DIRECTOR OF PUBLIC HEALTH'S ANNUAL REPORT 2015/16

RUTLAND

THE ROLE OF COMMUNITIES IN IMPROVING THE HEALTH AND WELLBEING OF THE POPULATION

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FOREWORD

In my last annual report, I set out the case for focusing on the social and economic factors which underpin health for everyone in Rutland. These include healthy housing, access to quality lifelong education, fair and secure employment and a supportive social circle. Last year's report also set out the roles public health can play: to be a leader in areas where we have a direct influence; to be a partner working alongside others in joint initiatives; and to be an advocate or champion for health in wider spheres.

This year's report seeks to build on this work by looking at how Rutland County Council and partners across the health system can strengthen and enhance the impact that communities have on people's health and wellbeing.

As the opening section of the report sets out, people in Rutland are living ever longer lives, meaning that there are increasing numbers of older people living with long-term conditions and disabilities. It is therefore essential that we focus on preventing ill health, so that the people of Rutland not only live longer lives but also remain healthier for longer. At the same time we have to recognise that more people will need support and help with their health and care needs.

The report describes the changing demography across Rutland over the next 25 years and highlights:

- there will be an estimated 49% growth in people aged 65-84 years and 227% growth in people aged 85 years and over;
- this will be accompanied by a 10% reduction in the number of working age adults (people aged 25-64 years);
- the increase in older people will mean that across Rutland there will be more people living for longer with long term conditions and age related disabilities;
- life expectancy across Rutland is significantly better than the England average, 81 years in 2010-12 for males and 84.7 years for females;
- healthy life expectancy (the number of years lived in good health), is however much lower for males and females at 65.5 years and 70.3 years respectively.

I have included the key headline data from Rutland's Joint Strategic Needs Assessment in Appendix A.

There is a need to work together across the wider health and wellbeing economy, to focus on how we support people to become healthy older people. Communities in Rutland have a valuable role to play in tackling these pressing concerns, through empowering people to help themselves and providing extra support where it's needed. Equally importantly, being part of a strong and supportive community that works together on local issues can in itself provide an enormous boost to people's health and wellbeing.

It is important that Rutland County Council and local health organisations work together in a coordinated approach to engage effectively with communities and to build community capacity. This will help to identify specific local needs and create innovative solutions to Rutland specific issues.

The pages of this report contain some outstanding examples of work to develop healthier communities across Rutland, and my thanks go not only to everyone who has played a part in these projects, but of course to everyone who has contributed to bringing this report together.

I look forward to working with you – whether as a partner organisation or as a member of our communities – to build on this good work over the coming year.

Mike Sandys
Director of Public Health

Executive Summary

This report focuses on the role that social and community networks have in improving the overall health and wellbeing of the population of Rutland. Social and community networks include our family, friends and the wider social circles around us and they have a significant protective factor in terms of our health.

People in Rutland are living ever longer lives, meaning that there are increasing numbers of older people living with long-term conditions and disabilities. It is therefore essential that we focus on preventing ill health, so that the people of Rutland not only live longer lives but also remain healthier for longer. At the same time we have to recognise that more people will need support and help with their health and care needs.

It is possible to identify the ways that communities can work together to address the factors that will cause people's health and wellbeing to deteriorate. Communities are vital building blocks for health and wellbeing and can provide support and assistance in keeping people supported in their own home and community. At an individual level, joining social activities, connecting to others and taking part in local decisions help to keep people healthy and well. At a collective level, confident and connected communities provide the social fabric that is necessary for people to flourish. It makes economic sense, to build on the capacity of communities. Social return on investment analysis of community development in local authorities has indicated a return of £2.16 for every pound invested, with a value to volunteers of £6 for every pound invested.[16]

INTRODUCTION

Each year the Director of Public Health publishes an independent report on the health and wellbeing of our local population. This report is a statutory duty and intended to inform local strategies, policy and practice across a wide range of organisations and interests. The purpose of the report is to highlight opportunities to improve the health and wellbeing of people in Rutland.

Last year the report focused on wider determinants of health and the social and economic factors that drive health and wellbeing needs for the population, using the 1991 Dahlgren and Whitehead model of the main influences on health and wellbeing (Figure 1).[1] The basis of the model is the concept that some of the factors that influence health are fixed and others can be influenced. The factors that can be influenced are known as the wider determinants of health.

Figure 1: The Determinants of Health

Source: Dahlgren and Whitehead 1992

This report focuses on the role that social and community networks have in improving the overall health and wellbeing of the population of Rutland. Social and community networks include our family, friends and the wider social circles around us and they have a significant protective factor in terms of our health.

The report explores the role that communities (both place-based and where people share a common identity or affinity) can have in improving the health and wellbeing of individuals, communities and populations. By doing this it is possible to identify the ways that communities can work together to address the factors that will cause people's health and wellbeing to deteriorate. Confident and connected communities provide the social infrastructure that is necessary for people to flourish. Individual and community empowerment are core components to improving the population's health and reducing

health inequalities. At an individual level, joining social activities, connecting to others and taking part in local decisions help keep us healthy and well.

The role that communities have in supporting health and wellbeing will become increasingly important over the next few years. All public services across Rutland will face a very difficult financial challenge. Cuts to the Revenue Support Grant, a key source of funding for the council, mean there is an extremely challenging time ahead and this is at a time when the need for services is growing. People are living longer, which means that when they need services they need them for longer. Whilst at the moment people are working for a smaller proportion of their lives this also means that there may be more people who can volunteer and support people in communities. As retirement ages increase this pattern may change and there may be less people in the community with the time and capacity to volunteer. Identifying the support required to sustain and develop both formal and informal volunteering in this changing environment will be important in meeting this challenge and ensuring good support is available in communities.

National Drivers

In 2015, Public Health England and NHS England published ***"A guide to community-centred approaches for health and wellbeing"***.[2] This guide summarises recent research and learning on community centred approaches for health and wellbeing, based on the premise that the assets within communities (such as skills and knowledge, social networks and community organisations) are the building blocks for good health and can help to increase people's control over their health and lives. The report groups a new 'family of community-centred approaches' under four different strands (Figure 2):[2]

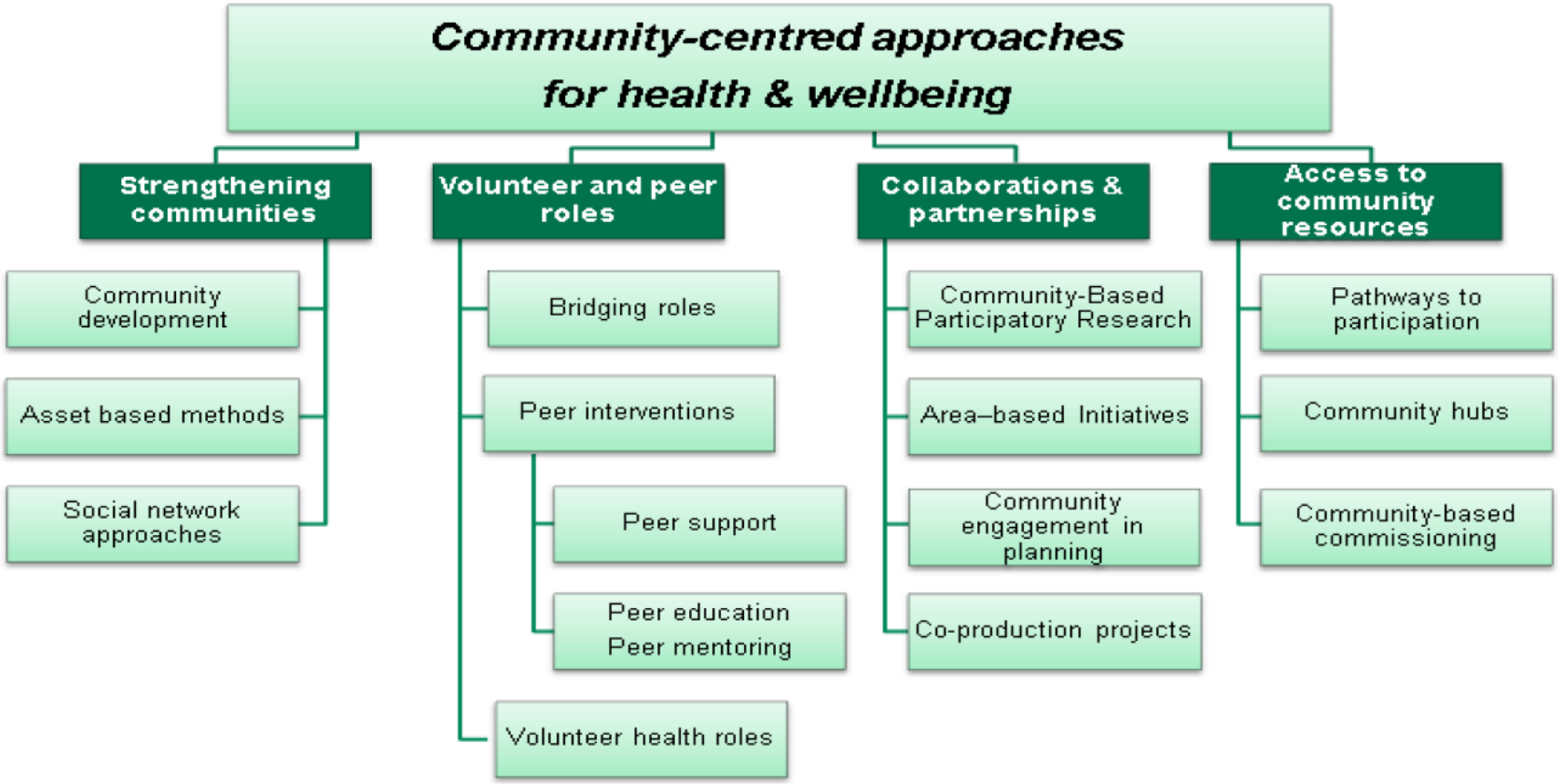
1. **strengthening communities** – building on community capacities to take action together on health and the social determinants of health;

2. **volunteer and peer roles** – enhancing individuals' capabilities to provide advice, information and support or organise activities around health and wellbeing in their or other communities;

3. **collaborations and partnerships** - communities and local services working together at any stage of the planning cycle, from identifying needs through to implementation and evaluation; and

4. **access to community resources** – connecting people to community resources, practical help, group activities and volunteering opportunities to meet health needs and increase social participation.

Figure 2: The family of community-centred approaches for health and wellbeing



The family of community-centred approaches for health and wellbeing (South, 2014)[2]

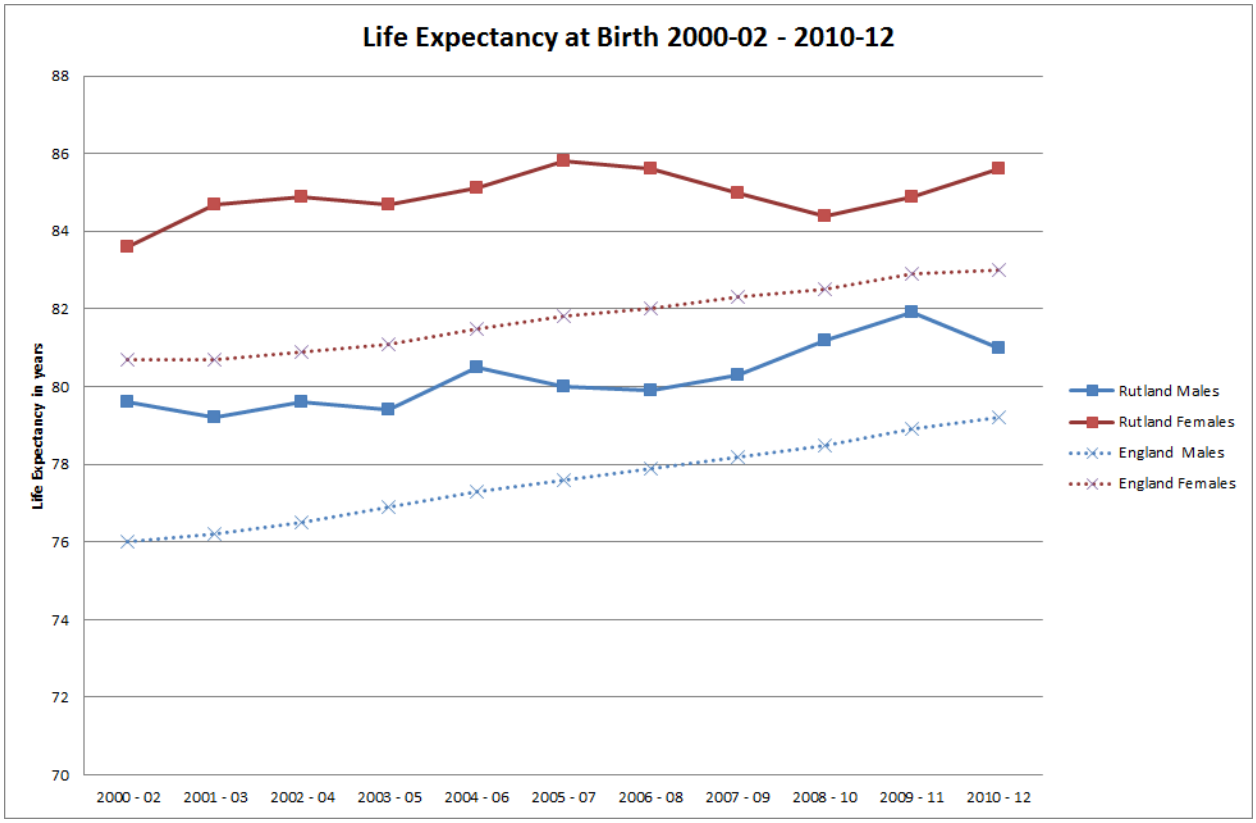
Local Drivers

The ***2015 Rutland Joint Strategic Need Assessment Overview*** describes the changing demography across Rutland over the next 25 years.[3] The key demographic drivers for Rutland are summarised below. Appendix A includes a summary of the key data within Rutland's JSNA.

