Report No: 207/2016
PUBLIC REPORT

PEOPLE (ADULTS AND HEALTH) SCRUTINY PANEL

1 December 2016

POVERTY IN RUTLAND

Report of the Director for People

Strategic Aim:	All	
Exempt Information	No	
Cabinet Member(s) Responsible:	Mr Richard Clifton (Portfolio Holder for Adult Social Care and Health)	
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Ward Councillors	N/A	

DECISION RECOMMENDATIONS
That the Panel: 1. Considers the topics and related issues/questions covered in this report; 2. Identifies any further information or work it may wish to undertake; 3. Authorises the Chair to produce a written report of findings to feed back into the overall project.

1 PURPOSE OF THE REPORT

1.1 The Scrutiny Commission has agreed to undertake a review of Poverty in Rutland. The project objectives are:

- To develop an agreed definition(s) of Poverty in Rutland;

- To develop a Council policy in the form of a White Paper to be approved by Full Council that will outline for Rutland how the Council will act to positively impact on poverty within the County.

2 BACKGROUND AND MAIN CONSIDERATIONS

2.1 Further to the initial workshop attended by Members on 13 September 2016, a list of areas was highlighted for further investigation by individual Scrutiny Panels. The following areas were identified for the People (Adults and Health) Scrutiny Panel to take forward:

- Health Inequalities
- Access to Services
- Vulnerable Adults

This report provides some information in relation the first two of those areas.

2.2 Scrutiny Commission have agreed the following timetable for this review:

Stage	**Panel**	**Date**
All member workshop		13th September 2016
Panel work to develop Green Paper	Adults and Health	1st December 2016 and 2nd February 2017
	Children's	17th November 2016 and 23rd February 2017
	Places	24th November 2016 and 9th February 2017
	Resources	10th November 2016 and 16th February 2017
Green paper to Cabinet	N/R	21st March 2017
Panel work on White Paper	Adults	6th April 2017
	Children's	4th May 2017
	Places	20th April 2017
	Resources	27th April 2017
White Paper to Cabinet	N/R	16th May 2017
White Paper to Council	N/R	June Council

2.3 Further to a meeting with the Chair of the People (Adults and Health) Scrutiny Panel, it was agreed that this Panel would focus on a number of key areas:

- Health Inequalities – focusing specifically on the relationship between of poverty with dental health and obesity, including related health issues such as diabetes
- Access to Services – how poverty in a rural setting affects the ability of people to access services, with a particular focus on health and social care services

2.4 To facilitate a discussion of each area, two short papers have been produced which are included as appendices to this report. The papers are not exhaustive but provide information to facilitate a discussion in each area. To assist the discussion there will be a panel of professional experts supporting the session and each area will be led by a key professional.

2.5 Further to the outcome of this meeting the Chair of the Panel will report back to the working group to consider next steps but this will be confirmed at the meeting.

3 CONCLUSION AND SUMMARY OF REASONS FOR THE RECOMMENDATIONS

3.1 This report gives further information requested by the initial Poverty project workshop.

4 BACKGROUND PAPERS

4.1 There are no additional papers.

5 APPENDICES

5.1 Appendix A – Health Inequalities

5.2 Appendix B – Access to Services

5.3 Appendix C – Additional Data - Citizens Advice and South Lincolnshire Food Bank

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

Appendix A. Health Inequalities

Report to People (Adults and Health) Scrutiny Panel

December 1st 2016

Poverty, inequalities and poor health

The link between poverty and poor health are well accepted. Social inequalities in health arise because of inequalities in the conditions of daily life and poverty is a key aspect of this. These differences have a huge impact, because they result in people who are worst off experiencing poorer health and shorter lives.

Health in Rutland is better than for most areas of the country and health outcomes are better than average as we have a comparatively affluent population and low levels of poverty compared to other areas. Currently

- 7.1% of children are in low income families in Rutland and this measure has been falling since 2008.[1]
- 7.9% Older people live in poverty in Rutland

However being poor in areas of affluence can provide additional strain. Some families may not be categorised as in poverty based on the national measures but just above the threshold.

Deprivation

Rutland is one of the most affluent counties in England; of 149 Upper Tier Local Authorities in 2010, Rutland ranked 148 (with 1 being the most deprived, and 149 being the least deprived).[2] In Health Profiles released by Public Health England (2013-15), Rutland has ranked first in the 10 best performing local authority districts for levels of deprivation. At a more granular level, there is variation across Rutland in levels of income and overall deprivation. In 2010, when placed in a national context, while there were no wards that ranked in the two most deprived quintiles nationally, two wards were in the middle quintile – Martinsthorpe and Oakham North West. However, 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. For those on modest incomes a greater proportion of their income will be spent on travel costs. Poor public transport means most families require a car. For poorer families this is a significant cost and impacts on older people no longer able to drive.

Deprivation is measured by the Index of Multiple Deprivation (IMD). *Please see appendix for description of IMD and the seven domains of deprivation that make up IMD.* In many cases pockets of deprivation and need can be hidden even when using IMD. The Index is therefore not a suitable tool for targeting individuals.

There are pockets of deprivation and disadvantage to be found in rural areas in Rutland. Rural deprivation has been described as "a set of economic and social conditions *... which excludes people from the styles of life open to the majority in the countryside* hence rural inequalities often remained hidden because of the way deprivation is measured.

In rural areas individuals may be classed as being deprived with or without a low income. Deprivation, as seen in urban areas, has traditionally been tackled in area-based initiatives, but in rural areas many people who experience deprivation live alongside the affluent, making it harder

[1] Public Health Outcomes Framework (PHOF) 2016
[2] Indices of Deprivation: 2010 by County Council

to target resources. Overall there are significant difficulties in collecting small area data and identifying deprivation in sparsely populated areas.[3]

Many indicators of health are measured at ward level. Almost all Rutland wards are similar to national levels or significantly better. However, contrary to this is Oakham NW where the Standardised Mortality Ratio (SMR)[4] for all causes, circulatory disease and stroke are significantly higher than the national average. There is also often a time lag in data and communities are changing all the time. In the case of Oakham NW there have been a significant number of new housing developments which is changing the overall demographic of the ward, such that it is no longer the most deprived ward in Rutland. *See map 1 in appendices.* However poorer and more deprived families continue to live within this ward.

