RUTLAND JOINT STRATEGIC NEEDS ASSESSMENT

HEALTH INEQUALITIES NEEDS ASSESSMENT

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Strategic Business Intelligence Team

Leicestershire County Council

Rutland County Council

NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

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Contents

Executive Summary

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

Notes:

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

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

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

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

Section 1 recommendations

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

Section 2 – Rurality and access

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

Access to Primary Care (p.28-29)

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

Access to hospitals (p.30-31)

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

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

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

Rural farming communities (p.37-38)

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

Section 2 recommendations

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

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

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

Section 3 – Inclusion health and vulnerable groups

Armed forces community (p.39-42)

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

Carers (p.43-44)

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

Homelessness (p.44-45)

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

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

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

Section 3 recommendations

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

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

Section 4 – Protected characteristics

Age (p.48-50)

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

Disability (p.51-53)

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

LGBTQ+ (p.54-55)

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

Section 4 recommendations

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

Introduction

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

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

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

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

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

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

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

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

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

What is a Health Needs Assessment?

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

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

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

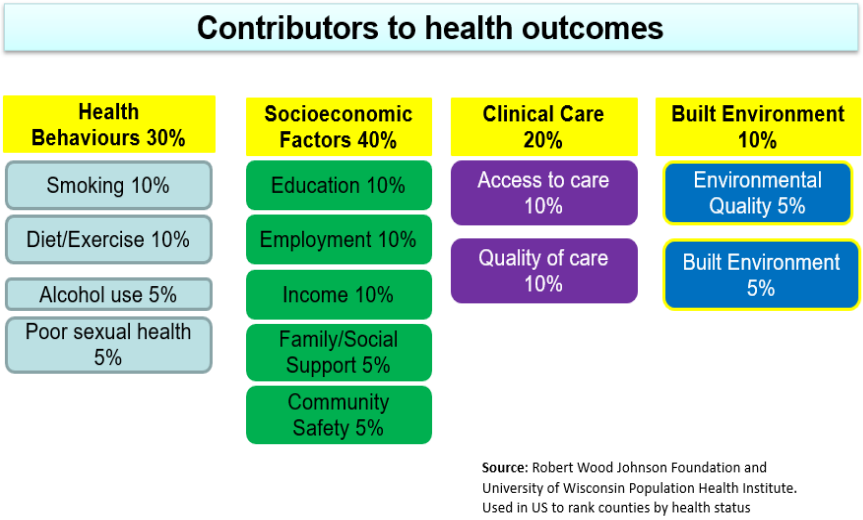


Figure 1 Contributors to health outcomes[6].

What are health inequalities?

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

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

Figure 2 Equality v Equity.

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

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

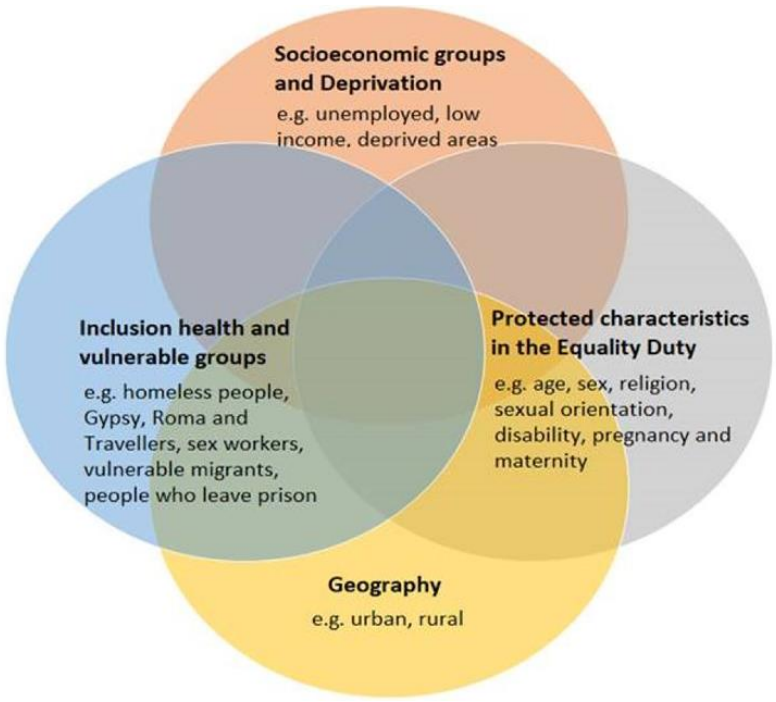


Figure 3 Overlapping dimensions of health inequality.

The impact of Covid-19 on health inequalities

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

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

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

Strategic context for addressing inequalities

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

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

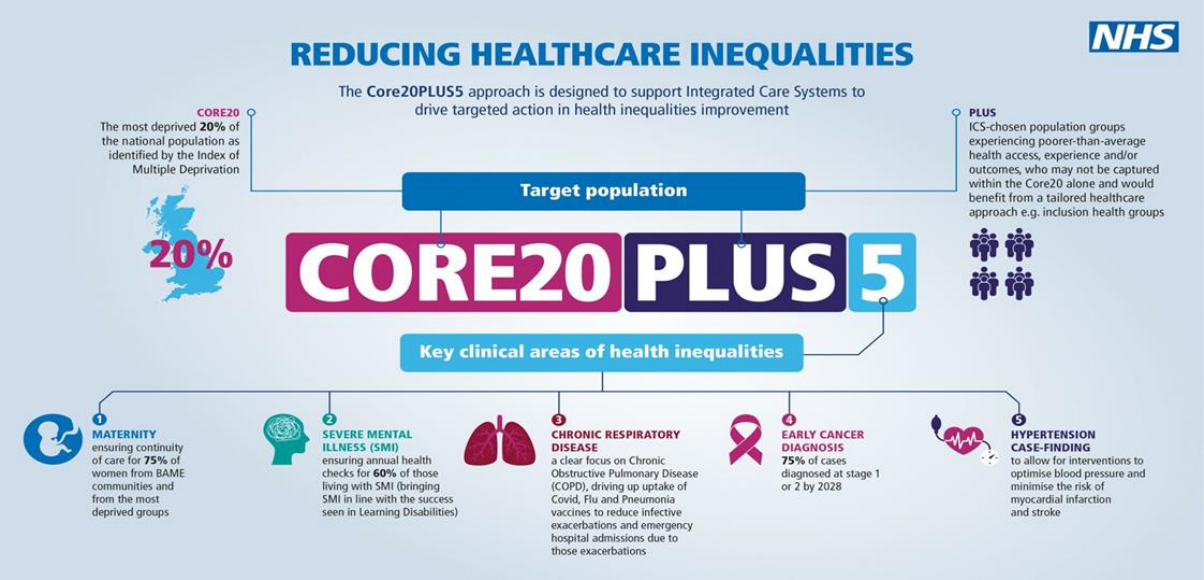


Figure 4 Core20PLUS5, NHS England and Improvement.

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

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

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

What Rutland residents say

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

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

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

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

Aims and objectives

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

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

Section 1 - Socio-economic and deprivation

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

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

Indices of deprivation

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

The Ministry of Housing, Communities and Local Government (as it was known at the time), stated that "it is important to note that these statistics are a measure of relative deprivation, not affluence, and to recognise that not every person in a highly deprived area will themselves be deprived. Likewise, there will be some deprived people living in the least deprived areas"[15]. Considering the rurality of Rutland, this is particularly pertinent in understanding local deprivation. The Indices of Deprivation aim to identify clusters and level of deprivation in small areas, rather than define every household within the LSOA.

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

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

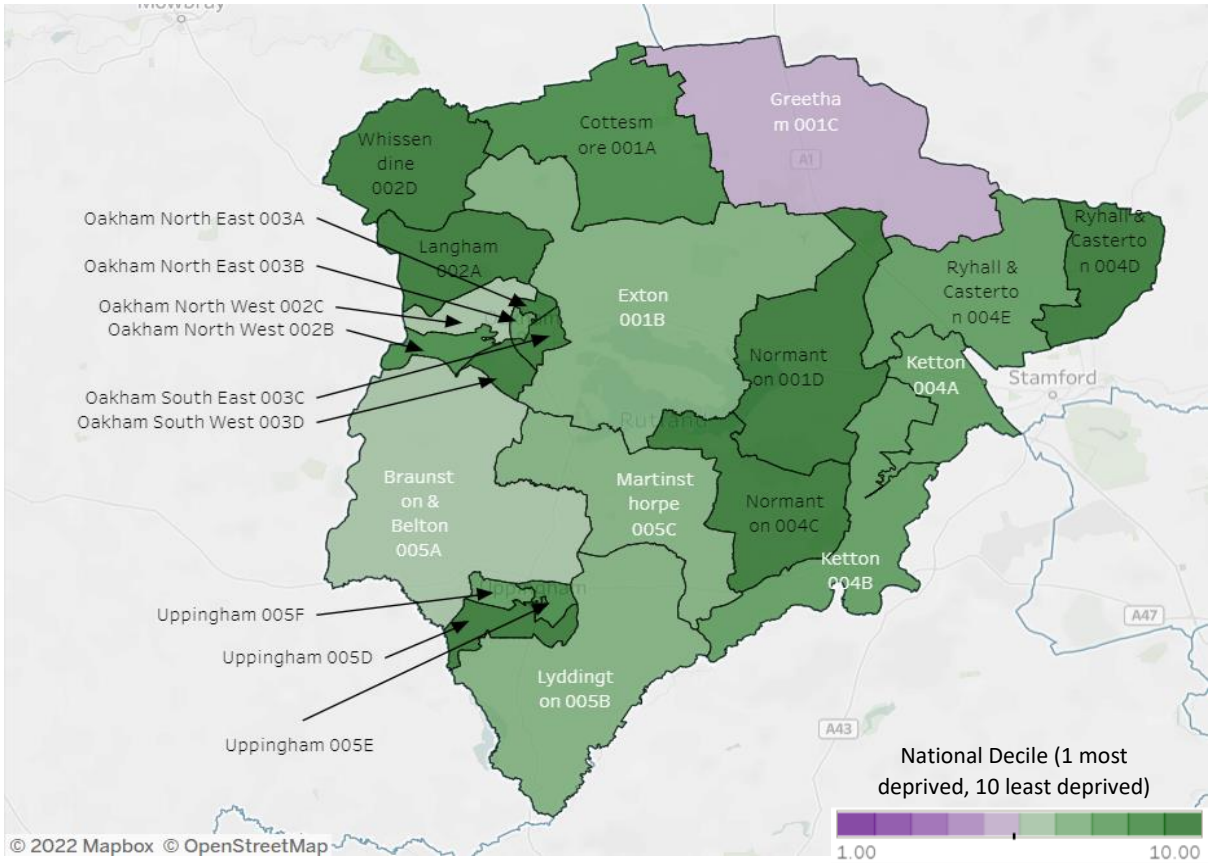


Figure 5 Index of Multiple Deprivation (IMD) in Rutland.