The health of the people of Rutland

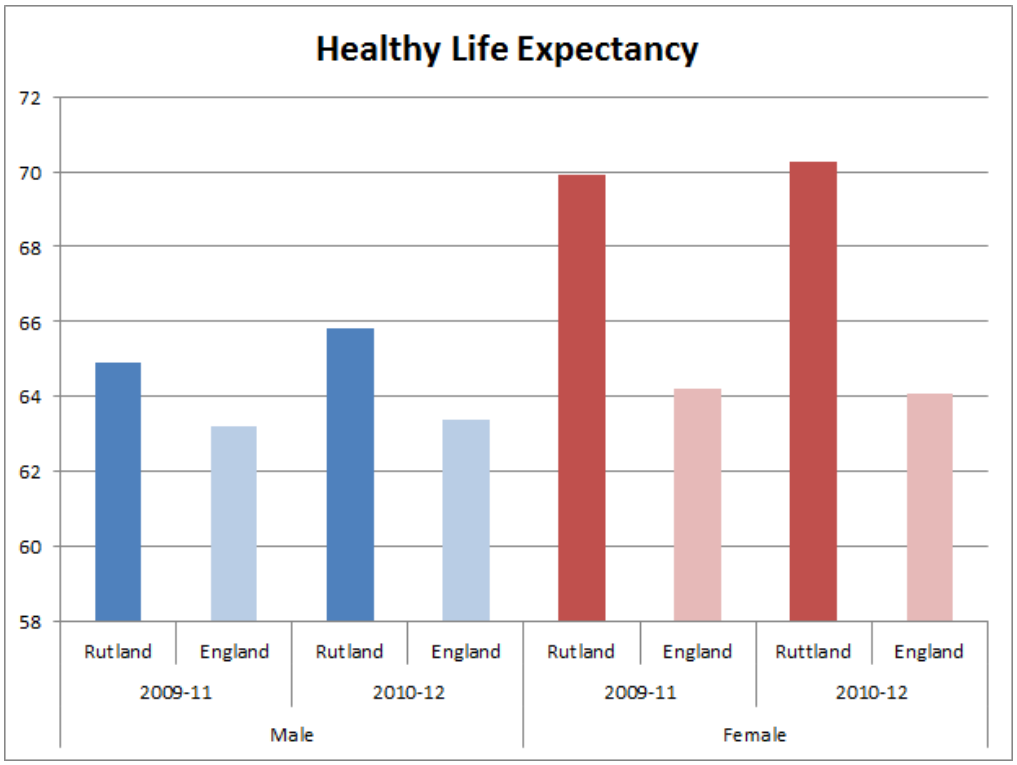
Life expectancy in Rutland continues to improve year on year and in the 10 year period from 2000-2002 to 2010-2012 there has been an increase in life expectancy of 1.4 years for men and 2.3 years for women. Life expectancy in Rutland is significantly better than the England average for both males and females at 81.0 years and 84.7 years respectively.[4]

Figure 3: Life Expectancy at Birth



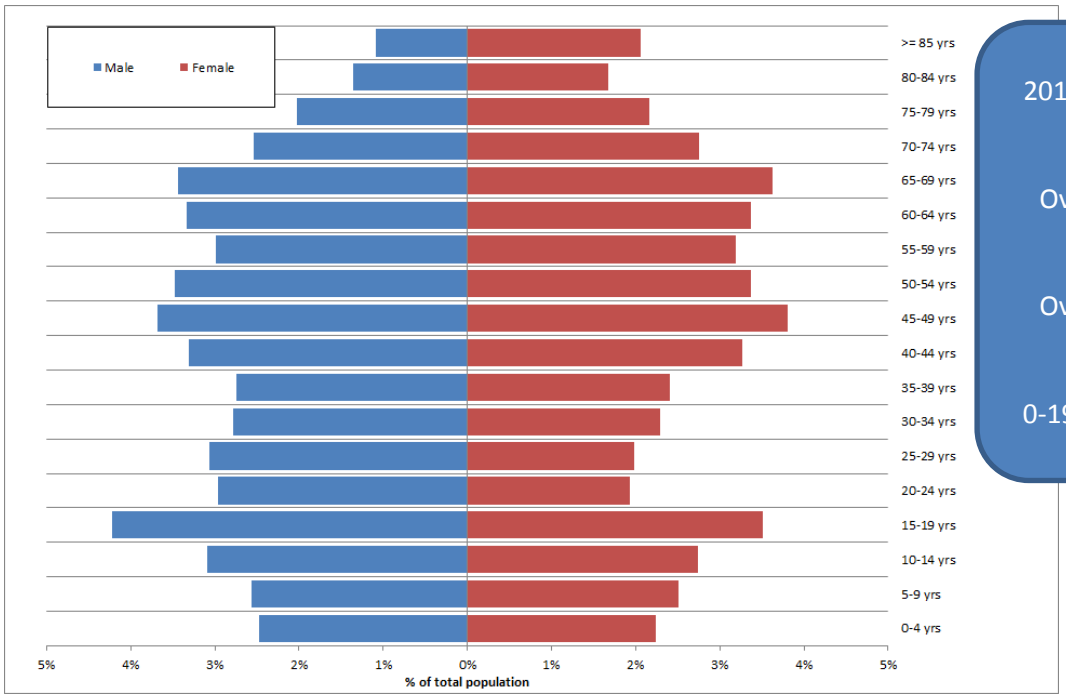
Healthy life expectancy is illustrated in Figure 4. Healthy life expectancy for 2010-12 is 65.8 years for males and 70.3 years for females. For both males and females, a significant proportion of the population will already be affected by poor health before they reach retirement age.[4]

Figure 4: Healthy Life Expectancy



The most significant driver of health needs for the Rutland population is the growing older population. In 2013, the total population for Rutland was an estimated 37,600 people. 8,540 people were estimated to be 65 years and over, and 1,180 were 85 years and over. 8,770 of the Rutland population were under 20 years of age.[5]

Figure 5: Mid 2013 Population Estimates for Rutland



2013 population – 37,600

Over 85 years – 1,180

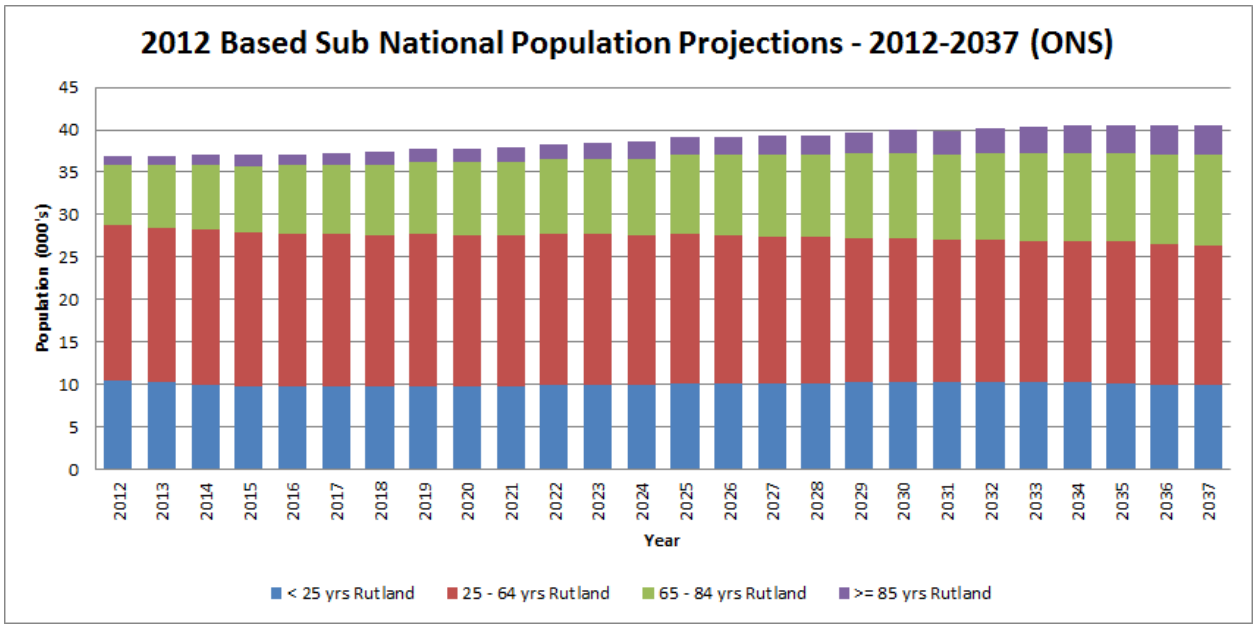
Over 65 years – 8,540

0-19 years – 8,870

The population of Rutland is growing – between 2012 and 2037 (25 years) it has been projected that the total population of Rutland will grow by 10% to over 40,800. However, this growth is not uniform across the age groups with a projected increase of:[6]

- 227% increase in people aged 85 years and over;
- 49% increase in people aged 65-84 years;
- 4% decrease in children and young people aged 0-24 years; and
- 10% decrease in the working age population (25-64 years).

Figure 6: 2012 Based Sub National Population Projections - 2012-2037 (ONS)



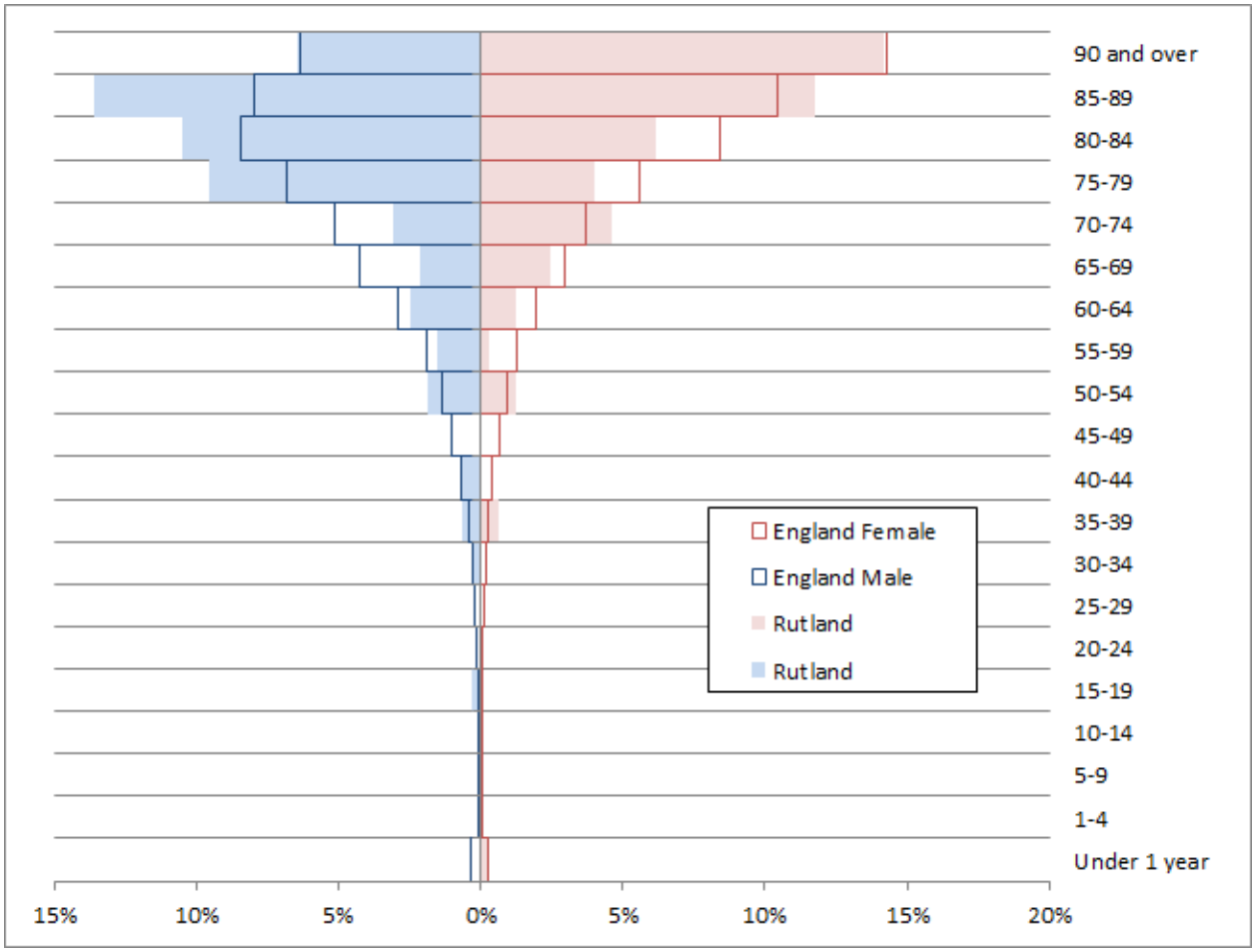
The total population is predicted to grow by 10%.
85 years + growth 227%, 1,100 to 3,600 people.
65-84 growth 49%, 7,100 to 10,600 people.
0-24 reduce by 4%, 10,400 to 10,000 people.