Care has to be taken with data at a population level in Rutland not least because of small sample numbers meaning that data can vary significantly from year to year. Therefore confidence in the quality of data is affected and note should always be taken of the confidence intervals given for each data field.

Oral health, diet, obesity, diabetes and long term conditions.

To give a focus to poverty and inequalities in health this report focusses on a number of interlinked areas of oral health, obesity and diabetes and to look at data relating to these areas and links with poverty.

Being on a low income impacts on the food choices individuals and families can make and ability to access a healthy diet. At a national level there is clear evidence of the links between:

- deprivation and tooth decay
- higher levels of excess weight for social classes 3, 4 & 5[5]
- higher numbers of fast food outlets in poorer communities[6]

According to oral health surveys for 3 and 5 year olds there are high levels of tooth decay in Rutland. 2012 data for five year olds indicated that 40.3% of children sampled had decayed missing or filled teeth[7]. This dropped to 28.8 in 2015[8] – but is still well above national levels. Additional mapping of 2012 data did not show a clear link between those areas of Rutland identified as more deprived (according to IMD) and high prevalence of tooth decay.

Each year the National Child Measurement Programme measures children in reception class and year 6. From this robust information on the level of healthy weight and excess weight of children is determined. We have looked at this data over several years and compared it with data on tooth decay and families in poverty or claiming out of work benefits. This has shown some correlation between areas of high tooth decay and excess weight in year 6 and children in families in poverty or claiming out of work benefits as shown in the maps in the attached appendix. However, this is just a snap shot for 2015/16 and it should be noted that long term unemployment doesn't show similar correlation. Data indicates that few people appear to become long term unemployed in Rutland.

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[3] www.ruralhealthgoodpractice.org.uk

[4] SMR **Standardized Mortality Ratio** is a **ratio** between the observed number of deaths in an study population and the number of deaths that would be expected, based on the age- and sex-specific rates in a **standard** population and the age and sex distribution of the study population

[5] National Obesity Observatory

[6] Angela Donkin UCL institute of Health Equity 2013

[7] Oral health survey of five-year-old children 2013 PHE

[8] Oral health survey of five-year-old children 2015 PHE

Given the issues outlined above regarding significant difficulties in collecting small area data and identifying deprivation in sparsely populated areas using IMD and small area data we also looked at Mosaic to see if it could shed any further light on family life. A description of Mosaic is contained in the appendix**.** The largest proportion of households (4654) in Rutland are categorised as – 'Country Living' – affluent households. This is followed by 'Rural Reality' - 3,756 households 9,464 people who live in rural communities and generally own their relatively low cost homes. Their moderate incomes come mostly from employment with local firms or from running their own small business – 20% of these earn under £15k per year. Rutland also has 558 'Vintage Value' households (939) people, described as elderly people who mostly live alone, either in social or private housing, often built with the elderly in mind. Levels of independence vary, but with health needs growing and incomes declining, many require an increasing amount of support. A further 329 'Family Basics' households - 851 people are families with children who have limited budgets and can struggle to make ends meet. Their homes are low cost and are often found in areas with fewer employment options. Whilst there are a greater proportion of Rural Reality households in those areas of higher tooth decay and some cross over with children with excess weight, care should be taken with drawing any significant link between the two. *Please see map 6 in appendix.*

Links between poor diet & ill health

Evidence shows that diets high in sugar are a cause of tooth decay and obesity. Last year insight work was undertaken in Rutland to look into the potential causes of high tooth decay in the area. The insight work identified grazing/ snacking throughout the day as a common health behaviour which means that teeth do not effectively get a break from damaging acids which form in the mouth every time a sugary snack is eaten and the acids continue to affect teeth for at least 20 minutes.

Portion size and diets high in calories and limited physical activity are causes of obesity.
Key risk factors for diabetes are being overweight or obese. Evidence shows low-income and poor people more likely to have diabetes, and once they have it much more likely to suffer complications. Diabetes and obesity increases risk of coronary heart disease and stroke and certain cancers.

67.3% of adults in Rutland are estimated to have excess weight (2016) significantly higher than national average (64.8)[9] . 6.75% Rutland population aged 17+ (1,954 people) are diagnosed with Diabetes. This is significantly higher than the England average of 6.4%. It is unclear as to the exact reason for this higher prevalence and it may be as a result of better diagnosis by local GP's.[10] However, there is evidence that the rate of diabetes is set to rise to over 10% in Rutland over the next few years. *See Appendix for chart 1*

Whilst data from the Active People Survey suggest that people in Rutland are more active than the national average encouraging sedentary people to be more active on a daily basis can reduce body weight by about 5% and could reduce risk of getting diabetes by more than 50%. [11]

Smoking, poverty and poor health

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[9] Active People Survey 2016 -sample 1372 people
[10] 2014-15 Quality and Outcomes Framework Data
[11] NHS Choices - Reduce your diabetes risk

Smoking shows one of the clearest links between poverty/ low income and poor health and kills 80,000 people in England each year. Workers in manual and routine jobs are twice as likely to smoke as those in managerial and professional roles and unemployed people are twice as likely to smoke as those in employment. On average in Rutland, 14.1% of adults smoke, rising to 29.6% for 'Routine and Manual' workers[12]*. See map 7 in Appendices*

National data indicates that 3 out of 4 families who receive income support spend a seventh of their disposable income on cigarettes. Described another way; when expenditure on tobacco is taken into account, over half a million households, 850k adults and 400k children, are classified as in poverty in the UK compared to the official *Households Below Average Income figures*. Tobacco imposes a real and substantial cost on many low-income households. *This is clearly illustrated for Rutland in the chart 2 of Appendices to this report*.