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

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

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

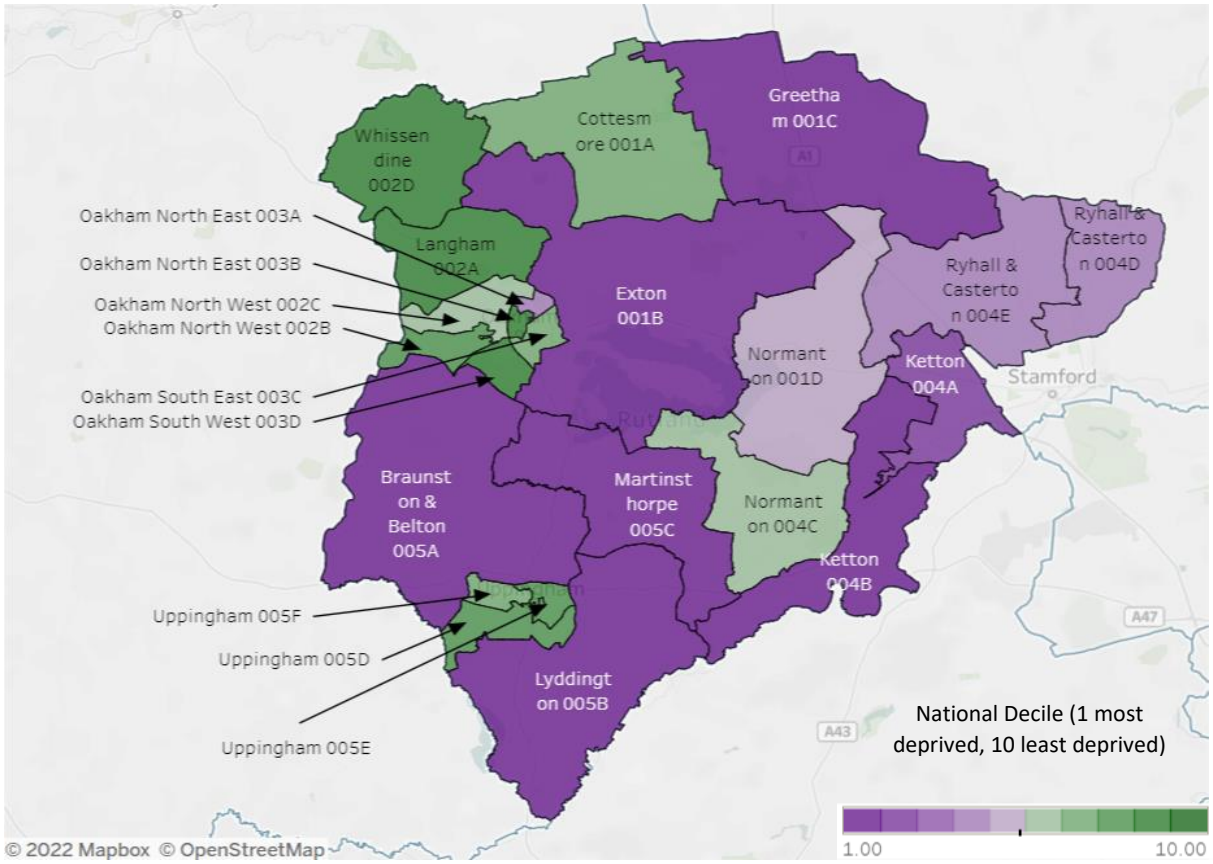


Figure 6 Barriers to Housing & Services[18]

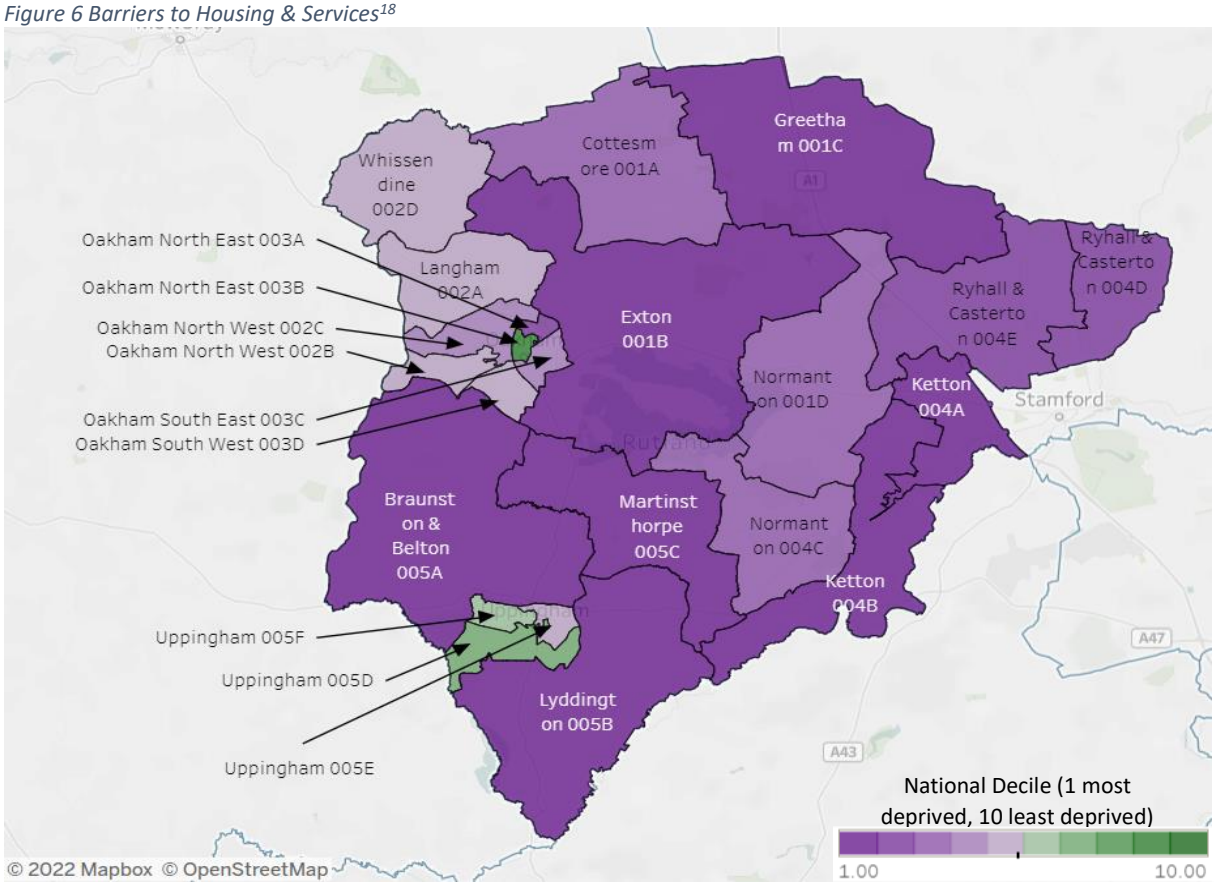


Figure 7 Geographical Barriers Sub-domain.

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

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

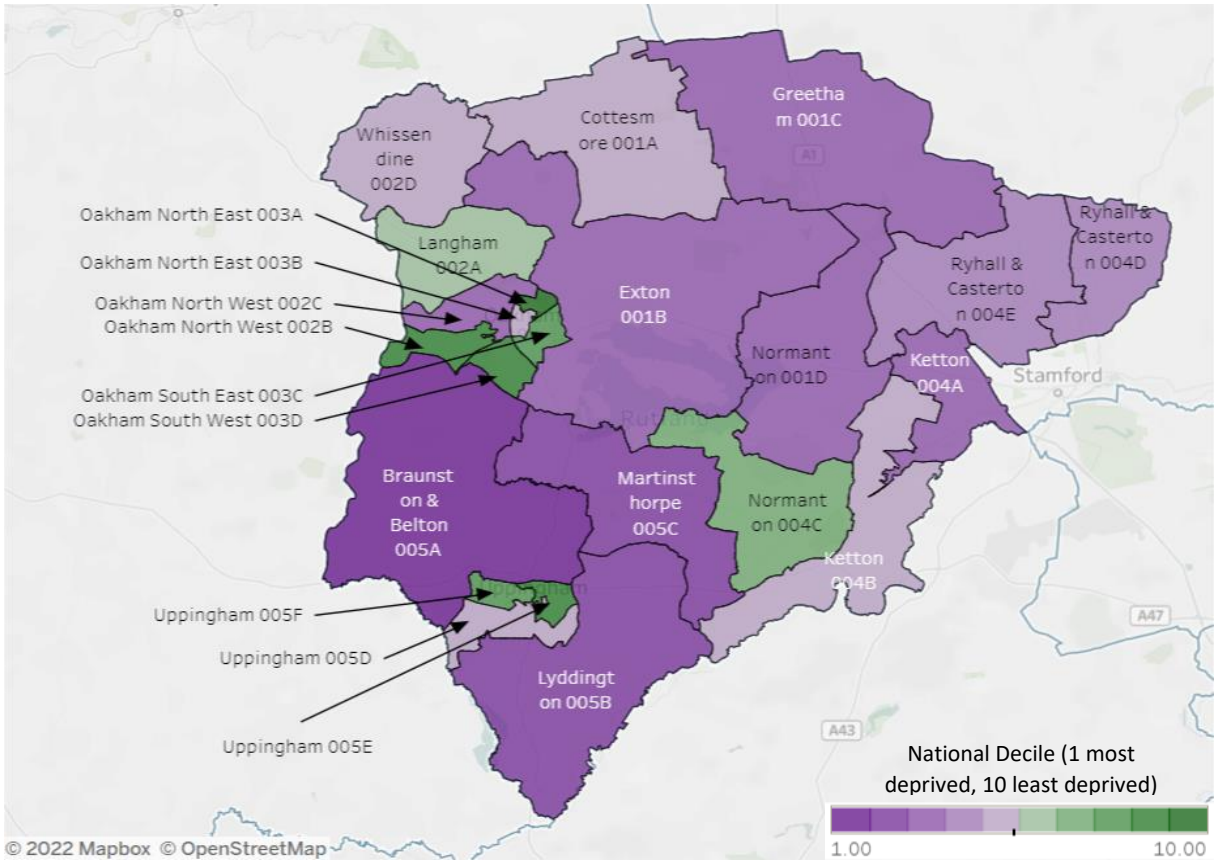


Figure 8 Indoors Sub-domain.

