to pilot the LLR Electronic Care Record to enable key information relating to an individual's care to be shared between all LLR health care settings and Rutland County Council staff (Q1 22/23) " • LPT and Rutland pilot teams ready to go live • Progress on extended UHL data which should be available in the LLRCR towards the end of July • Public engagement and comms continuation - positive feedback so far and good interest • In response to feedback GP connect information tab has been created in the interim of having structured data. This is now more visible in our new top-level tab structure."		too few professionals engaged with this project reduces the gain of using the system		
3.2.3	prompt safe hospital; discharge	1. Minimise hospital stay	Rcc hospital team	22/23	p	Length of stay 14+ days length of stay 21+ days	We currently don't have anyone that is 14 days plus.	Length of Stay isn't a good metric for this, swe have tried to look at the time taken from receiving the Home First form to the point of discharge. Ideally, we'd want this to be happening within 48hrs. However, we've got problems with these figures too – in that PCH sometimes send the form days or weeks before discharge is ready – so we can only really measure the UHL discharges – and looking at these for October (8 in total), only two were within 2 days – the others were all longer, but most of those delays were down to internal UHL processes rather than then RCC delay. Going to continue to explore this to find something we can measure to evidence we're doing what we can to minimise the delay.	measurement to show the outcomes delays are not attributable to RCC but the acute process	continue to discuss at LLR discharge meeitngs	
		2. Discharge to home first	Micare and therapy reablement	22/23	p	Discharge to usual place of residence	micare holding 16/17 cases daily in sept 2022 17 new starts and 15 cases ended of support	micare holding 14 cases a day with 38 D2A cases in Dec 20 new cases and 18 ended durign December	MiCare ability to recruit carers and therefore there might be insufficient capacity to support timely discharge.	full recruitment in place including a new video	
		3. assessment on discharge to right size support	Rcc hospital team	22/23	p	numbers on D2A	30 service users on D2A during September 2022	38 D2A in Dec			
		4. Increased reablement following hospital discharge			p	Reablement – effectiveness 91 days still at home	ave length of stay on reablement = 13 days for sept 22 Effectiveness – 100% in September Still at home 91 days after Reablement commenced – 100% in September	ave length of stay on reablement = 14 days effectiveness 100% dec 2022 100% still at home 91 days after reablement	Staffing: Ageing Well monies have been used to employ Therapists to cover weekend working, but unlikely to get repeat funding next year. No weekend OTs may impact on timely flow through		
	also in health plan	5. Implement Ageing Well Urgent Crisis Response 7-day therapy new ways of working in Rutland (22/23)	Rcc hospital team	22/23	p						
	also in health plan	Enhancing the end-of-life discharge pathway through testing an integrated EOL social care bridging and co-ordination offer (22/23)	Rcc hospital team	22/23	p		Currently a pilot being offered by ICRS to specific county resident post codes. Referrals continue to increase for County patients into the ICRS EoL service for patients in last weeks and month of life, supporting step up and discharge. Reducing reliance on CHC.				
3.3	**Support, advice, and community involvement for carers**										
3.3.1	support for carers	1. Identifying carers Identification of carers to be improved through distribution of information, improved online content and face to face engagement activities across the county to raise awareness and recognition of carers, their rights, needs and support available. This will include raising awareness with carers themselves, professionals and the wider public.	Rcc	22/23	p	Increase number known to RCC/PCN					
		2. Providing support Support to be provided for adult carers of adults directly through RCC's Carers Team and additional support available for carers of those living with dementia through the Admiral Nursing service. Support includes information, advice and signposting to other agencies, eg local voluntary partner agencies. Carers Passports to be available to carers of all ages to support with accessing services and valuing carers. RCC to explore signing up with Carefree to offer free short breaks to adult carers of carers.	rcc		p	Satisfaction and carers ability to care	The draft LLR Carer Strategy will go to cabinet on Dec 13th for sign off. Following further consultation by RCC, carers feedback has informed both the strategy and our local delivery plan.				

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		3. Launch of new carers support group – Oakham 'together we care'	carers centre	22/23	p	numbers attending group	launching on wed 9th Nov at St Josephs church hall 1 - 2.30pm				
3.4	**Healthy, fulfilled lives for people living with learning or cognitive disabilities and dementia**										
3.4.1	supporting people with LD and autism	1. Annual health checks	Rcc	22/23		% Number of LD health checks completed					
		2. Sharing Leder findings	rcc	23/24	s		The Autism Strategy Working Group will be meeting in November. This will begin the foundation of the delivery plan, identifying task and finish groups to work on the areas where there are gaps and mapping good practice. This is across all ages.	Dec's Leder steering group attended by RCC Manager. 2 leder governance summaries shared with current Learning into Actions identified These will be added to RCC's Leder CPD prsenatation. Aspiration Pneumonia Thematic analysis has been completed, health and clinicians are meeting to see how best to proceed with the learning from report.			
		3. Providing specialist care close to home		22/23	p	Qualitative feedback from this cohort number being carered for out of county					
		4. Supporting people with LD/autism to access vol/work/education opportunities		22/23	p	% Number in employment	RCC's employment officer has unfortunately been sick for the last few months, impacting on the delivery of this service	RCC's employment Officer is now back from sick leave. Currently working with 10 indiviuals who are wanting to either gain paid employment or voluntary positions. All 10 have outcomes and action plans to work towards.			
3.4.2	supporting people with dementia/cognitive impairment	1. Increase in identification of people likely to develop dementia through anticipatory care project – using Aristotle PHM tools	PCN	22/23	p	Number of people identified at risk of developing dementia	meeting to plan project 9/11/22				
		2. Increase diagnosis rate for Rutland population	icb memory clinic	23/24	s	Number of people with a diagnosis of dementia					
		3. Equity in access to admiral nurse	Admiral Nurses		p	Admiral Nurse service availability % number of people supported by admiral nurses	Referrals have increased to our dementia service following the targeted work on pre/peri diagnosis to support those waiting for a diagnosis and as part of the further complexities resulting from Covid. Due to cost savings required by the LA, we are not able to recruit to a dementia support worker for another 12 months, which will result in a waiting list for this service to manage risk and demand.				
		4 increase support opportunties for familes/carers/people with dementia	vol sector	22/23	s	number attending sailing club sessions	As part of the Living Well with Dementia Grant Fund, the Dementia Programme Board of Leicester, Leicestershire, and Rutland (LLR) have secured funding to support voluntary and community sector organisations (VCS), to enable them to continue to develop their work with people living with dementia, their family or informal carers. We are part of the VCS Dementia Grant Phase 1& 2 evaluation panel. In Phase 1 Rutland Community Ventures (RCV) were awarded funds to support carers of those awaiting or coping with a new diagnosis within Rutland. The aim is to run 4 workshop sessions, which will be craft based, offering an opportunity for conversation, and sharing at the end of the session . These will be run in a dementia-friendly environment at the Rutland Sailing Club.				

Priority 4: Ensuring Equitable Access to Services for all Rutland Residents and Patients

Senior Responsible Officer (on HWB) — **Debra Mitchell**

Responsible Officer (on IDG) — **Charlotte Summers**

GREEN = On Track

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4.1	**Understanding the access issues**									
4.1.1	Indentify services that are commissioned locally in Rutland via the LLR and ICB and map equivalent services available across the neighbouring borders. To include both Primary and secondary care. Identify the cohort of patients who are registered with a Rutland GP but outside of Rutland. Finding to inform future pathway design.	Identification of the number of patients who are registered with a Rutland GP but live outside of the Rutland CC boundary. Identification of patients who live inside the Rutland boundary but access GP services outside the Rutland CC boundary. Identify issues of health and social care provision across borders to inform targeted work looking at certain cohorts of patients. Check services available in Leicestershire and indentify pathways in neighbouring counties and vice versa. Indentify top ten secondary care referral specialities for Rutland patients. Identify top ten reasons for attendnace at A&E for Rutland patients. Identify top ten reasons for admission in to secondary care for Rutland patients. Identify RMH community hospital inpatient bed utilisation and occupancy rates, including Rutland patients who are admitted to a community hospital bed outside of Rutland. Operational Service mapping of key OOA pathways where there are inequalities	ICB	Apr-23	Place	Report on border issues Documented mapping of key OOA service pathways and reference to specific issues Agreement on areas of focus of inequalities as part of delivery of PCN Network DES Agreed data sets and reports available for Rutland on Aristotle.	Baseline of data available from the initial population health management work that idenitifies both patients who are registered with a Rutland GP but live outside the Rutland CC boundary and patients who live inside the Rutland CC boundary but are registered with a GP outside of Rutland. Additional deliverables have been included from November which will include further work in the coming months but key meaurement metrics have been indetified.	Variability in the availability of certain data from different providers. Some data may not already be routinely collected.	Work closely with Midlands and Lancs CSU and providers to ascertain whether it is feasible to establish regular data collection to inform measurement of the metrics.	Amber
4.1.2	Develop strategic relationships with cross border commisisoners and providers to ensure equitable services are developed and available ensuring Rutland's residents and those registered at a Rutland GP have greater choice across boundaries and inform future strategy development of partner ICB's. Build equitable access into pathway design.	Greater understanding of services that patients access or should be able to access across borders in Peterborough, Lincolnshire, Northamptonshire and Cambridge. Check services available in Leicestershire and indentify pathways in neighbouring counties and vice versa. Established links with associate commissioners and other partner agencies to inform future commissioning arrangements. Patients will feel more informed with regards to the services that they can access, where they can access and the different services available other than an appointment with a GP. Highlighting different roles such as first contact physio, clinical pharmacist, mental health practitioners.	ICB	Apr-23	Place	Improved patient feedback from people reporting health and care inequity Established regular meetings with associate commissioners and regular two way dialect.	Regular meetings have been established with assocate commissioners to better undertstand the devlopment of their place led plans. They have also been invited to attend the Rutland Strategic Health Developments Board. We have shared our local plans with both providers and commissioners so that our plans can be considered when developing theirs. Working collaboratively with Lincolnshire on the planning for a new housing devlopment and on the borders between Stamford North and South Kesteven. Anticipating the impact on local health care provision and how this can be mitigated.			Amber
4.1.3	Work with local Rutland population to understand the key issues that they identify as a patient living in a rural location such as Rutland. Publicise the wide range of services and extended roles available through primary care. Patient and public engagement to inform long term plans.	Engage with the local population with regards to the design of the enhanced access service. Address the key recommendations from the RCC Primary Care Access Survey. Engage with PPG's and Rutland HealthWatch	ICB	Apr-23	Place	Number of survey responses Patient feedback Progress against the individual recommendations outlined in the Primary Care Accesss Survey.	Comms and enagement working group established.			Amber
4.2	**Increase the availability of diagnostic and elective health services closer to home**									Amber
4.2.1	Improving public information about locally available diagnostic and planned care services as part of increasing access including urgent care and when mobile facilities such as the mobile breast screening unit are in the area, and accessible out of area provision.	GP, PCN and Rutland Information Service having dedicated areas on their websites/directories with information that is kept up to date and active signposting to out of county equivalent services. Map all local services available.	ICB	Apr-23	Place	Local communication plan and RIS development including specific campaign on out of hours access				Amber
4.2.2	Develop understanding of used and vacant space at Rutland Memorial Hospital to inform scope for potential solutions. Followed by strategic review of other vacant space that could enable health services closer to the population.	A completed estates review that identifies all areas that are curently being used, idenitfy areas for consideration not just from a health pespective but local authority and other local businesses such as leisure centres and voluntary sector organisations.	ICB	Apr-23	Place	Quantified understanding of available space and existing medical facilities' appropriateness for clinical activity	LPT strategic estates review currently underway which should be complete by January. MIU engagement to start in January. Preliminary engagement event held with Rutland HealthWatch RCC are also undertaking a strategic estates review. Stakeholder mapping currently underway.			Amber