In 2014/15, smokers in Rutland paid approx. £6.4m in duty on tobacco products. Despite this contribution to the Exchequer, tobacco still costs the local economy in Rutland roughly 1.5 times as much as the duty raised. This results in a shortfall of about £2m each year[13]

Research shows that smoking not only contributes to the social care bill but also has a significant impact on the wellbeing of smokers who need care on average nine years earlier than non-smokers. This is estimated to have cost circa £612k for social care for adults aged 50 plus 2012-13 in Rutland (622 individuals requiring additional social care)[14].

Helping disadvantaged smokers quit and interventions that focus on reducing levels of smoking are the best way to reduce health inequalities.

So what can a local authority achieve by reducing inequalities?

The Marmot Review on Inequalities [15] clearly identified that re-focusing solely on the most disadvantaged will not reduce health inequalities sufficiently and stated:

"To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism."

Marmot identified six policy objectives for action. These were:

- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention.

At a local level a range of services are provided to all on a universal basis and greater needs identified through universal services for those who need additional support. Examples either currently provided or planned include:

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[12] PHOF February 2016
[13] ASH Ready Reckoner Dec 2015 update. Version 5.3 (15 Jul 2016)
[14] PHE – Key data sources for planning effective tobacco control in 2017-18
[15] 'Fair Society Healthy Lives' (Marmot Review) 2010

- 0-19 Healthy Child Programme. 5 universal contacts, targeted additional partnership plus for those with additional needs. Includes oral health as a high impact area.
- National child measurement programme all children and targeted support offered to those identified with excess weight. Activity and food club.
- Supervised tooth brushing in pre-school settings to establish good oral health routines, use of pre-school and school food policies
- Working with employers of Routine & Manual workers to support them to give up smoking.
- Exercise and physical activity programmes with referral for additional needs by primary care staff to FaME falls prevention and GP Exercise on referral programmes.

Local authorities are uniquely placed to tackle health inequalities, as many of the social and economic determinants of health, and the services or activities which can make a difference, fall within their remit and poor health affects the economy and local services. For example: in England, the cost of treating illness and disease arising from health inequalities has been estimated at £5.5 billion per year. In terms of the working-age population, it leads to productivity losses to industry of between £31–33 billion each year. Lost taxes and higher welfare payments resulting from health inequalities cost in the region of £28–32 billion[16]
The rise in the state pension age – to age 66 by 2026 and 68 by 2046 – means many people who are disadvantaged will have to continue working while experiencing ill health or a disability. See figure 1 below. Keeping people well for longer should be a key goal for local authorities and this is recognised in the Rutland draft Joint Health & Wellbeing Strategy.

Figure 1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003

NICE outlines a number of areas where local authorities can achieve significant benefits for local people through their work to tackle poverty and inequalities[17] these include reducing premature deaths, improving the population health and creating happier healthier communities. A range of local authority services can help reduce social inequalities and improve health and wellbeing. These include environmental health, leisure, planning, education and transport. Interventions at

[16] 'Fair Society Healthy Lives' (Marmot Review) 2010
[17] NICE -HEALTH INEQUALITIES AND POPULATION HEALTH -LOCAL GOVERNMENT BRIEFING [LGB4] OCTOBER 2012

different stages of people's lives can make a real and measurable difference. For example, providing support for children and families during the early years of their children's lives can help break the cycle of deprivation and poor health. Local authorities can also encourage and support community-level action that strengthens positive relationships and networks by building trust and reciprocity ('social capital'). This can benefit everyone.
With healthier peoples there is potential to reduce costs to public services in the longer term with fewer people needing health and social care support.

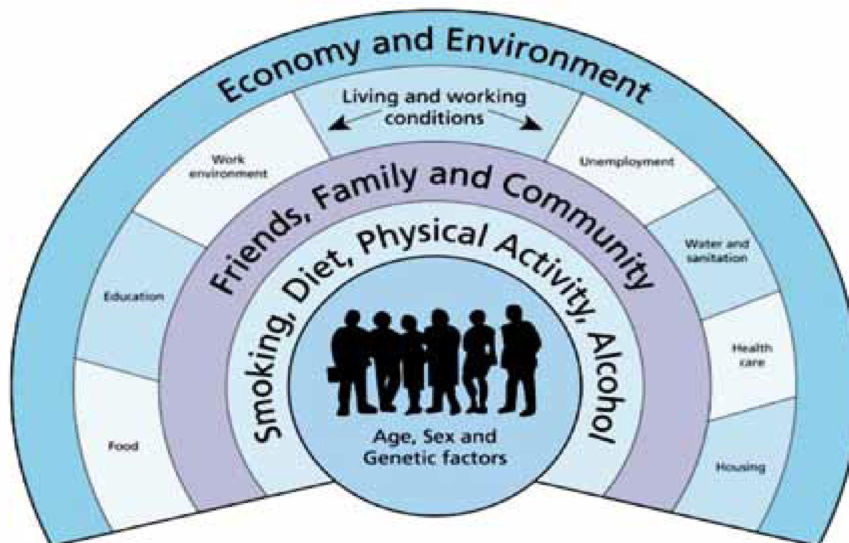
Areas to Consider

Scrutiny panel may wish to consider the following options for action in more detail:

- The balance of universal services versus targeted and ‛proportionate universalism’
- Considering the role of the local authority as a leader on tackling health inequality, as an advocate for others to do so and as a partner with other agencies in achieving this. What and how might this happen?
- Ensuring that health is considered in all Rutland Council policies
- Incentives – e.g. free physical activity programmes or paying people to quit smoking
- Further ways the local authority can support communities to help themselves – social capital
- Physical activity as the best medicine – a cure for most ill’s. Sedentary lifestyles – how to reach the most inactive and support the poorest to access these.

Appendix A (1) – backing data

The World Health Organisation defines health as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"*.



1. **Factors that influence health** *Source: Dahlgren and Whitehead 1992*

Marmot 2010 Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.