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

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

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

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

Hidden economic deprivation in Rutland

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

Child Poverty

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

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

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

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

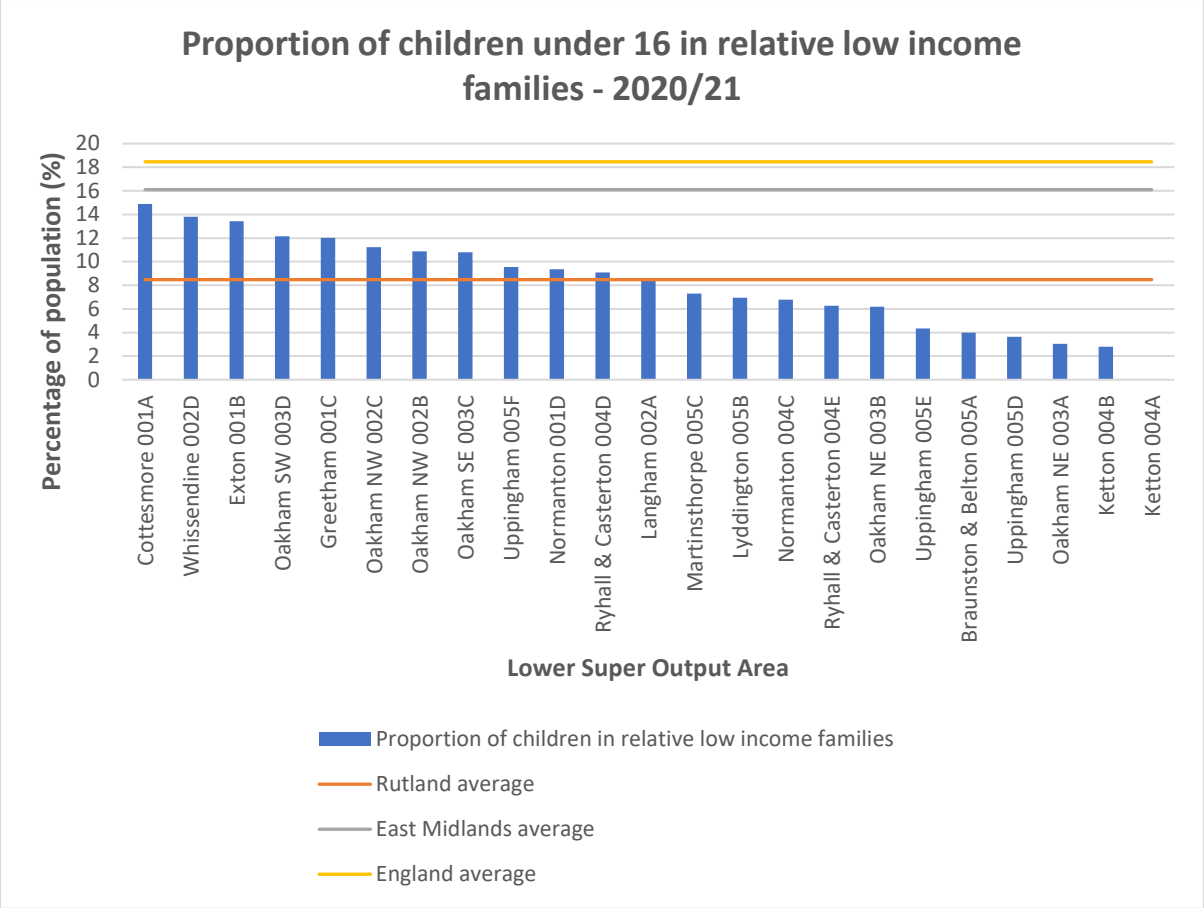


Figure 9 Proportion of children under 16 in relative low-income families - 2020/21.

Benefit support

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

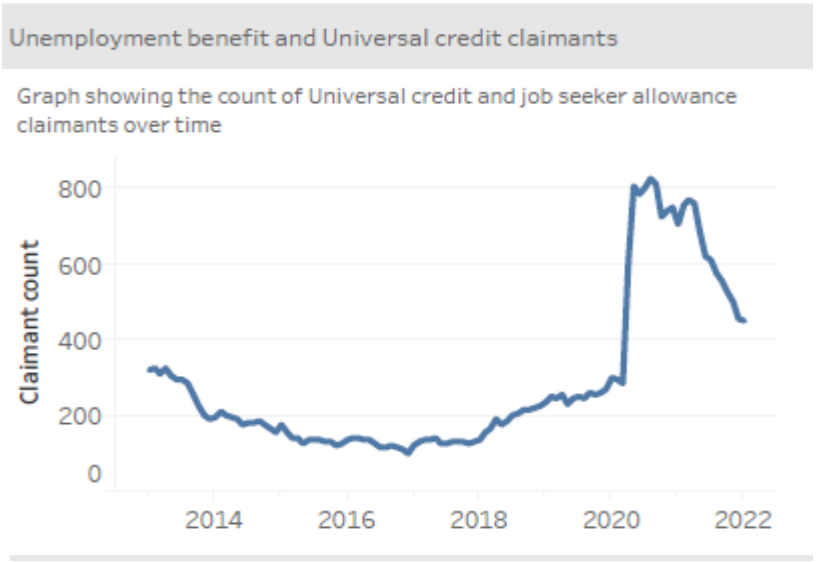


Figure 10 Unemployment benefits and Universal credit claimants.

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

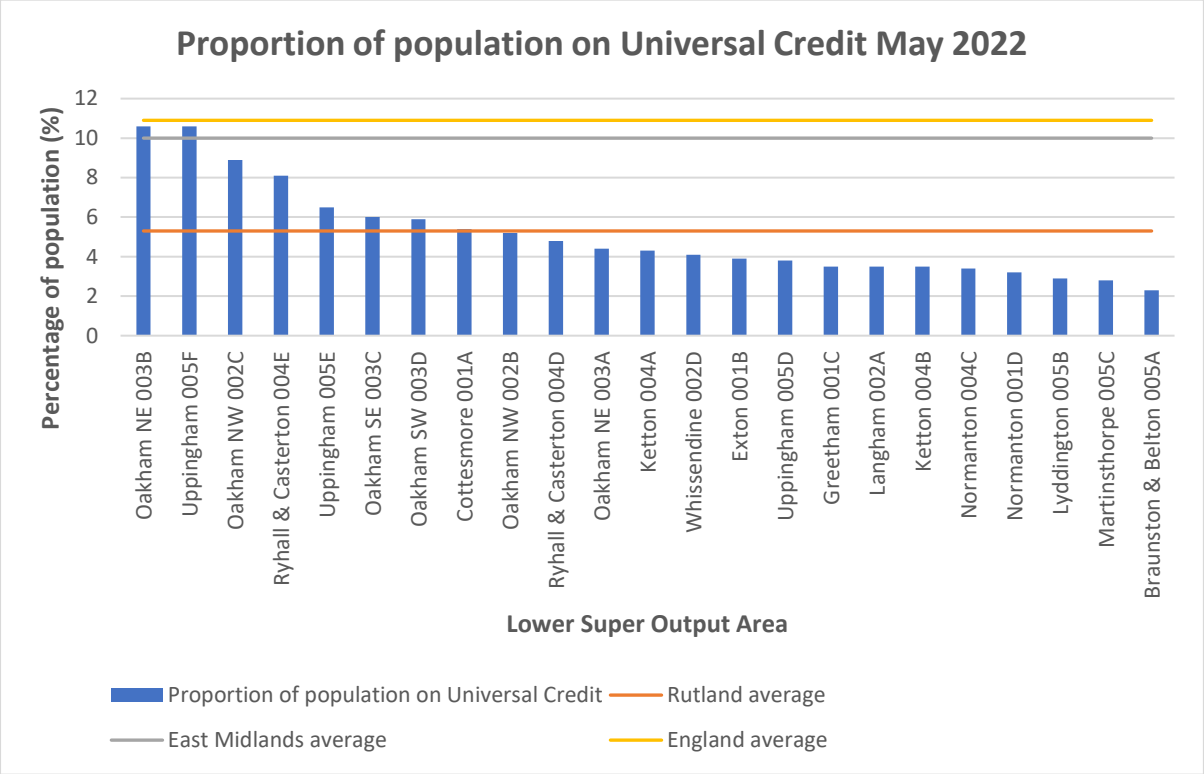


Figure 11 Proportion of population on Universal Credit May 2022.

Fuel poverty

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

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

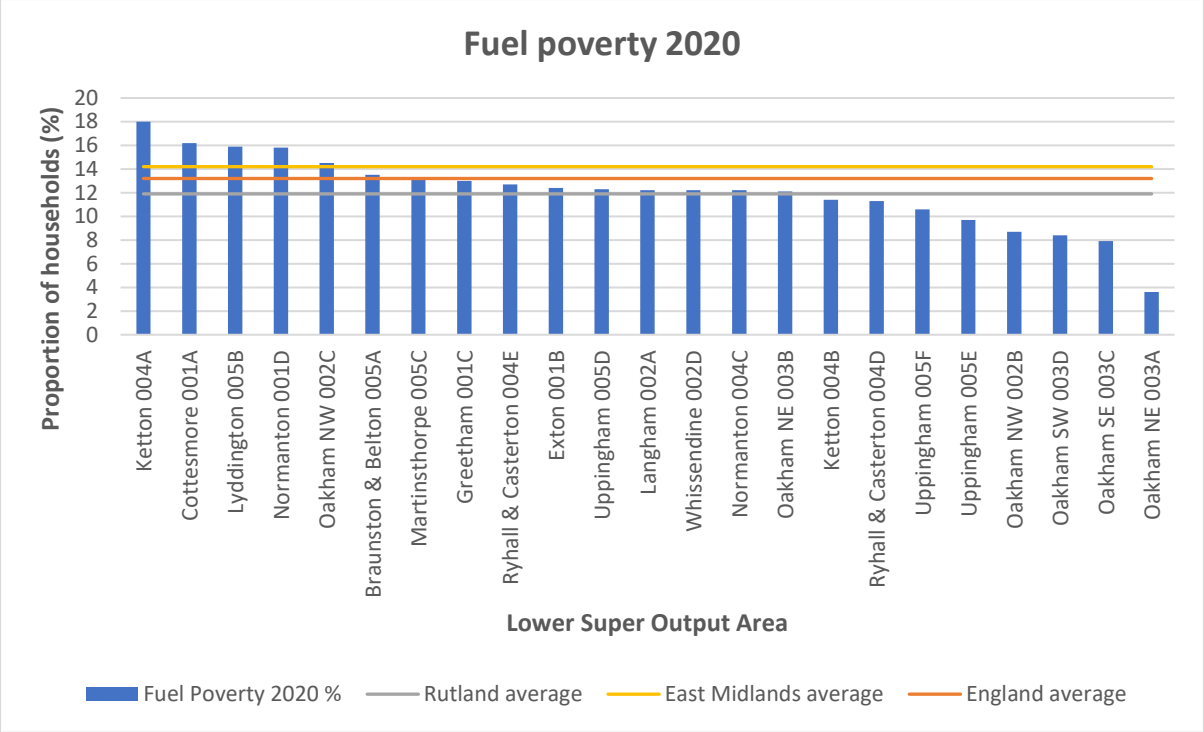


Figure 12 Fuel Poverty 2020.