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4.2.3	Review and identify potential solutions for Elective and Community services feasible for closer local delivery, to maximise the use of local existing estates Infrastructure whilst supporting restoration and recovery post covid including considering e.g. cancer 2 week wait, cardio respiratory services and orthopaedics and the delivery methods for such services i.e. virtual or face or face, satelite clincs. Consider longer term options for children's services (incl phlebotomy), end of life, chemotherapy and diagnostics. Consider both new and existing infrastructure sites including Rutland Memorial Hospital (RMH).	Clarity of what services are delivered by GP practices, PCN, PCL, Acute and Community Services both locally and out of county. Review waiting lists for key priority areas. Explore potential areas for consideration to support reduction in waiting times and post covid back log for elective and community services.	ICB	Apr-24		Review of current and potential services delivered at RMH Evaluation of AI Tele - dermatology service Increase in availability and access to services locally	Talks have been continuing with regards to the potential for a local MRI scanner, funding through a local charity has been sourced but housing of the unit is still to be resolved. The unit has special requirements and restrictions for power supply and also access to facilities for patients attending.	The unit has special requirements and restrictions for power supply and also access to facilities for patients attending.	Additional sites for housing the unit are being considered.	**Amber**
4.2.4	Explore the possibility for a localised Pulmonary Rehabilitation Service through the evaluation of the pilot project in train to inform local feasibility models/review in Rutland.	Establish current usage of pulmonary rehab, anticipated future requirements and commissioning a service to be provided locally if required.	ICB	Jun-23	Place	Evaluation of local pulmonary rehabilitation take-up Increased take-up of pulmonary rehabilitation by relevant patients	No update on progress to date			**RED**
4.2.5	Develop a longer term locally based integrated primary and community offer and supporting infrastructure for the residents of Rutland, driven forward by a dedicated partnership Strategic Health Development Group.	Establishment of Integrated Neighbourhood Teams by: Adopting a Population Health Management approach including risk stratification Delivering co-ordinated care at a local level Multi-disciplinary teams (MDT) working to deliver better outcomes Delivering a preventative approach to care, with access to a local prevention offer including social prescribing				Partnership agreement on way forward and dedicated plan on next steps	Integrated neighbourhood network established and meeting on a monthly basis. Monthly MDT's taking place			**Amber**
										Amber
4.3	**Improving access to primary and community health and care services**									
4.3.1	Improve access to primary and community health care: In primary care, take steps to increase the overall number of appointments in comparison to a baseline of 2019 and to ensure an appropriate balance between virtual and face to face appointments. (NB dependency on premises constraints). Increase uptake of community eye scheme provided by local optometrists and monitor usage. In community health, understand and work to reduce waiting lists/wait times for key services such as dementia assessment, community paediatrics and mental health.	Increase the undertstanding locally of the extended primary care team and the many ways in which an appointments can be booked . Implmented enhanced access locally More appointments in total in comparison to 2019 but acknowledgement of the wide range of appointment types available. Increase in the number of patients accessing the community eye scheme in comparison to baseline. Increase referrals to the community pharmacy referral scheme. A review of key services and waiting lists/times and put appropriate and deliverable plans in place to address whilst maximising the use of out of county providers and provision of more local services where possible.				•Increased access to GP practice appointment in comparison to 2019 •Appropriate proportion of appointments delivered face to face in comparison to Aug 21 baseline •Qualitative feedback on GP practice access across Rutland •Identified waiting lists/wait times reduced	Enhanced access was implmented from October 2023. Services are now available from 6.30 - 8.00pm Monday to Friday and 9.00 - 5.00pm on a Saturday. The most recent GPAD data demonstrates that all four practices are delivering more appointments than in comparison to pre-pandemic levels.	Phlebotomy blood collections	The ICB has been in negotation with UHL for addirional weekend blood collections. A paper has gone to SCG in December and it is hoped that PCN's can start to delivery a full saturday phlebotony service from Janaury.	**Amber**
4.3.2	Informing patients. Review PCN and practice website developments and online tools including review of usage data analysis to inform further website enhancements and engagement with registered population.	Standardised format for all 4 PCN practices making navigation easier. Recruitment of a digital inclusion officer (subject to funding) to work with patients to educate on the use of NHS app and websites. How to book appointments online, online consultations. Direct work carried our with the patients and public of Rutland to communicate the many services/clinics available and the varied roles. The role of care navigators and reception staff. Informing patients when appointments are released.	PCN	Apr-23		•Evaluation of PCN and practice websites and future developments.	PCN to look at reviewing each of the practices websites for usability and easy navigation. PCN is currently considering the the recruitment of a digital transformation lead as a result of additional in years scope with ARRS. This will also feed in to the work of the Comms and Engagement group.			**GREEN**
4.3.3	Review local pathways, with focus on: a)Satellite clinics nearer to Rutland – e.g. Joint injections at RMH being explored to manage local backlog b)Community Pharmacy Consultation Service (CPCS) pilot to support increase in referrals in key areas and reduce pressures in Primary care. This will be supported by the Rutland Pharmaceutical Needs Assessment.	Reduction in the number of patients waiting for joint injections. Increase in the number of patients being referred to community pharmacy and reduction in appointments in primary care that relate to conditions within the remit of CPCS.	ICB	Mar-24	Place	•Review of joint injections pathway •Reduced joint injection backlog •Reduced pressure on primary care •Review of community pharmacy services •PNA complete for October 22	**Update from Helen Mather Required**			**Amber**
4.3.4	Maximisation of clinical space utilisation within primary care including existing primary care premises.	Undertake a clinical estates strategy. Seek to increase clinical consultantation rooms at Oakham Medical Practice via S106 investment. Explore potential Increase in designated clinical space at Uppingham Surgery.	PCN	Jun-23	Place	•Practices with increased consulting spaces •Increased appointment capacity	There has been a slight delay in the production of the clinical estates strategy for Rutland and this is now antipated by end of January/early February. Amendments are currently being made to the Oakham S106 business case and will be submitted for consideration by RCC in Janaury 2023.			**Amber**
4.3.5	Review of GP registrations in the context of seldom heard or under-served groups to increase coverage where required for communities such as the travelling community, veterans and armed forces families (i.e. health equity audit learning from Leicester City Approach).	Establish links with primary care providers for military personnel. Identiication of seldom heard or under-served groups and increase in uptake of services via targeted comms and engagement.	ICB	Mar-24	Place	•Health equity audit on GP registrations	Comms and enagement working group established.			**GREEN**
4.3.6	Ensuring full use of specialist primary care roles tailored to needs (e.g. practice pharmacist, muscular-skeletal first contact, health coach).	Increase in number of ARRS roles year on year Increase in the number of patients being seen by these roles. Maximisation of ARRS allocation Increase in staff undertaking training and further development.	PCN	Mar-23	Place	•Employment and delivery of specialist primary care roles in Rutland •Impact on primary care capacity of specialist roles	All clinical pharmacists posts recruited to. Maximisation of ARRS allocation in year. Exploration of a digital and transformation lead as a part of the changing guidance in October.			**GREEN**

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4.3.7	Engage with local Armed Forces Defence Medical Services (DMS) to better understand to improve local health and social care interactions with regards to local service offers and and pathways. facilities to inform changes in local Health and Care services including referral processes/documentation e.g. RMH provision.	Establish links with primary care providers for military personnel. Identiication of seldom heard or under-served groups and increase in uptake of services via targeted comms and engagement. Reduction in barriers to referral to secondary care services.	Put in inequalities section links to service movements			•Qualitative feedback that local services better reflect the needs of the military population				
4.3.7	Develop a single point of contact for the Armed Forces community, offering support and guidance to navigate the (local) NHS systems and prevent disadvantage	Develop and outline LLR wide model to act a as a single point of contact embedding key elements of the due regard framework. Due regard for the armed forces in health referral e.g. duty to consider this population in pathway navigation and communicating appropriate health offers locally.	ICB	Sep-24	System	National and local pilot evaluation. Metrics to be agreed.	Task and finish group being established to work a model up by the end of January.			**GREEN**
4.3.8	Development of a Rutland wide partnership community transport project to look at demand and response bus service models with outline of enabling financial models. This will include current pilots e.g. Community Transport pilot in Uppingham.	****Identify lead for this****	RCC			•Pilot evaluation report of findings and recommendations •Options appraisal of community transport models including collaborative financial strategy with Parish Councils				
4.4	**Improving access to services and opportunities for people less able to travel, including through technology**									
4.4.1	Decrease digital exclusion and Increase digital inclusion by targeting people who want to use technology to improve access to services and/or reduce social isolation. a. Collaborative approach across involved agencies and services. Identify reasons for digital exclusion e.g, affordability, skills, confidence, connectivity, choice. Support to take up digital services e.g. access to medical record, booking appointments, virtual appointments, prescription ordering. b. Fit for purpose local internet infrastructure and access across Rutland including access to high speed broadband within community setting such as libraries. Advice to support household choices.	Increased number of people booking on line and using the practice websites. Increase in number of patients being seen virtually. Increase number of patients with digital access to their health care record. Provision of digital enablement sessions - training on how to use the NHS app and practice websites. Promotion of onine access at local events Consideration of a digital transformation lead within the PCN. Increase in number of location public access points for high speed broadband. Standardisation of the practice websites so they all have the same navigation for ease of use. Consideration of services that may be able to be offered virtually. Monitoring of website usage and collection of patient feedback.				•Number of people digitally enabled. •Residents in Rutland have the option to subscribe to high speed broadband •No. of public access points for high speed broadband •Number of people with access to their GP record •Numbers of people using the NHS app to order repeat prescriptions and make GP appointments against the baseline comparator. Practice website usage data and feedback Number of people attedning NHS App training sessions	Standardisation of practice websites being looked at, at a PCN level. PCN currently scoping the potential of a digital transformation lead. Work underway to see what baseline data we can capture for a number of the metrics.	Originally a business case was going to be written for consideration against BCF underspend for the digital enablement element of this work but this is no longer available.	Instead this will be taken forward through the work of the comms and engagement group, linking in with key stakeholders, local volunteers and linking with the PCN Digital Transformation Lead.	**AMBER**
4.4.2	Identify existing issues and routes /modes to improve physical access to services from rural areas by working with RCC Transport Plan team (including through further travel time mapping for different modes of transport and times of day, to support wider planning, also considering out of area access to services and ambulance response times).	****Confirm Reporting Lead for this element****				•Review of current transport routes and health inequalities needs assessment •Rutland travel time and bus route napping including costs				
4.4.3	Delivering commissioned services within Rutland. Encouraging LLR services commissioned from third party providers to be offered directly in Rutland including through venue support.	Review which third party services are provided and consister whether they are able to be delivered locally in Rutland. Increase in number of venues identified that can be used for health and social care service delivery. Identification of services that can be offered locally that were originally accessed external to Rutland.	ICB	Apr-24	Place	•More services delivered within Rutland wherever possible				
4.5	**Enhance cross boundary working across health and care with key neighbouring areas**									
4.5.1	Undertake an Out of Area contract review of LLR CCG commissioned services	Identify key contracts that are used by Rutland out of area.				•Review of cross boundary working across health and care				
4.5.2	Phase 2 of electronic shared care records including sharing with organisations not on the LLR Care Record system, notably out of area providers and other specialist providers including Defence Medical Services. Dependency on national shared care record programme. Explore potential for future digital referral routes from out of area.	**** Update from Sharon Rose Required****				Electronic shared records implemented across a range of health and care providers				

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4.5.3	Maintain close operational working with neighbouring CCGs, Councils and associate commissioners in Lincolnshire, Northamptonshire, Peterborough and Cambridgeshire with an initial focus on Primary Care impact on local provision, and implications of UHL restructure on demand for out of area services. Consider representation on respective governance groups.	Establish links with neighbouring commissioners and providers and establish regular dialect.	ICB	Mar-23	Place	Clear links with local CCGs and LAs re cross boundary working	Regular meetings have been established with assocate commissioners to better undertstand the devlopment of their place led plans. They have also been invited to attend the Rutland Strategic Health Developments Board. We have shared our local plans with both providers and commissioners so that our plans can be considered when developing theirs. Working collaboratively with Lincolnshire on the planning for a new housing devlopment and on the borders between Stamford North and South Kesteven. Anticipating the impact on local health care provision and how this can be mitigated.			GREEN

New Enhanced Access service resulting in more appointments available a minimum of two weeks in advance, and a mixture of in person face to face and remote (22/23)
Consider a local Enhanced Access service (part of review of access to primary and urgent and emergency care) encompassing same day access for Primary Care, Urgent Care, including (Minor Injuries), and Frailty Care

Recruit dedicated Digital Inclusion and Communications resources to support development, access, and navigation of e.g., Patient Online System/NHS App services/remote consultations/ practice websites (22/23)

Review GP registrations in the context of unique or under-served groups to increase registration for Health Services e.g., Armed Forces Families and Traveller Community (23/24)
Develop an enhanced access model that supports access to same day appointments. (22/23)
Review Minor Injury Service provision and Urgent Treatment Centre provision to ensure that it meets the needs of the local population and reduces the need for presentation at ED. (22/23)
Identify the highest utilised ED's out of county and across borders in relation to Rutland residents looking at reasons for presentation and reviewing associated pathways (22/23)
Expand the number of Clinical Pharmacists working locally who can treat Minor Illness such as coughs, UTI's and Cellulitis and Long-Term Conditions. (22/23)