2. Health Inequalities and how deprivation is measured

Health inequalities incorporate differences in how 'healthy' people are and not simply how long they live. Inequalities arise due to complex and interrelated factors such as upbringing, education, employment history, income, and lifestyle choices such as smoking. The wider determinants of health are described and measured within the English Indices of Deprivation. These are a group of measures which gauge different aspects of deprivation.
The Index of Multiple Deprivation (IMD) 2015 is the official measure of relative deprivation for small areas (or neighbourhoods) in England.
The IMD ranks every small area in England from 1 (most deprived area) to 32,844 (least deprived area). The small areas used are called Lower-layer Super Output Areas (LSOA). They are designed to be of a similar population size with an average of 1,500 residents each and are a standard way of dividing up the country.

The indices of deprivation use several measures in each of seven domains:
Income deprivation, including Income deprivation affecting children (IDACI) and Income deprivation affecting older people (IDAOPI);
Employment deprivation;
Health deprivation and disability;
Education, skills and deprivation;

Barriers to housing and services;
Crime domain; and
Living environment deprivation domain

The measures are combined into an overall measure of the amount of deprivation in an area called the Index of Multiple Deprivation (IMD). The IMD allows the identification of the most and least deprived areas in England and to compare whether one area is more deprived than another. They are collated by quintile where 1 is most deprived and 5 is least deprived.

Mosaic segmentation

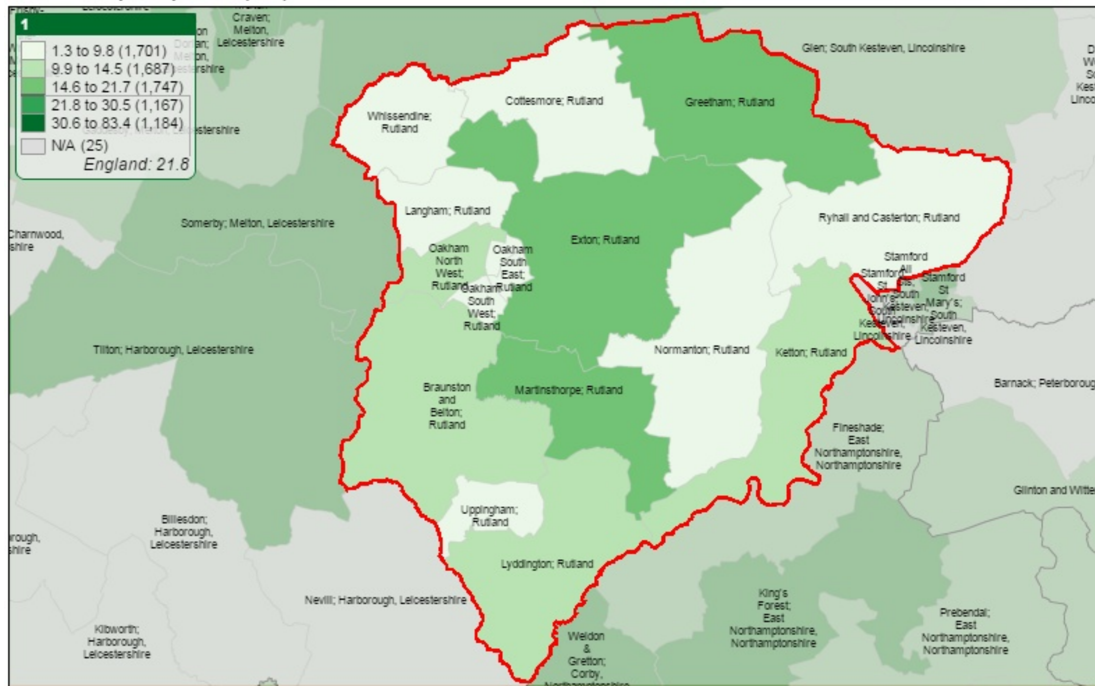
Produced by Experian Mosaic uses data from many sources to group and segment households into 15 groups and 66 types and updates constantly.

	Households	Population	Postcodes
A - Country Living	4,654	11,001	487
G - Rural Reality	3,756	9,464	256
H - Aspiring Homemakers	1,557	3,951	105
B - Prestige Positions	1,339	3,285	94
D - Domestic Success	1,100	2,757	40
U - Unclassified	0	1,704	74
E - Suburban Stability	456	1,073	18
L - Transient Renters	515	992	28
N - Vintage Value	558	939	31
M - Family Basics	329	851	10
F - Senior Security	399	781	26
J - Rental Hubs	199	316	16
K - Modest Traditions	145	315	9
I - Urban Cohesion	23	39	4
C - City Prosperity	3	8	1
O - Municipal Challenge	0	0	0

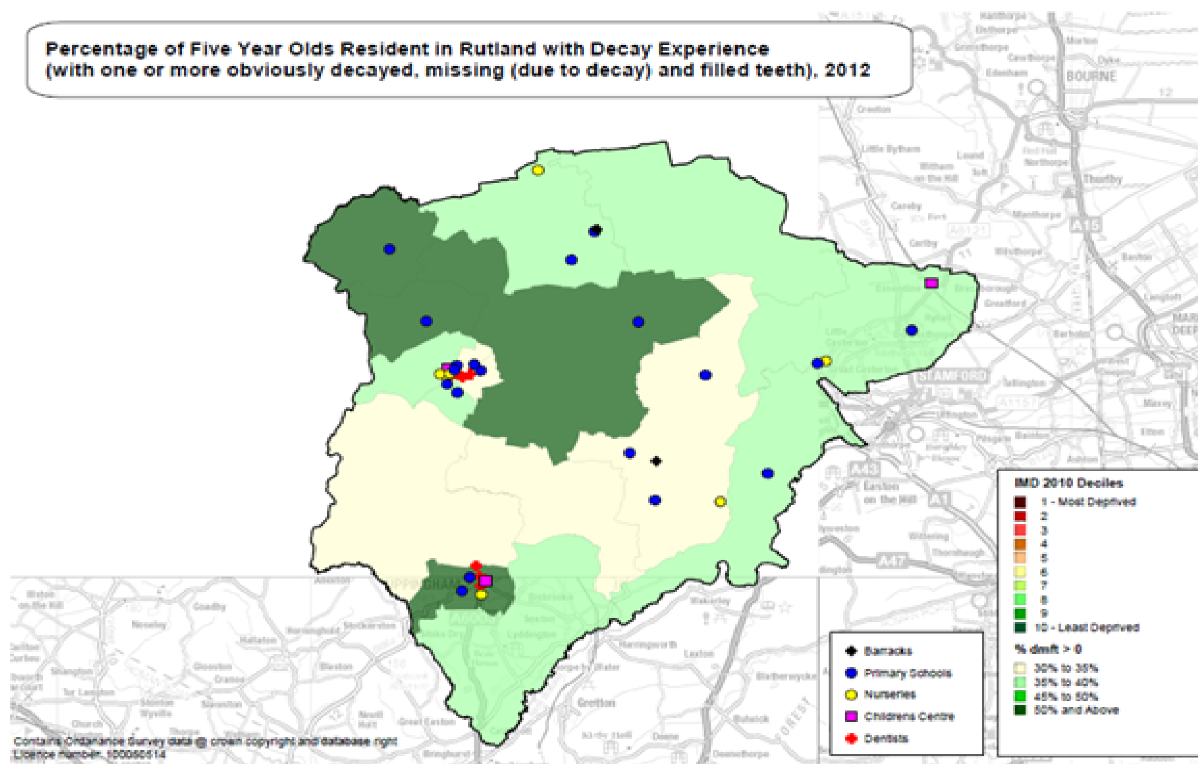
For more detail on each of the mosaic categories go to: http://www.experian.co.uk/marketing-services/knowledge/videos/mosaic-videos.html