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

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

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

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

Areas showing greatest need

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

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

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

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

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

Economic support services demand

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

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

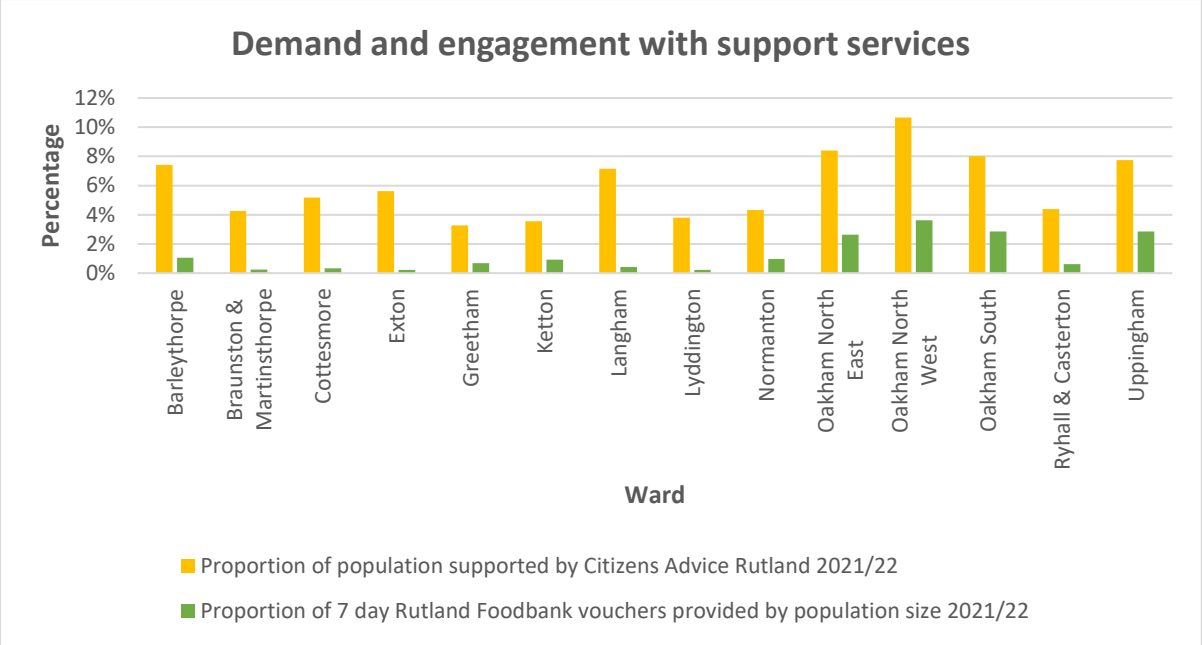


Figure 13 Demand and engagement with support services.

Rutland Foodbank

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

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

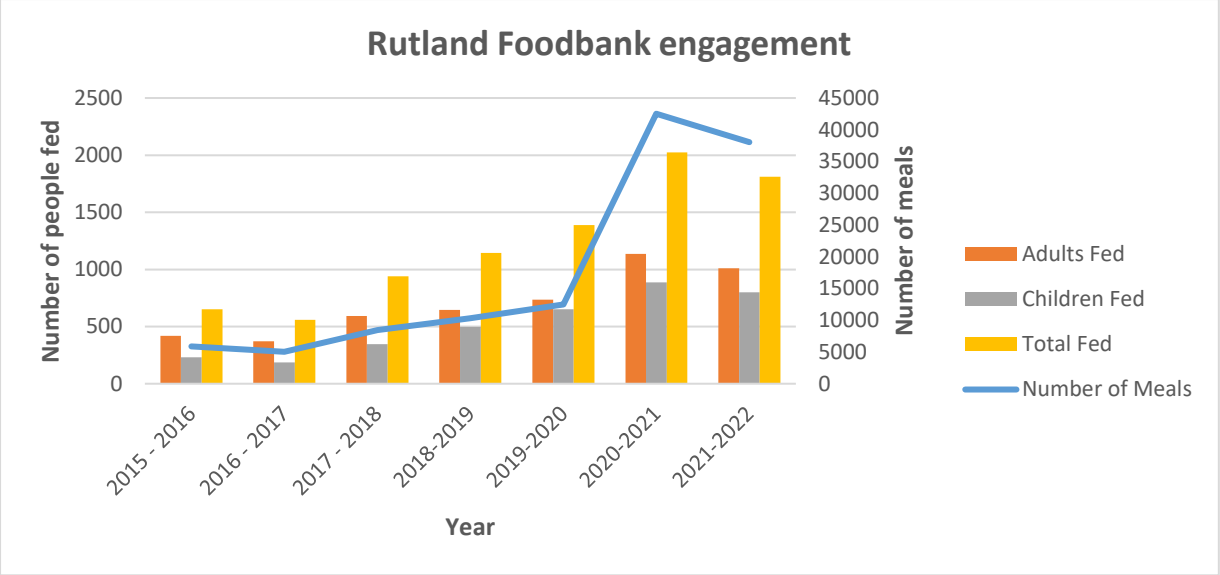


Figure 14 Rutland Foodbank engagement.

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

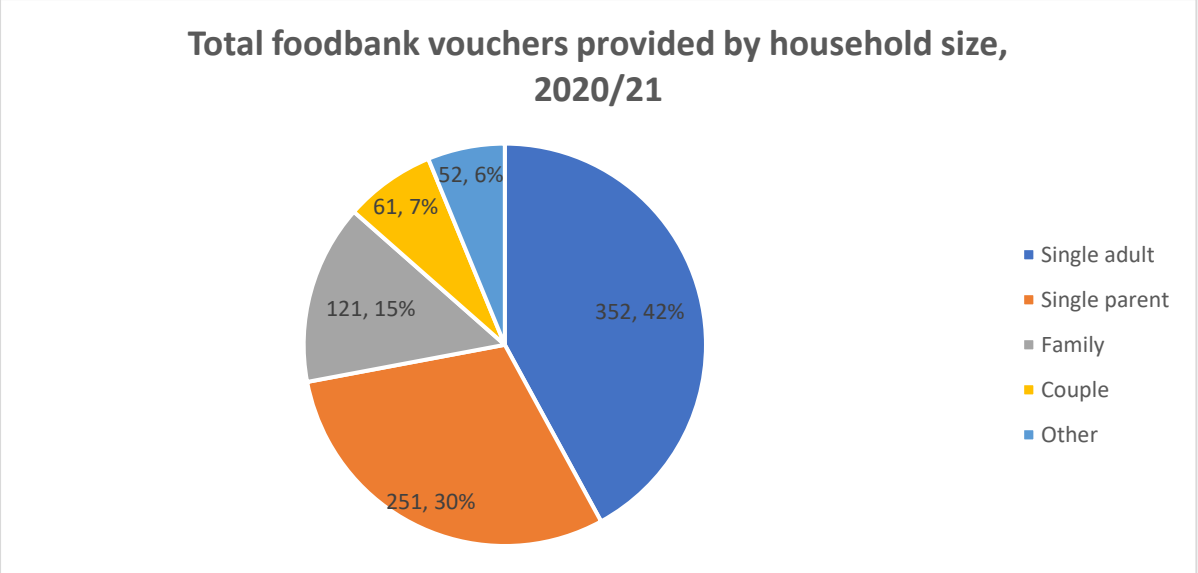


Figure 15 Total foodbank vouchers provided by household size, 2020/21.

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

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

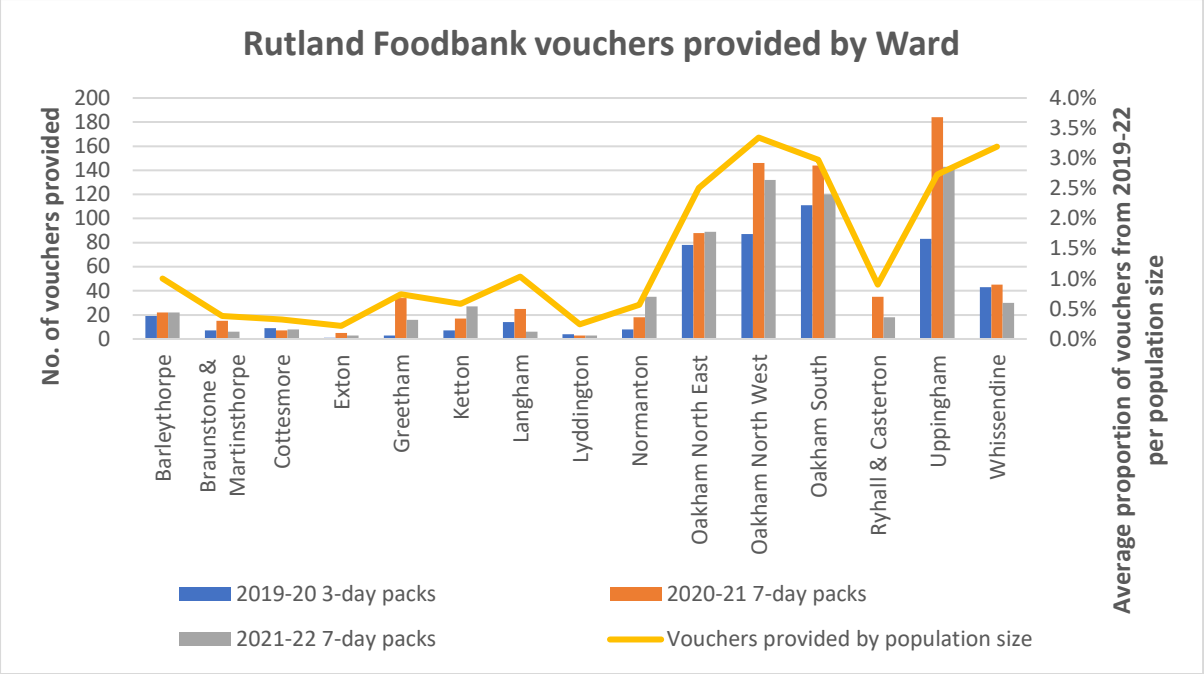


Figure 16 Rutland Foodbank vouchers provided by Ward.

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

Acorn Classification

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

The 'Financially Stretched' category combines the following factors:

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

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

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

Table 1 Rutland population by Acorn category.

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

Demographic variation

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

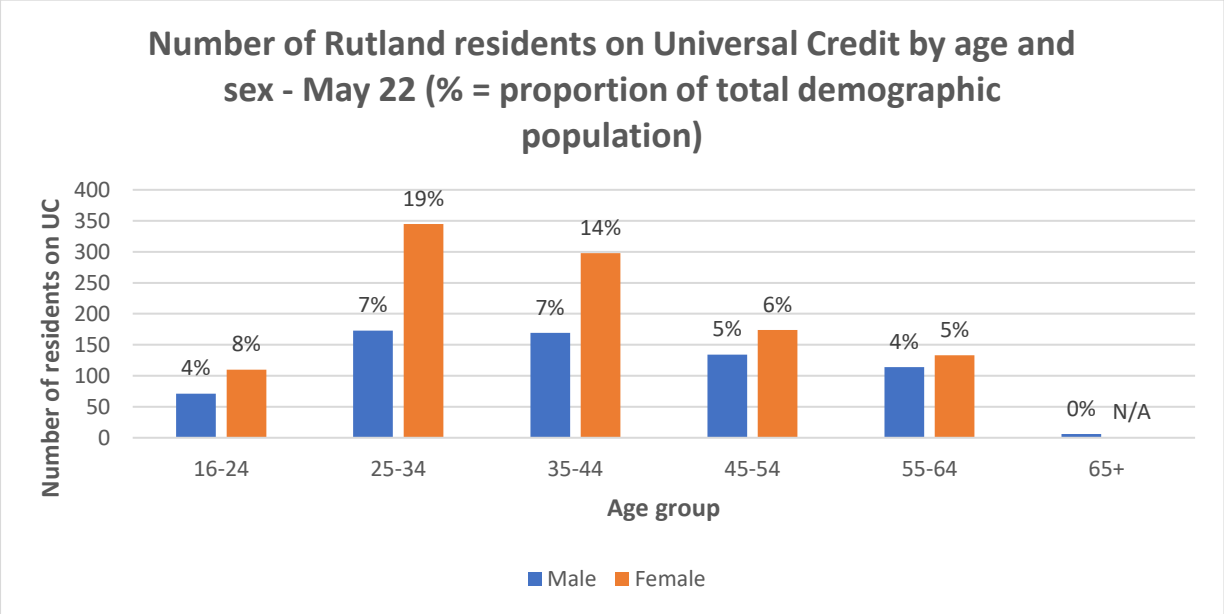


Figure 17 Number of Rutland residents on Universal Credit by age and sex.