Priority 5: Preparing for our Growing and Changing Population

Senior Responsible Officer (on HWB) **Sarah Prema**

Responsible Officer (on IDG) **Jo Clinton**

GREEN = On Track
AMBER = Off track but

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5.1	**Planning and developing 'fit for the future' health and care infrastructure**									
5.1.1	Work with local/ neighbouring Integrated Care Systems (ICSs) partners to share information to ensure in border and cross border population health impacts are consistently understood	•LLR CCGs PCES Population Model that shows impact on health infrastructure as a result of growth in the Rutland border • Documented population health impact of Stamford North Housing Developments outside of the border shared with partners • Routine joint dialogue between partners •Initial baseline of Non Local plan impact by Rutland LSOA • Ongoing 6 monthly reviews and updates of latest LSOA level impact vs initial baseline position •RCC and Neighbouring LPA approach to prioritisation and CIL allocation plans is in place and visible to partners •Agreed population model with robust methodology that can be used to support dynamic impact modelling by LSOA •Work with Rutland County Council to facilitate development of a set of options for a Health Campus /Medi-tech trials facility	RCC/ICB	Apr-24	Place	•Aligned fit for the future plans with neighbouring ICS's • Healthcare is confirmed as priority for infrastructure funding and recieved adequate support in line with growth and impact • Understanding of current CIL funding including trajectory of allocations and any unallocated funding • Understand where Healthcare sits in wider prioritisation of infrastructure support • Agreed updated Information requirements and timely sharing with health partners to inform dynamic modelling •RCC to undertake a Community Infrastructure Levy (CIL) policy review with due consideration of enabling greater support for local healthcare infrastructure to ensure this is a key priority area of support going forward •Health Strategic Partners Involvement in CIL review process and receipt of report on new policy implications	• ICB has provided comments on the Rutland Local Plan Issues and Options • CIL Cabinet paper has been developed by RCC which indicates priorities for CIL funding inc Healthcare • Awiating site list with relevant information from RCC to enable baseline model			Amber
5.1.2	Work with in county and out of county providers and commissioners to cross share plans for Healthcare to inform future local service provision	• Routine joint dialogue between partners on latest plans and possibilities for joint solutions •Aligned fit for the future plans with neighborhing Places to inform local commissioning in and out of county provision in the future • Agreed LLR representation on North Place Alliance • Ongoing Engagement with OOA senior transformation leads for Primary Care and Planned Care Transformation • Cross sharing of latest LLR and OOA CDC plans with understanding of timelines and key service offers to plans impacting Rutland residents	ICB	Apr-24	Place	•Aligned fit for the future plans with neighborhing Places to inform local commissioning in and out of county provision in the future • Documented population health impact of Stamford North Housing Developments outside of the border shared with partners • Understanding of emerging options for joint solutions on the Stamford and Rutland border • Joint messaging around direction of travel for cross border developments in place and evolving over time	• Established partnership links with our Local Planning Authority (LPA) and commissioning partners not only in Rutland but over the border with Lincolnshire ICB and South Kesteven Local Authority. Extended to include Allison Homes for developments in Rutland and Gummer Leathes in Stamford, with regular meetings now in place • Meeting with Andrew Pike has taken place to see whether there are any learnings from other areas in how to take fwd locally • Regular meetings with ICB lincs are taking place to ensure allignment of Primary Care Clinical and Estates Strategy • Stage 1 Outline Proposal submitted to National LUF Team	Local Primary Care Project Provider for LLR Wave 1 programme has been de commissioned and a new provider to take fwd is being identified. This will result in delay to development of Rutland PCN Clinical and Estate Strategy		Amber
5.1.3	Enable a fit for the future local healthcare	• Documented PCN Clinical and Estates Strategy to inform how future clinical strategy can be supported to deliver going fwd. • Business Cases development and approvals for future Estate solutions •Undertake strategic site feasibility review of local Health Estates including Rutland Memorial Hospital	ICB	Apr-23	System and Place	• Identified PCN clinical priorities and reccomendations for future sustainable solutions that are documented and that can inform the delivery of the Healthcare Plan • Quantified understanding of available space on site at Rutland Memorial Hospital within existing medical facilities' appropriateness for clinical activity against criteria • Develop a Business Case for RMH based on feasibility findings	• Rutland Health PCN are being engaged as part of phase 1 of LLR programme to develop Clinical/Estates Strategy. • Feasibility work has been commissioned by the ICB and is in development for findings to be shared by end Feb • Oakham Business case is still being finalised and is currently sitting with the Strategic Estates Team. Once finalised it will be submitted to the Strategic Estates Group for consideration.	Local Primary Care Project Provider for LLR Wave 1 programme has been de commissioned and a new provider to take fwd is being identified. This will result in delay to development of Rutland PCN Clinical and Estate Strategy		Red
5.2	**Health and care workforce fit for the future**									
5.2.1	Develop training for new ways of working	Ensure appropriate local development opportunities are being accessed by all roles where available i.e. Community Pharmacy Academy development programme - for Occupational Therapy, Clinical Pharmacist, Paramedic connected to Network, muscular-skeletal first contact staff and health coach	PCN/RCC	Apr-23	Place	•Completion of PCN training courses and evaluation of training and impact on patient outcomes	James / Emma Jane to Advise			
5.2.2	PCN continue to expand on its Additional Roles Reimbursement Scheme	• Recruitment of all ARRS roles outlined in the 2022/23 workforce plan for Rutland Health PCN • Looking at care co-ordination and clinical pharmacists' capacity	PCN/RCC	Apr-23	Place		The PCN has ran a very successful Clinical pharmacist recruitment campaign which will equate to 7 new clinical pharmacists joining the PCN. They also have in train 1 wte first contact physio, 4 care coordinators which will support a lot of the care planning and proactive care work.			
5.2.3	Develop Career Development Structures	• Mat to advise whether to remain, be changed or removed • Consider projects to increase career development and satisfaction for retention e.g. via delegation of health tasks	RCC			•Carer development and increased potential for workforce •Proportion of health and care staff remaining in work after 55	Mat to advise whether to remain, be changed or removed			
5.2.4	Promote local Career Opportunities	• Mat to advise whether to remain, be changed or removed • Increase engagement with local young people around careers in health and care, including through collaboration with schools and opportunities for work experience	RCC			•Sustainable health and social care workforce •Increase in proportion of staff in health and care sector locally	Mat to advise whether to remain, be changed or removed			
5.3	**Health and equity in all policies, in particular developing a healthy built environment aligned for projected growth**									

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5.3.1	Embed Health and Equity in all strategies and policies across Rutland County Council and then partner organisations	• Core partnership working group estavblished to take this forward in an agreed timeline • To consider their impact on mental and physical health, health inequalities and climate change. This will include Health and Equity Impact assessment development and training. See 2.4. • Public Health and Health Strategic partners to support the Planning Authority on the RCC Local Plan development to maximise the opportunity for a healthy built environment aligned to projected growth in Rutland. Work will utilise the national evidence base combined with locally developed resource, for example the 'Active Together – Healthy Place Making' toolkit. • Completion of a Health Impact Assessment of the Local Plan at the appropriate point of development with clear recommendations for mitigation and/or enhancement.	PH	TBC	Place	•Completion of a Local Plan Health Impact Assessment with clear and achievable recommendations •Progress against identified recommendations in the Local Plan development •Health and Equity in all policies embedded across Rutland Completion of a Health Impact Assessment of the Local Plan at the appropriate point of development with clear recommendations for mitigation and/or enhancement.	Paper for RCC being developed in New Year. Leicestershire are looking at a HiAP training package, which we will be utilising in Rutland if it's agreed. We're waiting for this offer to be finalised and then we have more of a 'sell' for the broader HiAP paper and recommendations as this one will be more tangible. The Whole Systems Approach to obesity work the Staying Healthy Group will be working on will be an example of HiAP			**GREEN**

Priority 6: Ensuring People are Well Supported in the Last Phase of Their Lives

Senior Responsible Officer (on HWB) **James Burden**

Responsible Officer (on IDG) **Charlie Summers**

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RED = Off track and at risk
GREY = Not Started
BLUE = Complete

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6.1	**Each person is seen as an individual**									
6.1.1										
6.1.2										
6.2	**Each person has fair access to care**									
6.2.1		Refresh our JSNA and LLR all age end of life strategy (22/23)					LLR strategy to be in draft form by March 2023 - meetings being arranged to review both the EOL Ambitions Framework and JSNAs to ensure where strategy needs to focus - other work will form part of EOL task force workplan			
6.2.2										
6.2.3										
6.3	**Maximising comfort and wellbeing**									
6.3.1		Strengthen our community palliative and end of life care offer (22/23)					This is included within the revised Statutory Guidance for ICBs and will form part of LLR EOL task force workplan			
6.2.2		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 (22/23					System-wide launch of ReSPECT V3 planned for 2023 - this will include training and comms to system partners.			
6.2.3										
6.3	**Care is coordinated**									
6.3.1		Improve access to end-of-life care provision through design and mobilisation of a 24/7 advice line for patients, carers, and professionals (23/24)					Proposals to be considered as part of EOL task force workplan.			
6.3.2		Enhancing the end-of-life discharge pathway through testing an integrated EOL social care bridging and co-ordination offer (22/23)					Currently a pilot being offered by ICRS to specifica county resident post codes. Referrals continue to increase for County patients into the ICRS EoL service for patients in last weeks and month of life, supporting step up and discharge. Reducing reliance on CHC.			
6.3.3		Increase advance End of Life Care Planning by using risk data tools to identify people reaching last years of their life (22/23)					part of the national core metrics data for 'improving access' will be to identify their last year of life and percentage of individuals in the last year of life who have been offered personalised care planning - quarterly reporting from start of Q2			
6.4	**All staff are prepared to care**									
6.4.1		Quality and co-production review of patient and carer experiences at end of life. Ensure end of life remains everyone's business through appropriate training and support (22/23)					•Commissioned a co-production piece of work, which resulted in the identification of an approach for co-production. However, this needs support to mobilise and will be picked up via home first agenda			
6.4.2										
6.5	**Communities are prepared to help**									

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6.5.1		Raise local awareness to Integrated Community Specialist Palliative Care Service, specialist nursing, virtual day therapy, befriending support (22/23)					There are plans to have a communications campaign that pulls together the golden thread of 'Home First', which will include key messages for EOL support			
6.5.2										
6.5.3										
6.5.4										

Priority 7a: Cross Cutting Themes - Mental Health

Senior Responsible Officer (on HWB) - 7a Mental Health **Mark Powell**

Responsible Officer (on IDG) - 7a Mental Health **Justin Hammond**

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7.1	**Supporting good mental health**									
7.1.1	Increase access to perinatal Mental health support services, wherever Rutland women have chosen to give birth.	1.2.2 Healthy lifestyle information for women pregnant or planning to conceive (c) mental health.	LPT	2022/23	System		Not yet underway.			Grey
7.1.2	Understand the gaps in service reported by service users where children and young people need help with their mental health but have not reached the thresholds for mainstream mental health services, or have reached thresholds but are on waiting lists for CAMHS services, and ways to address these, including via new local services and low level/interim support offers delivered through library and wider commissioned and community services. Factor in anticipated future changes e.g. end of Resilient Rutland funding for children and young people's counselling in 2023.		LPT, PH	2022/24	Place and System		Not yet underway.			Grey
7.1.3	Increasing local resource to respond to children and young people's mental health need through implementation of Key Worker role, Mental Health support workers support in Schools, contribution of Resilient Rutland programme (funding ending Jan 23). Support to families on waiting lists and for those requiring support but not reaching CAMHS thresholds. Parallel support for parents and carers of children and young people with mental health needs.		LA, VCS, CCG	2022/23	Place		Not yet underway.			Grey
7.1.4	Transformation project for Rutland- Ensuring Mental Health services are delivered in Rutland including; a) Supporting services via funding bids: (Mental Health VCS grant scheme – crisis café - second round June 2022, Small grants - £3k - £50k - second round to open June 2022, OPCC commissioner safety fund – up to £10k) b) A clear co-designed approach to supporting farmers' and other individuals' needs linked to rurality c) A clear co-designed approach to better meeting veterans' and armed forces families' mental health needs d) A clear local plan to better coordinate care across neighbouring service areas		LPT/ CCG/ RCC	2022/23	Place and System		Early actions underway: * Publicising open calls for funding bids to local agencies. * LLR workshops underway developing system and place MH plans. * Third round of senior mental health lead recruitment underway for Rutland.			Green
7.1.5	Increased response for low level mental health issues. Promotion of recognised self-service self-help tools and frameworks notably Five ways to wellbeing. Expansion of capacity in local low level mental health services and closer working between involved local agencies and services, including in the voluntary and community sector and peer support, so more people access help sooner in their journey. Opportunities to develop resilience skills, e.g. through the Recovery College.		PCN, LPT, RCC, VCS	TBC	Place		* LLR workshops underway developing system and place MH plans. * Third round of senior mental health lead recruitment underway for Rutland.			Green
7.1.6	Deliver on the Long-term plan objectives for mental health for the people of Rutland: a) Move towards an integrated neighbourhood based approach to meeting mental health needs in Rutland b) Annually assessing the physical health needs of people with Serious Mental Illness (SMI) in Rutland c) Aiding people with serious mental illness into employment d) Delivering psychological therapies (IAPT - VitaMinds) for individuals as locally as possible to Rutland		LPT, PCN, RCC, VitaMinds	2022/23	System and Place		* New neighbourhood facilitator in post to organise MDT holistic approach of support. * LLR workshops underway developing system and place MH plans. * Agreement of physical space for Vita Minds to deliver support from within Rutland. * Resources agreed and transferred to Rutland Council by CCG to support development of prevention and resilience schemes.			Green

Priority 7b: Cross Cutting Themes - Inequalities

Senior Responsible Officer (on HWB) - 7b Inequalities **Mike Sandys**

Responsible Officer (on IDG) - 7b Inequalities **Adrian Allen**

GREEN = On Track
AMBER = Off track but mitigations in place top recover
RED = Off track and at risk
GREY = Not Started
BLUE = Complete

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for December 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
7.2	**Reducing Health Inequalities**									
7.2.1	Complete a needs assessment to understand the current health inequalities in Rutland. The assessment will apply a rural lens, considering hidden deprivation and the resultant needs, calling on wider sources of intelligence across the community, voluntary and faith sector. The assessment will also focus on geographical inequality, inclusion health and vulnerable populations.		PH	2022/23	Place		Health inequalities study well underway, engaging partners to maximise local insight. The report is on the HWB forward plan for Autumn 22.			BLUE
7.2.2	Embedding a proportionate universalism approach to service delivery including principles of the CORE 20 PLUS 5 and HEAT tool. Targeted support based on need including for families and communities who experience the worst health outcomes across Rutland e.g. military, rurally isolated, carers, SEND, LD children in care etc.		All	2024/25	Place and System		Not yet underway.			Grey
7.2.3	Strengthen leadership and accountability for health inequalities including health inequalities training with senior leaders and use of the Inclusive Decision Making framework		ICB, PH, LLR Academy	2023/24	System		Not yet underway. Will be informed by 7.2.1 Inequalities report.			Grey
7.2.4	Embed Military Covenant duties across all key organisations across the system but specifically in Rutland (due regard for armed forces in health, housing, and education).		RCC, ICB, Providers	2022/23	Place and System		Armed Forces lead newly in post at RCC.			Green
7.2.5	Complete military and veteran health needs assessment to understand the inequalities facing this group	Refresh Inisghts data to reflect Rutland. Qualitative piece for current personnel and people coming back from Cyprus.	ICB, PH	2022/23	Place and System		System level analysis underway.			Green
7.2.6	Mapping Rutland community assets, including its voluntary and community sector.		RCC	2022/24	Place		Initial mapping of the voluntary and community sector across Rutland is underway, also drawing on data from the Rutland Information Service directory.			Green
7.2.7	Role of anchor institutions in reducing health inequalities. Working with key Rutland organisations considering how they can support reducing health inequalities through employees, resources and estate.		System and RCC	2024/25	System		Not yet underway.			Grey
7.2.8	Ensuring complete and timely datasets. Collecting data on protected characteristics (including ethnicity and disabilities) to support future service needs and development		All providers	2024/25	System		Neighbourhood facilitator in post to progress Population Health Management approaches via Aristotle.			Grey

Priority 7c: Cross Cutting Themes - Covid Recovery

Senior Responsible Officer (on HWB) - 7c Covid Recovery — **Mike Sandys / James Burden**

Responsible Officer (on IDG) - 7c Covid Recovery — **Adrian Allen**

GREEN = On Track
AMBER = Off track but mitigations in place top recover
RED = Off track and at risk
GREY = Not Started
BLUE = Complete