The 25 year time frame that we are looking at is important. The Better Care Together (BCT) Strategy 2014-19, published in June 2014, is a five year strategic plan for Leicester, Leicestershire and Rutland.[7] This five year strategy identifies the changes that are needed to make the health and social care system work more effectively in the immediate future. However, there is a need to consider the longer term care needs for the population. With an ageing population, there is a need to consider the plans that need to be put in place to

manage future health and care needs and demands in the longer term, with a focus on reducing preventable ill health, particularly in working age adults.

The population is living longer than ever before. For males, the most frequent age of death in Rutland is 85-89 years, with 26% of male deaths occurring in this age group. Overall, 75% of deaths in males are over 75 years of age and 85% are over 65 years of age. For females, the most frequent age of death in Rutland is over 90 years of age with 30% of female deaths occurring in this age group. 77% of female deaths occur at over 75 years of age and 92% of female deaths occur at over 65 years of age.[8]

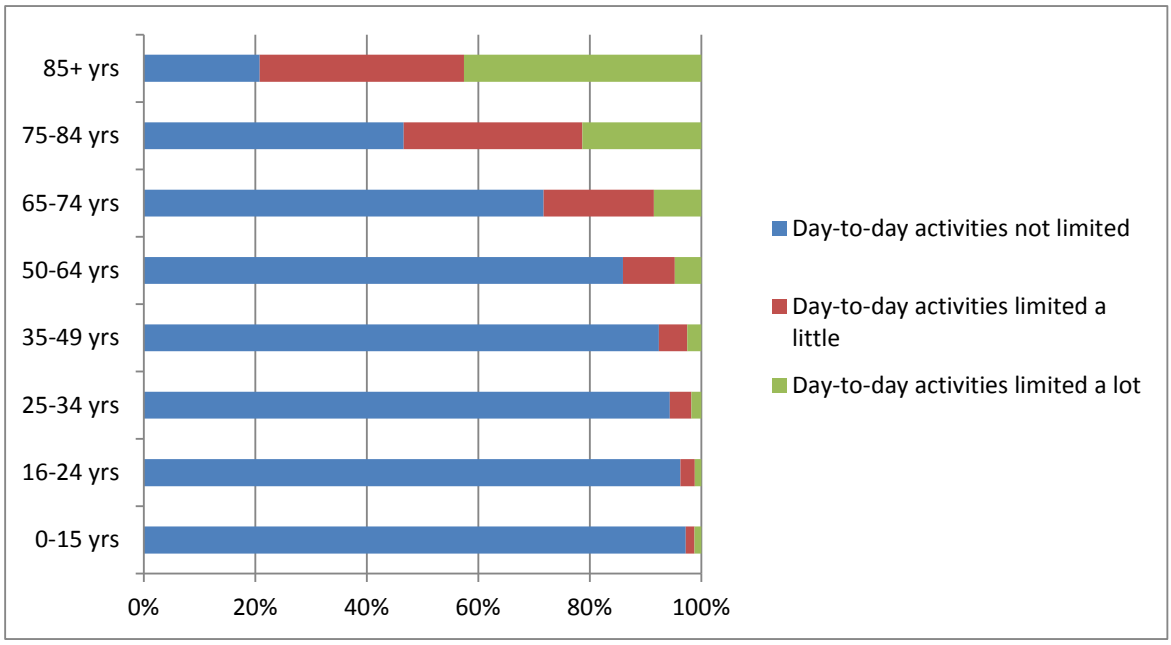
Figure 7: Deaths by Age Group in Rutland and England 2013



Health needs increase with age. The 2011 Census data for Rutland shows us that for people aged 85 years and over, only 21% of the population do not have their activities of daily living limited (ADL) by a long term health problem or disability. Over a third of this age group have their ADL limited a little and over two fifths have their ADL limited a lot. There is a clear correlation with age and as people become older their care needs linked to ADL increase. In terms of absolute numbers, the population with the highest number of people with ADL limited either a little or a lot is the population aged 75-84 years, affecting over 1,300 people. Understanding the population that have health and care needs linked to

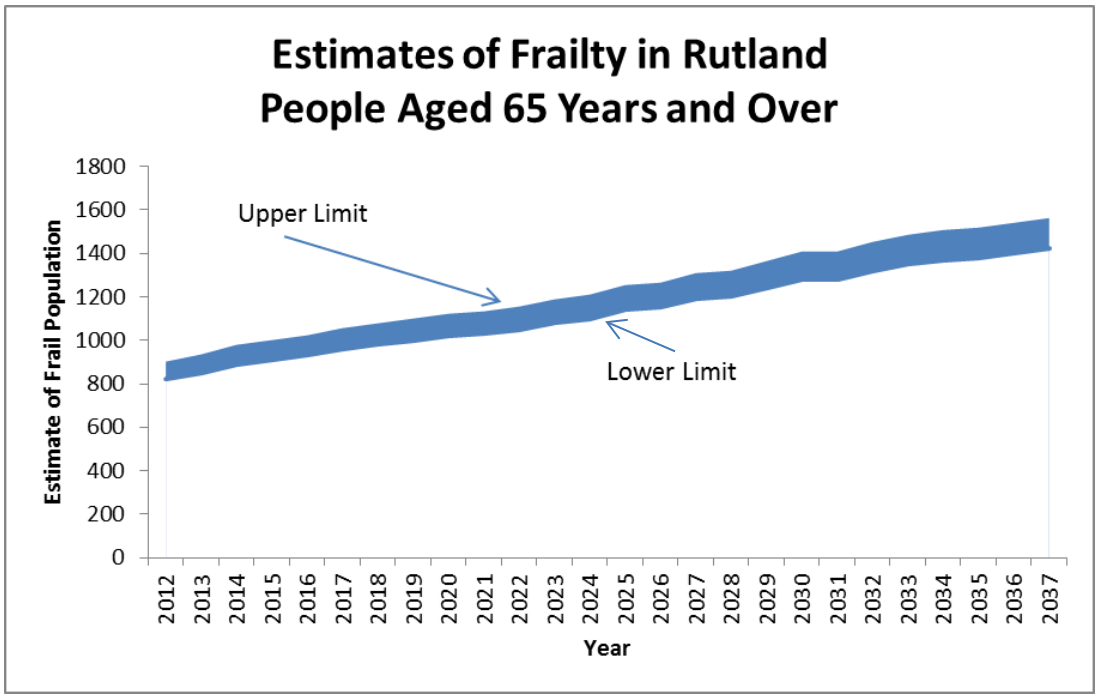
ADL is a useful way to target our preventative services to reduce longer term dependency on services.[9]

Figure 8: Long term health problem or disability by age for Rutland residents, 2011



The increasing older population will drive an increase in the number of people affected by frailty. This is illustrated in Figure 9 which applies an estimate of between 10-11% of the population aged 65 years and over affected by frailty, estimating the number of people in Rutland that are affected by frailty as between 820 and 900 in 2012 and between 1,420 and 1,560 people in 2037.[6] [10]

Figure 9: Estimates of Frailty in Rutland



The population growth patterns have implications for the provision of services for older people. There will be more older people with complex care needs who will require input from all parts of the health and social care system. This will need to be supported by people providing unpaid care through informal caring arrangements. However, the reduction in working age adults suggests that, as well as planning for the increased needs for services, there is a long term need to consider the infrastructure needed locally to support people. Carers will become increasingly significant to the wider health and care system and we will need to ensure that their health and wellbeing needs are addressed. This will be essential to maintaining independence and to support people to manage their own health and care needs with a shrinking network of informal care and support. Supporting people to live independently through appropriate housing provision is also a key enabler for the future sustainability of health and social care. Added to this and in common with many rural areas Rutland has 65% of its areas measured as deprived in terms of access to local services and this will need to be factored in to any service planning.

Rutland County Council

Rutland is changing. As the population grows older and young people with disabilities live longer, there will be additional challenges to keeping Rutland a healthy place to live.

The People First Review set a way forward for services that will meet the needs of individuals, families and our communities.[11] Taking into account the views of the public, it set the vision for the future and committed Rutland to:

- enable individuals and families within our community to achieve their full potential and be safe from harm;
- target services in particular at the most vulnerable and those who need us the most;
- integrate services more closely with the Health and Voluntary, Community and Faith (VCF) Sectors based on care pathways that support independent living;
- be clearer about what individuals, families and our community can expect;
- focus on finding different ways to do things rather than reduce or remove services; and
- adopt an early help and prevention approach.

The **Adult Social Care Strategy** sets the council's vision for everybody to have the best health and wellbeing throughout their life, and access the right support and information to help manage, reduce, prevent or delay the need for care and support.[12] Using the findings from engagement with the people of Rutland, it is clear that health and wellbeing is best promoted within people's own homes and from within people's own communities. By empowering people in Rutland to have choice and control over their lives, the council aims to maximise their wellbeing and independence in their local community, preventing and postponing the need for care and support.

The strategy is based on three themes:

1) Healthy Rutland - Healthy lifestyles are important for everyone from those with pre-existing health conditions or disabilities to those without. A healthy lifestyle will help prevent or delay the onset of long term limiting illnesses. They also prevent the recurrence of problems and reduce further deterioration and the likelihood of intensive or long-term health and social care need. In this respect, supporting people to eat healthily, manage their weight, stop smoking, increase their physical activity and reduce alcohol consumption is particularly important.

2) Independent Rutland – Using the findings from the "People First Review" it is clear that addressing an individual's needs sit within a wider network of personal and social relationships in the community. Connecting individuals with family, friends and community support networks is generally extremely important for people's wellbeing and to prevent or postpone the need for funded care and support services. The council wants to promote personal responsibility and for people to have opportunities to become a greater part of their community through increased opportunities for socialising, gaining personal recognition and building relationships, while remaining in their own homes for as long as possible.

3) A Sustainable Future – The council wants more collaborative working with health and other partners to deliver integrated community health and primary care services to improve health and social care for people. Delivering an integrated health and social care system will ensure services are best suited to local needs and circumstances, enabling people to enjoy good health and wellbeing living at home as independently as possible.

KEY FINDINGS AND RECOMMENDATIONS

Rutland County Council's People First report clearly set out how people would be at the heart of service delivery.[11] The recently published Adult Social Care Strategy and Market Position Statement determines that to achieve this people and communities will need to be engaged in the design and delivery of services.[12] [13] This report is therefore timely as it sets out a framework for developing community based approaches that can improve the health and wellbeing of the population, and provides examples of some of the initiatives that are already happening across Rutland.

