Leicestershire County Council

Director of Public Health Annual Report 2013

Health through the life cycle: Report 3 - Working Age Adults

Foreword

Public health aims to stop people from becoming unhealthy. This year, responsibility for public health transferred from the NHS to local government and I believe that, by being part of Leicestershire County Council, my team can make an even bigger difference to the health of the population. Our priorities are to tackle obesity, promote mental health and reduce the harm caused by alcohol and tobacco. We also want to reduce health inequalities, whether they are within particular areas or within particular social groups.

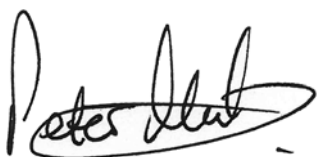Leicestershire is one of the healthiest places in England, but that overall picture masks certain issues and we're determined to tackle them. Being part of the council enables us to work more closely with key services such as education, social care and transport. Another advantage of being part of a council is that we will enjoy clearer, more direct links to the public.

Councillors sit on the health and wellbeing board, which helps to bring together councils and NHS bodies to set priorities and work together effectively. We work closely with the county council's cabinet member for health, to ensure our work fits in with the public's priorities and the decision-makers are aware of the opportunities to link up.

We are also keen to work closely with community forums and other council initiatives that encourage neighbourhoods to identify issues and consider how to solve them.

This is the first Director of Public Health's Annual Report to be published from our new base within the County Council. This report is the third report in a series of three looking at health and wellbeing issues through the life cycle, with a focus on working age adults. It reviews the key health issues that we need to address with our working age population to help people to enjoy longer healthier lives.

I would like to thank all of the people that have contributed to this report, particularly the staff in Public Health and Chief Executives at Leicestershire County Council, and the Health Protection Team and the Screening and Immunisation Team at Public Health England. I would particularly like to thank Janine Dellar whose hard work editing and coordinating this series of reports has been crucial.

Dr Peter Marks
Joint Director of Public Health Leicestershire and Rutland

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Introduction

1. Background

This is the last in a series of three reports from Leicestershire's Director of Public Health reviewing health across the life cycle. This report focuses on the health and wellbeing of working age adults. Earlier reports focussed on the health of children[1] and the health of older people.[2]

This report is supported by the Joint Strategic Needs Assessment (JSNA) for Leicestershire County Council.[3]

Adults form a large segment of the population. Choices and behaviours during adulthood can have profound impacts on people's health for the rest of their lives. Being in positive employment is a critical influence on health and wellbeing, and the public health challenges in adulthood include preventing chronic illness later in life.[4]

Taking into account the nature and quality of employment, there is strong evidence to suggest that work is generally good for physical and mental health and wellbeing.[5] For healthy people of working age, many disabled people, most people with common health problems and social security beneficiaries, work can be therapeutic and can reverse the adverse health effects of unemployment.[6]

Conversely, improving health is also important for increasing employment.[5] Particular groups of people have traditionally had lower chances of being in work, including disabled people, people with mental health conditions and people with long term conditions.[7]

The costs of working-age ill-health in the UK run to £100 billion per year – this is more than the annual budget for the NHS.[5] Around 172 million working days were lost to sickness absence in 2007, at a cost of over £13 billion to the economy.[5] Of these, the leading causes were mental health problems and musculoskeletal conditions.

In England, one in ten people provide unpaid care to relatives or friends, and 1.2 million people care for over 50 hours a week. In the 2001 census, carers providing high levels of care were twice as likely to report poor health compared with those who did not have any caring responsibilities.[8]

Towards the end of a person's working life diseases such as cancer start to form a significant proportion of all deaths. Early detection and diagnosis of cancer has a significant impact on health outcomes, and can be achieved through earlier symptomatic diagnosis or screening.

Note:

This report is a report on the health of Leicestershire's population. However, because public health transferred into the local authority in April 2013 the data is not always available for Leicestershire. Where the data is not available just for Leicestershire the report references data for Leicestershire County and Rutland (LCR).

2. Key health policy drivers

The transfer of responsibility for public health to local authorities, and the establishment of Leicestershire's Health and Wellbeing Board, is a real opportunity to work together across the wider partnerships for maximum health benefit. The key to this will be collaboration between the county council, district councils, Clinical Commissioning Groups (CCGs), the Leicester Shire Economic Partnership and other partners to facilitate development of local strategies for improving adult health and wellbeing.

Appendix A provides a summary of the new public health system.

Key documents:

"Our Health and Wellbeing Today",[4] emphasises the fact that health and wellbeing needs evolve throughout our lives and the need to consider the influences on health at all stages of the life cycle. This report emphasises the links between work and good health and the need to promote healthy lives throughout the life course to reduce premature mortality and support better health in later years.

"Healthy Lives, Healthy People",[9] the public health White Paper published in November 2010, proposes ways in which populations need to be supported to "live well", by increasing access to healthy choices. It also discusses the positive benefits to health of working and the government's plans to increase people's access to work. In addition to supporting people to find work, the paper discusses the need for employers to support their staff to be healthier.