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for December 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
7.3	**Covid recovery and readiness**									
7.3.1	Review the impact of the Covid-19 pandemic period on emerging demand for prevention services including sexual health and provide recommendations for service adjustments or future commissioning of services to respond to these changing needs. This will take place in response to intelligence about patterns of need, and/or as each service is recommissioned.		RCC, PH	2022/23	Place		Not yet underway			Grey
7.2.2	Consider the service offer for patients with long Covid, including accessibility.		LPT	TBC	Place		Not yet underway			Grey
7.2.3	Pandemic readiness. Maintaining a collaborative health protection approach and response ready for future Covid-19 surges or other future pandemics.		PH	Ongoing	Place and System		Ongoing readiness via the UK Health Security Agency and relevant local Public Health teams, for infectious diseases that could be a significant threat to health, including Covid-19 variants and monkeypox. Rutland specific Health protection and infection control resource now in place.			Green

8. Communications and Engagement

Senior Responsible Officer (on HWB) **John Morley**

Responsible Officer (on IDG) **Katherine Willison/Charlie Summers**

GREEN = On Track
AMBER = Off track but mitigations in place top recover
RED = Off track and at risk
GREY = Not Started
BLUE = Complete

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for November 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
8.1	**Readiness to deliver the plan**									
8.1.1	Sustain communications working group through year 1 of the plan to support establishment of new ways of working.									
8.1.2	Strengthening this plan through engagement with the public and professionals									
8.1.3	High-level audit of communications and engagement assets across involved partners (skills, resources, channels and tools) to help to plan coordinated approaches to communications (assets and gaps/opportunities).									
8.1.4	Review of the overarching JHW strategy delivery plan to identify key comms and engagement linkages and dependencies									
8.1.5	Agree scope to coordinate with system/ICS level communications activity and mechanisms – e.g. access to citizen panels.									
8.1.6	Establish working group and outline reporting timescales for IDG and HWB on communications and engagement activity and performance.									
8.2	**Ensuring people have access the information they need to maintain their health and wellbeing and to navigate change successfully**									
8.2.1	Coordinate with ICB and places on a visual brand for health and wellbeing in Rutland – consult to see if this is a want across the Place (inc Sue Venables) Agreed approach for collaborative communications across health and care in Rutland.									
8.2.2	Investigating mechanisms to engage Rutland's population in improved communications and communications management (digital impact)									
8.2.3	Shared, rolling communications campaign calendar with selected campaigns prioritised and/or in common across the year – design, maintain, deliver.									
8.2.4	Training: Progress training opportunities including behavioural insights, social media.									
8.2.5	Link to local actions building digital confidence – to consult with the proposed leads. (Join up with initiatives across LLR)									
8.2.6	Enhance the Rutland Information Service (RIS) as a key shared source of information about local services and opportunities. • Develop RIS social media presence – bringing content to the online places people visit. • Website technical code refresh for accessibility and ease of use via a mobile phone. • Using website usability testing to increase the effectiveness of RIS content. Map digital confidence To consult									
8.3	**Raising the profile of the Rutland Health and Wellbeing Board**									

Ref	What Do We Want To Achieve?	How Are We Going To Do It?	Lead Organisation	Timeframe for Delivery (Month/Year)	Level (System, Place or Neighbourhood)	How Will Success Be Measured?	Progress for November 2022	Key Identified Risks	Mitigations	November 2022 Project RAG Status
8.3.1	Web content conveying the role and purpose of the HWB and inviting public involvement. The role of the HWB is already on the RCC site. Query inviting public involvement in the role and purpose of the Board. What is this trying to achieve?									
8.3.2	Visual identity for the HWB – papers, web page, social media. Minutes and papers are available on the RCC site for the public. Do we want a separate page for HWB? Do we want a Twitter account?									
8.3.3	Social media account for HWB health and wellbeing news/messages with shared hashtags. As above?									
8.3.4	Ongoing promotion of HWB activity including public engagement opportunities in health and wellbeing change. Yes - We can cover this in delivering actions 1 and 2 – ensure this weaves within all comms and engagement where appropriate									
8.4	**Involving the public and professional stakeholders in service design and change**									
8.4.1	Identify key stakeholders for delivery									
8.4.2	Business case setting out options for engagement activity depending on level of resourcing.									
8.4.3	Mapping events held over the year to contribute/offer advice and information/gain views Programme of engagement activity - supporting delivery of JHWS priorities. (RCC Comms +)									
8.4.4	Establish an engagement approach, including a toolkit for partners to use, drawn from wider best practice. To include: • Approach to compensation where required. • Existing groups who could be engaged. • How to reach less often heard groups and groups facing inequalities.									
8.4.5	Sharing of ‘you said, we did’ outcomes via the HWB and/or Rutland Information Service.									

Strategic Priority Area	Strategic Priority Worksream	Workstream/Project Lead	Email
Best Start in Life	1.1 Healthy child development in the 1,001 critical days (conception to 2 years old)		
	1.2 Confident Families and Young People		bcaffrey@rutland.gov.uk
	1.3 Access to Health Services		jdowling@rutland.gov.uk
Prevention	2.1 Supporting people to take an active part in their communities		
	2.2 Looking after yourself and staying well in mind and body		
	2.3 Encourage and enable take up of preventative health services		
	2.4 Maintaining and developing the environmental, economic and social conditions to encourage healthy living for all		
Living With Ill Health	3.1 Healthy ageing, including living well with long-term health conditions, and reducing frailty and over 65s falls		
	3.2 Integrating services to support people living with long-term health conditions		
	3.3 Support, advice, and community involvement for carers		
	3.4 Healthy, fulfilled lives for people living with learning or cognitive disabilities and dementia		
Equitable Access	4.1 Understanding the access issues		jamesburden@nhs.net
	4.2 Increase the availability of diagnostic and elective health services closer to home		debra.mitchell3@nhs.net
	4.3 Improving access to primary and community health and care services		
	4.4 Improving access to services and opportunities for people less able to travel, including through technology		
	4.5 Improving access to services and opportunities for people less able to travel, including through technology		
	4.6 Enhance cross boundary working across health and care with key neighbouring areas		
Growth and Change	5.1 Planning and developing 'fit for the future' health and care infrastructure		
	5.2 Health and care workforce fit for the future		
	5.3 Health and equity in all policies, in particular developing a healthy built environment aligned for projected growth		
Dying Well	6.1 Each person is seen as an individual		
	6.2 Each person has fair access to care		
	6.3 Maximising comfort and wellbeing		
	6.4 Care is coordinated		
	6.5 All staff are prepared to care		
	6.6 Communities are prepared to help		
Cross Cutting Themes	7.1 Mental Health		
	7.2 Inequalities		
	7.3 Covid Recovery		

Acronyms and glossary

A&E	Accident and Emergency
ACG	Adjusted Clinical Groups (tool for health risk assessment)
BCF	Better Care Fund
CAR	Citizens Advice Rutland
CIL	Community Infrastructure Levy
CCG	Clinical Commissioning Group(s)
Core20PLUS5	NHS England and Improvement approach to reducing health inequalities
CPCS	Community Pharmacy Consulting Service
CVD	Cardio Vascular Disease
CYP	Children and Young People
EHCP	Education and Health Care Plan
FSM	Free School Meals
HEE	Health Education England
HIA	Health Impact Assessment
HWB	Health and Wellbeing Board
ICON	Framework to prevent shaking of crying babies (Infant crying is normal, Comfort methods can work, Ok to take five, Never shake a baby)
ICB	Integrated Care Board
ICS	Integrated Care System
JHWS	Joint Health and Wellbeing Strategy
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LAC	Looked After Child
LD	Learning Disability
LeDER	Learning from deaths of people with a learning disability programme
LLR	Leicester, Leicestershire and Rutland
LPT	Leicestershire Partnership Trust
LTC	Long Term Condition
MDT	Multi-Disciplinary Team
MECC+	Making Every Contact Count
MH	Mental Health
NCMP	National Child Measurement Programme
NEWS	National Early Warning Score
ONS4	A 4-factor measurement of personal wellbeing
OOA	Out of Area
OOH	Out of Hospital
OPCC	Office of the Police and Crime Commissioner
PCH	Peterborough City Hospital
PCN	Primary Care Network
PH	Public Health
RCC	Rutland County Council
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
RIS	Rutland Information System
RISE	Rutland Integrated Social Empowerment
RMH	Rutland Memorial Hospital
RR	Resilient Rutland
SEND	Special Educational Needs and Disability
SMI	Serious Mental Illness
TBC	To be confirmed
UHL	University Hospitals of Leicester
VAR	Voluntary Action Rutland
VCF	Voluntary Community and Faith
VCS	Voluntary and Community Sector

Rutland
County Council

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

Rutland

January 2023

Business Intelligence Service
Leicestershire County Council

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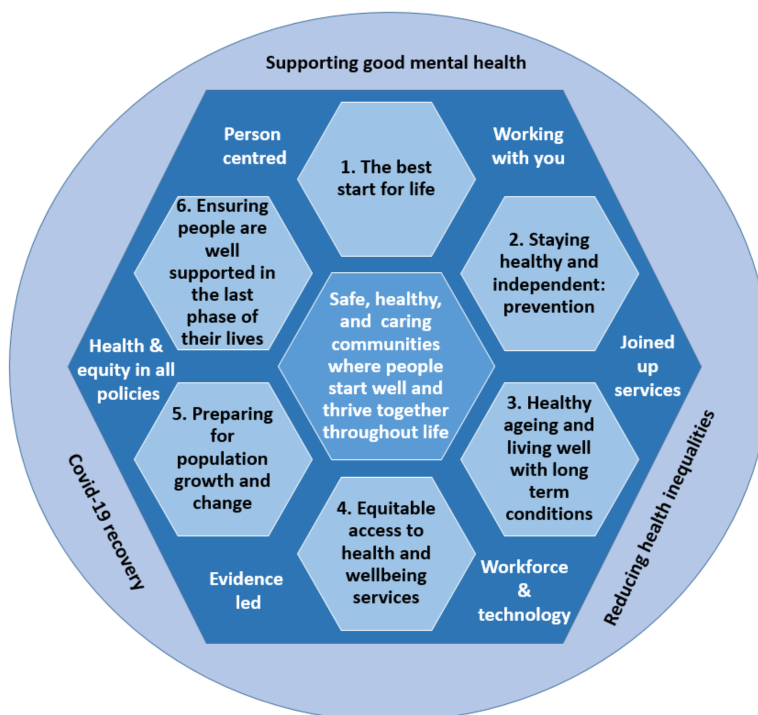
Whilst every effort has been made to ensure the accuracy of the information contained within this report, Leicestershire County Council cannot be held responsible for any errors or omission relating to the data contained within the report.

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 four are red. Two indicators have no comparison, and two indicators are lower than national.

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

  Proportion of children receiving a 12-month review - Rutland is ranked 16th out of 16 in 2021/22. The proportion of children receiving a 12-month review has decreased from 37.0% in 2020/21 to 29.7% in 2021/22.

  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.

  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%.

  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%.

- Of the seven green indicators, Rutland ranks 1st (best performing) when compared to its similar neighbours for the following indicators: 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):

  - Neonatal mortality and stillbirth rate
  - Proportion of children receiving a 12-month review
  - Children in care immunisations
  - HPV Vaccination coverage for one dose (12-13 year) (Females)
  - 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	2021/22	20.3	5/16	17.3	25.5	22.3		
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		
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	2021/22	29.7	16/16	97.4	29.7	81.9		
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		
Proportion of infants receiving a 6 to 8 week review	P	6-8 weeks	2021/22	83.7	12/16	97.6	7.6	81.5		
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		
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	2021/22	6.8	3/16	5.6	12.4	9.1		
C07 - Proportion of New Birth Visits (NBVs) completed within ..	P	<14 days	2021/22	88.8	6/16	94.8	32.7	82.6		
C08a - Child development: percentage of children achieving a ..	P	2-2.5 yrs	2021/22	81.3	11/16	90.1	43.5	80.9		
C09b - Year 6: Prevalence of overweight (including obesity)	P	10-11 yrs	2021/22	30.2	2/16	28.4	39.1	37.8		
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 to 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		
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 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		
Hospital admissions for mental health conditions	P	<18 yrs	2020/21	127.4	12/16	72.9	251.0	87.5		
School pupils with social, emotional and mental health needs: ..	P	School age	2021	2.4	7/16	1.9	3.5	2.8		

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 December 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 2017/18-2020/21. 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	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	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	79.6	1/16	79.6	73.7	74.7		
C24d - Cancer screening coverage: bowel cancer	P	60-74 yrs	2021	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/

Produced by Business Intelligence Service
Updated December 2022

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	No significant change	Similar
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	No significant change	Better
E13 - Hip fractures in people aged 65 and over	P	65+ yrs	2020/21	608.4	15/16	425.4	647.5	528.7	No significant change	Similar
E14 - Excess winter deaths index	P	All ages	Aug 2019 - Jul 2020	50.2	16/16	9.1	50.2	17.4	Cannot be calculated	Worse

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 December 2022

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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Updated December 2022

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.

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	2021/22	6.8	5/16	-0.5	14.4	9.9		
B12b - Violent crime - violence offences per 1,000 population	P	All ages	2021/22	17.3	1/16	17.3	38.9	34.9		
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/

Produced by Business Intelligence Service
Updated December 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, one is amber, two are higher and one is lower.

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

  Percentage of deaths that occur at home – Rutland is ranked 16th out of 16 in 2021. The proportion of deaths that occur at home (all ages) has decreased from 33.9% in 2020 to 33.6% in 2021, which is significantly higher than the national average of 28.7%.

  Percentage of deaths that occur in care homes – Rutland is ranked 15th out of 16 in 2021. The proportion of deaths that occur in care homes (all ages) has increased from 27.5% in 2020 (where it performed statistically similar to England) to 28.0% in 2021, which is significantly higher than the national average of 20.2%.