The framework outlined in this report is an effective approach for providing communities with opportunities to improve health and wellbeing. However, the very nature of community led approaches means that to be most effective each community will need to be able to develop the community interventions that are most suitable for their needs. Whilst there are some good examples of community engagement in Rutland there are areas where there is less evidence of local activity or of being systematically applied across Rutland. Proposals for more joined up working and better coordination of the range of community services will help ensure a more effective and co-ordinated approach to prevention. The proposal to develop an integrated health and wellbeing service will require community approaches to be central to development and delivery.

With community-centred approaches outcomes are often connected to one another. For example improvements in mental health may have resulted from lifestyle changes. People involved in providing support through community-centred approaches are as likely to benefit from their involvement as the people that are receiving the support. This is illustrated in the case studies that have been used within this report. These links are reinforced where an intervention has worked well. The range of outcomes from each of the community-centred approaches is shown in Table 1.

The case studies presented in the report show many positive outcomes from working with communities. However, not all community-centred approaches will deliver measurable improvements in outcomes for people. Many schemes will not have sufficient evidence to draw firm conclusions or will report mixed results.

Table 1: The range of outcomes from community centred approaches

Individual	Community level	Community process	Organisational
Health literacy – increased knowledge, awareness, skills, capabilities **Behaviour change** – healthy lifestyles, reduction of risky behaviours **Self-efficacy, self-esteem, confidence** **Self-management** **Social relationships** – social support, reduction of social isolation **Wellbeing** – quality of life, subjective and objective wellbeing Health status physical and mental **Personal development** – life skills, employment, education	**Social capital** – social networks, community cohesion, sense of belonging, trust **Community resilience** **Changes in physical, social and economic environment** **Increased community resources** – including funding	**Community leadership** – collaborative working, community mobilisation/ coalitions **Representation and advocacy** **Civic engagement** – volunteering, voting, civic associations, participation of groups at risk of exclusion	**Public health intelligence** **Changes in policy** **Re-designed services** **Service use** – reach, uptake of screening and preventive services **Improved access to health and care services, appropriate use of services, culturally relevant services**

It makes economic sense, to build on the capacity of communities. Using 2011 figures the cabinet office calculated the monetary value of volunteering to the wellbeing of the volunteers as £13,500 per person per year.[14] Time banking can have a net value of £667 per person rising to £1,312 if quality of life is improved.[15] Social return on investment analysis of community development in local authorities has indicated a return of £2.16 for every pound invested,[16] with a value to volunteers of £6 for every pound invested.[16] There is definite potential to offer significant return on investment, however, poor retention of volunteers, high turnover and low levels of ownership can push costs up.

Throughout the report, case studies have been presented that cross many sectors of the community. This work is led by the different organisations that work together across Rutland to improve health and wellbeing. These organisations are collectively represented on Rutland's Health and Wellbeing Board. Support for and acknowledgement of the value and importance of community based approaches is a significant step towards identifying opportunities to work together more effectively to build community capacity. There are some really good examples of local community schemes that are delivering real benefits for local people. However, there are gaps and potential duplication in what is being delivered and opportunities to do more and coordinate more effectively. In particular, community based participatory research; community-based commissioning and co-production projects are approaches where a limited number of case studies and examples of good local practice were found. There is also scope to engage communities more actively in service planning and development.

For community based approaches to have the maximum impact for local people there needs to be good local leadership of this agenda. This will ensure that all communities are able to make best use of the opportunities to build their own local capacity. From a council perspective, there is a need to work together with other public sector agencies and the voluntary sector to increase capacity within local communities to ensure real engagement and a move away from doing things 'to' and 'for' people to 'with' or 'by' them.

Communities are vital building blocks for health and wellbeing. At an individual level, joining social activities, connecting to others and taking part in local decisions help to keep people healthy and well. At a collective level, confident and connected communities provide the social fabric that is necessary for people to flourish. An equitable health system involves people in determining the big questions about health and care and actively removes barriers to social inclusion. That is why individual and community empowerment have to be core to efforts to improve the population's health and reduce health inequalities.

RECOMMENDATIONS

It is recommended that:

1. That future programmes focus on extending **healthy life expectancy** (the number of years lived in good health) and closing the gap by targeting specific groups with worse health. This should include routine and manual workers, service families, children living in poverty and older people in greater need.

2. The development of community prevention and wellness services provides a good opportunity to measure benefits and impact of services based on a model of building community capacity and resilience to improve health and wellbeing. Mechanisms for evaluating the effectiveness of these services in achieving this should be built in to the service design from the start.

3. Cross agency working and partnerships are extended to more fully involve local people and communities as the next step to increase and improve **community engagement in planning.**

4. **Co-production models** (where service users work jointly with professionals to design and deliver services) are trialled for several projects in Rutland with the aim of developing more suitable services and reducing exclusion.

5. The Council uses a **Health Impact Assessment (HIA)/ Health in All Policies** approach to support local communities in influencing **major** developments and policies. HIA's can facilitate active engagement of local communities in the assessment process and enable consideration of the health impacts of proposals from a range of perspectives so that positive impacts can be increased, negative impacts identified and ways to mitigate these considered.

6. It is made easier for people to find out what services are on offer locally to support health and wellbeing, through better coordination and communication of prevention activities within Rutland.

COMMUNITY CENTRED APPROACHES TO HEALTH AND WELLBEING IN RUTLAND

This report uses the family of approaches, outlined in Figure 2, as a framework to review the evidence for community based working. It also provides examples of where these approaches are being used across Rutland. The report highlights the opportunities to further develop these approaches in Rutland and makes recommendations on ways that partners across the health and wellbeing system can work together to improve health and wellbeing.

1. Strengthening Communities

This group of approaches involves building community capacity to enable community action that will improve health and the social determinants of health.[2] There are a wide variety of community capacity building approaches and evidence has shown initiatives are more effective if they are shaped according to the needs and characteristics of a particular community. Taking this into account, such approaches have been shown to increase social cohesion, creating communities that feel more connected with each other and the wider services in their community.[17] [18] Benefits include the development of skills and knowledge and the building of a more united local voice with an increased sense of being able to rely on friends or relatives for support.[19] Benefits extend beyond the community group involved to the wider community as a whole.[20] Overall, community capacity building has been shown to deliver a net economic benefit.[2]

1.1 Community development

"A long term value-based process which aims to address imbalances in power and bring about change founded on social justice, equality and inclusion".[21]

A community-led approach to health improvement is concerned with supporting communities to identify and define what is important to them about their health and wellbeing; the factors that impact on their wellbeing and take the lead in identifying and implementing solutions.[22] This results in interventions which aim to bring together a group of people, who often share a common experience or characteristic, for support.[23]

Case Study - Rutland Community Agents - http://www.rutlandcommunityagents.org.uk/

The Rutland Community Agents (RCA) service has been developed as an asset based community development approach. The focus of community agents is to identify and provide support to vulnerable people of all ages building social capital. This includes older people at risk of isolation, those with mental health needs, autistic spectrum disorders or

learning disabilities.

RCA aims to promote social interaction and foster peer networks for a supportive community that improves wellbeing. The service acts as a single point of access, ensuring every contact counts and providing timely advice and local information for people on keeping safe and well and managing their long-term health conditions. This includes greater use of local individual and community solutions, resources and networks, building the resilience of those who need help before they hit crisis and diverting use from formal services.

RCA provides a variety of tailored support needs; from helping with housing, employment, legal advice and finances to holding pop-up clinics, setting-up new community groups and providing volunteer befrienders.

CA service established 24 hour online provision with 4,263 visits since April. The site provides access to online training, self-help toolkits and information on a wide range of topics including; Health, Education, Social Activities, Support, Employment and Lifestyle including support group locators and volunteering opportunities. The site also links to the Rutland Information System, enabling easy identification and access to services that meet Rutland citizens' needs.

As of the October 2015 the RCA service has:

- provided one-to-one advice / signposting to 277 Rutland residents;
- made direct contact with 848 residents through local groups and events where discussions around how the RCA's can support communities took place;
- made 246 referrals to external partner agencies;
- identified 48 new services which have been added to the RCC RIS; supporting self-help and better access to services within Rutland;
- reported 100% of individuals receiving short term advice and assistance have demonstrated progression in their overall health, well-being and quality of life assessed using the Well-being Outcome Star Tool; and
- implemented 9 new groups/events across Rutland including partner drop-in clinics and CCC (Coffee, Cake & Chat) groups in areas where isolation is identified as a core issue.

The Community Health Link Agent has made strong links with relevant partners and is now

working closely with a number of health care professionals to improve hospital discharge and prevent unnecessary admissions. Referrals are being received and support provided to patients from a number of local hospitals and Rutland GP surgeries. To date the HLA has offered advice, assistance and signposting to 83 individuals to support them to sustain their independence. Of these 46 have been supported to leave hospital or prevent a hospital admission.

1.2 Asset based methods

"In an asset based approach, the glass is half-full rather than half empty".[24]

The ethos of this approach is to value and accentuate the positive capabilities of communities, starting with strengths and focusing on local capacity, skills, knowledge, connections and potential. The focus is on building networks, promoting resilience, self-esteem and coping abilities of individuals and communities, eventually leading to less dependency on professional services.[25] The aim is to build up community groups and voluntary organisations; their informal associations and networks, their collaborative relationships, their shared knowledge and therefore their social power to make positive changes.

1.3 Social network approaches

"Outcomes include more cohesive and stronger communities, improved self-esteem and people who feel more in control of the decisions that affect them." [26] [27]

These approaches include community organised activities which strengthen social support between members. Interventions both enhance existing networks and create new ones to improve the social links between people. There are health and non-health benefits including reduced illness and premature deaths, improved mental health and resilience, reduced crime and delinquency and positive impacts on employment.[28] The results are more confident and active communities, including increased social engagement, support and more extensive networks.[2]

1.4 Summary

The community agents case study reinforces the importance of the underpinning principles of the "strengthening communities" approaches. It demonstrates the value of building networks and capacity to enable more connected and resilient communities, which can then continue to support each other.

There are also other community based projects being supported throughout Rutland which contribute to strengthening the community, some of which may not be widely known or celebrated. However, much of the available evidence of outcomes is based on small scale case studies. There is a need for a holistic approach to the development and evaluation of these approaches across different communities and partner service providers in the area. There is a gap in the evidence of the benefits of the strengthening communities approaches, both in terms of health and wellbeing outcomes and financially in terms of cost benefits and return on investment to service providers.

It is essential that more innovative approaches to the evaluation of community led approaches are developed and implemented to provide robust evidence of the benefits of these approaches.

2. Volunteer and Peer Roles

This group of approaches focuses on an individual's capacity and competence to provide advice, information and support including organising activities around health and wellbeing in communities. Volunteers or peer supporters are mainly drawn from their local neighbourhood, and receive training to enable them to undertake a health promoting role within their community. Most volunteers are unpaid and deliver this role on a voluntary basis.

There is a long history of volunteering within the UK, with research studies showing participation in volunteering is strongly associated with better health, lower premature death, better functioning, life satisfaction and decreases in the occurrence of depression.[29] Giving to others is one of the five steps to mental wellbeing with volunteering identified as one of the ways to do this.[30] Volunteers are seen as 'active citizens' and there have been a number of examples of highly successful public health volunteer projects ranging from access to contraception in the early 20th century to campaigns on disability rights.[31]

In addition to personal mental and physical health benefits, volunteers gain both formal and informal skills which can, over time increase their employability[32] as well as their confidence and self-esteem.[33] The use of peer educators or community volunteers in health improvement activities can be effective in changing certain health behaviours.[34] Involvement of volunteer led activities requires investment and funding but has been shown to have a positive return on investment.[2]

2.1 Bridging roles

These are usually carried out by volunteers (rather than 'peers') who formally signpost people to services and information, supporting them to improve their health and

wellbeing.[35]

Case study – SmokeScreen Promoter

The Tobacco Free Schools Project is developed and funded by the Public Health Grant. It is a comprehensive school-based programme to prevent the uptake of smoking by young people in Rutland.

Part of the Tobacco Free Schools project is the role of the peer mentor/ youth advocate/ 'SmokeScreen' promoter. The roles vary depending on whether they are developed within primary or secondary schools, and include supporting and advocating for smoke free environments, particularly in homes and cars. They also involve helping to promote the message that not smoking is the norm as most students don't smoke, and using this to encourage those who do smoke to stop and those who don't not to start.

A range of promotion methods are used including creating posters that will be placed around the school or college and entered into an annual poster competition. The overall outcomes of the project include:

- an increase the number of young people who seek assistance to quit smoking;
- a reduction in the number of young people taking up smoking and using tobacco; and
- a reduction in overall smoking prevalence for the population of Rutland.