Section 1 recommendations

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

Section 2 – Rurality and access

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

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

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

Rurality of Rutland

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

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

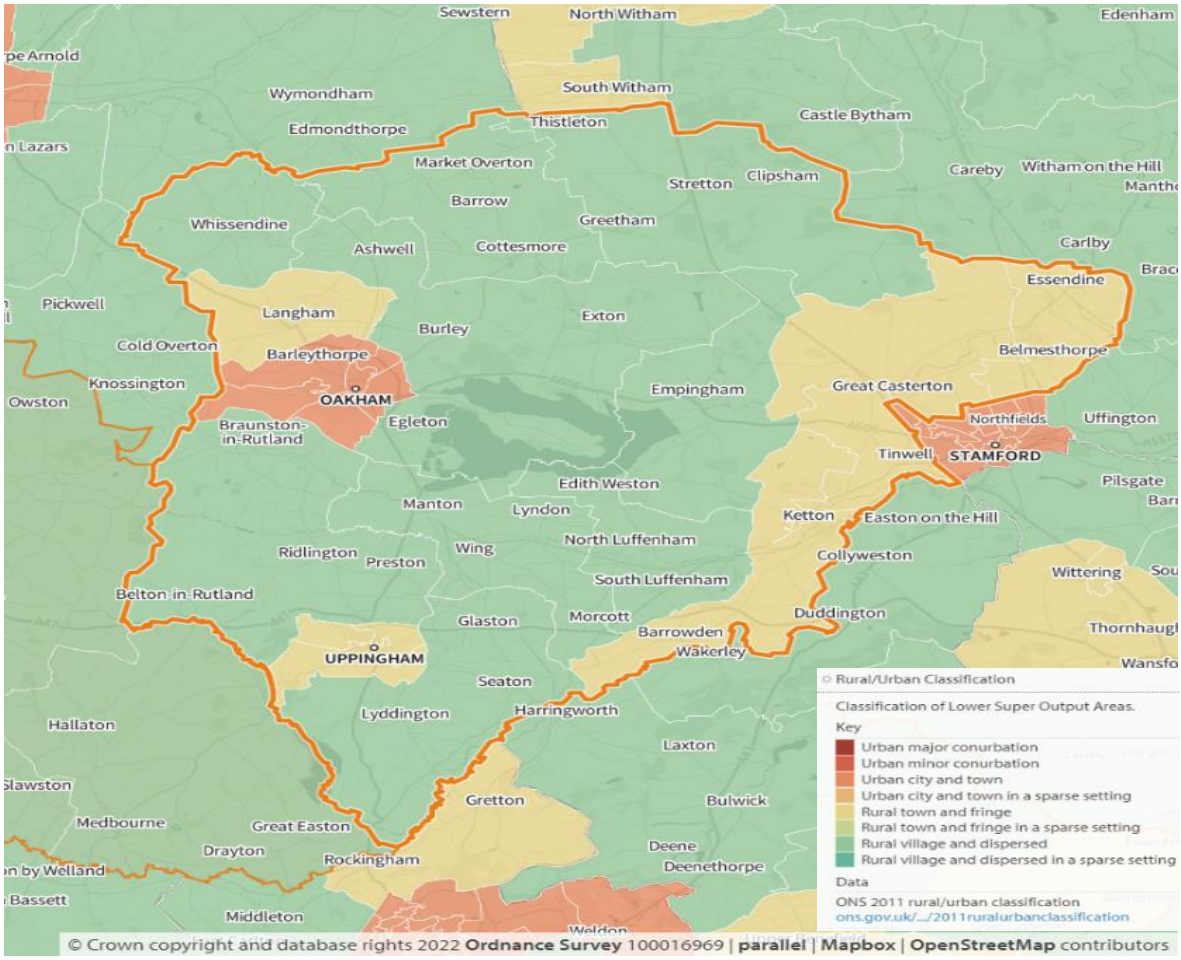


Figure 18 Rural/Urban Classification.

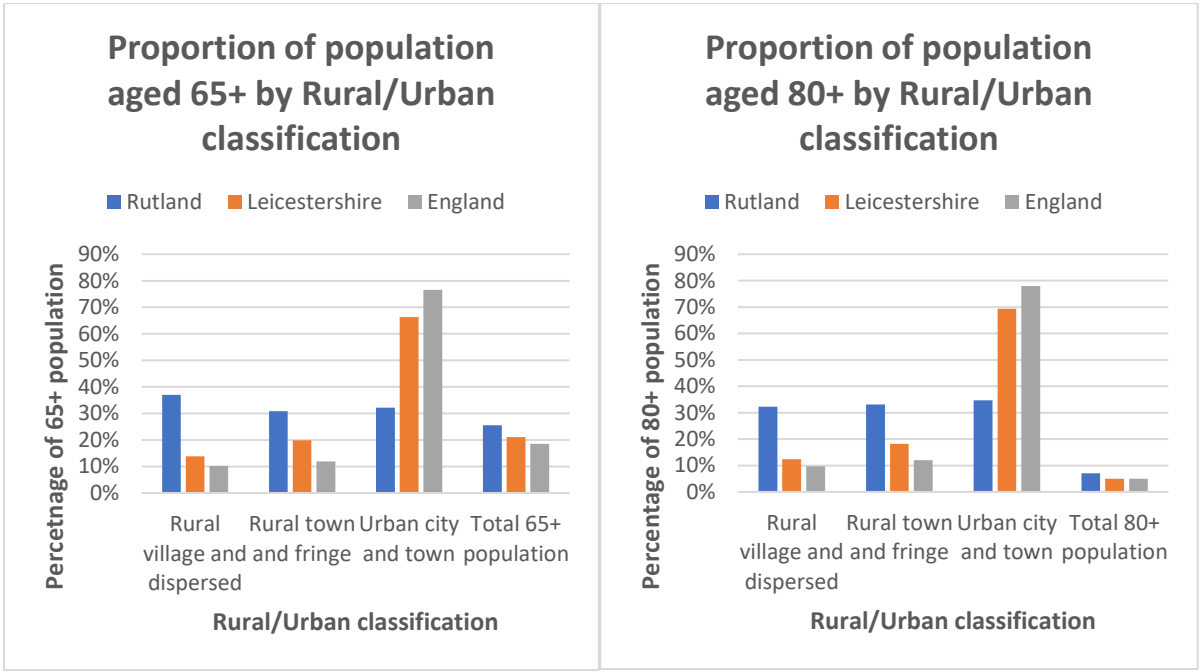


Figure 19 Proportion of population aged 65+ and 80+.

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

Access to Primary Care

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

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

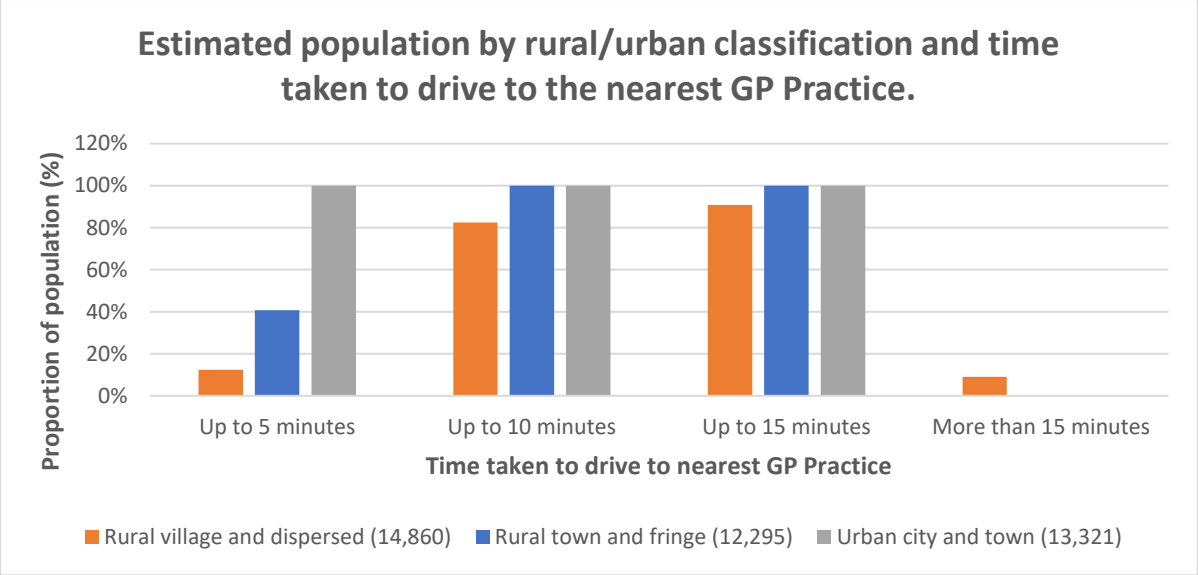


Figure 20 Access to GP Practices by time taken to drive.

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'.

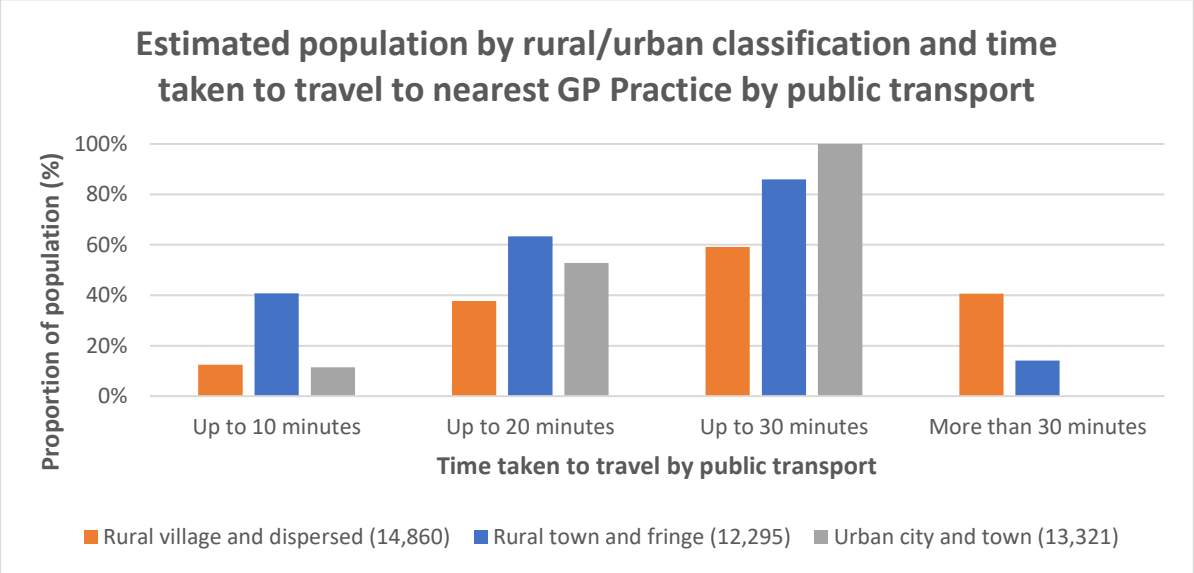


Figure 21 Access to GP Practices by time taken via public transport.