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

  Percentage of deaths that occur in hospital – Rutland is ranked 1st out of 16 in 2021. The proportion of deaths that occur at hospital (all ages) has increased from 33.9% in 2020 to 35.5% in 2021. 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	2021	33.6	16/16	25.0	33.6	28.7	No significant change	Higher
Percentage of deaths that occur in care homes	P	All ages	2021	28.0	15/16	15.1	30.3	20.2	No significant change	Higher
Percentage of deaths that occur in hospital	P	All ages	2021	35.5	1/16	35.5	48.5	44.0	No significant change	Lower
Temporary Resident Care Home Deaths, Persons, All Ages (%)	P	All ages	2020	29.3	3/16	26.3	45.6	35.2	Cannot be calculated	Similar

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 December 2022

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
B11 - Domestic abuse-related incidents and crimes	P	16+ yrs	2020/21	23.1	2/16	22.5	37.3	30.3		
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		
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		
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		
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		
Depression: QOF prevalence (18+ yrs)	P	18+ yrs	2021/22	11.2	2/14	10.9	14.9	12.7		
Mental Health: QOF prevalence (all ages)	P	All ages	2021/22	0.7	3/14	0.7	1.2	1.0		
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		

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 December 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/

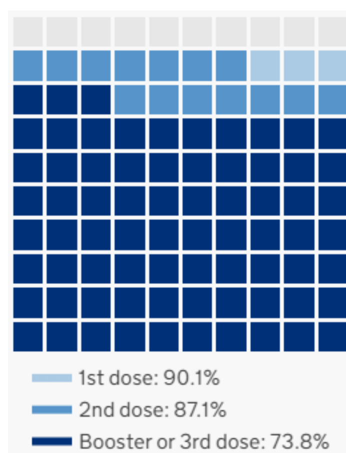
Produced by Business Intelligence Service
Updated December 2022

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 22nd December 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 December 2022 (since the start of the pandemic), there have been a total of 128 hospital admissions with Covid-19 at UHL from Rutland residents. Out of the 128 admissions, 77% were aged over 60 and 23% 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 48 in 2022, there have been a total of 108 Covid-19 deaths in Rutland. Of the total deaths involving Covid-19 in Rutland, 55 (50.9%) were in a hospital setting and 43 (39.8%) were in a care home setting.

  Since the beginning of the pandemic (week 12, 2020) there have been a total of 1145 deaths (all causes) in Rutland.

  Based on the average mortality data for 2015-19, we would expect 1021 deaths in Rutland for this period. This reveals an excess of 124 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)

Rutland County Council

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۔

假如閣下需要幫助，用你的語言去明白這些資訊，請致電 0116 305 6803，我們會安排有關人員為你提供幫助。

Jeżeli potrzebujesz pomocy w zrozumieniu tej informacji w Twoim języku, zadzwoń pod numer 0116 305 6803, a my Ci dopomożemy.

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Agenda Item 10a

Report No: 19/2023
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

24 January 2023

HEALTH AND WELLBEING COMMUNICATION AND ENGAGEMENT PLAN 2022-2027

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

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor 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 progress of the Health and Wellbeing Communication and Engagement Plan (currently in draft) towards being finalised following input from stakeholders

1 PURPOSE OF THE REPORT

1.1 The purpose of this report is to brief the Health and Wellbeing Board (HWB) on the progress of the Health and Wellbeing Communication and Engagement Plan.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The Communication and Engagement Plan (CEP) was developed to support the role of the HWB and successful delivery of the HWB Strategy. Organisations work together through the delivery of the strategy to ensure that people have the right information, advice and help at the right time. Another important element is to empower people to play a full role in looking after their own health and provide them with opportunities to get involved in shaping the local priorities and services they need.

2.2 The purpose of the CEP is to enhance the health and wellbeing of people in Rutland by facilitating effective health and wellbeing communications and engagement.

2.3 The plan was developed by a working group with a range of representation from HWB partner organisations. The plan is focussed on communication and engagement involving two key sets of stakeholders:

- Residents and patients of Rutland
- Agencies and their workforces

2.4 **A Delivery Plan** has been developed with the following elements:

- Readiness to deliver the plan
- Ensuring people have access to the information they need to maintain their health and wellbeing and to navigate change successfully
- Raising the profile of the Rutland Health and Wellbeing Board
- Involving the public and professional stakeholders in service design and change

3 CONSULTATION

3.1 A meeting of the working group will take place in January 2023. It will be decided which stakeholders are required to be consulted with regard to the CEP and a timescale for comments.

3.2 The proposal is to engage with the public and the workforce, including presenting key aspects to interested groups such as the Patient Participation Groups (PPG) and those 'Experts by Experience', to further enhance and inform the draft CEP.

4 ALTERNATIVE OPTIONS

4.1 Not applicable at this time.

5 FINANCIAL IMPLICATIONS

5.1 The CEP has been developed using existing staffing resources. The delivery of the CEP will depend upon time being committed by partners.

5.2 £25,740 was allocated from the 2022-23 Rutland Better Care Fund for the purpose of progressing the plan. There is potential for this money to be invested into the Quality Assurance Team to support the work of the Improvement Officers. See 'Health and Wellbeing Implications' below.

6 LEGAL AND GOVERNANCE CONSIDERATIONS

6.1 The draft CEP has been produced with involvement from stakeholders and will be finalised only after further consultation from stakeholders. The delivery plan of the CEP will be presented to the Integrated Delivery Group on a monthly basis for monitoring of progress.

7 DATA PROTECTION IMPLICATIONS

7.1 There are no new Data Protection implications. The CES contains only anonymised information.

8 EQUALITY IMPACT ASSESSMENT

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 Co-production acknowledges that people with 'lived experience' of a particular condition are often best placed to advise on what support and services will make a positive difference to their lives. Incorporating co-production principles into programmes for people with long-term conditions can help them to gain knowledge, learn skills and adopt behaviours that are thought to be important in achieving better health and wellbeing.

10.2 Principles of 'Think Local, Act Personal's (TLAP)' 'Making It Real' will be central to communication and engagement practice. 'Making It Real' is a framework to support good, personalised care and support for providers, commissioners and people who access services. This is in line with the 'Thriving Places Guidance' which is within the plan, which asks place-based partnerships to 'systematically involve professionals, people and communities in their programmes of work and decision-making processes'.

10.3 The RCC Quality Assurance Team has been expanded with two new Improvement Officers. These workers will be supporting with the Joint Health and Wellbeing Communication and Engagement Plan within the community and developing our digital and self - assessment portal. They will be enhancing our existing strong partnership links with Public Health, PCN, Healthwatch, Citizens Advice, Age UK and Housing, amongst a plethora of community based groups and to ensure the voice of those more marginalised and deprived groups are represented and heard within the finalisation of the CEP.

11 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

11.1 The Committee is recommended to note contents of the report

12 BACKGROUND PAPERS

12.1 There are no additional background papers to the report.

13 APPENDICES

13.1 Appendix A: Action Plan

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

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JHWB Communication and Engagement Plan

Action Plan – update January 2023

Charlie Summers (CS) – Integration and Transformation Manager, ICB
Alexandra Chamberlain (AC) – Co-Production and Engagement Lead, RCC
Katherine Willison (KW) – Health and Wellbeing Integration Lead, RCC
Caroline Bysouth (CB) – Adult Social Care Improvement Officer, RCC
Lewis Mattock (LM) – Adult Social Care Improvement Officer, RCC

Outline delivery plan 2022-23

Action	Lead	Timetable	AC Progress
0. Readiness to deliver the plan			
Sustain communications working group through year 1 of the plan to support establishment of new ways of working.	Working group	Jan 2023 ongoing	Re-launch of working group Jan 2023
Strengthening this plan through engagement with the public and professionals	Working group	Jan 23 ongoing	Re-launch of working group Jan 2023
High-level audit of communications and engagement assets across involved partners (skills, resources, channels and tools) to help to plan coordinated approaches to communications (assets and gaps/opportunities).	Working group	Jan 23 ongoing	Re-launch of working group Jan 2023
Review of the overarching JHW strategy delivery plan to identify key comms and engagement linkages and dependencies	CS/AC/KW	Jan 2023	Updated Paper submitted by KW with Section 10 Health and Wellbeing Implications updated by AC.
Agree scope to coordinate with system/ICS level communications activity and mechanisms – e.g. access to citizen panels.	LLR leads working together.	Jan 2023 ongoing	

Establish working group and outline reporting timescales for IDG and HWB on communications and engagement activity and performance.	Working group	Jan 2023 and ongoing	Re-launch of working group Jan 2023
1. Ensuring people have access the information they need to maintain their health and wellbeing and to navigate change successfully			
Coordinate with ICB and places on a visual brand for health and wellbeing in Rutland – consult to see if this is a want across the Place (Inc. Sue Venables) Agreed approach for collaborative communications across health and care in Rutland.	CS/AC/KW initially	Jan/Feb 2023	AC and team to meet with Sue Venables to discuss visual branding and to review membership of working group prior to disseminating invite for Re-Launch of Working Group. AC meet with RCC Comms to confirm collaborative comms.
Investigating mechanisms to engage Rutland's population in improved communications and communications management (digital impact)	Working group	Feb 2023	Feedback from Working Group Jan 23
Shared, rolling communications campaign calendar with selected campaigns prioritised and/or in common across the year – design, maintain, deliver.	RIS lead TBC	March 2023	AC requested meetings with RIS, Public Health, PCN, Healthwatch, Age UK etc. to receive a quarterly campaigns schedule to ensure RIS and QA Team aware of what's taking pace and arrange engagement. To also share with RCC Comms. Campaigns likely to overlap and can be brought to Working Group to ensure we are working collaboratively.
Training: Progress training opportunities including behavioural insights, social media.	Sue Venables TBC	Jan/Feb 2023	Meeting Sue Venables in Jan 23
Link to local actions building digital confidence – to consult with the proposed leads. (Join up with initiatives across LLR)	RCC Comms and QI Team	Feb 2023	Improvement Officer (IO) Lewis (LM) to lead with Digital innovation and Accessibility Project and Data Project. Link in with PCN with Accessing NHS App and digital confidence.
Enhance the Rutland Information Service (RIS) as a key shared source of information about local services and opportunities. • Develop RIS social media presence – bringing content to the online places people visit.	AC and QI team: Kevin Quinn/RCC Coms	Jan 2023	Meeting requested by AC with Kev and RIS Team. LM to lead as aligns with Digital Innovation and Accessibility, Digital Confidence, Data returns and Self-Assessment.

• Website technical code refresh for accessibility and ease of use via a mobile phone. • Using website usability testing to increase the effectiveness of RIS content. Map digital confidence To consult			
2. Raising the profile of the Rutland Health and Wellbeing Board			
Web content conveying the role and purpose of the HWB and inviting public involvement. The role of the HWB is already on the RCC site. Query inviting public involvement in the role and purpose of the Board. What is this trying to achieve?	RIS lead	2023 Q4	
Visual identity for the HWB – papers, web page, social media. Minutes and papers are available on the RCC site for the public. Do we want a separate page for HWB? Do we want a Twitter account?	TBC	2023 Q4	
Social media account for HWB health and wellbeing news/messages with shared hashtags. As above?	RCC comms	2023 Q4	
Ongoing promotion of HWB activity including public engagement opportunities in health and wellbeing change.	RIS lead	Ongoing	

Yes - We can cover this in delivering actions 1 and 2 – ensure this weaves within all comms and engagement where appropriate			
3. Involving the public and professional stakeholders in service design and change			
Identify key stakeholders for delivery	AC/CS/KW	Jan 2023	AC and Team meeting with Sue Venables to review membership of Working Group. AC disseminate invite to re-launch of Working Group re-launch for end Jan 23. Small sub- sets of working groups i.e.: digital confidence/NHS App etc. will come from main Working Group.
Business case setting out options for engagement activity depending on level of resourcing.	AC/QI Team	Feb 2023	Resourcing with two new Improvement Officers (IO) who are mapping out what engagement activities exist and what can be added/enhanced. IO and partners to identify volunteers who would be interested in supporting with engagement activity/training re: digital innovation etc., co-production etc. IO coordinate with PCN on digital confidence and alignment of Practice Websites at a Local Level and how to promote this. Training packages for all colleagues, partners etc. to be proposed and whether resource is required or can be performed in-house. 45 mins Awareness Training on Co-Production with more advanced training for those involved in Service Development to ensure co-production from concept to completion. Clear guidelines/training for those ‘Experts by Experience’; what commitment/expectations/rewards etc. look like. Ensure it is a shared understanding of roles. Possible use of Volunteers for spreading the word/training for co-production.

Mapping events held over the year to contribute/offer advice and information/gain views Programme of engagement activity - supporting delivery of JHWS priorities. (RCC Comms +)	AC/QI Team KW/CS Sue Venables	Feb 2023	AC requested meetings with RIS, Public Health, PCN, Healthwatch, Age UK etc. to receive a quarterly campaigns schedule to ensure RIS and QA Team aware of what's taking pace and arrange engagement. To also share with RCC Comms.
Establish an engagement approach, including a toolkit for partners to use, drawn from wider best practice. To include: • Approach to compensation where required. • Existing groups who could be engaged. • How to reach less often heard groups and groups facing inequalities.	AC initially	Update Jan 2023	Renumeration still not resolved but will share what Birmingham City are doing and other LAs from Regional Leads Co-Production meetings. Issue that NHS pays for Experts by Experience (AC not aware how much etc.) and advised this is a higher amount than any LA's at present, which presents an issue. Also, if joint working on HWB engagement, whose budget does this come out of – health or LA's? Vouchers versus petty cash. Also some offer training as payment but need to be aware anything over 16 hrs can also affect benefits. Feedback that some citizens happy with not being paid due to it adding a 'stress' to their existing financial arrangements – good to offer 'Opt In' for renumeration or 'Opt out' so it manages expectation/commitment from start. Benefit Officers do not all support with same practice. Advised in Regional Leads meeting this morning 09/01/23 that group awaiting Best Practice Piece from Think Local, Act Personal (TLAP) re: renumeration/rewards. QA Team to visit Simon Furze – Public Participation Officer, Strategy, Equality and Partnership Directorate, Birmingham City Council to understand how they have a large number of citizens signed up to engagement. They have commissioned a Gov Delivery Channel and using specific database and Microsoft

			Forms format to engage and share comms for people in community to get involved. QA team to visit Lyn Knights as above. Embedding 'Making It Real' principles within ASC and Partners. AC completing application/mission statement once practice improvement area identified. Does not require member sign off but Ac taking to next month's DMT. Identify how we can be working collaboratively to reduce organisational boundaries for our co-production and engagement within the community.
Sharing of 'you said, we did' outcomes via the HWB and/or Rutland Information Service.	Working group KW & AC	June 2023	
Review previous Healthwatch report on local needs of population of Rutland	Working Group, AC and QA Team	Jan/Feb 23	QA Team to connect with Patient Participation Groups (PPG), Healthwatch, Armed Forces, GLT. Link in with CAB Forums Link in with Public Health's Public Inequalities project
Review previous outcomes from the PCN's Primary Care Task Force Survey.	Working Group, AC and QA Team	Jan/Feb 23	QA Team to connect with Patient Participation Groups (PPG), Healthwatch, Armed Forces, GLT. Link in with CAB Forums Link in with Public Health's Public Inequalities project

Report No: 16/2023
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

24 January 2023

ADDENDUM TO THE 2022 TO 2023 BETTER CARE FUND - ADULT SOCIAL CARE DISCHARGE FUND

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

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor 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 Adult Social Care Discharge Fund planning template, submission of which to the BCF national team on 16 December 2022, was signed off by the Chair of the Health and Wellbeing Board. 3. Notes the Rutland 2022-23 Better Care Fund Adult Social Care Discharge Fund first report which was submitted to the BCF national team on 6 January 2023

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 Adult Social Care Discharge Fund (BCF ASC DF) Plan and Reporting.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 The annual 2022-23 BCF Plan was signed off by the HWB chair and was submitted to the national BCF team on 29 September 2022. The BCF ASC is an addendum to

this 2022-23 BCF Plan.