2.2 Peer based interventions

These interventions aim to capitalise on the social influence of people who share similar experiences or characteristics by recruiting and training people from within the community of interest. This approach develops the capacity of volunteers or peers to become 'agents of change'.

2.3 Volunteer health roles

These are more 'formal' volunteer health roles which are often focused on reducing health inequalities. Volunteers usually receive training to undertake the role and professional support is provided. For example Voluntary Action Rutland (http://www.varutland.org.uk) supports and promotes local voluntary action by providing advice, information, support, training and consultation. They offer a wide range of services to members of the Rutland community and give priority to those most in need. They hold a database of organisations looking for volunteers and people willing to offer voluntary work for the benefit of their community.

Case Study - Breastfeeding peer support service in Rutland 'Breastfeeding Support Rutland'

Breastfeeding Peer Support Rutland offer support to mothers in Rutland. The peer supporters are mothers who have breastfed their babies, or are currently breastfeeding. They are trained to provide other mothers with support via antenatal & postnatal support and regular coffee mornings in Rutland's Children centres.

This project covers the whole of Rutland. The aim of the project is to contribute to increasing breast feeding rates at initiation and 6-8 week duration. Breast feeding peer supporters can support mothers by providing information about the benefits of breastfeeding, thus ensuring that women can make informed decisions on how to feed their baby. For those who have chosen to breastfeed, they can provide advice, support and encouragement when requested.

This project is co-ordinated by the Infant Feeding team at Leicestershire Partnership NHS Trust.

The project currently has 11 active peer supporters with a further 10 mothers who have recently been trained. Breastfeeding Peer Support contributes to an increase in the proportion of mothers breastfeeding in Rutland. A rise from 240 initiating breast feeding in 2013-14 to 282 in 2014-15.[4]

2.4 Summary

These local case studies support the evidence on the positive impact of taking part in volunteering. The evidence highlights the positive impact of volunteering for the volunteer or peer supporter, as well as for the target group or recipient of the support.

Using 2011 figures, the Cabinet Office calculated the monetary value of volunteering to the wellbeing of the volunteers as £13,500 per person per year.[14] An analysis of the value of volunteers running activities was £6 to £1 invested to employ a community development worker.[16] This demonstrates potentially a significant return on investment.

Volunteering delivers a whole range of benefits, which include:

- having a positive impact on the community and increasing the connections within that community;
- supporting individuals to make new friends and contacts;
- increasing social and relationship skills;
- improving mental and physical health; and
- improving job skills or providing career experience.

These benefits are in addition to the support that is being provided within the local community through the specific and targeted volunteer and peer roles.

3. Collaboration and partnerships

A key strand of community centred approaches is to engage and work with communities to improve planning and decision making, ensuring a greater focus on 'done with rather than done to'. Collaborative approaches that involve communities and local services working together can range from a one-off consultation to longer term participation in planning and service delivery. Partnerships with communities may include jointly identifying need, agreeing priorities and actions and planning, implementing and evaluating results.[2] There is good evidence that involving communities in the processes of planning, design, decision-making and delivery can improve health and well-being and make policy initiatives more sustainable.[34] Whilst no particular model of community engagement is thought to be more effective than any other,[36] engagement is seen to work best where it is an ongoing cumulative process enabling relationships and trust to build and strengthen over time.[37]

Community collaborations and partnerships can help to address a sense of powerlessness on the part of the community leading to a more resilient, inclusive approach and a more positive view on the way a community feel about their local area.[17] [38] In some areas of work such as social housing, communities that have owned and managed the work have performed better than local authority owned social housing.[39] Community coalitions can contribute to the effectiveness of certain community health improving behaviour change, particularly if they have been involved in the planning of the initiative.[34]

3.1 Community-based participatory research

This is where a partnership between communities, services and researchers work together to identify the needs of the community and develop programmes to meet those needs.

3.2 Area based initiatives

This refers to community based initiatives that are targeted in a particular geographical neighbourhood. This allows plans to be focused on the issues that affect a particular geographical community and that tackle multiple issues that are affecting the area in a holistic way.

Case study - 'Whissendine Good Neighbour Scheme': Local people set up a good neighbour scheme in a Rutland village

The village of Whissendine in Rutland has around 500 houses, a church, a windmill, 2 pubs, a sports club and various community groups. What is doesn't have is a post office, doctor's surgery or until recently a shop. It's a nice place to live and many choose to live there independently as long as they can. A parish plan was initiated in the village, and a questionnaire circulated asking residents how they felt about the village and how they thought it could be improved. Among other things the need for transport and befriending were highlighted. The Rural Community Council -who were assisting with the plan, suggested they set up a Good Neighbour Scheme along the lines of a scheme operating in Leicestershire. A steering group was formed, and a public meeting held where 30 people came forward to volunteer.

The Good Neighbour Scheme in Whissendine was set up in 2010. It is run by local volunteers who support people living in the village. A duty co-ordinator holds a mobile phone, and those requiring assistance ring to make a request and the co-ordinator finds a volunteer to help. Some volunteers provide transport to medical appointments or to social events in the village, others help with small DIY or gardening tasks. Some volunteers befriend, such as dropping in for a chat. The only charges made are for petrol, trips outside the village and parking. The scheme has its own website, advertises monthly in the village newsletter Grapevine, and in 2011 the scheme was awarded a Gold Award for Village Achievement from the Rural Community Council.

Feedback has been very positive, with residents saying they don't know how they managed before, and more than one person saying they feel more confident about living independently in the village in spite of increasing age.

"Most weeks I have a welcome visit from a lady from the Good Neighbour Scheme. As I spend the greater part of each day on my own, it is good to have someone call who is always cheerful, helpful and interesting to talk to."

Initial set-up costs were covered by funding from Rutland Community Spirit and Whissendine Parish Council. A Grass Roots grant via Voluntary Action LeicesterShire (VAL) was also obtained.

The Rural Community Council, who assisted at the beginning, continue to support the scheme. Rutland County Council agreed to be the umbrella organisation for DBS checks, processing them initially free of charge. Voluntary Action Rutland and VAL provided information and training.

3.3 Community engagement in planning

This is an approach that aims to involve local communities in planning and decision making with local government and the NHS. It brings in the insights of the local communities on the issues that are affecting their lives and also means that the local community has a greater sense of ownership of the plans that are developed. Public Health are developing a Health Impact Assessment / Health in All Policies approach to support local communities in influencing major developments and policies that will increase the potential positive impacts and mitigate identified negative impacts.

3.4 Co-production projects

These are projects that seek to develop equal partnerships between professionals and those using health and care services. This approach is similar to many of the other approaches but is focussed on people with established care needs.

Case Study - Health for Kids – Health for Teens

School nurses at Leicestershire Partnership Trust wanted to enable children and young people to 'help themselves' to health in a format of their choice and to provide an extension to their school nursing services. They developed a Health for Kids website: https://www.healthforkids.co.uk/ and a Health for Teens website: https://www.healthforteens.co.uk/. Children and young people were actively involved in co-designing the websites and the websites ensure that children and young people have access to good, sound, safe and accurate information.

Several separate groups of children and young people were involved in focus groups to develop the ideas and topics to be included and in particular shape how they wanted to receive the information. The children designed the characters and games used for the Health for Kids website. In its first 18 months, the Health for Kids website has had more than 39,000 visits and 175,000 page views. In the first week of a new campaign' Move it Boom!' has seen 27,000 page hits and 700 children have signed up to participate and record their activities.

School teachers in Rutland are using the site in lessons and have welcomed the emotions section as an excellent learning tool. Over eleven thousand individuals visited The Health for Teens website in its first 9 months, with 50,000 individual page views. During this time The Health for Teens twitter feed had 769 followers and these are growing steadily. Young people have continued to be involved in its development and as a result a range of additional topics, apps, videos and vlogging (video blogging) facilities are being added to the website. An editorial team of young people is being established and consultations will continue on an ongoing basis to ensure the websites stay fresh and meets the needs of children and young people and that the content and style is always driven by what children and young people want to know about. The website has recently won a communications industry award for the 'Best website' from the Association for Healthcare Communications and Marketing (AHCM). The children and young people have expressed their pleasure at seeing their ideas and views taken on board as can be seen in the video they prepared for several awards

3.4 Summary

These collaboration and partnership approaches can lead to more positive health and wellbeing outcomes and have been shown to improve a sense of belonging to a community (social capital) and to improve a sense of wellbeing. The chance to co-produce services can increase confidence and self-esteem. Using people's local knowledge and experience to design or improve services can ensure they are more appropriate, effective, cost effective and sustainable. They can encourage health enhancing attitudes and behaviours. Individuals and communities can gain a sense of increased control over decisions affecting their lives.[40] There is good evidence of the benefits of working in partnership with communities to enable better planning, decision making and delivery. For these opportunities to be used more widely and effectively statutory organisations and professionals need to be committed to sharing power and decision making and support the development of staff to have the skills, knowledge and values to work in this way.[40] Whilst there are good examples of partnerships and collaboration in Rutland, extending cross agency working and partnerships to more fully involving local people and communities

would be a next step in developing these approaches.

4. Access to community resources

The assets within communities, such as its skills and knowledge, social networks and community organisations, are building blocks for good health. It is important that we enable people and communities to participate, contribute and also access these assets in order to be able to improve their health and wellbeing.

Resources can include anything that may be community based, for example, parks and green spaces or community pharmacies. Parks and green spaces can help to address issues such as obesity, cardiovascular disease, mental ill health or antisocial behaviour.[41] There is evidence that community pharmacies can have an impact upon smoking cessation activities, cardiovascular disease prevention and management of diabetes.[42]

Access to assets can be helped through the provision of local information and services, support groups and organisations which both signpost to support or assist people in getting access to support. Examples include “community hubs” such as children’s centres, community libraries and citizens advice centres.

Using an asset based community development approach starts with the process of locating the assets, skills and capacities of residents, citizens associations and local institutions. This builds up community groups and voluntary organisations; their informal associations and networks, their collaborative relationships, their shared knowledge and therefore their social power to make positive changes.

4.1 Pathways to participation

This covers the many routes that are being developed locally to help people to access interventions that will improve their health and wellbeing. These all build on the assets that already exist within the community – be it the physical assets in the form of parks, green spaces or community centres or the assets that exist in the people that live within these communities through their own experiences and expertise and time. Local examples include “social prescribing” to activities outside of the traditional health sector, which links people up to activities in the community that they might benefit from. For example referral to green gyms or walking schemes for physical activity, food banks and welfare and debt advice.

Case Study - STEP TO IT – an inclusive dance group for girls and boys aged 12-19

"STEP TO IT" is an inclusive dance group for girls and boys aged 12-19 years old with a disability, enabling them to be part of a weekly dance session. The sessions are delivered by Rutland youth dance academy, and supported by Rutland County Council Active Rutland officers. They are held at Brightways Community Centre. The group have performed at the community dance show and even in front of royalty. This year the group won "Project of the year" at Rutland Sports awards.

The session begins with dynamic movement skills, to help refine and improve gross motor skills, and to get those body parts moving! Participants engage their creativity by moving around the room in different ways. The second part of the session is more structured with different routines being built upon every week. The session ends with 5-10 minutes of relaxation and stretching, allowing a focus on the body and spatial awareness as well as time to reflect on what the dancers have just learnt. Comments from users include:

"Step To It has been a brilliant project for me. I've never really been interested in dance or preforming, but I have loved being given this opportunity to learn hip hop/pop by a professional and then being able to perform! It's definitely helped my confidence and self-esteem as I've been able to express myself through dance and get fit at the same time; I hope this group continues and I'd recommend dance to anyone."

"Step to It is a fantastic project of 'feel good' personified! An hour in this environment is developing our daughter's co-ordination, concentration, strength and communication whilst doing something she loves with her peers - a well spent hour! With our daughter's level of learning and physical disability we struggle to find inclusive, ongoing activities that she can realistically access for long enough to experience success. Step To It provides this platform."

The programme is funded through Sport England "Sportivate" funding.

4.2 Community hubs

These are community centres or organisations focused on health and wellbeing that can provide multiple activities to address health or the wider determinants of health.

Case Study - Rutland Food Bank

23rd September 2015 marked the second birthday of Rutland Food Bank. During that time 1500 people have received emergency packs of food to last 3 days and 23.5 tonnes of food collected mostly by the generosity of local people.

In Rutland there are two Foodbanks – on Melton Road in Oakham and Uppingham Parish Church. Both provide a community hub where clients are able to share their experiences and are signposted to agencies who can offer additional help and begin to resolve any underlying problems.