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.

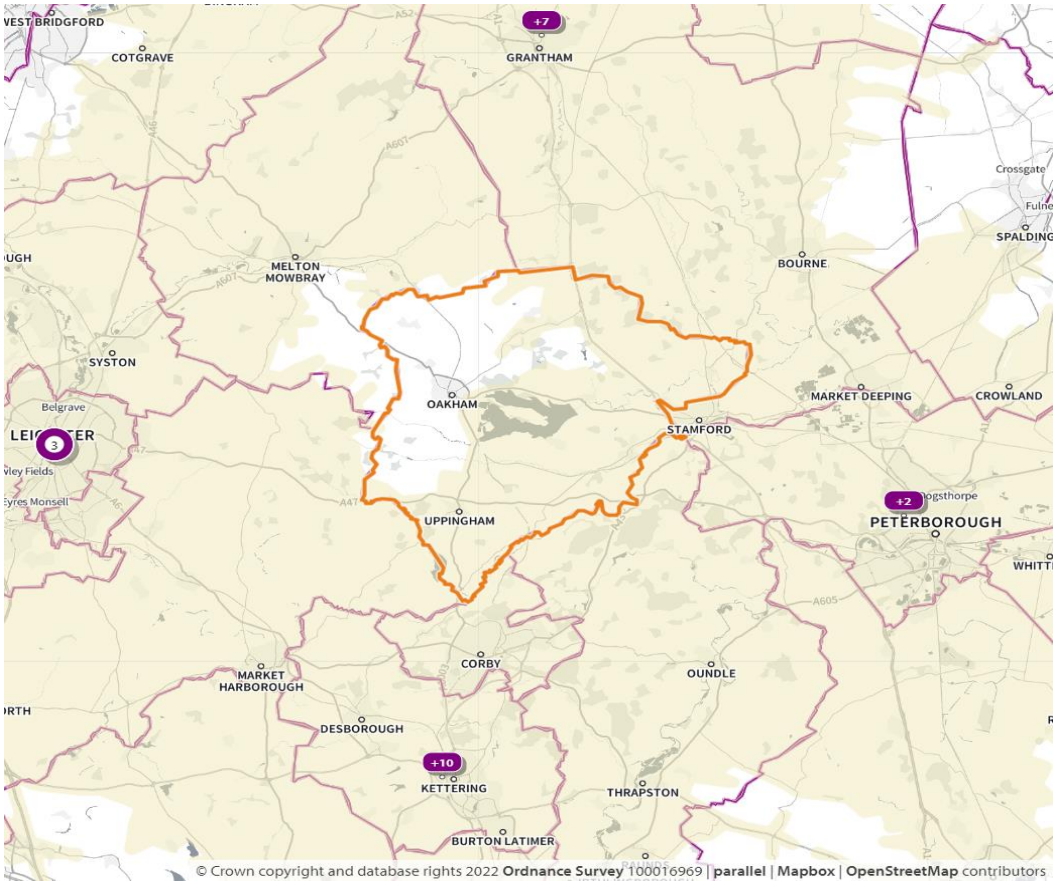


Figure 22 Proportion of Rutland residents within a 30-minute drive of acute hospitals.

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.

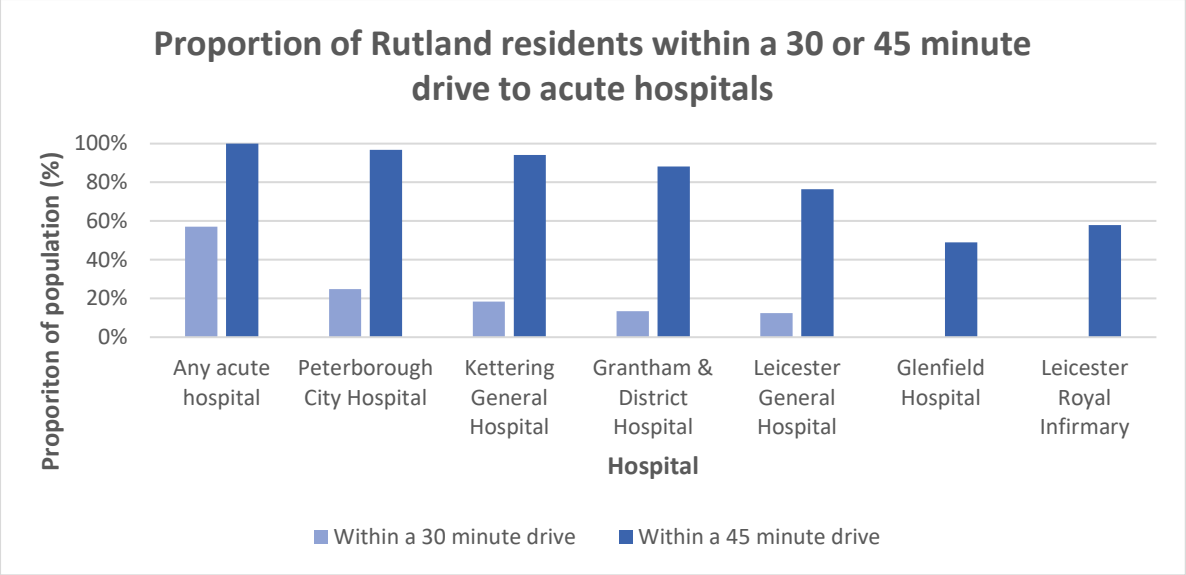


Figure 23 Proportion of Rutland residents within a 30- or 45-minute drive to acute hospitals.

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.

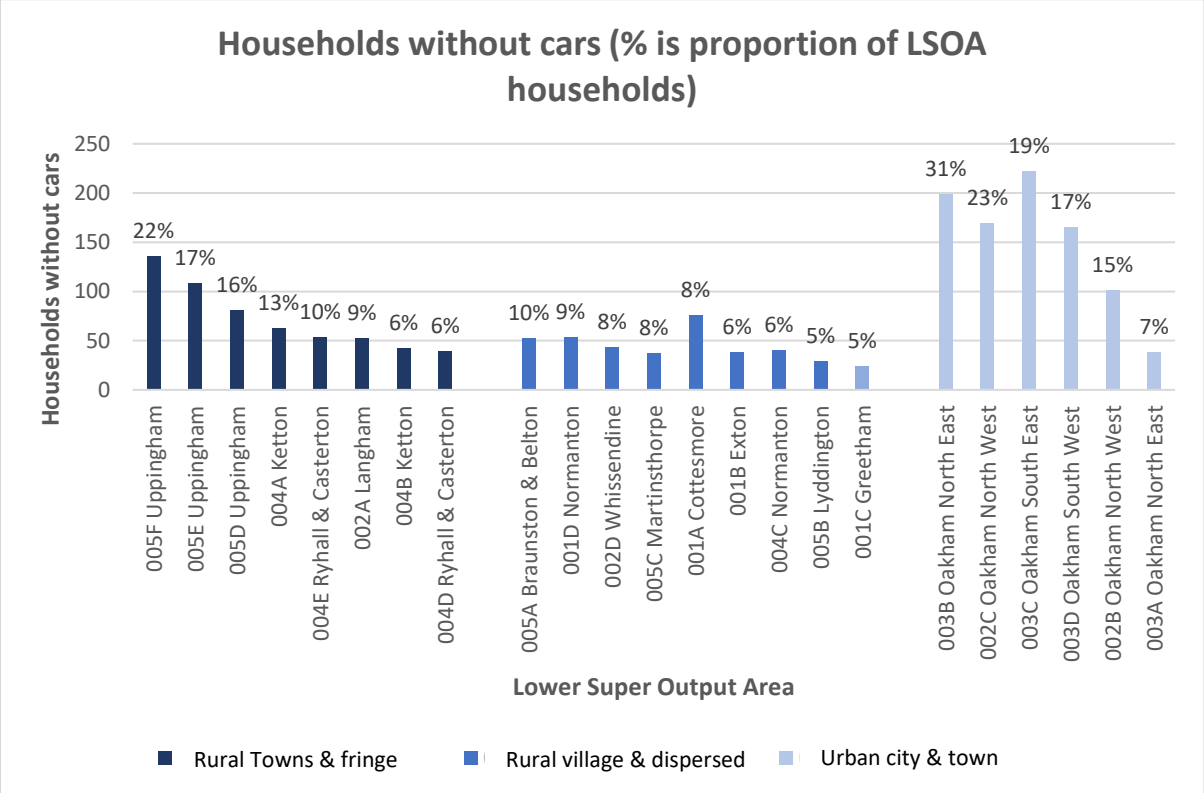


Figure 24 Households without cars (% is proportion of LSOA households).

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.