"The Marmot Review, *Fair Society, Healthy Lives* – A Strategic Review of Health Inequalities in England post 2010"[10] drew attention to the evidence that social inequalities result in many lives being cut short and many people not living life to the full and enjoying opportunities open to them. The review reinforced the message that disadvantage starts before birth and accumulates throughout life. It suggests that the greatest return comes from addressing inequalities in childhood, however it is possible to work to address inequalities at any stage of the life course for a significant return in terms of population health outcomes.

"Working for a healthier tomorrow"[5], a review by Dame Carol Black (2008), looks at the health of working age adults, the role of health on people's ability to work, and the role of working in influencing health. The review set out three main objectives:

• Prevention of illness and promotion of health and wellbeing;

• Early intervention for those who develop a health condition; and

• An improvement in the health of those out of work – so that everybody with the potential to work has the support they need to do so.

3. Public health priorities in Leicestershire

Leicestershire County Council published its first Joint Health and Wellbeing Strategy (JHWS) for 2013-16 in December 2012.[11] This strategy was based on the evidence and analysis of the JSNA refresh completed in 2012.

The main aim of the strategy is to "add quality and years to life" by improving health throughout people's lives, reducing health inequalities and focusing on the needs of the local population.

The core of the strategy is to focus collective efforts on improving outcomes related to four priorities:

- Getting it right from childhood;

- Managing the shift to early intervention and prevention;

- Supporting the ageing population; and

- Improving mental health and wellbeing.

Central to the strategy is the need to work together across the wider partnership to deliver the best outcomes for the people of Leicestershire. In order to ensure that this happens, these four priorities are supported by a cross cutting theme:

- Tackling the wider determinants of health by influencing other boards.

This report focusses on working age adults and how the partnership can work together to manage that shift to early intervention and prevention. The key public health priorities that are considered in this report are:

- Health inequalities;

- Tobacco control;

- Healthy weight;

- Substance misuse[a];

- Sexual health;

- NHS Health Checks;

- Health at work; and

- Mental health.

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[a] In this report, the term substance misuse includes the misuse of alcohol, illicit drugs and Novel Psychoactive Substances (NPS), sometimes known as 'legal highs'.

Summary of Recommendations

Inequalities

- The Health and Wellbeing Board must work with the wider Leicestershire Together Partnership to influence:

  » Welfare support: working with the voluntary sector and other relevant partner agencies to ensure those most vulnerable to welfare reforms are supported and not disproportionately affected by welfare reforms. Also ensuring a smooth transition between benefits and returning to work;

  » Access to training and education: agencies should work together to make it easier for people from disadvantaged backgrounds and the long term unemployed to become trained, educated and gain relevant experiences in order to obtain and keep jobs;

  » Healthy workplaces: working in partnership with local businesses and enterprise to embed health protection and health promotion incentives into their workforce, creating a healthier and more productive workplace;

  » Getting people back to work: working in partnership with local enterprise and voluntary sector organisations to improve access to paid and unpaid work for the long term unemployed. This should include long term support programmes for people once they have returned to work;

  » Addressing equality and diversity: improve the quality and security of employment across Leicestershire and Rutland including ensuring public and private sector employers adhere to equality guidance and legislation.

Assets

- To adopt an assets based approach across Leicestershire and use this to influence commissioning of public health interventions;

- To increase the measurement and evaluation of assets within the JSNA for Leicestershire to underpin future commissioning decisions and influence the future development of the JHWS.

Tobacco control

- To help young people to resist taking up smoking and to motivate and support all smokers to quit, including through stop smoking services;

- To lobby the government to maintain support in implementing the *"Under the Counter"* legislation (Tobacco Advertising and Promotion (Display) (England) Regulations 2010) for tobacco products in small shops to begin in April 2015;

- To lobby the government to revisit their decision on standardised packaging of tobacco products.

- To encourage all smokers to Step Right Out and not smoke inside their home or car for the benefit of their loved ones;

- To address the problems of underage and illegal tobacco, through gathering high quality intelligence for trading standards, and increasing awareness and enforcement of the issue.

Healthy weight

- To ensure that future policies and planning decisions reduce the obesogenic environment[b] through county and district council partnership working, and to make physical activity and healthy eating an easier choice.

- To continue to develop population scale weight management services, delivered in creative and innovative ways for example, through partnership with commercial sector providers.

- To continue to build opportunities for routine daily physical activity into people's lives, through programmes for the whole population, as well as through targeted interventions to support the most inactive individuals to increase their levels of activity.

Substance misuse including alcohol

- To integrate into children and family services work to prevent substance misuse and intervene early when issues arise;

- To build the capacity of frontline staff in key organisations to deliver information and brief advice, particularly relating to alcohol;

- To share more of the treatment of substance misuse between specialist community services and GP practices;

- To focus on supporting recovery and reintegration, with an emphasis on understanding the resources that exist within communities to help to deliver this;

- To ensure the safe transfer of substance misuse treatment in criminal justice settings to the new provider of services.

Sexual health

- To ensure prevention of sexual ill-health is prioritised and developed in line with the latest evidence;

- To ensure information about sexual health and services is widely available;

- To continue to improve access to sexual health services for Leicestershire residents, and develop robust care pathways across sexual health and other relevant services such as alcohol and drug misuse services.