3. Maps

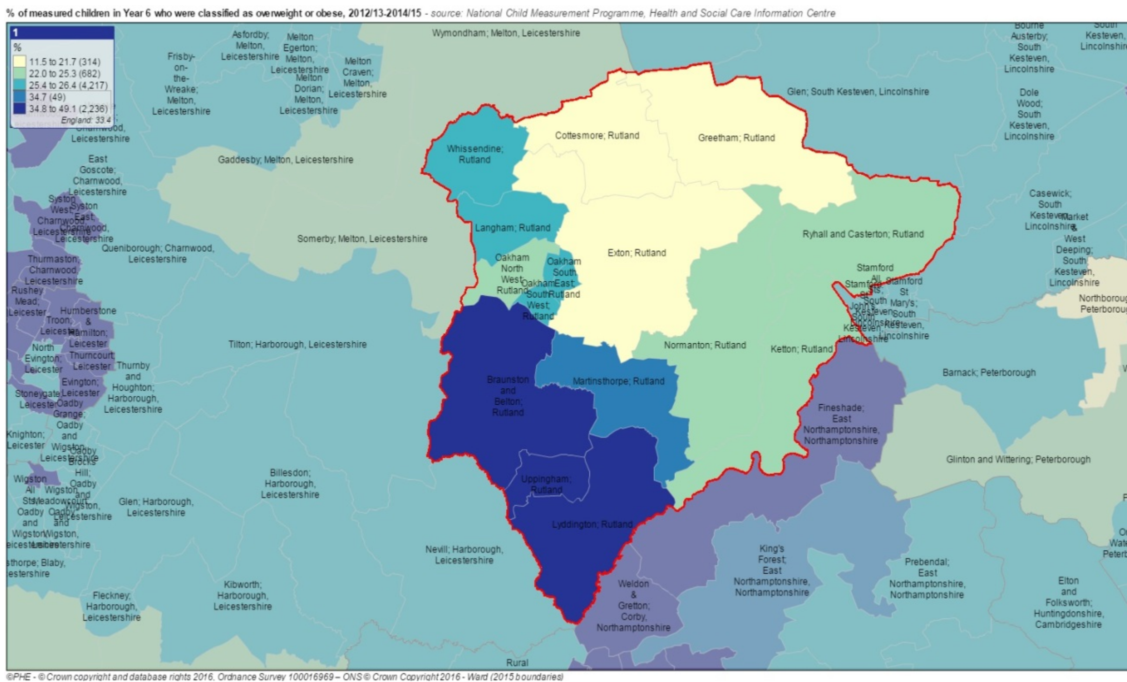
Index of Multiple Deprivation (IMD) Score 2015



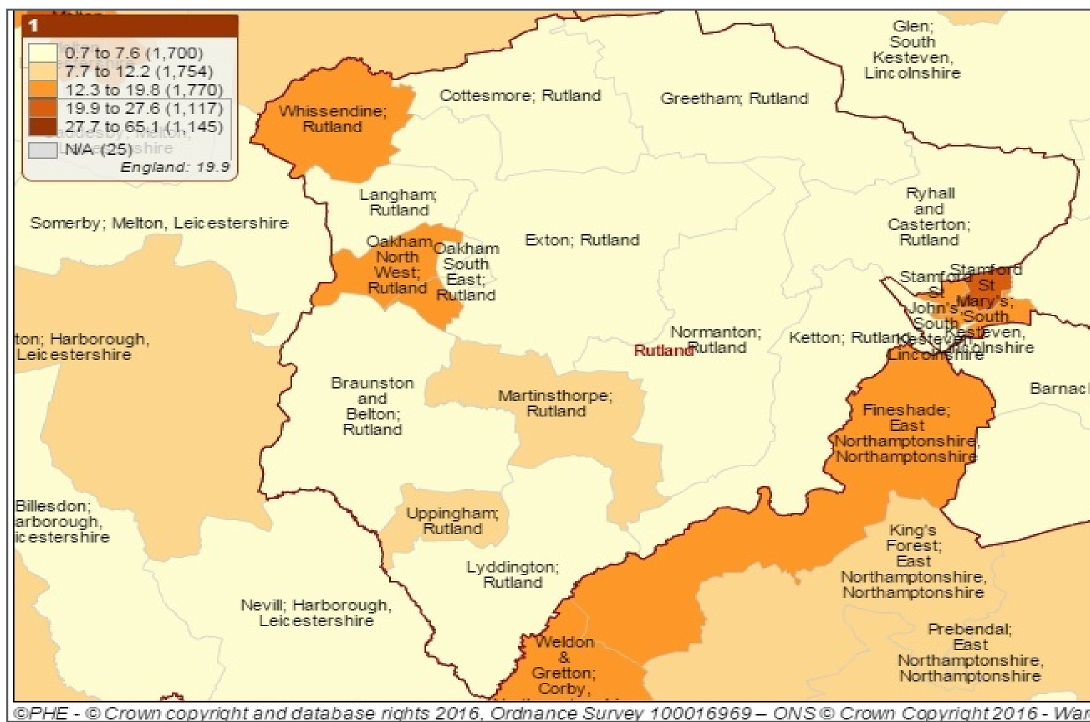
©PHE - © Crown copyright and database rights 2016, Ordnance Survey 100016969 – ONS © Crown Copyright 2016 - Ward (2015 boundaries)