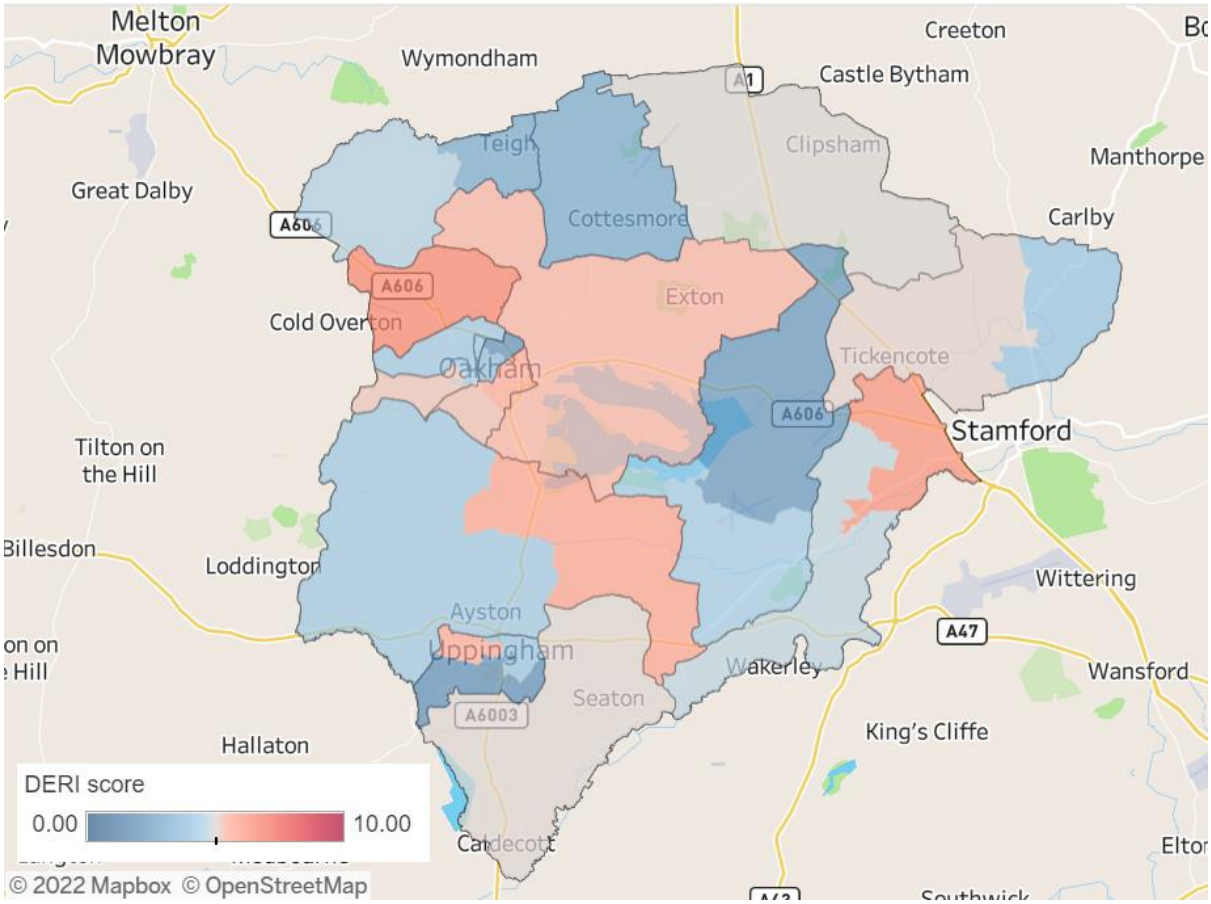


Figure 25 Digital Exclusion Risk Index mapping.

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.

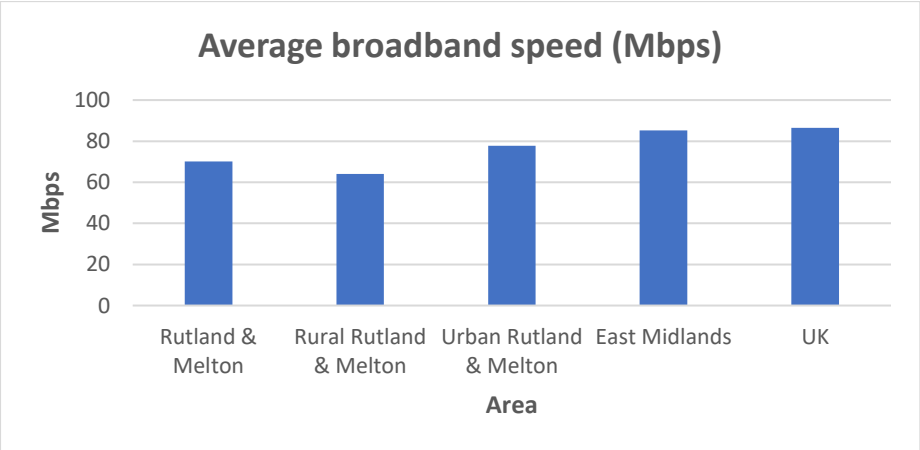


Figure 26 Average broadband speeds.

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.

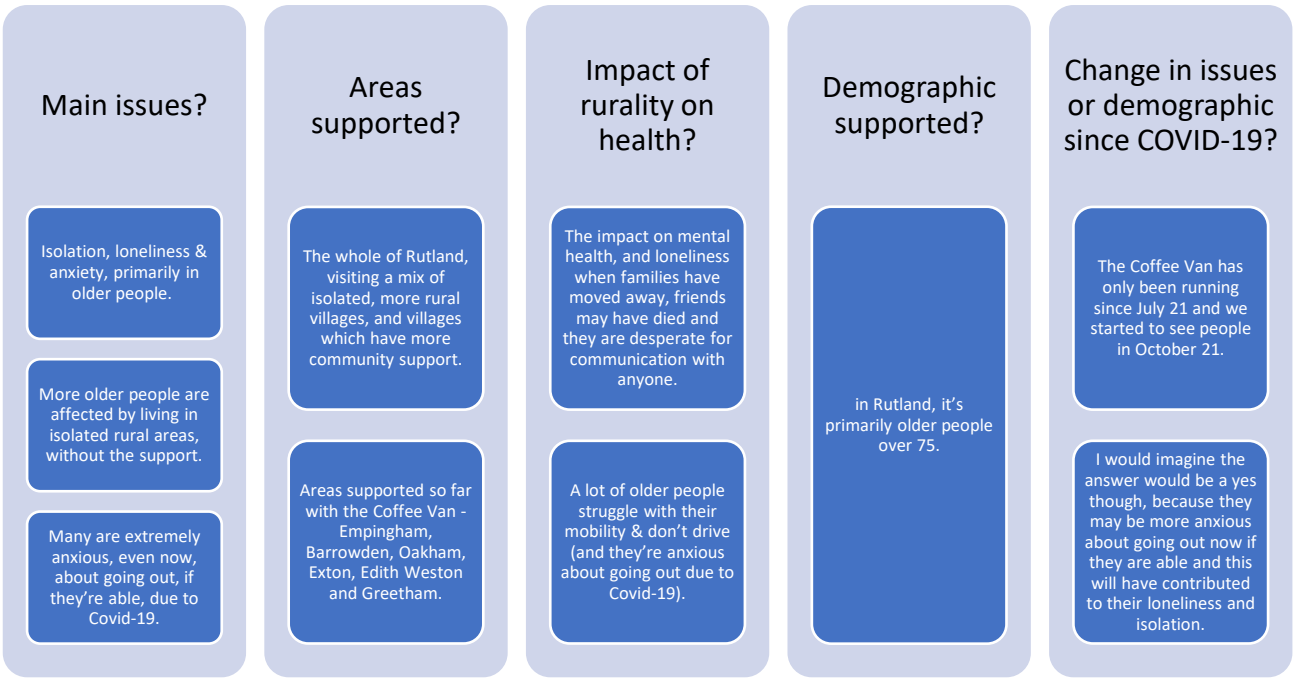
To mitigate against digital exclusion, The Leicester, Leicestershire and Rutland Integrated Care Board have funded local Voluntary and Community Sector organisations to deliver digital literacy programmes amongst groups of people for whom digital inclusion is often more of a challenge. They will be extending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

Carers

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

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

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

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

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

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

Homelessness

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

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

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

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

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

Table 4 Homelessness Relief and Prevention breakdown.

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

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

Support available

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

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

Gypsy, Roma, and Traveller communities

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

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

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

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

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

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

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

Income & employment	• Gypsy & Traveller people have the lowest rate of economic activity of any ethnic group. • Children from Irish Traveller families - 3 times as likely to be eligible for free school meals than White British children.
Education	• 60% of Gypsy and Traveller people have no formal qualifications. • Pupils from a Gypsy or Roma background and those from a Traveller or Irish Heritage background had the lowest attainment of all ethnic groups.
Housing	• There is a national shortage of culturally apporpriate accommodation. • 34% of Gypsy or Traveller households owned their own home, compared with a national average of 64%.
Racism & discrimination	• 91% of Gypsy, Roma and Traveller people have experienced discrimination. • Most common forms of hate sppech/crime are exclusion and discrimination from and within services, negative stereotypes, social media and media incitement.

Prison population and prison leavers

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

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

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

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

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

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

Section 3 recommendations

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

Section 4 - Protected Characteristics in the Equality Duty

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

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

Protected characteristics

Age

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

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

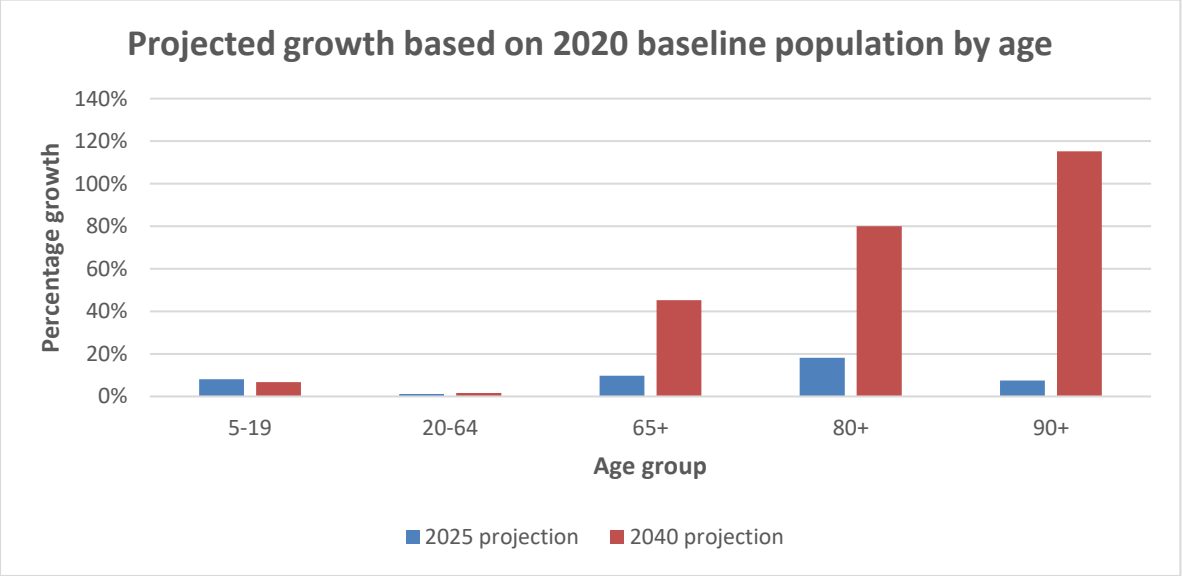


Figure 27 Projected growth based on 2020 baseline population by age.