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[b] The term 'obesogenic environment' refers to 'an environment that promotes gaining weight and one that is not conducive to weight loss' within the home or workplace.

NHS Health Checks

- To commission a NHS Health Check programme that includes the new dementia awareness and alcohol auditing components;

- To ensure that all GP practices support the NHS Health Check programme;

- To develop a media campaign to increase uptake for NHS Health Checks;

- To consider other models and services for delivery of NHS Health Checks for hard to reach groups (such as pharmacies or health centres).

Health and work

- To deliver on the recommendations of Dame Carol Black's review, Working for a Healthier Tomorrow, through collaborative working with partners;

- To improve promotion of health and wellbeing and prevention of illness in the workplace;

- To improve provision of early interventions for those at work who develop a health condition;

- To address the additional health needs of those who are out of work;

- To help people who have not yet found work, or have become workless, to enter or return to work, with a special emphasis on 16 to 18 year olds who are classed as Not in Education, Employment or Training (NEET).

Mental health

- To work with partners to prioritise mental health and to deliver on the emerging mental health strategy;

- To strengthen mental health and wellbeing for all, thereby recognising that good mental health is more than the absence of mental illness;

- To address wider determinants of health and to enable individuals to fulfil their potential through partnership working across departments and agencies;

- To protect investment in prevention and tackle the wider determinants of health as the return on investment per pound spent in this area is good.

Health Protection

- To establish and operate a Health Protection Board that seeks to provide assurance to the local authorities in Leicestershire, Leicester and Rutland (LLR) about the adequacy of prevention, surveillance, planning and response with regard to health protection issues.

- To continue to assure that NHS England maintain high coverage and uptake of national immunisation and screening programmes

The health of working age adults

1. Demography

The 2011 Census reported:

- The population of Leicestershire in 2011 was 650,489; [12]

- In 2011, 400,968 people were aged 18-64 (62%) and 417,671 were aged 16-64 (64%);[12]

- The population of Leicestershire aged 18-64 is projected to increase 413,300 by 2021, an increase of 12,200 people or 3.1%.[13]

The **ethnicity** of the population of Leicestershire is included in the 2011 Census. This demonstrates that:[12]

- 595,000 people are from White ethnic backgrounds (91%);

- 41,000 people are from Asian ethnic backgrounds (6%);

- 4,000 people are from Black ethnic backgrounds (<1%);

- 9,000 people are from Mixed ethnic backgrounds (1%).

The **general health** status and the limiting **long term condition or disability** for people aged 16-64 reported in the 2011 Census indicates:[12]

- 354,000 people reported that they were in good or very good health (87%);

- 40,000 people reported that they were in fair health (10%);

- 12,500 people reported that they were in bad or very bad health (3%);

- 26,500 people have their activities limited a little by their condition or disability (7%);

- 16,300 people have their activities limited a lot by their condition or disability (4%).

2. Mortality in working age adults

In 2011 in Leicestershire, there were:

- 5,456 deaths for all residents;[14]

- 817 of these deaths were in people aged 16-64 years (15% of all deaths);[14]

- The main causes of death for this age group are (Figure 1):

  » Cancer (42%);

  » Cardiovascular diseases (23%);

  » External causes, such as road traffic accidents (11%);

  » Diseases of the digestive system (7%);

  » Respiratory diseases (6%).

Figure 1: Mortality by Cause in Leicestershire, 2011, Age 16-64
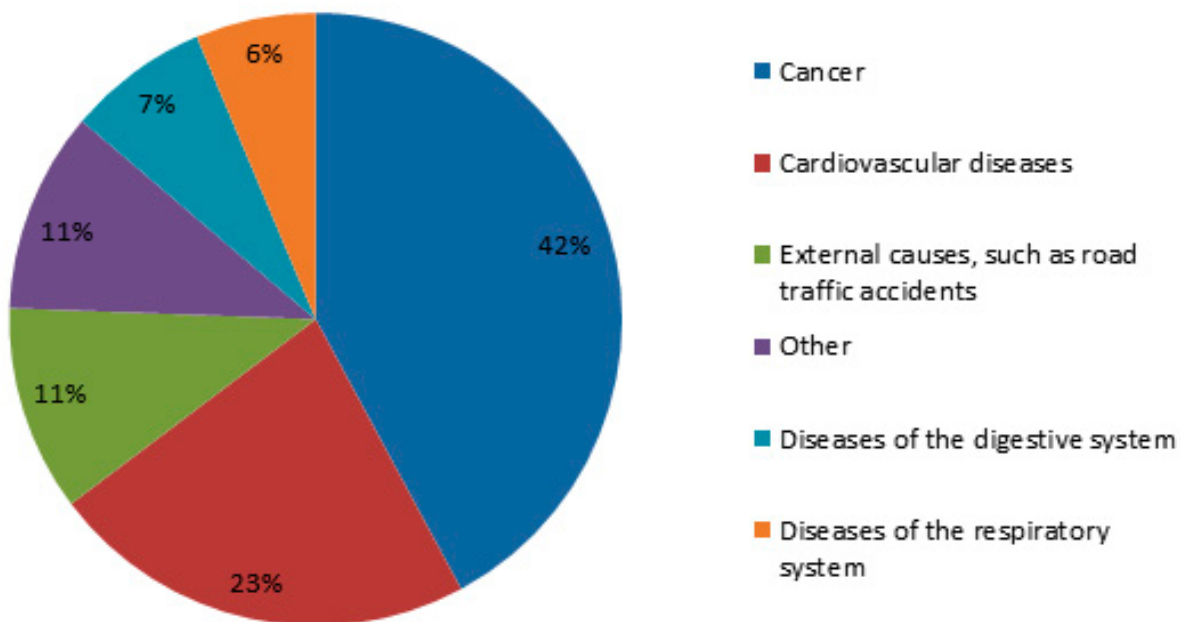
Source: ONS Public Health Mortality File