2.2 On 22 September 2022, the government announced its 'Plan for Patients' which committed £500 million for the rest of the financial year, to support timely and safe discharge from hospital by reducing the number of people delayed in hospital awaiting social care. The funding has been distributed to local authorities and ICBs to pool into the local BCF. In line with usual BCF requirements, the use of both elements of this funding must be agreed between local health and social care leaders. The funding must complement plans for improving discharge outcomes under condition 4 of the main BCF plan

2.3 BCF National condition 4: 'implementing the BCF objectives' 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.

2.4 The BCF ASC DF plan was submitted to the national BCF team on 16 December 2022. The plan is a record of planned expenditure for a number of schemes to facilitate discharge from hospital, in line with the requirements of the 11 funding conditions.

2.5 Funding conditions include:

- Funding should only be used on permitted activities that reduce flow pressure on hospitals…by enabling more people to be discharged to an appropriate setting, with adequate and timely health and social care support
- Funding should prioritise those approaches that are most effective in freeing up the maximum number of hospital beds and reducing the bed days lost
- Local areas should submit fortnightly reports setting out what activities have been delivered in line with commitments in the spending plan

2.6 Health and social care partners across Leicester, Leicestershire and Rutland (LLR) worked together to agree schemes which would benefit discharge processes at both Place and System levels. There are also schemes specific to Rutland at Place level.

2.7 **Income:**

Funding for 2022-23 ASC DF is set out in Table 1.

Table 1: BCF budget for 2022-23

Source of Funds	**(£)**
ICB	155,271
LA Grant	113,100
Total	**268,371**

2.8 **Expenditure:**

Planned spend on the ASC DF is £286,371

2.9 Rutland's BCF ASC DF plan was approved by John Morley on behalf of the Council. All three LLR plans went to the LLR ICB Executive Management Team on for ICB approval. The HWB Chair approved the Rutland plan on behalf of the Rutland Health and Wellbeing Board prior to its submission on 16/12/22.

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 ICB, pending national publication of guidance. This continues to be the case with this ASC DF.

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

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. 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

11.1 The Committee is recommended to note the Rutland 2022-23 Better Care Fund Adult Social Care Discharge Fund plan and initial, 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 ASC Discharge Fund - Sources of Funding

Appendix A. Rutland 2022-23 BCF ASC Discharge Fund - Sources of Funding

Discharge Fund 2022-23 Funding Template			
Rutland Health and Wellbeing Board			
Source of Funding		**Amount pooled**	**Planned spend**
LA allocation	Rutland	£113,100	£113,100
ICB allocation	NHS Leicester, Leicestershire and Rutland ICB	£155,271	£155,271

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Agenda Item 12a

Rutland Children and Young People's Partnership
(Subgroup of the Rutland Health and Wellbeing Board)

TERMS OF REFERENCE

December 2022 DRAFT

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1. Purpose

1.1 The Rutland Children and Young People's Partnership, (known as the Partnership), through a collaborative partnership approach supports the development and improvement of services for children and young people 0 – 25 years in Rutland. The agreed vision and priorities are set out in the Children and Young People Strategy 2022-2025.

1.2 The Partnership aims to ensure that all children and young people in Rutland are happy, safe and successful and empowered to be the best they can be. This will be achieved through a focus on intervening early to avoid problems escalating.

1.3 The Partnership will work together to ensure that the improved and developed services which have been achieved in Rutland are maintained and sustained in the long term. Continued work with our families, our local commissioners and our decision makers will sustain the key elements of success, particularly through strong multi-agency partnerships to co-ordinate early help systems and moving into much more community-based, networked local solutions.

2. Rutland Joint Health and Wellbeing Board

2.1 The Partnership is a sub-group of the Rutland Health and Wellbeing Board (HWB) and thereby provides leadership, direction and assurance on behalf of the Rutland HWB.

The Partnership will:

2.2 Report to the Rutland HWB to ensure that the needs of children, young people and families in Rutland influence planning for health and wellbeing improvements across services and support the delivery of the Joint Health and Wellbeing Strategy.

2.3 Propose the scope for the plans for the health and wellbeing needs of children, young people and families in Rutland, and drive forward and oversee their delivery on behalf of the HWB.

2.4 Provide updates on the Partnership activity to the Health and Wellbeing Lead, to enable a quarterly report to be delivered to the HWB

2.5 Undertake monitoring of the Partnership action plan and escalate risks to delivery to the HWB and the corporate governance systems of partner organisations as appropriate

3. Our Aims

- Every child lives in a happy and safe environment
- Children who do becomes looked after, or are receiving care, are supported to achieve the best emotional, physical and learning outcomes
- Children experience an aspirational and inclusive education offer in their community
- The emotional health and wellbeing of children in Rutland will be promoted

4. Membership

4.1 The Membership of the Partnership will consist of:

- Lead Member Children's Services and Education
- Strategic Director for Children and Families - Rutland County Council.
- Head of Service, Children's Social Care - Rutland County Council.
- Head of Service, Early Intervention SEND and Inclusion - Rutland County Council.
- Head of Learning and Skills - Rutland County Council.
- Rutland Parent Carer Voice Representative.
- Early Years Provider Representative.
- 2 Head Teachers - Primary and Secondary Education Provision Representatives.
- Youth Offending Service.
- Leicestershire Constabulary.
- Healthwatch Rutland.
- Public Health Lead, Rutland and Leicestershire.
- LLR Integrated Care Board
- NHS Leicestershire Partnership Trust (Families, Children & Young People Division).
- UHL NHS Trust.
- Voluntary & Community Sector Representative.

4.2 Members of the Partnership will represent their parent organisation and/or their sector constituency. The members of the Partnership will act with the necessary delegated responsibility from their organisation and, where responsibility is delegated, take decisions on behalf of that organisation in relation to the work of the Partnership. Members will nominate appropriate and suitable representatives to attend Partnership meetings relevant to the topics for discussion and action. When representatives cannot attend, they will make every effort to put forward a deputy to attend in their absence.

5. Governance and Administration

5.1 The Partnership is not a committee of the Council under s.101 of the Local Government Act 1972 and will have no delegated powers and is not subject to the rules under the 1972 Act and Part 8 of the Council's Constitution requiring public access to agendas and meetings. However, agendas and reports will be subject to access by request under the Freedom of Information Act 2000 unless an exemption applies to specifically requested information.

5.2 The Partnership will be accountable to the Rutland Health and Wellbeing Board.

5.3 The group will meet quarterly, where possible in advance of each Health and Wellbeing Board meeting.

5.4 To meet quorum, at least half of the group's membership must be in attendance.

5.5 Decisions will be made by a simple majority vote.

5.6 The group will be administered by an officer of Rutland County Council.

6. Chair

6.1 The Chair of the Rutland Children's and Young People's Partnership will be the Portfolio Holder for Children and Young People.

7. Review Date

7.1 These Terms of Reference will be reviewed as and when circumstances require

LINKS:

Health and Well Being Strategy - https://www.rutland.gov.uk/my-services/health-and-family/health-and-nhs/health-and-well-being-strategy/

TERMS OF REFERENCE
FOR THE RUTLAND INTEGRATED DELIVERY GROUP

December 2022

Purpose of the Integrated Delivery Group
The Integrated Delivery Group is a sub-group of the Rutland Health and Wellbeing Board (HWB). The purpose of the Integrated Delivery Group (IDG) is to provide leadership, direction and assurance, on behalf of the Rutland HWB, so that the place and neighbourhood based vision for integrated health and care in Rutland is delivered, in line with national policy and local priorities.

Terms of Reference
The IDG, as a subgroup of the HWB, has a role and duties which include:

1 General

- To propose the scope for integrated health and care programmes in Rutland and to drive forward and oversee their delivery on behalf of the HWB.
- To deliver a report on IDG activity to each of the quarterly HWB meetings.
- To use data and evidence to inform plans and action.
- To quality assure business cases for developments intended to further the integration of health and care.
- To oversee the management of risks to the health and care integration programme and to escalate risks to the HWB and/or to the corporate governance systems of partner organisations as appropriate.
- To make recommendations to relevant partner governing bodies on the allocation of the resources necessary to deliver the integration programme as a whole and its individual components.
- To ensure alignment between the integration programme and the strategic plans of partner organisations and the health and care system as a whole, and to support the planning cycles of partners.
- To identify and promote opportunities for innovation, research and evaluation within the health and care integration programme.
- To work on the development of data sharing, integration and technology to support the integration of health and social care in Rutland, ensuring alignment with the Local Digital Roadmap and Business Intelligence priorities of partners.
- On behalf of the HWB, to support a communication and engagement plan about health and care integration, engaging a wide range of stakeholders across the health and care system, with particular emphasis on the needs of the public.

- To receive assurance that joint commissioning priorities are being delivered and that risks are being appropriately managed/mitigated.

2 Joint Health and Wellbeing Strategy (JHWS)/Place Based Plan

- To support the development of the Rutland JHWS for approval by the HWB, and to lead its delivery on behalf of the HWB.

- To undertake monitoring of the JHWS and take any necessary remedial action as required and escalate risks to the HWB.

- To make recommendations to the HWB on the operation of the JHWS.

3 Better Care Fund (BCF)

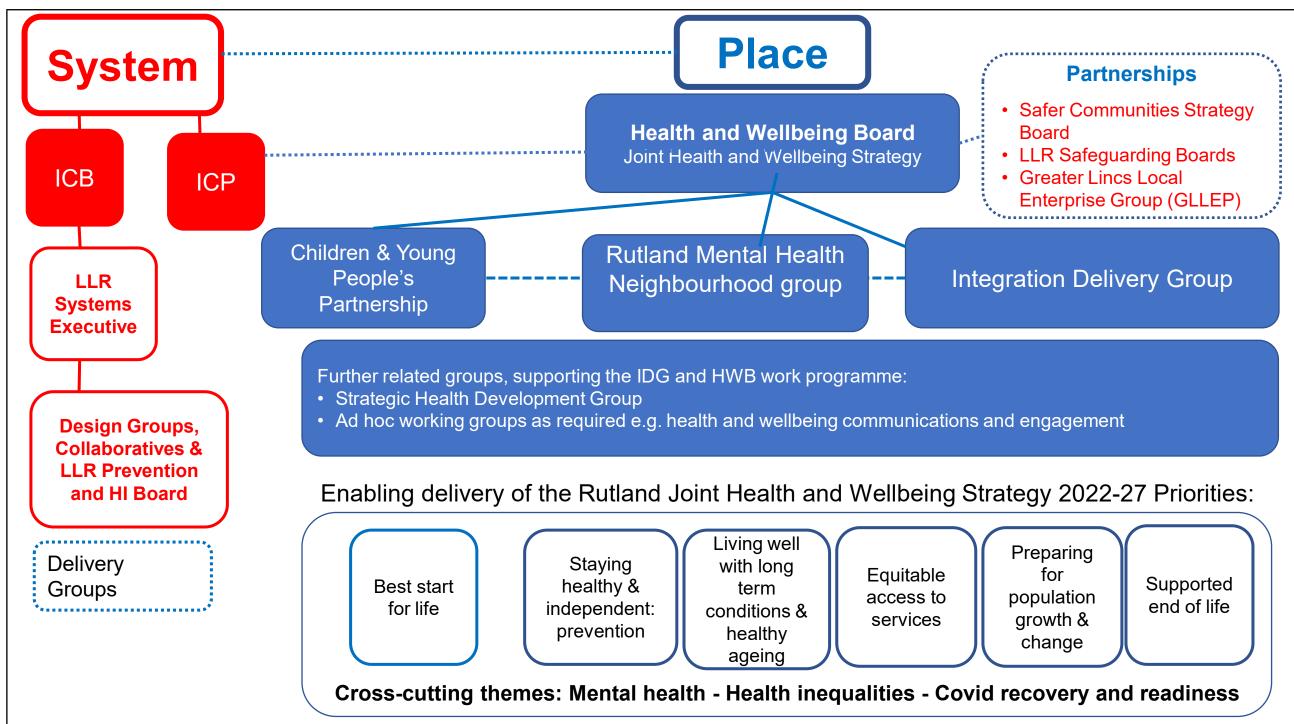
- To support development of the Rutland BCF Plan and associated metrics and expenditure plan for approval by the HWB and funding partners, and to lead its effective delivery.

- To undertake and feed into BCF monitoring locally, regionally and nationally including statutory returns at intervals required by NHS England and take any necessary remedial action in order that plans demonstrate and maintain all statutory requirements.