All food given out by the foodbanks is donated. Often this is from schools, churches, businesses, individuals, or through supermarket collections. Supermarket collections help foodbanks engage the public. Foodbank volunteers offer shoppers a 'foodbank shopping list' and ask them to buy an extra item with their shop. This food is then handed to volunteers waiting beyond the checkout who pack it before it is taken to the foodbank warehouse for further sorting and storage. Food is sorted and stored at the warehouse, where volunteers weigh and sort the donated food according to type and 'best before date'. They also check it is undamaged and suitable for use before packing it into boxes for storage.

Professionals from statutory and voluntary organisations such as doctors, health visitors, social workers, Citizens Advice Bureau staff, welfare officers, the police and probation officers, identify people in crisis and issue them with a foodbank voucher. Clients bring their voucher to a foodbank centre where it can be exchanged for three days supply of emergency food. The list of foods in each parcel have been designed by dieticians to provide recipients with nutritionally balanced food.

4.3 Community based commissioning

This refers to a process by which local communities are involved in the commissioning cycle and includes community engagement to understand community needs, and commissioning services through third sector providers. The Council is now focussed on improving prevention and resilience (in line with current key strategies and Better Care Together and Better Care Fund),[11] [12] [13] by supporting people to help themselves, and concurrently building capacity in communities. To do this Rutland are considering using a 'Partnership' approach to commissioning that co-designs services with both providers and our communities.

4.4 Summary

Improving access to community resources has a number of health and wellbeing benefits. Using community assets innovatively increases the awareness of the assets and will generate further use. As people access the benefits of different facilities and services they will start to use treatment and support services more appropriately and to manage their non-clinical needs more effectively. The case studies presented in this section demonstrate significant benefit to people accessing community resources, both as a user of the service and as a citizen contributing to the community based approach.

FEEDBACK FROM RECOMMENDATIONS FOR 2014

In this section we highlight some of the initiatives that have taken place in the past year that are linked to the recommendations from the 2014 report.

The best start in life

- Over 40% of 5 year olds in Rutland were shown to have had experience of tooth decay in the 2012 oral health survey. This is significantly higher than national levels. A project on oral health has been undertaken to provide insight into why levels of tooth decay in children in Rutland are higher than expected and to develop an evidence-based oral health promotion programme for the future.

- Health Visiting and Children Centre staff have proactively promoted the Free Early Education Entitlement for two year olds to eligible families and a 91.6% take up has been achieved. This is expected to help to contribute towards improved School Readiness across the County.

- A multi-agency integrated antenatal, perinatal and post-natal pathway is being developed in Rutland to ensure a holistic approach to all of these services in line with the '1001 Critical Days' cross party manifesto – the goal of which is for every baby to receive sensitive and responsive care from their main caregivers in the first year of life.

Healthy schools and pupils

- School pupils in Rutland are encouraged to contribute to improving the health and wellbeing of children and young people through the use of a 'Whole School Approach' and by making use of the Leicestershire healthy school resources.

- Schools are encouraged to incorporate more physical activity in the curriculum working with Leicestershire and Rutland Sports Partnership, Active Rutland, and Rutland County Council active transport team. Active Rutland has worked with 26 schools and the active transport team supported 360 Year 5 & 6 children to take part in Bikeability Levels 1 & 2 programmes and 10 children to achieve Level 3.

- Schools are encouraged to adopt the Personal, Social and Health Education (PSHE) Association's PSHE programme of study, and that they utilise the new Leicestershire PSHE Toolkit: 'PSHE: Better than Good Enough.'

Economy and employment

- Rutland County Council has established a group on work and health for council employees, and using the National Workplace Wellbeing Charter to benchmark and assess their progress. A staff engagement and health questionnaire had a 63.7% response rate and provided the group with useful insight to inform their work. From the results 3 priority areas were identified and working groups established on mental

health, work environment and communications. This has resulted in a wide range of activity including: policies revised and updated; staff benefits packages further developed; health and wellbeing days, mindfulness taster sessions and courses on Mental Health First Aid held and staff health discussions integrated into managers meetings.

- More widely The County Council has also worked with local employers around green travel planning and provides employers with a range of support to do this including starting greener driving courses for employees who drive for work.

Strong communities, wellbeing and resilience

- Development of a unified prevention model for Rutland has continued and includes plans to further develop a network of community agents procured from the private/voluntary, community and faith sector. In the first 9 months of operation Community Agents have seen 400 individuals and prevented 60 clients admission to hospital or supported their leaving hospital.

- A Falls Summit was held in Rutland as part of the Better Care Fund and included a wide range of participants from public, voluntary and community agencies. This identified that whilst there was already significant activity, there were gaps and there was a need for better coordination, publicity and a clear pathway. These findings are now being used to develop falls prevention work further. Greater integration across health and social care services in Rutland have been achieved by the REACH re-ablement service where occupational therapists, physiotherapists and nurses have worked as a team using individual care plans to maximise independence and wellbeing. This has resulted in less people going into residential care and seen a small drop in hospital admissions.

Active and Safe Travel

- An Active School Travel Health Needs Assessment is being developed for Leicestershire and Rutland. The aim is to understand the perceptions of road safety and road traffic injuries associated with active school travel and how closely these match the real risk in terms of road traffic accidents occurring on the school commute and the benefits in terms of increased physical activity in children.

Access to green and open spaces and the role of leisure services

- The Active Rutland team, supported with Public Health funding, held Rutland Walking and Cycling Festivals, and the Rutland Round. 2015 saw over 300 people participate in week long programme of walking events across Rutland's green spaces. There are 2 Walking for Health accredited groups. The Oakham group has around 20 walkers and the Ketton group has 50-60 walkers each week. 3 additional run leaders have been starting up new sessions for people across the county including programmes for

beginner runners. The established Rutland Water Parkrun averages around 100 participants each week, and to date has seen 720 different runners.

- The Sports Arena held at the annual Rutland Day celebrations based at Sykes Lane had over 5,000 people attend. Local clubs put on sessions for the public to try a new activity and promoted what is on offer across Rutland for people to get involved in.

Warmer and safer homes

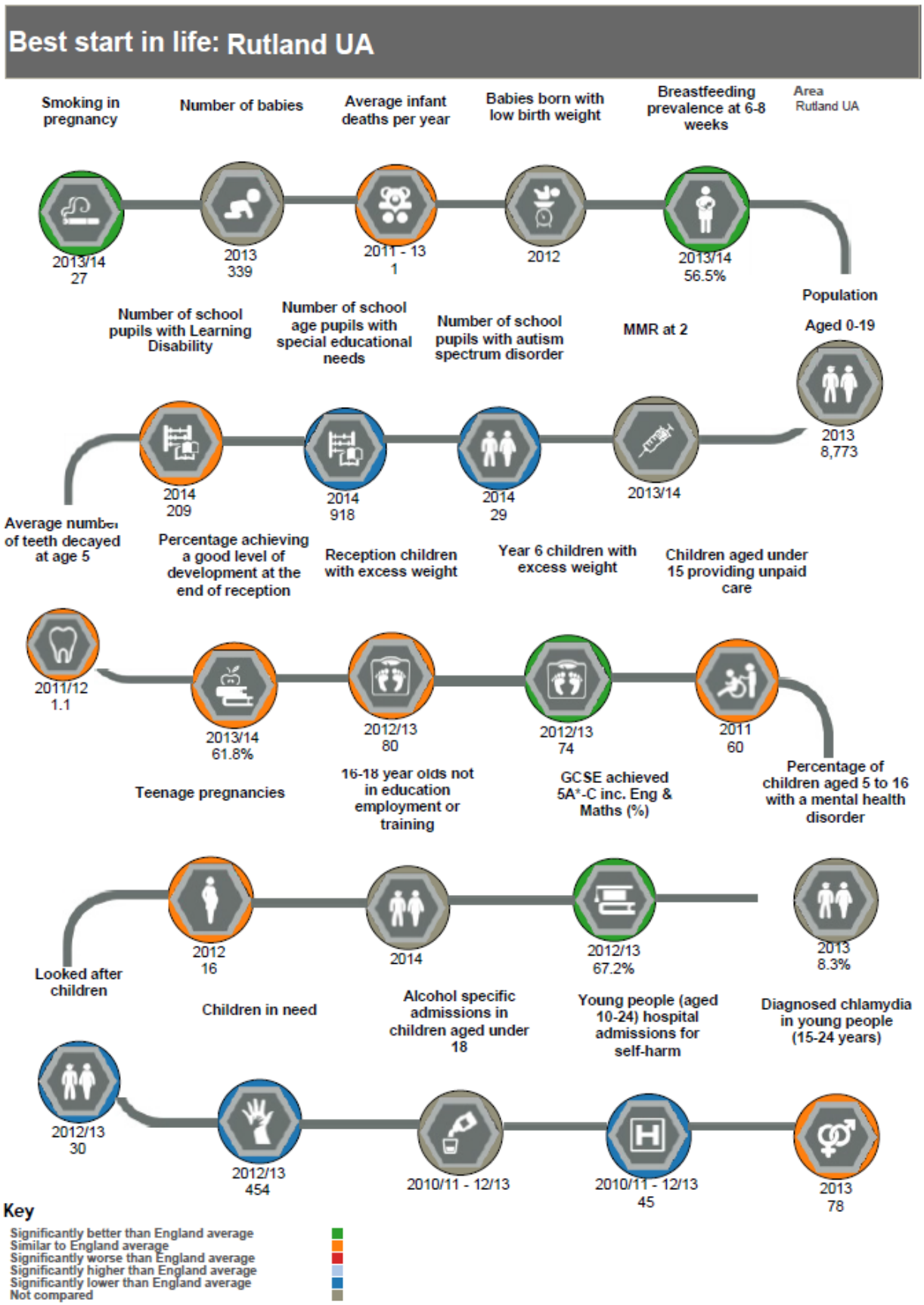
- Rutland Better Care Fund resourced the delivery of the Falls Management Exercise (FaME) programme. This is being evaluated externally through funding from CLAHRC (Collaboration for Leadership in Applied Health Research and Care) funded project. There is also a falls prevention action plan in place.

- In 2014/15 Rutland County Council funded a third party provider to carry out energy audits and advise residents with options to make their homes warmer. Between January 2015 and June 2015 152 visits were carried out within Rutland.

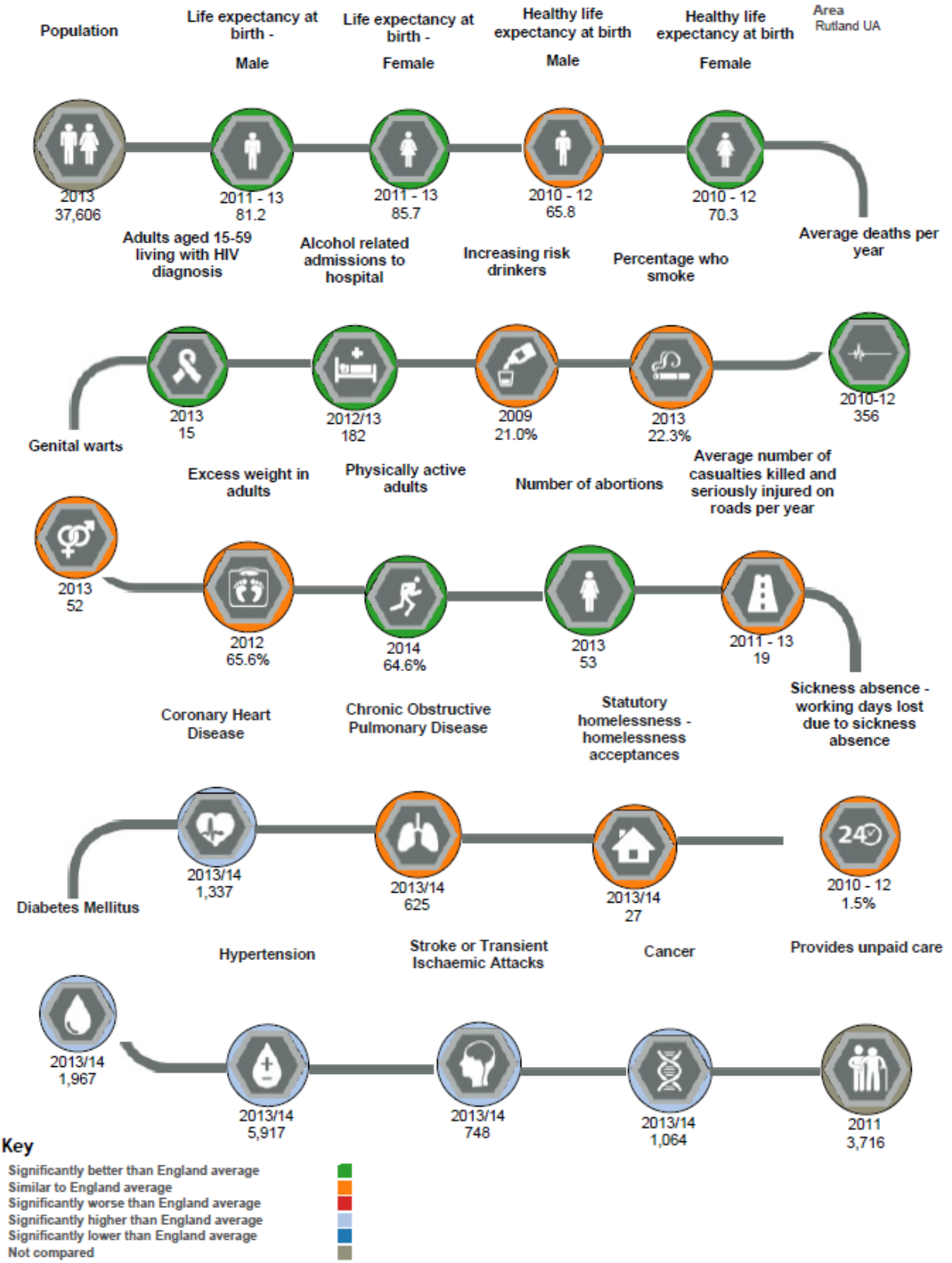
Public Protection and Regulatory Services

- A number of programmes are commissioned to encourage and promote healthy food choices and alternatives to fast food. In Rutland this includes the Family Lifestyle Club (FLiC) and Lifestyle Eating Activity Programme (LEAP). These services are being redesigned to ensure an appropriate model of delivery for Rutland.