2.1. Longer Lives

Longer Lives is a major initiative of Public Health England that was launched on 11 June 2013 and can be accessed from: http://longerlives.phe.org.uk/.

The first phase of Longer Lives is a new website to illustrate how premature mortality (deaths under 75 years) varies between English local authorities, and to provide links to examples of how some of the most important causes can be reduced at population or individual levels.

Longer Lives displays premature mortality from all causes, cancer, heart disease and stroke, lung disease and liver disease.

The key findings for Leicestershire for premature mortality between 2009 and 2011, when compared with the national average are:

- Between 2009 and 2011 there were 5,355 premature deaths in Leicestershire;

- The premature mortality rate for Leicestershire is 236 per 100,000 population, this is significantly lower (or better than) the England rate;

- Leicestershire ranks 30 out of 150 local authorities in England (1=best and 150=worst).

The results for Leicestershire compared with the national average demonstrate that at a national level Leicestershire is performing very well. However, Leicestershire is an affluent area and it is important that we compare Leicestershire population with areas that have a similar socio-economic profile to assess how the area is comparing with similar areas ("peer groups").

Local authorities have also been allocated to ten groups according to their index of multiple deprivation, allowing their premature mortality rates to be compared with 14 other areas that have similar socio-economic status. The results for Leicestershire show:

- For all cause premature mortality, Leicestershire ranks 13th out of 15;

- The all cause premature mortality rate for Leicestershire is significantly higher (or worse) than the average for the peer group of local authorities.

- Leicestershire is the 13th most deprived of the 15 local authorities in this group, a key driver for premature mortality rates.

The headline results for the four most common causes of premature mortality in Leicestershire are summarised in Table 1.

Table 1: Longer Lives Summary

Cause	Number of premature deaths	Premature Death Rate per 100,000 population	Rank and Significance compared with England	Rank and Significance compared with peer group
All causes	5,355	235.6	30 ●✓	13●✗
Cancer	2,301	99.4	32 ●✓	12●↓
Heart disease and stroke	1,210	52.3	32 ●✓	13●✗
Lung disease	452	18.7	39 ●✓	13●↓(out of 14)
Liver disease	261	12.0	38 ●✓	10●✗(out of 14)

Source: Longer Lives http://longerlives.phe.org.uk/

Key: ● ✓ Significantly better than average

● ↑ Better than average

● ↓ Worse than average

● ✗ Significantly worse than average

The JHWS includes priority actions that will contribute to improvements in premature mortality across Leicestershire.

Cancer: Following a report to the Health and Wellbeing Board on cancer mortality it was agreed that the biggest issue in Leicestershire was early diagnosis of symptomatic cancer and a specific priority was added to the JHWS to reflect this. Screening performance in Leicestershire is good and it appears that treatment outcomes are also good once cancers are diagnosed. The key lifestyle factors that contribute to cancers: smoking, obesity and alcohol are also all included as priority actions in the JHWS.

Heart disease and stroke: The major preventative aspects of heart disease and stroke (smoking, obesity and alcohol) are identified as priorities in the JHWS, as are improvements in stroke care and management of long term conditions (including heart disease itself and diseases that increase the risk of heart disease and stroke such as diabetes and high blood pressure). The NHS Health Checks programme, now a mandatory service for local authorities, is aimed at early identification of disease and risk factors and the county council is working closely with the two CCGs in Leicestershire to increase the uptake of these checks.

Lung disease: Smoking is the biggest risk factor for lung disease and is a priority in the JHWS. The CCGs have both been very active in working with GP practices to improve the detection and management of chronic lung diseases.

Liver disease: Of the four disease areas in this report, liver disease has the lowest number of deaths and Leicestershire is below the England average. However, the number of deaths in Leicestershire appear to be increasing at a greater rate than in England as a whole, despite hospital admissions for alcohol related illnesses starting to decrease locally. The biggest risk factor for liver disease is alcohol, which is already identified as a priority area in the JHWS and has been the subject of intensive work through the community budgets programme.

Longer Lives identifies the key lifestyle interventions that contribute to these premature mortality rates. These are demonstrated in Table 2.