- To make recommendations to the BCF Partnership Board and/or the HWB on the operation of the BCF Plan as appropriate.

4 Wider Governance

The position of the Integrated Delivery Group in wider system and place governance is set out below:



Membership of the Integrated Delivery Group

Name		Organisation
1.	Debra Mitchell (CHAIR)	Deputy Chief Operating Officer NHS Leicester, Leicestershire & Rutland (LLR) Integrated Care Board (ICB)
2.	John Morley (VICE CHAIR)	Director of Adult Services and Health, Rutland County Council (RCC)
3.	Adhvait Sheth	Planning Manager, Strategy and Planning Directorate, LLR ICB
4.	Adrian Allen	Assistant Director - Delivery, Public Health (Rutland Lead), Leicestershire County Council (LCC)
5.	Bernadette Caffrey	Head of Early Intervention, SEND and Inclusion, RCC – attendance by exception
6.	Charlotte (Charlie) Summers	Integration and Transformation Manager, LLR ICB
7.	Dawn Godfrey	Strategic Director Children and Families, RCC
8.	Duncan Furey	Chief Executive Officer, Citizens Advice Rutland
9.	Emma Jane Perkins	Head of Service Community Care Service, RCC
10.	James Burden (Dr)	Clinical Director, Rutland Health Primary Care Network
11.	Sammi Le-Corre	Senior Anticipatory Care Project Officer, LLR ICB
12.	Joanna Clinton	Head of Strategy & Planning, LLR ICB
13.	Katherine Willison	Health and Wellbeing Integration Lead, RCC
14.	Kim Sorsky	Head of Service Adult Social Care, RCC
15.	Mat Wise	Hospital and Clinical Integration Lead, RCC
16.	Mayur Patel	Senior Integration & Transformation Manager, LLR ICB
17.	Mark Young	Senior Mental Health Neighbourhood Lead Community Care Services, RCC
18.	Melanie Thwaites	Head of Women's and Children's Transformation, LLR ICB
19.	Mitch Harper	Strategic Lead – Rutland, Public Health, LCC
20.	Nikki Beecher	Leicestershire NHS Partnership Trust
21.	Susan Venables	Head of Engagement and Insights, LLR ICB
22.	Tracey Allan-Jones	Manager, Healthwatch Rutland

Meetings

Meetings will take place monthly in private.

Chair

The Chair is the Deputy Chief Operating Officer, LLR ICB, and the Vice Chair is the Director of Adult Services and Health, RCC.

The Group may also meet for workshops and development sessions. These meetings will be informal and not held in public.

Meeting Administration
Meetings will be administered by the ICB Integration and Transformation Directorate.

The Agenda will be maintained by the Chair, supported by the Officers of the HWB (Katherine Willison and Charlie Summers).

The agenda and papers will be issued no later than 4 working days in advance unless later circulation has been authorised by the Chair (exceptional circumstances).

Location of Meetings
Meetings will be held via MS Teams. Face to face or hybrid meetings, when required, will be held in a suitable nominated venue.

Quoracy and Decision-making
To conduct routine business and take decisions, including on joint commissioning, 6 members must be present of which at least:

- 1 must be a representative of Rutland County Council
- 1 must be a representative of the LLR ICB
- 1 must be a clinical representative
- 1 must be a provider

The preferred route to decision-making will be consensus without the need for formal voting. Where voting is to be used for decision-making, all members of the Group are allowed to vote.

Decisions can be taken by the Chair or Vice Chair where necessary for reasons of urgency outside of formal meetings. Any decisions taken outside formal meetings shall be recorded at the following meeting along with the reasons for the urgency and the basis for the decision.

Reporting Arrangements
The IDG will provide the following to the HWB:

- Quarterly reports on the performance of health and care integration programmes, notably the BCF and JHWS;
- Annually, a report on the use of resources in support of the BCF and JHWS.
- Reports or updates on specific work commissioned by the HWB, as and when requested.

Terms of Reference Review
There will be a review of the scope, conduct, composition and effectiveness of the Board at 12 months, then annually unless circumstances require more frequent review, with any significant changes put to this group for decision.

Report No: 15/2023
PUBLIC REPORT

RUTLAND HEALTH AND WELLBEING BOARD

24 January 2023

RUTLAND MENTAL HEALTH NEIGHBOURHOOD GROUP - TERMS OF REFERENCE

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

Strategic Aim:	Healthy and Well	
Exempt Information	No	
Cabinet Member(s) Responsible:	Councillor Samantha Harvey: Portfolio Holder for Health, Wellbeing and Adult Care	
Contact Officer(s):	Mark Young, Senior Mental Health Neighbourhood Lead	myoung@rutland.gov.uk
	Emma Jane Perkins, Head of Service Community Care Services	eperkins@rutland.gov.uk
Ward Councillors	N/A	

DECISION RECOMMENDATIONS
That the Committee: 1. Approve the Terms of Reference for the Rutland Mental Health Neighbourhood Group, which is attached as Appendix A to this report.

1 PURPOSE OF THE REPORT

The purpose of this report is to seek the Health and Wellbeing Board's approval for the Terms of Reference for the Rutland Mental Health Neighbourhood Group, a subgroup of the Rutland Health and Wellbeing Board.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 Mental health is an important area reflected in the recognition and commitment to parity of esteem in national strategies by which mental health and physical health must be given equal priority, an approach which is enshrined in law by the Health and Social Care Act 2012 and the recent Health and Care Bill 2022, which became law in April 2022.

2.2 The Rutland Mental Health Neighbourhood Group brings partners together in Rutland to lead on driving, coordinating and enabling mental health transformation

within Rutland. The Rutland Mental Health Neighbourhood Group will work with the Rutland Health and Wellbeing Board, local authority, local VCS partners and local health organisations to set local priorities and take informed local decisions on implementation.

2.3 There is recognition within the Rutland Joint Health and Wellbeing Strategy: The Rutland Place based Plan 2022 – 2027 for the need to address and improve mental health which is recognised as a cross-cutting priority. In this plan, this group will aim to deliver specific actions:

- 7.1.4 - Creating a local plan to better coordinate care for mental health across neighbourhood service areas.
- 7.1.5 - Increased response for low level mental health issues.
- 7.1.6 - Long-term objectives to deliver an integrated neighbourhood approach to mental health needs in Rutland are met.

3 CONSULTATION

3.1 A collaborative approach including members from the local authority, local VCS partners and local health organisations have discussed the Terms of Reference and agreed on what they feel best represents the group and the direction forward.

4 ALTERNATIVE OPTIONS

4.1 Not applicable

5 FINANCIAL IMPLICATIONS

5.1 Where it is deemed relevant, the group will assess any funding opportunities. By using local data and evidence-based insights to support neighbourhoods with information and themes, we can better enable them to design initiatives to meet local needs.

6 LEGAL AND GOVERNANCE CONSIDERATIONS

6.1 The Rutland Mental Health Neighbourhood Group is a sub-group of the Rutland Health and Wellbeing Board.

6.2 The group is also part of the LLR Mental Health collaborative governance. Collectively, this brings together three Place-based Mental Health groups from Rutland, Leicester City and Leicestershire alongside the LLR Mental Health Collaborative Group. The collaborative governance feeds directly into the Integrated Care Board. The Place-based groups are not subordinates to the collaborative group but will work together to form the Mental Health Collaborative for the Leicester, Leicestershire and Rutland system.

7 DATA PROTECTION IMPLICATIONS

7.1 Data Protection Impact Assessments (DPIA) will be undertaken for individual projects as and when required to ensure that any risks to the rights and freedoms of natural persons through proposed changes to the processing of personal data are appropriately managed and mitigated.

8 EQUALITY IMPACT ASSESSMENT

8.1 An Equality Impact Assessment (EqIA) will be completed for each project by the group. For the strategy, work in this area will provide positive impact to all Rutland residents.

9 COMMUNITY SAFETY IMPLICATIONS

9.1 Having a safe and resilient environment has a positive impact of health and wellbeing and people's mental health. There are no specific community safety implications, and we will continue to work closely with our neighbourhood partners to build strong and resilient relationships across Rutland.

10 HEALTH AND WELLBEING IMPLICATIONS

10.1 The Rutland Mental Health Neighbourhood strategy and Place-led plan that will be designed by the Mental Health Neighbourhood Group will bring local partners to work together effectively with the aim to enable positive mental health transformation within Rutland, which will look to enhance the health and wellbeing of the local population. An overview of this strategy is detailed in Appendix B.

11 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

11.1 We want the people in Rutland to live long and healthy lives. By ensuring that support for their mental health needs is met using the data already researched that shows any current need and gaps, as well as working closely with the local population, will be key to seeing this vision realised. To achieve this, the collaborative group will develop and implement a Place-based mental health strategy and delivery plan. This will identify the needs of Rutland, being locally informed and responsive to local populations. We are therefore looking to have the Terms of Reference approved for the group, which will confirm the Rutland Mental Health Neighbourhood as a subgroup of the Rutland Health and Wellbeing Group.

12 BACKGROUND PAPERS

12.1 There are no additional background papers to the report.

13 APPENDICES

13.1 Appendix A - Mental Health Neighbourhood Group - Terms of Reference - DRAFT 4

13.2 Appendix B – Rutland Mental Health Neighbourhood Group – Strategy Overview

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

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Rutland Mental Health Neighbourhood Group

Terms of Reference DRAFT

Version 4

21 December 2022

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PURPOSE

The Rutland Mental Health Neighbourhood Group will bring partners together in Rutland to lead on driving, coordinating and enabling mental health transformation within Rutland.

The Rutland Mental Health Neighbourhood Group will work with the Rutland Health and Wellbeing Board, local authority, local VCS partners and local health organisations to set local priorities and take informed local decisions on implementation.

We want the people in Rutland to live long and healthy lives. By ensuring that support for their mental health needs is met using the data already researched that shows any current need and gaps, as well as working closely with the local population, will be key to seeing this vision realised.

The focus is on integration and better management of the transition between services and providers will be enhanced by closer partnership working on a common delivery footprint.

The group will develop and implement a Place-based mental health strategy and delivery plan. This will identify the needs of Rutland, being locally informed and responsive to local populations rather than a one-size fits all approach across Leicester, Leicestershire and Rutland (LLR).

The group will adopt a Do, Sponsor and Watch approach:

- **Do** – The group will lead on specific things ourselves that we set in our Place-led plan and strategy. Updates will be sent regularly to the group. The group will be responsible for these actions being delivered.
- **Sponsor** – The group may sponsor or oversee a project or work which others undertake that is of interest to the group and are there to offer support where necessary. Updates will be published to the group when required.
- **Watch** - We'll keep an oversight of what other groups are doing, even if no direct involvement is required. Updates will be shared when required.

Mental health cuts across all the seven priorities in the Rutland Joint Health and Wellbeing Strategy: The Rutland Place-based Plan 2022 – 2027. It is key to ensure that these priorities are adhered to when making decisions based on the local needs.

Additional resources, such as the Rutland Health Inequalities & Hidden Need report, Healthwatch Rutland's 'What Matters to You' report and 'The Future Rutland Conversation' will also help to identify health inequalities.

RESPONSIBILITY

The Rutland Mental Health Neighbourhood Group will be responsible to deliver the new Rutland Mental Health Neighbourhood strategy, which will be aligned to the Rutland Health and Wellbeing Board strategy.

- Prevention and mental health and well-being
- Urgent and emergency mental health (sponsor watch)
- Planned community mental health
- Children and young people mental health and well-being
- Getting help in neighbourhoods
- Dementia and pre-dementia support

- Support for carers mental health
- Supporting more access locally
- Develop a lived experience network
- Suicide prevention
- Strategy to be completed by spring 2023

ACCOUNTABILITY

The Rutland Mental Health Neighbourhood Group is a sub-group of the Rutland Health and Wellbeing Board. There are specific actions within the Rutland Joint Health and Wellbeing Strategy that the group will work to when creating the Rutland Mental Health Neighbourhood strategy and Place-led plan. These are:

- **Action 7.1.4** - Creating a local plan to better coordinate care for mental health across neighbourhood service areas.
- **Action 7.1.5** - Increased response for low level mental health issues.
- **Action 7.1.6** - Long-term objectives to deliver an integrated neighbourhood approach to mental health needs in Rutland are met.

This group is part of the LLR Mental Health collaborative governance. Collectively, this brings together three Place-based Mental Health groups from Rutland, Leicester City and Leicestershire alongside the LLR Mental Health Collaborative Group. The collaborative governance feeds directly into the Integrated Care Board. The Place-based groups are not subordinates to the collaborative group but will work together to form the Mental Health Collaborative for the Leicester, Leicestershire and Rutland system.

LLR Mental Health Collaborative Governance

AUTHORITY

The Rutland Mental Health Neighbourhood Group will create and design a plan and report to the Rutland Health and Wellbeing Board on a quarterly basis.

In line with the new LLR collaborative group, the group will be focusing on Rutland specific outcomes and any delegations from the collaborative group will be agreed by the Rutland Health and Wellbeing Board.