Map 3. % year 6 children with excess weight – 2012-13 – 2014-15



Map 4. Children 0-15 living in income deprived households 2015



Map 5. % of working age population claiming out of work benefit 2015/16

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Map 6. Mosaic Map of Rutland Households

Rutland Postcodes by Mosaic Sector Group

- A Country Living (487)
- B Prestige Positions (94)
- C City Prosperity (1)
- D Domestic Success (40)
- E Suburban Stability (18)
- F Senior Security (26)
- G Rural Reality (256)
- H Aspiring Homemakers (105)
- I Urban Cohesion (4)
- J Rental Hubs (16)
- K Modest Traditions (9)
- L Transient Renters (28)
- M Family Basics (10)
- N Vintage Value (31)
- U Unclassified (74)

Produced by the Strategic BI Team, Leicestershire County Council. Contains Ordnance Survey d
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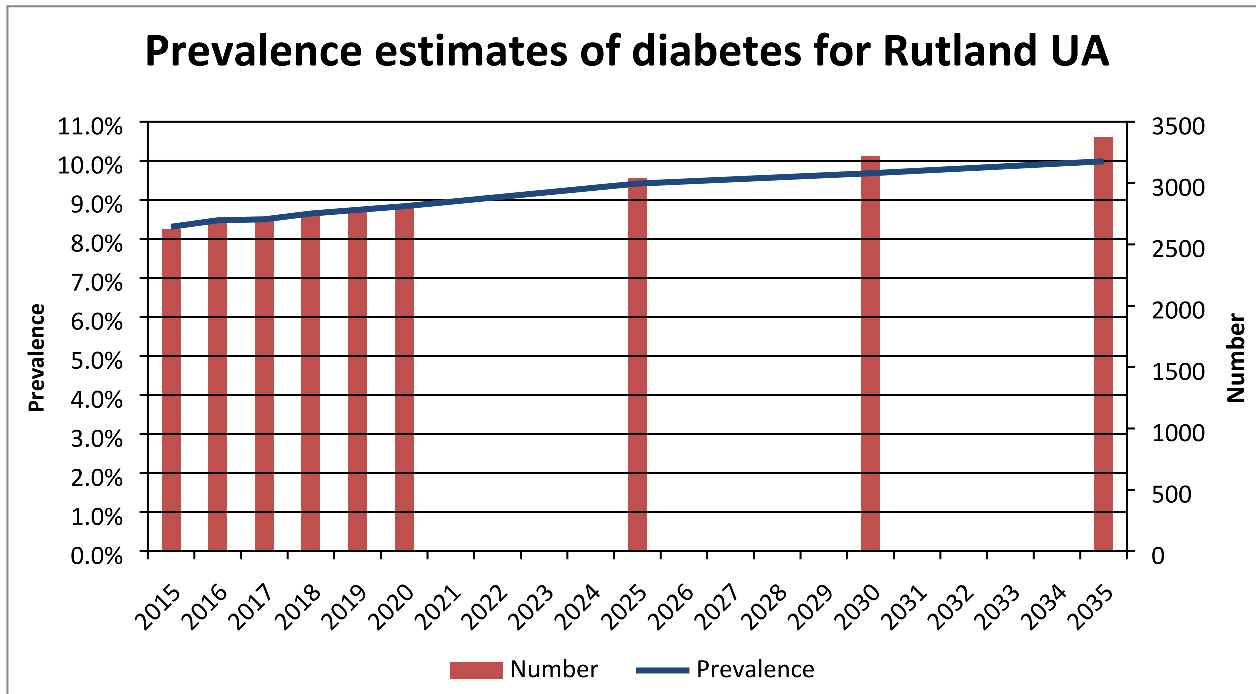
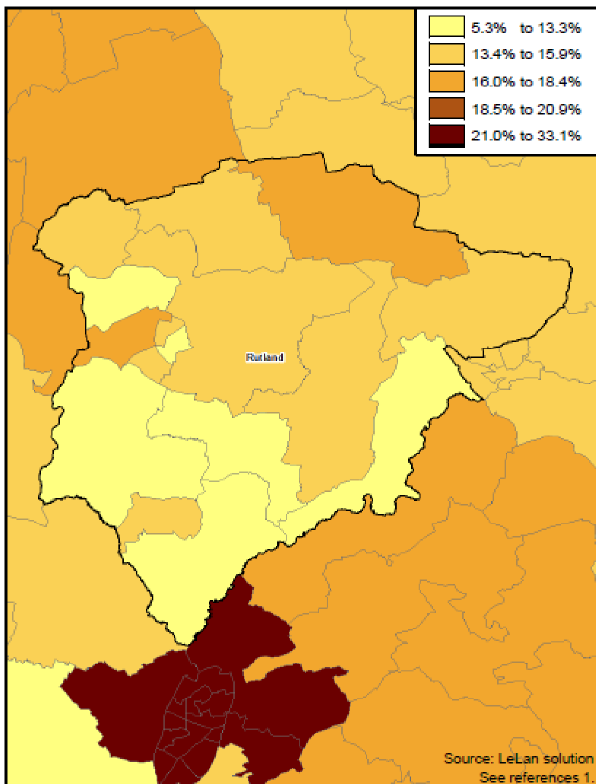
Produced by Divya Patel on 14/11/16

Chart 1. Diabetes is set to rise



Map 7 Smoking Prevalence - Rutland

Smoking prevalence 18+ (Ward level)