Table 2: Longer Lives common causes of premature mortality

	Cancer	Heart	Lung disease	Liver disease
Smoking	✓	✓	✓	
Alcohol	✓			✓
Obesity, poor diet and physical activity	✓	✓		✓
High blood pressure		✓		
Air pollution			✓	
Hepatitis				✓

Source: Longer Lives http://longerlives.phe.org.uk/

3. Hospital care for working age adults

Table 3 details the spend on hospital services commissioned by LCR Primary Care Trust (PCT) on behalf of Leicestershire residents in 2012/13. The total spend for Leicestershire residents in 2012/13 was £311 million, £142 million was spent on adults aged 16-64 years, 45% of total spend.[15]

Table 3: Hospital activity for Leicestershire residents in 2012/13 - all ages and 16-64 year olds

	All Ages		16-64 Year Olds	
	Activity	**Cost**	**Activity**	**Cost**
Hospital inpatient stays	164,00	£232 million	84,000	£99 million
Hospital outpatient attendances	660,00	£67 million	359,000	£36 million
Accident and emergency department attendances	127,000	£13 million	71,000	£7 million
Total hospital activity spend		£311 million		£142 Million

Numbers may not sum due to rounding
Source: HERA Health, Evidence, Reporting, Analysis, NHS Leicester, Leicestershire and Rutland

4. Long term conditions in adulthood

The prevalence of many common long term conditions increases with age. However, towards the end of their working lives adults are starting to be affected by the illnesses that will reduce their independence as they become older. The disease burden for a number of long term conditions for people aged 16-64 years is indicated in Table 4

Diseases have only been included where we can separate the working age adults from the overall data.

Table 4: Estimated number of people aged 16-64 years in Leicestershire with common long term conditions in 2010

	Number of people
Coronary Heart Disease	9,355
Coronary Obstructive Pulmonary Disease	7,536
Hypertension	86,355
Stroke	3,699

Source: APHO Estimates of disease prevalence

5. Estimates of care needs in adulthood

Projecting Adult Needs and Service Information (PANSI) can be found at www.pansi.org.uk. It gives access to projections of the numbers, characteristics and care needs of people aged 18-64 in England at national, regional and council level. This data demonstrates that by 2021, the working age population of Leicestershire is predicted to increase by 3.1%. Most of the predicted increases in adult social care needs from PANSI are in line with, or less than, this population increase. However, some characteristics and care needs are predicted to increase at a greater rate:[16]

- Profound hearing impairment predicted to increase by 7.4% by 2020;

- Moderate or serious physical disabilities by 4.1% by 2020;

- Moderate or serious physical care disability 4.3% by 2020;

- Young onset dementia 6.1% increase by 2020.

More detailed information is presented in the data appendix.

6. Health inequalities

Everyone in Leicestershire has a right to a long and healthy life. On the whole, the working age population of Leicestershire is affluent and healthy. Yet some working age people still unjustly experience worse health or die younger than others, because of who they are and where in Leicestershire they live.

Health inequalities are unjust differences in the health of our population. They stem from social inequalities, caused by disparities in the distribution of money, power and resources across our population. Many inequalities affecting the working age population will have been determined before birth. Inequalities become more established in each stage of life; growing in breadth and the extent of disadvantage caused. The accumulating effects of inequalities include worsening states of health and wellbeing for those disadvantaged at each life stage. This ultimately results in differences between those disadvantaged and the rest of society widening over a lifetime. Health inequalities allowed to perpetuate in our working aged population will result in poorer health outcomes in the future old age population.