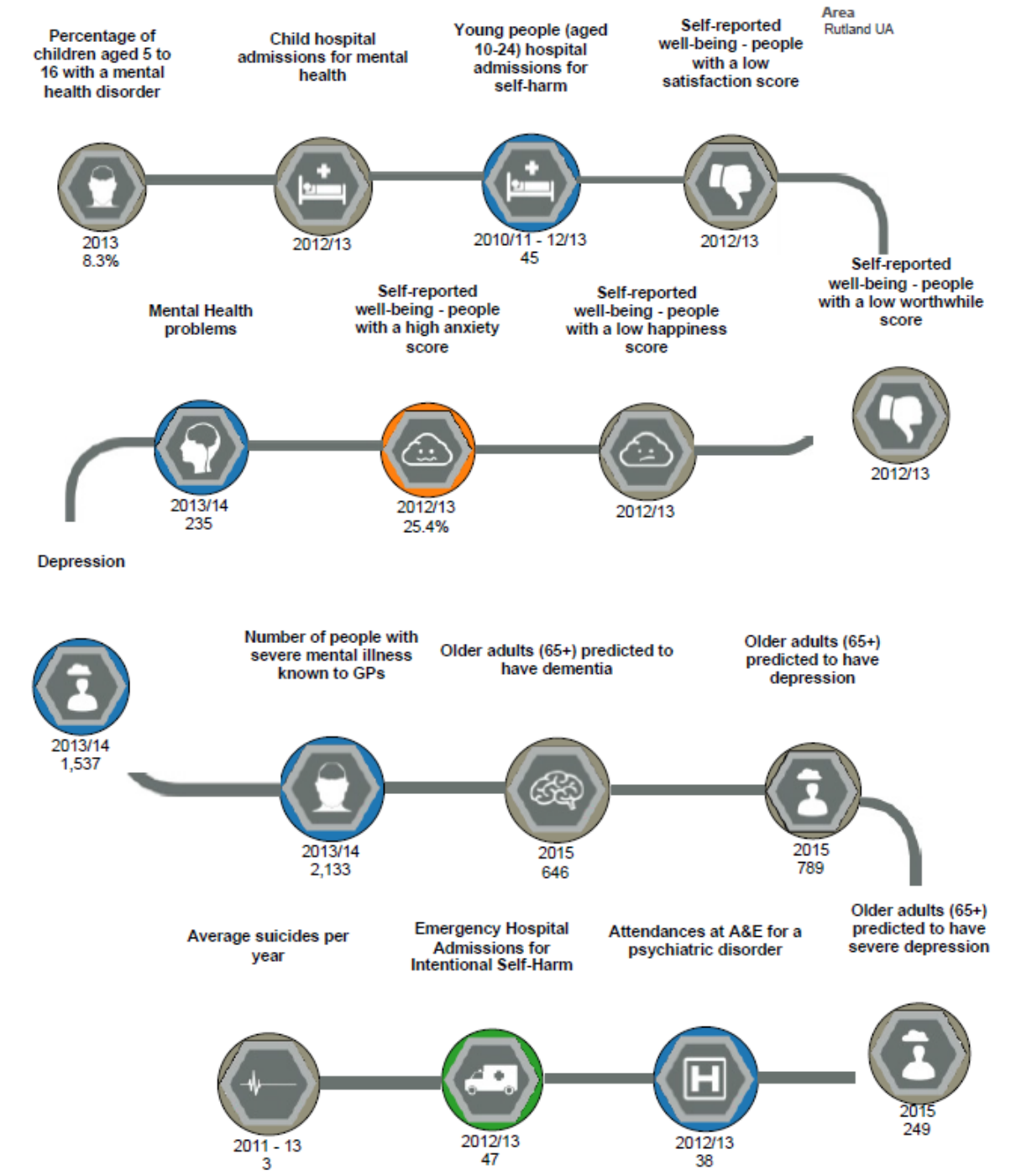
APPENDIX A: RUTLANDS JSNA HEADLINES


Best start in life: Rutland UA
Smoking in pregnancy
2013/14
27
Number of babies
2013
339
Average infant deaths per year
2011 - 13
1
Babies born with low birth weight
2012
Breastfeeding prevalence at 6-8 weeks
2013/14
56.5%
Area
Rutland UA
Population
Aged 0-19
2013
8,773
MMR at 2
2013/14
Number of school pupils with autism spectrum disorder
2014
29
Number of school age pupils with special educational needs
2014
918
Number of school pupils with Learning Disability
2014
209
Average number of teeth decayed at age 5
2011/12
1.1
Percentage achieving a good level of development at the end of reception
Reception children with excess weight
Year 6 children with excess weight
Children aged under 15 providing unpaid care
2013/14
61.8%
Teenage pregnancies
2012/13
80
16-18 year olds not in education employment or training
2012/13
74
GCSE achieved 5A*-C inc. Eng & Maths (%)
2011
60
Percentage of children aged 5 to 16 with a mental health disorder
2012
16
Looked after children
Children in need
2014
Alcohol specific admissions in children aged under 18
2012/13
67.2%
Young people (aged 10-24) hospital admissions for self-harm
2013
8.3%
Diagnosed chlamydia in young people (15-24 years)
2012/13
30
2012/13
454
2010/11 - 12/13
2010/11 - 12/13
45
2013
78
Key
Significantly better than England average
Similar to England average
Significantly worse than England average
Significantly higher than England average
Significantly lower than England average
Not compared

Health and wellbeing of adults: Rutland UA



Mental health: Rutland UA

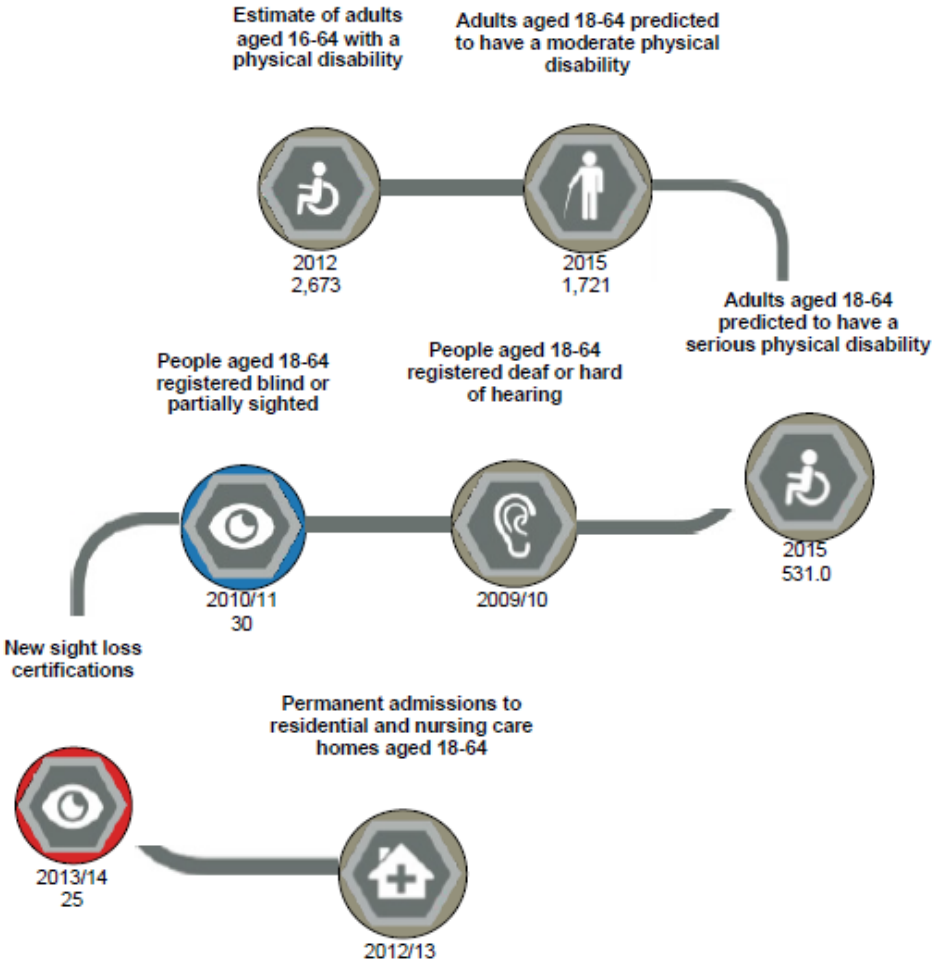


Key

- Significantly better than England average
- Similar to England average
- Significantly worse than England average
- Significantly higher than England average
- Significantly lower than England average
- Not compared

Physical and sensory disabilities: Rutland UA

Area
Rutland UA



Key

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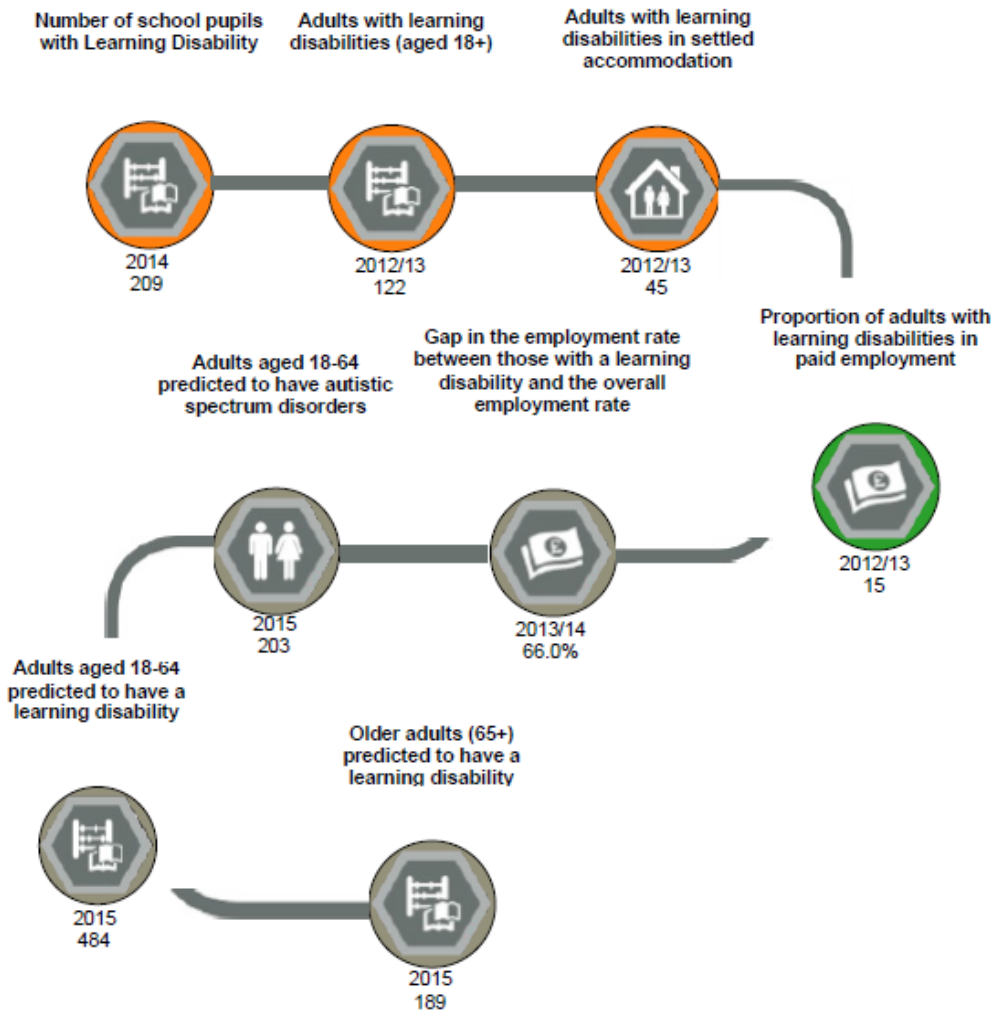
- Similar to England average
- Significantly worse than England average
- Significantly higher than England average
- Significantly lower than England average
- Not compared