Smoking prevalance 18+ routine and manual (Borough level)

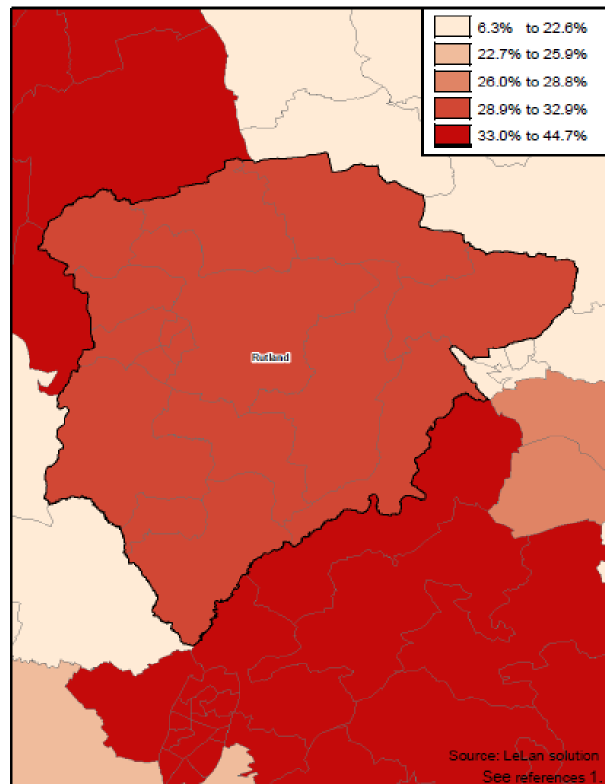
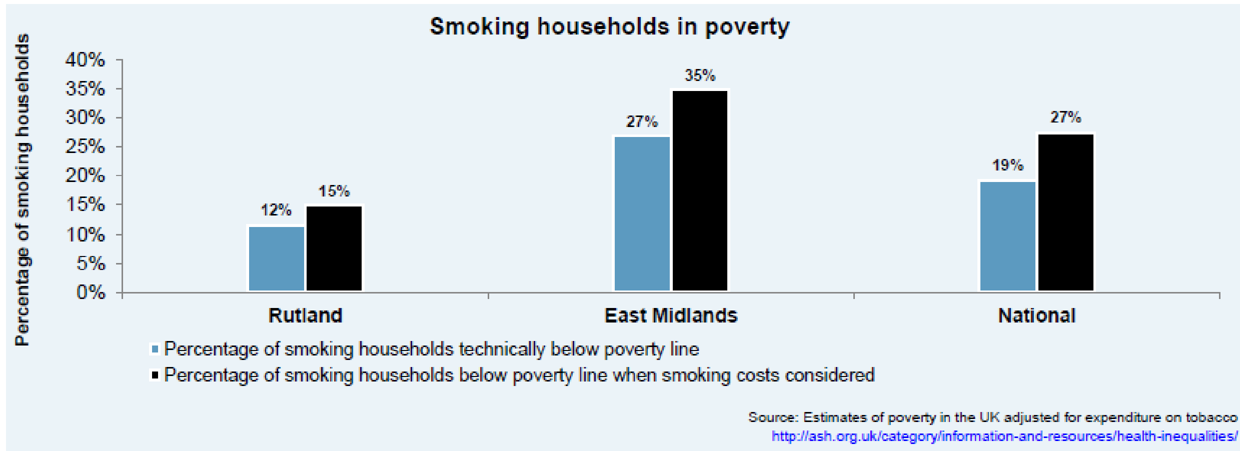


Chart 2



Appendix B. Access to Services

People (Adults & Health) Scrutiny Panel meeting, 1st December 2016

Inequality of Access to Services

Discussion Provided by Healthwatch Rutland

Background

The Council have agreed to undertake a review of poverty in Rutland. Healthwatch Rutland, as the statutory function responsible for acting as an independent health and social care watchdog, has been asked to consider issues of inequality in accessing health and social care services.

According to The King's Fund 2015 report 'Inequalities in Life Expectancy'

"Our health as individuals, and as communities, is influenced by many factors – our family background, our lifestyles, the health and other services we receive and the wider physical, social and economic environment in which we are raised, live and work."

This discussion paper focusses on the health and other services we receive and the difficulties certain groups have in accessing these services in a Rutland context.

Definitions of Poverty – The Rutland Context

The rural nature of Rutland means that even when people live above national levels of poverty, the cost for them of accessing services from a distance can be prohibitive. This is compared to people on lower incomes able to access services in an urban environment more cheaply and easily.

With a demographically older population that than other nearby areas, the issue of older people's deprivation, in terms of accessing services must be considered. Again, this group of people may have incomes that are above national poverty levels, but living in a rural location, or having to travel further for acute hospitals and other services, may mean that accessing transport may be cost prohibitive or physically difficult.

The charity sector in Rutland has identified that being poor in an area such as this, where there is considerable affluence, can be an issue for people accessing services. Feeling disadvantaged can be a disincentive for people accessing services.

Living with disabilities in a rural environment can also add another layer of disadvantage.

Access to Information

Ensuring that information is received and used by hard to reach groups requires investigation into the best way of conveying this information; is it by written material, electronic resources, face to face via appropriate networks or in other ways?

There is often an assumption that everyone has access to internet services to find information on services. This means that anyone unable to access the internet, either

through a lack of equipment or a lack of knowledge, is at a disadvantage in gaining information on what services are available to them and how to access them.

There is also an important question around ensuring that information aimed at those at the lower levels of the economic scale can understand the information that is being shared. Health literacy can be defined as 'the personal characteristics and social resources needed for individuals and communities to access, understand, appraise and use information and services to make decisions about health.'(WHO, 2015). Research has shown that low levels of health literacy are linked to higher mortality and higher rates of illness. In addition, it has been shown that low health literacy levels are strongly linked to social determinants such as poverty (http://www.healthliteracy.org.uk/). Research published by the British Journal of General Practice in 2015 shows that between 43 percent and 61 percent of English working age adults do not understand health information (Rowlands et al, 2015). Are there sections of the population in Rutland with low health literacy who are not even aware of services that may be available to them?