Figure 2: Life expectancy and disability-free life expectancy at birth, persons by neighbourhood income level, England, 1999-2003
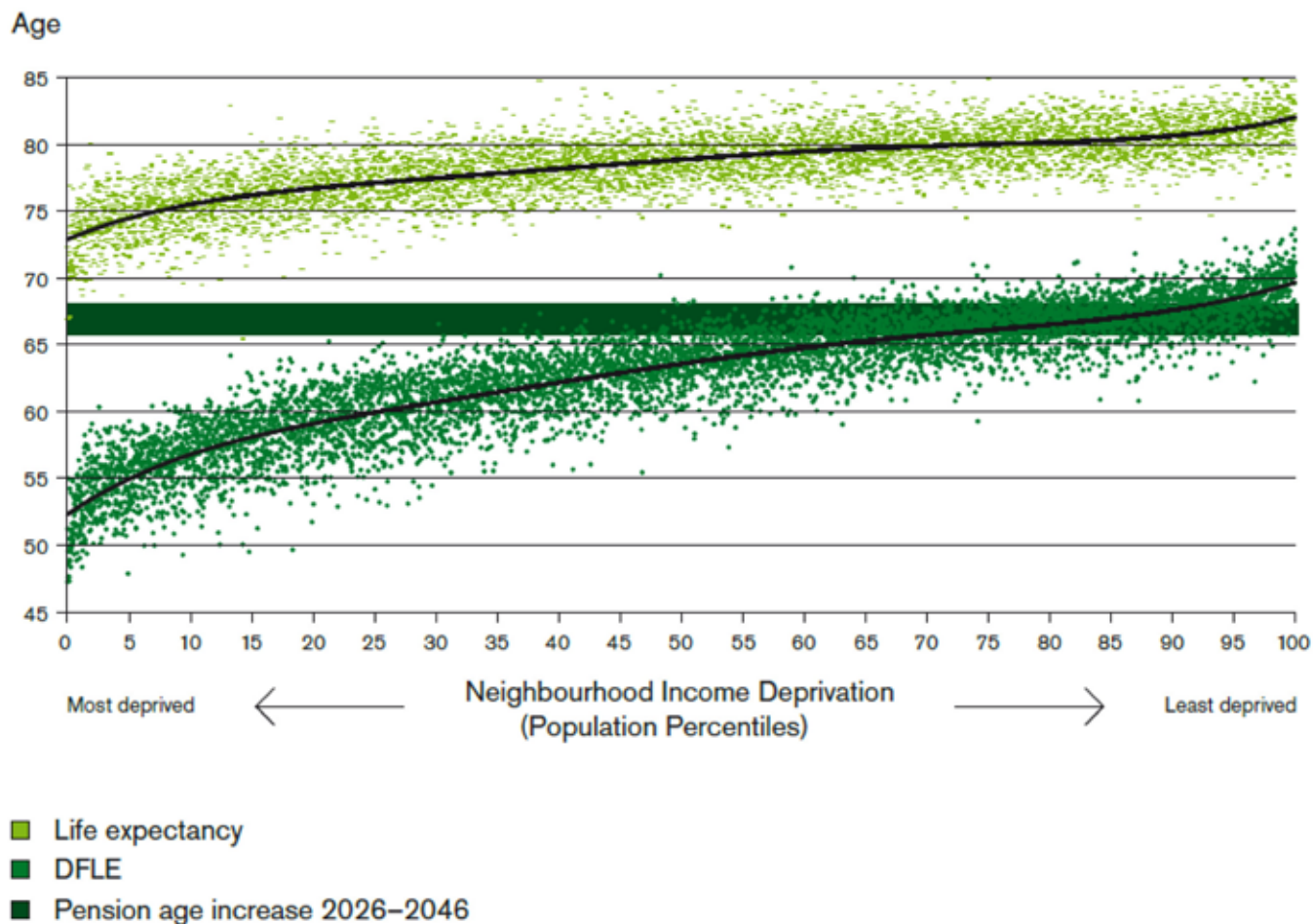
Source: Fair Society, Healthy Lives: Strategic review of health inequalities in England post 2010.

Health inequalities between deprived and non-deprived areas have grown in the last decade. Measures of inequalities consistently show that the higher a person's socio-economic status the better their health and the longer their life expectancy (Figure 2).

The Spirit Level by Wilkinson and Picket (2009) provides evidence that there is a relationship between income inequality and social problems in relatively wealthy societies where there are greater levels of income inequality.[17] The graph in Figure 3 illustrates that the UK has a high level of income inequality that is driving a range of health and social problems.

Figure 3: Correlation between income inequality and an index of health and social problems
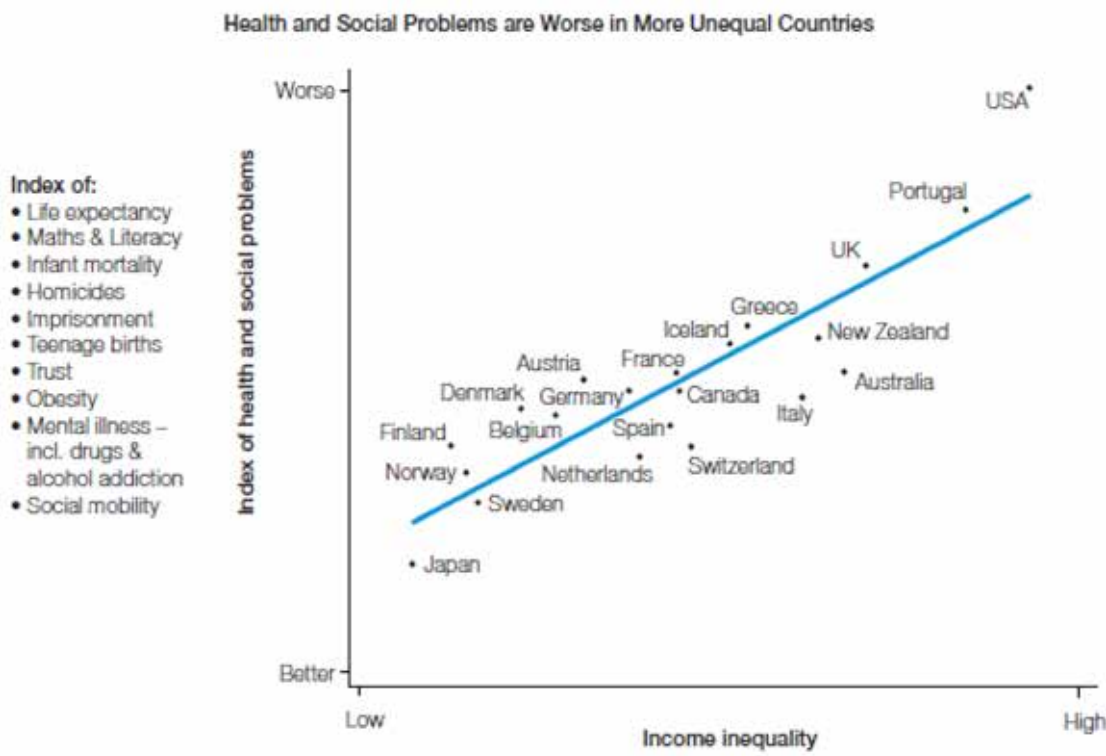
Source: Wilson and Pickett

As well as geographical and economic inequality, inequalities exist within specific population groups as a result of other forms of social exclusion. These groups can suffer worse health and experience difficulty in gaining access to health care. Examples include black and minority ethnic people (BME); disabled people; people with mental health problems; lesbian, gay, bisexual people and transgender people (LGBT); prisoners and offenders; gypsies and travellers; the homeless; asylum seekers and refugees. Additional risk factors for these groups can include poor support systems, isolation, substance misuse and unemployment. Examples of these health inequalities are included in Table 5.