Learning disabilities and autism: Rutland UA

Area
Rutland UA



Key

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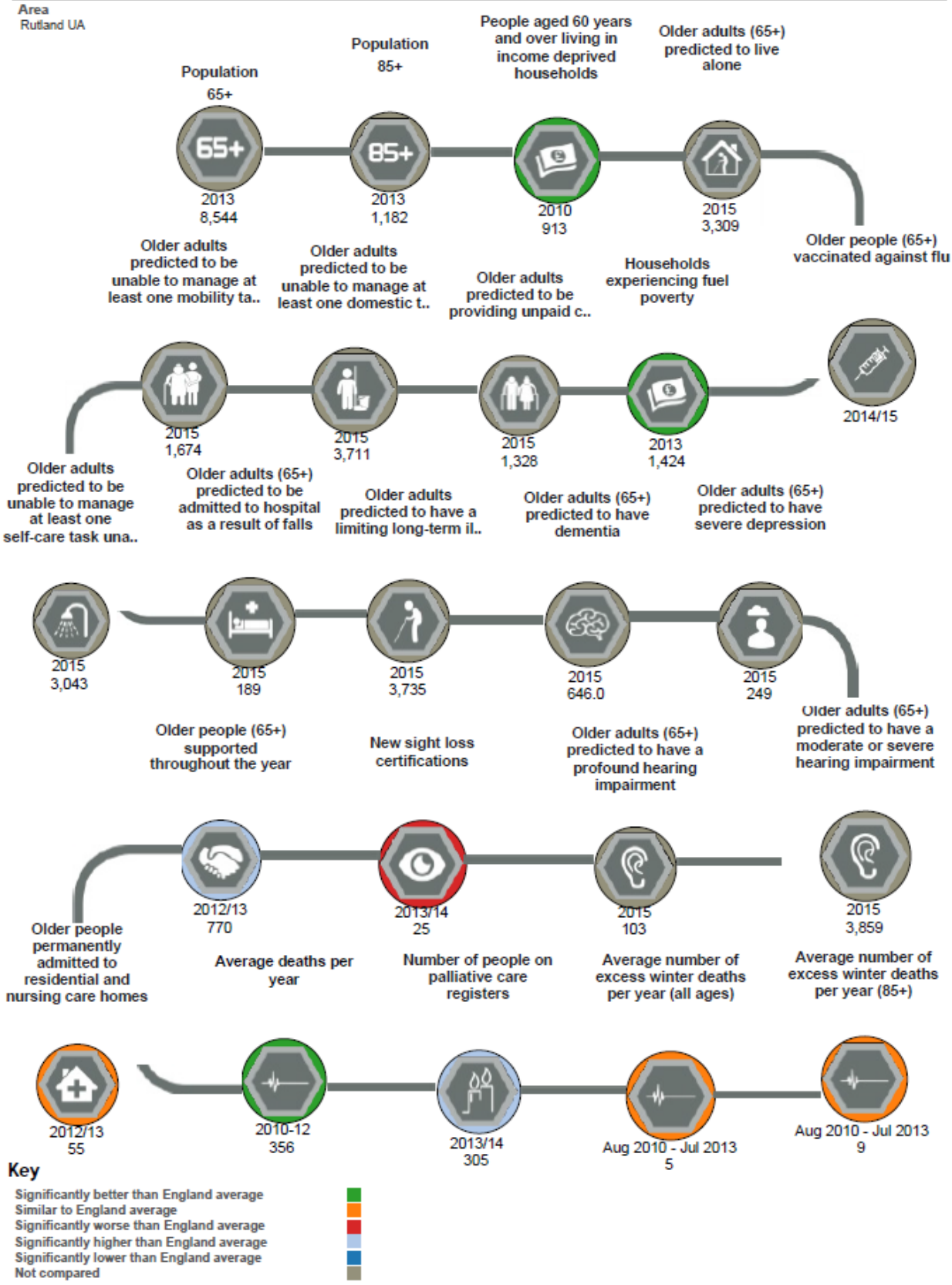
- Similar to England average
- Significantly worse than England average
- Significantly higher than England average
- Significantly lower than England average
- Not compared

Issues specific to ageing: Rutland UA



LIST OF ABBREVIATIONS

BCF	Better Care Fund
CCC	Coffee, Cake & Chat
CCG	Clinical Commissioning Group
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
DBS	Disclosure Barring Service
DIY	Do it Yourself
FaME	Falls Management Exercise
FFLP	Food For Life Partnership
FLiC	Family Lifestyle Club
GP	General Practice or General Practitioner
HIA	Health Impact Assessment
JSNA	Joint Strategic Needs Assessment
LEAP	Lifestyle Eating Activity Programme
LPT	Leicestershire Partnership Trust
NHS	National Health Service
PHSE	Personal Health and Social Education
RCA	Rutland Community Agents
RIS	Rutland Information System
UK	United Kingdom
VAL	Voluntary Action LeicesterShire
VCS	Voluntary and Community Services

REFERENCES

1. Dahlgren, G. & Whitehead, M. *Policies and strategies to promote social equity in health*. (1991).

2. Public Health England & NHS England. *A guide to community-centred approaches for health and wellbeing*. 48 (2014). at <https://www.gov.uk/government/publications/health-and-wellbeing-a-guide-to-community-centred-approaches>

3. Rutland County Council. Rutland County Council Joint Strategic Needs Assessment Overview 2015. (2015).

4. Public Health England. Public Health Outcomes Framework. (2014). at <http://www.phoutcomes.info/>

5. Office of National Statistics. ONS Mid-2013 Population Estimates. (2014). at <www.statistics.gov.uk>

6. Office for National Statistics Population Projections Unit. *2012-based sub-national population projections*. (2014).

7. Better Care Together. A Partnership of Leicester Leicestershire and Rutland Health and Social Care. Better Care Together Plan 2014. (2014). at <http://www.bettercareleicester.nhs.uk/the-bct-plan/>

8. Office of National Statistics. *VS3 MORTALITY BY CAUSE* - 2013 REGISTRATIONS TO 2013 BOUNDARIES DEATHS TO PERSONS RESIDENT IN: LOCAL AUTHORITY*. (2014).

9. Office of National Statistics. Census 2011 - Nomis. *Crown Copyright* (2013). at <http://www.nomisweb.co.uk/census/2011>

10. Fried, L., Furrucci, L., Darer, J., Williamson, J. & Anderson, G. Untangling the concepts of disability, frailty and co-morbidity: implications for improved targeting and care. *Journals Gerontol.* **Series A: ,** 255–263 (2004).

11. Rutland County Council. *People First Final Report - People First Review January to July 2014*. (2014). at <http://www.rutland.gov.uk/pdf/Report No. 202-2014 People First Appendix A.pdf>

12. Rutland County Council. *Adult Social Care Strategy 2015-2020 Healthy and Independent Lives – A Sustainable Future*. (2015). at <Adult Social Care Strategy 2015-2020 Healthy and Independent Lives – A Sustainable Future>

13. Rutland County Council. *Adult Social Care Market Position Statement 2015*. at <http://www.rutland.gov.uk/pdf/Rutland ASC Market Position Statement 2015-20.pdf>

14. Fujiwara, D., Oroyemi, P., McKinnon, E., Oroyem, i P. & McKinnon, E. *Wellbeing and civil society. Estimating the value of volunteering using subjective wellbeing data*. (2013).

15. Knapp, M., Bauer, A., Perkins, M. & Snell, T. Building community capital in social care: is there an economic case? *Community Dev. J.* **48,** 313–31 (2013).

16. nef Consulting. *Catalysts for community action and investment: A Social Return on Investment analysis of community development work, based on a common outcomes framework. Executuive Summary.* (2010).

17. Cairncross, L., Morrell, C., Darke, J. & Brownhill, S. *Tenants managing: an evaluation of tenant management organisations in England.* (2002).

18. Popay et al. *Community engagement in initiatives addressing the wider social determinants of Health A rapid review of evidence on impact, experience and process.* (2007).

19. Winters, M. & Patel, K. *The Department of Health's Black and Minority Ethnic drug misuse needs assessment project.* (2003).

20. Grimsley, M., Hickman, P., Lawless, P., Manning, J. & Wilson, I. *Community Involvement and Social Capital.* (2005).

21. Lifelong Learning UK. *National Occupational Standards for Community Development*. (2009).

22. Daily, J. & Barr, A. *Understanding a Community-led Approach to Health Improvement*. (2008). at <http://www.scdc.org.uk/media/resources/what-we-do/mtsc/Understanding a community-led approach to health improvement.pdf>

23. Elliott, E. *et al. Connected Communities - A review of theories, concepts and interventions relating to community-level strengths and their impact on health and well being*. (2011).

24. Foot, J. & Hopkins, T. *A glass half-full: how an asset approach can improve community health and well-being*. *Improvement and Development Agency* (2010). at <http://www.local.gov.uk/c/document_library/get_file?uuid=fc927d14-e25d-4be7-920c-1add80bb1d4e&groupId=10171>

25. Morgan, A. & Ziglio, E. Revitalising the evidence base for public health: an assets model. *Promot. Educ.* **Suppl 2,** 17–22 (2007).

26. Wallerstein, N. *What is the evidence on effectiveness of empowerment to improve health?*. (2006).

27. Woodall, J., Raine, G., South, J. & Warwick-Booth, L. *EMPOWERMENT AND HEALTH & WELL-BEING: Evidence Review*. (2010).

28. Fisher, B. *Community Development in Health – a Literature Review*. (2011).

29. Jenkinson, C. *et al.* Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers. *BMC Public Health* **13,** (2013).

30. NHS. Five steps to mental wellbeing. *2014* at <http://www.nhs.uk/Conditions/stress-anxiety-depression/Pages/improve-mental-wellbeing.aspx>

31. Laverack, G. Health activism. *Health Promot. Int.* **27,** 429–434 (2012).

32. Seyfang, G. & Smith, K. *The time of our lives: Using time banking for neighbourhood renewal and community capacity building*. (2002).

33. Boyle, D., Clark, S. & Burns, S. *Hidden work: Co-production by people outside paid employment.* (2006).

34. Swainston, K. & Summerbell, C. *The effectiveness of community engagement approaches and methods for health promotion interventions. Rapid Review Phase 3*. (2008).

35. Eng, E., Parker, E. & Harlan, C. Lay health advisor intervention strategies: a continuum from natural helping to paraprofessional helping. *Heal. Educ. Behav.* **24,** 413–417 (1997).

36. O'Mara-Eves, A. *et al. The effectiveness of community engagement in public health interventions for disadvantaged groups: a meta-analysis*. (2015).

37. Community Planning Toolkit - community engagement. at <www.communityplanningtoolkit.org>

38. Tunstill, J. *et al. Implementing Sure Start local programmes: An in-depth study*. (2005).

39. Goodlad, R., Docherty, I. & Paddison, R. Responsible participation and housing: Restoring democratic theory to the scene. in *Housing Studies Association, Autumn Conference.* (2003).

40. National Institute for Health and Clinical Excellence. Community Engagement NICE Guidelines [PH9]. *NICE guidelines [PH9]* (2008). at <https://www.nice.org.uk/guidance/ph9>

41. Pevalin, D. & Rose, D. *Social Capital for Health: Investigating the links between social capital and health using the British Household Panel Survey*. (2003).

42. Public Health England. Consolidating and developing the evidence base and research for community

pharmacy's contribution to public health: a progress report. in *Task Group 3 of the Pharmacy and Public Health Forum* (Public Health England, 2014).