MEMBERSHIP

Identified members attending the Rutland Mental Health Neighbourhood Group are:

	Name	Organisation	Function/Role	Contact Email Address
1.	Alex Magliulo	Rutland County Council	RISE Mental Health Care Manager	amagliulo@rutland.gov.uk
2.	Alison Corah	Uppingham Surgery	Mental Health Lead GP	alison.corah11@nhs.net
3.	Alison Marjoram	P3 - People Potential Possibilities	Head of Development	alison.marjoram@p3charity.org
4.	Bernadette Caffrey	Rutland County Council	Head of Early Help, SEND and Inclusion	bcaffrey@rutland.gov.uk
5.	Charlie Summers	NHS Leicester, Leicestershire & Rutland Integrated Care Board	Integration and Transformation Manager	charlotte.summers7@nhs.net
6.	Debi O'Donovan	Leicestershire Partnership Trust	Service Manager	debi.odonovan1@nhs.net
7.	Duncan Furey	Citizens Advice Rutland	Chief Executive Officer	duncan.furey@citizensadvicerutland.org.uk
8.	Emmajane Perkins	Rutland County Council	Head of Service Community Care Services	eperkins@rutland.gov.uk
9.	Glynn Attiwell	Rutland County Council	Active Rutland Hub Coordinator	gattiwell@rutland.gov.uk
10.	Janet Dowling	Rutland County Council	Family Hub Programme Manager	jdowling@rutland.gov.uk
11.	Johanne Barrass	P3 - People Potential Possibilities	Operations Manager	johanne.barrass@p3charity.org
12.	Justin Hammond	NHS Leicester, Leicestershire & Rutland Integrated Care Board	Head of All Age Mental Health, Learning Disability, Autism and Dementia Services	justin.hammond@nhs.net
13.	Kirsteen McVeigh	The Carers Centre	Chief Executive Officer	kirsteen@thecarerscentre.org.uk
14.	Mark Young	Rutland County Council	Senior Mental Health Neighbourhood Lead	myoung@rutland.gov.uk
15.	Mia Brophy	Longhurst Group	Sheltered Housing Team Leader	mia.brophy@longhurst-group.org.uk
16.	Mikhail Foster	Leicestershire County Council	Strategic Lead for Mental Health	mikhail.foster@leics.gov.uk
17.	Mitchell Harper	Public Health	Strategic Lead - Rutland	mitchell.harper@leics.gov.uk
18.	Nicky Beasley	P3 - People Potential Possibilities	Rutland Service Manager	nicky.beasley@p3charity.org
19.	Nicola Turnbull	Rutland Health PCN	PCN Manager	nicola.turnbull5@nhs.net
20.	Osas Adetutu	Vita Health Group	Partnership Liaison Officer	osas.adetutu@vhg.co.uk
21.	Pippa Gorman	Pepper's – A Safe Place	Development Manager	info@peppersasafeplace.co.uk
22.	Rob Melling	Leicestershire Partnership Trust	Mental Health Improvement and Transformation Lead	rob.melling@nhs.net
23.	Ruth Martin	Longhurst Group	Scheme Assistant	ruth.martin@longhurst-group.org.uk
24.	Stephanie Logue	Rutland County Council	Health and Wellbeing Officer	slogue@rutland.gov.uk
25.	Susan-Louise Hope	Public Health	Strategic Lead – Rutland Commissioning	susan-louise.hope@leics.gov.uk
26.	Tracey Allan Jones	Healthwatch Rutland	Healthwatch Manager	tracey.allanjones@healthwatchrutland.co.uk
27.	Tracy Webb	Rutland County Council	Service Manager - Prevention and Safeguarding	twebb@rutland.gov.uk
28.	Troy Young	Age UK - Leicester Shire & Rutland	Assistant Director	troy.young@ageukleics.org.uk

Lived experience
As well as the members listed, the Rutland Mental Health Neighbourhood Group are keen to invite people with relevant lived experience to join the meetings. We aim to regularly meet and engage with people with lived experience who will help to inform and co-produce the direction of the group.

ATTENDANCE

Members of the Rutland Mental Health Neighbourhood Group are expected to prioritise attendance at each meeting. If a member if unable to attend, they should inform the Chair and seek to nominate a deputy to attend on their behalf.

QUORACY

For meeting to be quorate, there will need to be a minimum of at least one representative in attendance from the following:

- One must be from Rutland County Council
- One must be from Public Health
- One must be from health services
- One person from the community

CHAIRING

The Rutland Mental Health Neighbourhood Group will be chaired by a member from Rutland County Council.

FREQUENCY AND FORMAT

The Rutland Mental Health Neighbourhood Group will normally meet monthly. Meetings will be held via Microsoft Teams.

Members of the group should inform the Chair if they have any accessible information requirements.

CONFLICTS OF INTEREST

Members of the group are required to disclose if there are any actual or potential conflicts of interest relating to any matter to be considered at each meeting. Anything raised will be recorded in the minutes and where necessary at the discretion of the Chair, an individual may be asked to withdraw from that part of the agenda.

DECISION-MAKING AND VOTING

The Rutland Mental Health Neighbourhood Group will seek to reach conclusions by consensus, which will be evidence-based or underpinned by the most relevant information we have at that point in time. As the group is a sub-group of the Rutland Health and Wellbeing Board, we will report any decisions made back to the HWB where it is appropriate to do so.

BEHAVIOURS AND CONDUCT

The Rutland Mental Health Neighbourhood Group has agreed to a set of expected behaviours and conduct. This is to make sure that everyone feels safe and can fully participate in the meetings. These conducts will be reviewed annually. The group members are asked to:

1. Be friendly, polite and courteous.
2. Make criticisms and challenge in a helpful and constructive way. Think about and offer solutions.
3. Be objective and fair.
4. Be open and honest.
5. Be respectful of other people's views and opinions. Everybody's views are important.
6. Listen to other people without interrupting.
7. Be on time. Let others know if you are unlikely to attend a meeting or will be late or leave early.
8. Read the papers beforehand so you come prepared.
9. Be responsible for letting the Chair know when they are representing their own personal views. Only use personal experiences if you are doing so to explain something.
10. Respect people's confidentiality. Do not use any personal information outside the neighbourhood group meetings.
11. Declare interests ahead of relevant agenda items.

CONFIDENTIALITY

All discussions held with the Rutland Mental Health Neighbourhood Group will be considered confidential. Members of the group should normally preserve the confidentiality of what is discussed at meetings. The approval of the chair should be sought prior to any disclosure.

ADMINISTRATIVE SUPPORT

Meeting will be administered by the Senior Mental Health Neighbourhood Lead, employed by Rutland County Council. The responsibility of this role will lead on taking of meeting notes and recording actions, as well as reporting back information from the group to the Rutland Health and Wellbeing Board and LLR Mental Health Collaborative Governance.

The agenda and subsequent minutes from the meetings will also be maintained by this role.

REPORTING ARRANGEMENTS

The Rutland Mental Health Neighbourhood Group will report back to the Rutland Health and Wellbeing Board at their quarterly meetings, as well as reporting back to this collaborative neighbourhood group and the wider LLR Mental Health Collaborative Governance.

REVIEW OF THE TERMS OF REFERENCE AND THE EFFECTIVENESS OF THE GROUP

An initial review of the Terms of Reference will occur after six months to check the current scope, conduct, composition and effectiveness of Rutland Mental Health Neighbourhood Group. After this, the review will take place annually unless circumstances require a review more frequently.

Appendix 1 - Charter for Mental Health

Every person has the right to Mental Health services that:

1. Work together with respect, dignity and compassion
2. Make a positive difference to each person's recovery and quality of life.
3. Are guided by the individual's views about what they need and what helps them.
4. Treat everyone as a capable citizen who can make choices and take control of their own life.
5. Give people the appropriate information they need to make their own decisions and choices about their recovery
6. Recognise that mental health services are only part of a person's recovery.
7. Communicate with each person in the way that is right for them.
8. Understand that each person has a unique culture, life experiences and values.
9. Recognise, respect and support the role of carers.
10. Support their workers to do their jobs well.
11. Challenge stigma, fear and discrimination both within mental health services and in the wider society.
12. Put mental health on a par with physical health
13. Are culturally competent and can meet the diverse needs of local people.

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Rutland Mental Health Neighbourhood Group

Strategy Aims

- Work with Neighbourhood partnerships and other stakeholders to develop and implement a Place-based mental health strategy and delivery plan.

- Facilitate co-ordination, oversight, and collaborative working – across Rutland in relation to the spectrum of the mental health and emotional well-being agenda.

- Lead on driving, co-ordinating and enabling mental health transformation within Rutland.

- Work with the Health and Wellbeing Board, Rutland County Council, local VCS partners and local health organisations to set priorities and take informed local decisions on implementation.

- To work collaboratively with other Health and Wellbeing board subgroups (Integrated Delivery Group (IDG) and Children and Young People's Partnership (CYPP)) to ensure that there is a shared view of the mental health agenda; and to help avoid duplication.

- To work collaboratively with wider mental health system partners, including the LLR wide Mental Health Collaborative.

Rutland Mental Health Neighbourhood Group

Strategy Headings

- Introduction
- Strategic context
- Our current journey – where we are now
- Our vision – where we want to be now and long-term
- How do we achieve these aims - sustainability
- Strategic priorities and cross-cutting themes
- How we will make this happen – strategic enablers
- Governance
- Measurable outcomes
- Funding opportunities, financial and delivery plans
- Review

Rutland Mental Health Neighbourhood Group

Strategy Areas of Focus

- Adult Community Mental Health (ACMH)
- Ageing well/healthy ageing
- Armed Forces
- Carers
- Children and Young People (CYP), including SEND children
- Cost of Living
- Dementia
- Early Interventions in Psychosis (EIP)
- Engagement - identify vulnerable people not engaging
- Families
- Farming communities
- Improving Access to Psychological Therapies (IAPT)
- Individual Placement and Support (IPS)
- Inpatient and Out of Area Placement (OAPs)
- Lived experience network
- Mental Health Urgent and Emergency Care (MH UEC)
- Perinatal
- Personality Disorder
- Population growth
- Prisoners
- Severe Mental Illness (SMI)
- Suicide
- Waiting Lists

Staying Healthy Partnership 6-month plan

The below plan sets out a 6 month action plan to develop and start delivering on two key workstreams – tackling health inequalities and a whole system approach to obesity.

Workstream 1 – tackling health inequalities

Purpose

Workstream 1 will focus on engaging senior leadership, developing insight and agreeing an approach to tackling health inequalities across all service areas. There will be clear evaluation to monitor progress in support those populations and areas most in need.

Six month action plan					
Action	**Aims**	**Responsible**	**Due date**	**Progress**	**Outcomes**
1. Complete Health Needs Assessment for Rutland Health Inequalities.	• Develop a greater insight into health inequalities across Rutland.	Public Health and partners	Oct 22	Complete	Needs Assessment complete and published online. HWB approval in October for a Board development session.
2. 1:1 partner engagement on current work supporting population groups and geographical areas highlighted in the needs assessment.	• Understand the current position across partners supporting those most in need. • Understand where gaps exist supporting populations and identify opportunities to work across partners where a population/area is already engaged. • Use examples within the development session.	Public Health and partners	Jan 23		
3. Health & Wellbeing Board development session on health inequalities.	• Gain Senior buy in for Rutland to tackle inequalities. • Share insight from the Needs Assessment. • Gain insight into current work supporting different populations	HWB, wider partners	Jan 23	Ongoing - board session booked for end of Jan 23.	

	and geographical areas identified as most in need, supporting action 2. • Discuss and agree priority areas with clear actions to take forward.				
4. Develop actions from the development session recommendations with oversight from the Staying Healthy Partnership.	• Have a clear, coherent plan for Rutland to support those most in need across all services. • Enable collaborative working on inequalities. • Develop shared responsibility and accountability.	Staying Healthy Partnership	March 23 meeting		
5. Develop a framework to monitor and evaluate progress.	• Produce a clear process to monitor and evaluate progress. • Develop a clear understanding on the progress and impact made delivering the action plan. • Continuously assess priority groups and gaps as time progresses.	Public Health and Staying Healthy Partnership	March 23 meeting		
6. Partners to start implementing actions into their services.		All partners	April 23 onwards		

Workstream 2 – whole system approach to obesity

Purpose

Workstream 2 focuses on a whole system approach to obesity model, factoring in a range of obesity causes and mapping current activity and gaps across each (food environment, physical activity provision, schools, workplaces etc). The purpose is to map the local system to collate current actions and provide recommendations where there are gaps.

Development and implementation will focus on the Office for Health Improvement and Disparities (previously PHE) guidance https://www.gov.uk/government/publications/whole-systems-approach-to-obesity. Phases 1 to 3 focus on mapping, evidence and partner buy in. Phases 4 to 6 over action, monitoring and evaluation.

Six month action plan					
Phases of development	**Aims and actions**	**Responsible**	**Due date**	**Progress**	**Outcomes**
Phase 1: Setup – Secure senior-level support and establishes the necessary governance and build the narrative.	• Build a narrative around why we need to focus on obesity in a whole system approach. • Engagement with senior leaders.	Public Health	Jan 23	Ongoing – Senior engagement and narrative is being developed to support the 'why'.	
Phase 2: Building the local picture – Gather information required to understand the local picture of obesity, including its prevalence, local impact, relevant organisations and people, community assets and existing actions to address.	• Collate local information about obesity. • Establish an overview of current actions across Rutland organisations. • Start to understand local	Public Health and partners	March 23	Ongoing - local intelligence being collated	

	assets including community capacity and interest.				
Phase 3: Mapping the local system - Bring stakeholders together to create a comprehensive map of the local system that is understood to cause obesity.	• Map of the local system understood to cause obesity. • Run a workshop with wider stakeholders.		March 23		

Future phases to be incorporated into the plan after 6 months:

Phase 4 – Action

Phase 5 – Managing the system network

Phase 6 – Reflect and refresh

Agenda Item 14

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 ICS
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 c) Rutland Mental Health Neighbourhood Group	 Cllr Wilby Debra Mitchell Mark Young

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

13/12/22 SPECIAL MEETING	Health and Wellbeing Partnership – Draft Integrated Care Strategy: review	Sarah Prema, Chief Strategy Officer, LLR ICS	Discussion

24/01/23	**JSNA: Update & Timeline** JSNA Overview (statutory) Oral Health Needs Assessment	Hannah Blackledge & Adrian Allen, Public Health Andy Brown	Decision
	Staying Healthy Partnership	Adrian Allen / Mitch Harper	Discussion
	~~Primary Care Task and Finish Survey~~	~~TBC~~	~~Decision~~
	Sub-Groups • Approval of Terms of Reference	Mark Young/ Cllr Wilby / Debra Mitchell (LLR ICB)	Decision
	JHWB Strategy Communication and Engagement Strategy and Plan	Katherine Willison	

21/03/23	Primary Care Strategic Review / Task and Finish Group Survey	Jo Clinton/ Adhvait Sheth	Discussion
	RMH Feasibility Study	Sarah Prema / Mark Powell	Discussion
	For Information Only Director of Public Health Annual Report (statutory)	Mike Sandys, Director of Public Health	For Noting