Possible questions:

1. How do we ensure that people can access appropriate information about services?
2. How do we address issues of Health Literacy in the poorer and other sections of the community?

Social Isolation

“Most governments and policy makers define poverty by income. Yet poor people often define poverty more broadly, such as lack of education, health, housing, empowerment, employment, personal security and more. No one factor is able to capture all the aspects that contribute to poverty, making poverty a multidimensional concept. One dimension of poverty that has been often overlooked is connectedness. Social connectedness is an important missing ingredient of multidimensional poverty, with social isolation being a central component” (Samuels et al, 2014).

The very nature of rural communities can lead to social isolation. We know that social relationships, norms and networks, and the absence of them, have an impact on the development of and recovery from health problems such as heart disease (Kim et al 2014). Given the demographics of Rutland, the King’s Fund publication ‘Improving the Public’s Health’ (Buck and Gregory 2013) found that the corrosive effect of the lack of community and networks on the health of older people was a bigger risk factor for health for this group than either moderate tobacco smoking or obesity. Therefore, it can be seen that access to services to reduce isolation are important.

Possible Questions:

1. How do we access people who are isolated?
2. How do we ensure that isolated people are able to access services?

Transport

Public transport links in a rural population are minimal compared to an urban environment. Those living on lower incomes may not have access to a car, and public transport services may not be sufficient to allow people sufficient access to health and social care services.

In addition, those with a disability may encounter further barriers to transport. This includes those with hearing or sight impairments that may limit their ability to access transport information.

If the cost or difficulty of accessing transport is a factor for people accessing services, it becomes even more important for services to be joined up so that multiple journeys are not required.

Possible questions:

1. How do we address issues around transport to services for people living on limited incomes in rural locations?
2. How do we ensure people in rural locations are aware of transport services available for them to access health and social care services?
3. Are there opportunities for services to go to people with limited means to access transport themselves?

References:

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Appendix C. Additional Data - Citizens Advice and South Lincolnshire Food Bank

Council Tax Support – Total Number of claimants 2015-16			
Ward	**Pension Age**	**Working Age**	**Total**
Braunston and Belton	25	19	44
Cottesmore	59	52	111
Exton	41	36	77
Greetham	26	21	47
Ketton	72	53	125
Langham	37	24	61
Lyddington	23	16	39
Martinsthorpe	31	16	47
Normanton	66	42	108
Oakham North East	87	95	182
Oakham North West	118	193	311
Oakham South East	106	55	161
Oakham South West	62	62	124
Ryhall and Casterton	93	51	144
Uppingham	145	172	317
Whissendine	28	21	49
Total	**1019**	**928**	**1947**

Council Tax Support – Total Number of claimants with children 2015-16			
Ward	**Pension Age**	**Working Age**	**Total**
Braunston and Belton		6	6
Cottesmore		30	30
Exton		20	20
Greetham		9	9
Ketton		29	31
Langham		13	13
Lyddington		6	6
Martinsthorpe		8	8
Normanton		22	22
Oakham North East		39	39
Oakham North West		108	108
Oakham South East		25	25
Oakham South West		45	45
Ryhall and Casterton		37	38
Uppingham		77	77
Whissendine		14	14
Total		**488**	**491**

Housing Benefit – Total Number of claimants 2015-16			
Ward	**Pension Age**	**Working Age**	**Total**
Braunston and Belton	29	22	51
Cottesmore	59	53	112
Exton	42	33	75
Greetham	25	22	47
Ketton	73	56	129
Langham	37	25	62
Lyddington	23	17	40
Martinsthorpe	34	15	49
Normanton	67	41	108
Oakham North East	87	105	192
Oakham North West	114	221	335
Oakham South East	102	66	168
Oakham South West	64	67	131
Ryhall and Casterton	96	57	153
Uppingham	144	180	324
Whissendine	27	28	55
Total	**1023**	**1008**	**2031**

Housing Benefit – Total Number of claimants with children 2015-16			
Ward	**Pension Age**	**Working Age**	**Total**
Braunston and Belton		9	9
Cottesmore		30	31
Exton		17	17
Greetham		11	11
Ketton		34	36
Langham		15	15
Lyddington		8	8
Martinsthorpe		8	8
Normanton		25	25
Oakham North East		49	49
Oakham North West		125	126
Oakham South East		28	28
Oakham South West		47	48
Ryhall and Casterton		39	39
Uppingham		90	90
Whissendine		18	18
Total		**553**	**558**

Food vouchers issued by Ward from Stamford food bank – April 1st 2016 to October 1st 2016				
Ward	No. Vouchers	Adults	Childrens	Total
All Saints Ward	40	62 (59.62%)	42 (40.38%)	104
Fineshade Ward, East Northamptonshire	3	6 (40%)	9 (60%)	15
Dole Wood Ward	3	4 (66.67%)	2 (33.33%)	6
Ketton Ward, Rutland	3	8 (57.14%)	6 (42.86%)	14
King's Forest Ward, East Northamptonshire	4	5 (100%)	0 (0%)	5
Market and West Deeping Ward	2	2 (100%)	0 (0%)	2
Glen Ward	6	11 (84.62%)	2 (15.38%)	13
NFA	31	36 (87.8%)	5 (12.2%)	41
Northborough Ward, Peterborough	1	2 (100%)	0 (0%)	2
Oundle Ward, East Northamptonshire	5	5 (100%)	0 (0%)	5
Bourne Austerby Ward	2	4 (100%)	0 (0%)	4
Ryhall and Casterton Ward, Rutland	7	11 (61.11%)	7 (38.89%)	18
St. George's Ward	33	36 (52.17%)	33 (47.83%)	69
St. Mary's Ward	80	118 (80.27%)	29 (19.73%)	147
St. John's Ward	3	5 (45.45%)	6 (54.55%)	11
Casewick Ward	1	2 (100%)	0 (0%)	2
Unknown	6	7 (26.92%)	19 (73.08%)	26
Totals	230	324	160	484