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

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

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

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

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

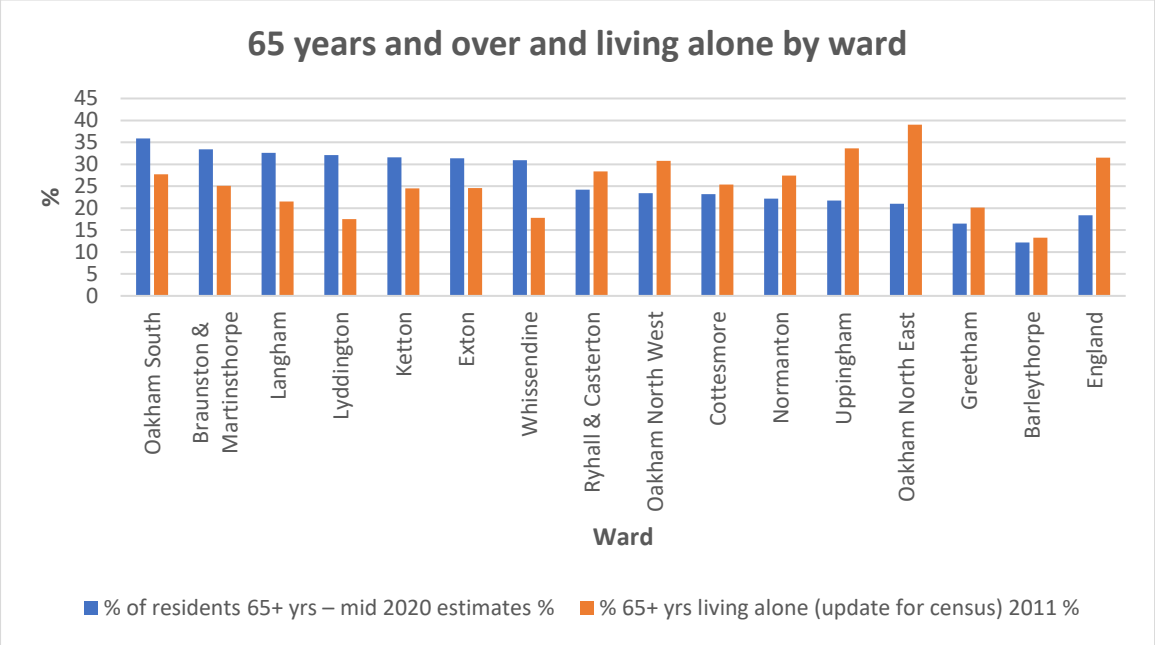


Figure 28 65 years and over and living alone by ward.

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

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

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

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

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

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

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

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

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

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

Disability

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

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

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

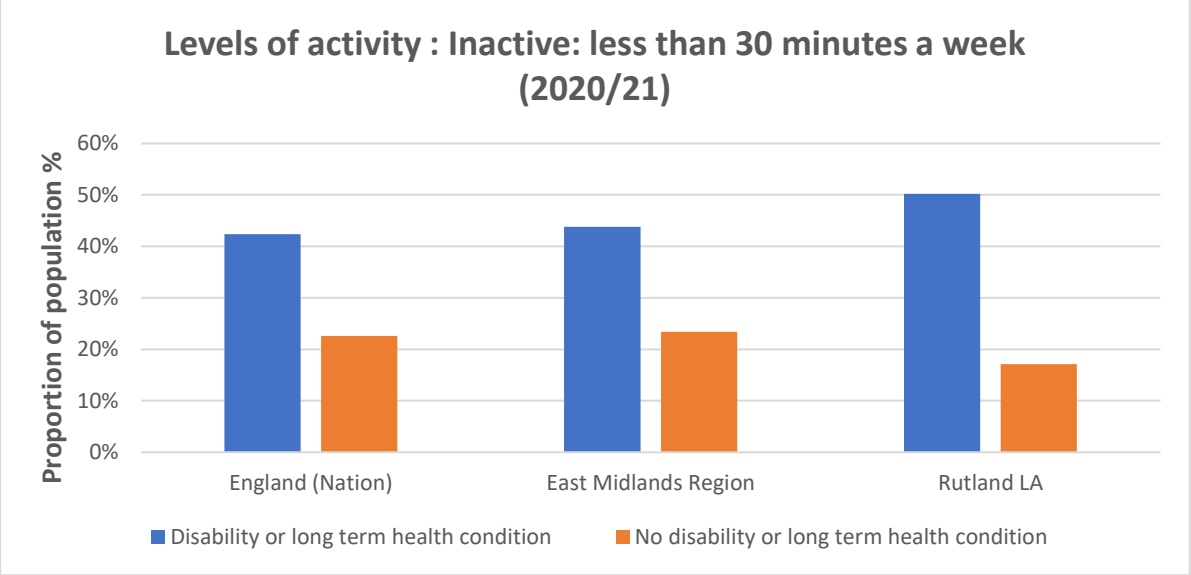


Figure 29 Inactivity by disability status.

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

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

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

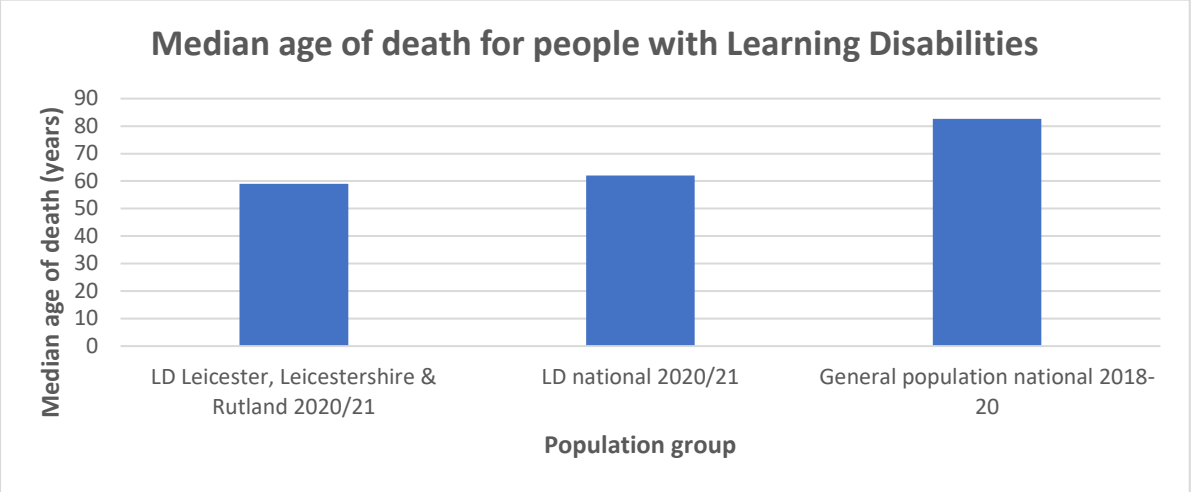


Figure 30 Median age of death for people with Learning Disabilities.

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

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

Impairments

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

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

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

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

Sex

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

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

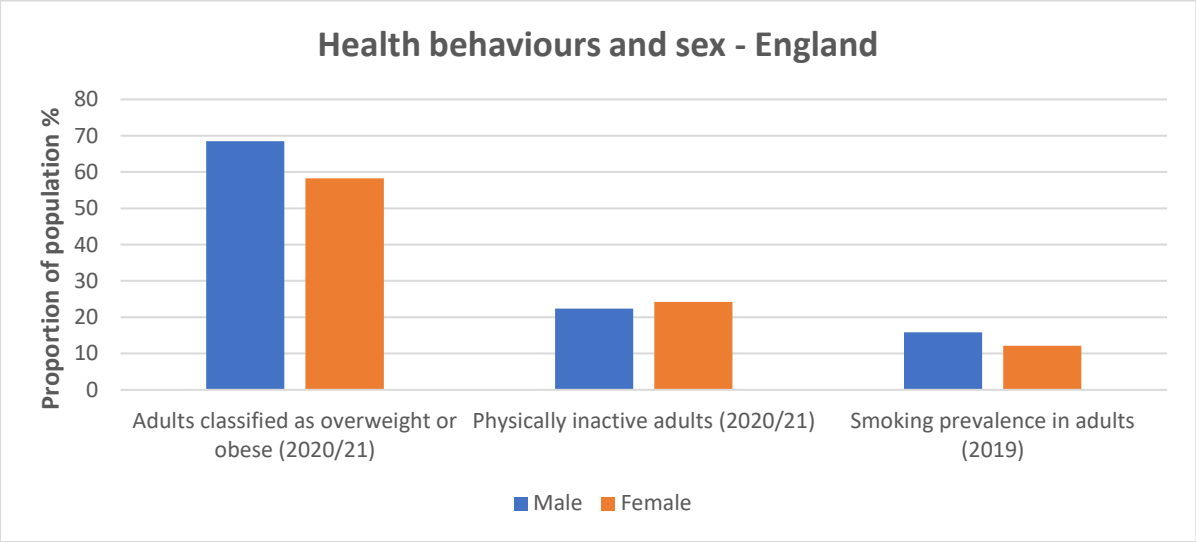


Figure 31 Health behaviours and sex - England.

Ethnicity

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

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

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

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

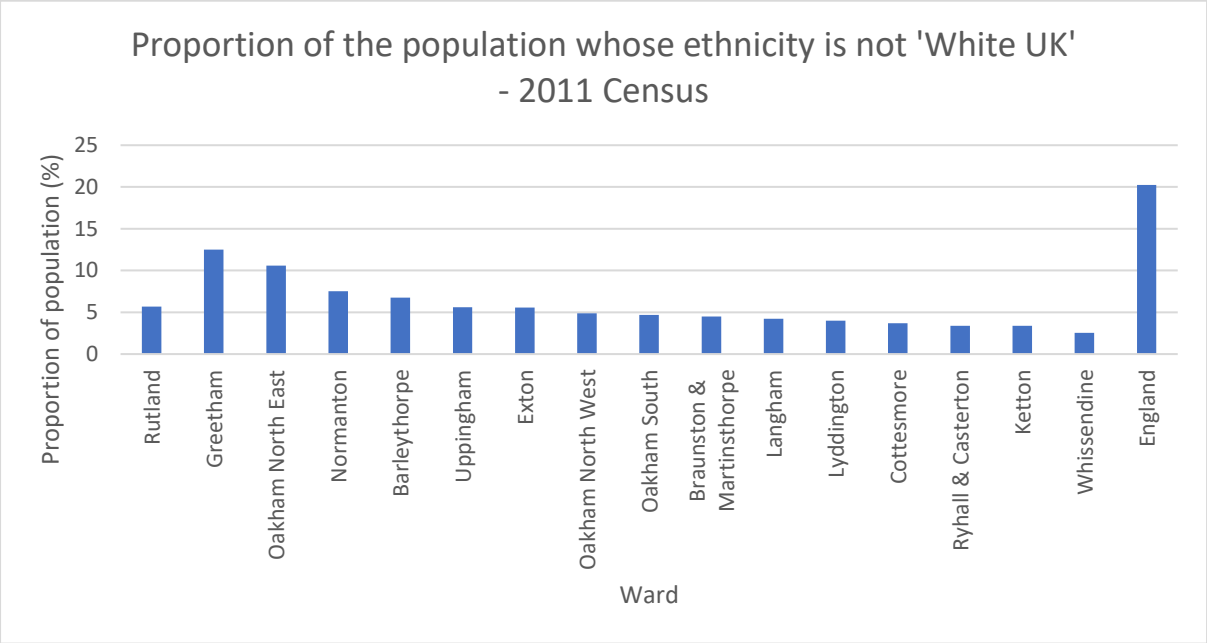


Figure 32 Proportion of the population whose ethnicity is not 'White UK'.

LGBTQ+

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

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

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

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

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

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

Section 4 recommendations

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

Conclusion

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

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

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

Glossary

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

Acknowledgements

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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 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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