Rural deprivation and rural health inequalities are important issues for Leicestershire. On average people in rural communities enjoy better health and wellbeing than their urban counterparts. However, many rural areas are characterised by high levels of inequality within them with real difficulties faced in many rural communities. Poverty, lack of services, poor public transport and traumatic social or economic changes at a local level are examples.

To reduce health inequalities our actions should focus on reducing the social gradient in health. Universal proportionalism advocates allocating resources in proportion to need, i.e. across the social gradient the intensity of investment should increase with need. Key drivers for health inequalities in working aged people are:

• Employment;

• Worklessness; and

• Income and the impact of welfare reforms.

Table 5: Examples of inequalities affecting different population groups

Group	Example of Health Outcome	Comment
BME Groups	Men born in South Asia are 50% more likely to have a heart attack or angina than men in the general population. Bangladeshis have the highest rates, followed by Pakistanis, then Indians and other South Asians.[18]	Classical risk factors like smoking, blood pressure, obesity and cholesterol fail to account for all these ethnic variations. Other factors include the long term impact of migration, racism and discrimination, poor delivery and take-up of health care, differences in culture and lifestyles, and biological susceptibility.
Learning disabilities	People with learning disabilities have poorer health than their non-disabled peers, differences in health status that are, to an extent, avoidable.[19]	All cause mortality rates among people with moderate to severe learning disabilities are three times higher than in the general population, with mortality being particularly high for young adults, women and people with Down's syndrome
Offenders	Adults and young people in contact with the criminal justice system are more likely to be socially excluded and experience high levels of health inequalities.	They are more likely to suffer from mental health problems and learning disabilities, and to have problems with drugs or alcohol. The link between offending, reoffending and wider factors, including health, is widely recognised.[3]
LGBT	Studies show that lesbian, gay and bisexual people show higher levels of anxiety, depression and suicidal feelings than heterosexuals.	Poor levels of mental health among gay and bisexual people have often been linked to experiences of homophobic discrimination and bullying.[20]
Gypsies and travellers	Gypsies and Travellers die earlier than the rest of the population and experience worse health, yet are less likely to receive effective, continuous healthcare.[21]	Gypsy and Traveller communities experience wide ranging inequalities and the lack of suitable accommodation underpins many of the inequalities that these people experience and a lifespan of experiencing racism and discrimination in education, access to health care, employment and other social and public contexts
Homeless	The average age of death of a homeless person is 47 (43 for homeless women), compared to 77 for the general population.[22]	Drug and alcohol abuse are particularly common causes of death among the homeless population, accounting for just over a third of all deaths. Homeless people are more than nine times more likely to commit suicide than the general population.
Asylum Seekers and Refugees.	Asylum seekers are one of the most vulnerable groups within our society, with often complex health and social care needs.[23]	Within this group are individuals more vulnerable still, including pregnant women, unaccompanied children and people with significant mental ill-health.[24]

Source: Leicestershire County Council Public Health Department

6.1. Employment

Working, whether paid or not, provides a wealth of health and social benefits to individuals, families and community. Employment can provide material gains (if paid), but also delivers social value, personal growth and fulfilment of aspirations leading to better mental and physical health.

Amongst our working population there are inequalities reflected and reinforced by differences in types of employment and in the level of control and reward in particular job roles. The type of employment has a gradient with socio-economic class and inequalities. Poorer people are more likely to be routine manual workers: characteristically these are more physically demanding jobs, with little legal, financial or emotional security or rewards.

Children who grow up in low-income or workless households are more likely to suffer worse health themselves, be workless and live in poverty when they become adults. The prevalence of psychiatric disorders among children in families whose parents have never worked is almost double that among children with parents in low-skilled jobs.[5]

6.2. Worklessness

People who are unemployed generally experience worse health compared to those in employment. The negative health effects of worklessness result from:

- Living in relative or absolute poverty;

- Being more likely to develop risky behaviours; and

- Increased risk of physical and mental health problems.

Education and retraining are key opportunities to get people back into the workplace and to sustain their position there. A clear gap exists between educational and training attainments at all ages across the social gradient. This increases the likelihood of school leavers from lower socio-economic groups not having the skills or education to secure or retain a job.

Case study - Leicestershire and Rutland Probation Health Trainer Service

A team of health trainers and health champions recruited from the 'offender' community to support offenders to improve their social and health status by:

1. Helping offenders register with GPs and dentists;

2. Working on a one-to-one basis with offenders developing a personal health plan and facilitating health improvement particularly around diet, fitness, smoking cessation and alcohol use and also addressing wider determinants of health including employment, income, benefits and housing;

3. Delivering group work sessions on general health and wellbeing issues to offenders attending the criminal justice drug treatment programmes (CJDT) or participating in offending behaviour group work programmes;

4. Participating in multiagency health promotion campaigns.

6.3. Welfare

The current economic climate and increasing cost of living present challenges for our population with more people affected by poverty both in and out of work. Half of working-age adults (and children) in poverty live in a working household.[25] The number of people in low-income, working households has grown almost every year, from 5 million in 2000/01 to 6.1 million in 2009/10, an increase of more than one-fifth in ten years.[25] Adults who do not work and those with low incomes are most likely to need support from our welfare state.

The current welfare reforms seek to more appropriately allocate welfare budgets to eligible claimants. This includes the introduction of a Universal Credits System, to replace the means tested benefit with affect from 2013.[26] Welfare cuts are likely to hit low-income households more than once, through changes to both income-related and housing benefits.[25] Welfare support is no longer concentrated in the social rented sector – the numbers of private renters in poverty are now as high, having doubled in the last decade.[25] Changes to disability benefit could also mean low-income disabled people being hit even harder.

During this period of economic down-turn and welfare reform it is important to ensure that the most vulnerable in our society are not disproportionately affected.

Recommendations

- The Health and Wellbeing Board must work with the wider Leicestershire Together Partnership to influence:

  » Welfare support: working with the voluntary sector and other relevant partner agencies to ensure those most vulnerable to welfare reforms are supported and not disproportionately affected by welfare reforms. Also ensuring a smooth transition between benefits and returning to work;

  » Access to training and education: agencies should work together to make it easier for people from disadvantaged backgrounds and the long term unemployed to become trained, educated and gain relevant experiences in order to obtain and keep jobs;

  » Healthy workplaces: working in partnership with local businesses and enterprise to embed health protection and health promotion incentives into their workforce, creating a healthier and more productive workplace;

  » Getting people back to work: working in partnership with local enterprise and voluntary sector organisations to improve access to paid and unpaid work for the long term unemployed. This should include long term support programmes for people once they have returned to work;

  » Addressing equality and diversity: improve the quality and security of employment across Leicestershire and Rutland including ensuring public and private sector employers adhere to equality guidance and legislation.

7. Leicestershire's working age assets

'A glass half-full', published by the Improvement and Development Agency on behalf of the Local Government Association in 2010[27] introduced the assets principles:

- Assets are any resource, skill or knowledge which enhances the ability of individuals, families and neighbourhoods to sustain their health and wellbeing. Assets can include such things as supportive family and friendship networks, community cohesion, environmental resources and employment security;[28]

- Assets approaches make visible, value and utilise the skills, knowledge, connections and potential in a community. They promote capacity, connectedness, reciprocity and social capital. The aim is to redress the balance between meeting needs and nurturing the strengths and resources of people and communities;

- Asset working seeks ways to value the assets, nurture and connect them for the benefit of individuals, families and neighbourhoods. Instead of starting with the problems, it starts with what is working, what makes us feel well and what people care about. The more familiar deficit approach starts with needs and deficiencies and designs services to fix the problem and fill the gaps.

Current evidence proposes that the important factors for life satisfaction are being happy at work and participating in social relationships. High income and occupational status are less important than have been previously believed.[29]

The importance of the quality of relationships both at work and at home needs to be recognised in the work environment. Work teams where there are good relationships between workmates are more productive and have lower levels of sickness absence. The same is true of working arrangements where allowance is made for giving support and care to family members.[29]

Mental wellbeing is a core asset, protecting and enhancing the lives of individuals and communities.[29]

There is a tendency to think about illness rather than wellness and to consider the things that make people ill, rather than the things that promote wellbeing. For example, when we are asked whether we are 'well', we tend to answer in terms of 'not being ill'. These immediate responses are reflected in two general tendencies in public health policy:[29]

- A tendency for the promotion of health and wellbeing to be framed largely in terms of the prevention of illness and injury rather than the promotion of wellness;

- A tendency for health policy interventions to be focused initially on encouraging people to withdraw from risk rather than on removing risk from the environment.

An assets approach to health and development encourages the full participation of local communities in the health development process. Assets can be viewed at individual, community and institutional levels, for example:

- Individual level might focus on building self-esteem and resilience for young people;

- Community level could look at social networks and community cohesion;

- The institutional level might examine how local authority transport planners could promote active transport and prioritise walking and cycling above other forms of transport.

Where to start?

Jane Foot outlines the ten key 'asks' to creating a whole system approach.[29]

1. Understand health as a positive state and its determinants as those factors that protect and promote good health and wellbeing, rather than describing health as disease and the risk factors for ill-health.

2. Describe the population's health through the assessment of assets, that is, looking at the presence of good health and wellbeing and indicators on what creates and influences good health, rather than needs assessment that only includes information on disease, death and risk factors for illness.

3. Map community assets. This would include the valuable resources and places, the strengths, knowledge and skills of people, understanding what the community define as assets using asset mapping approaches.

4. Sustain and build assets within communities through continuous community development and approaches that empower citizens and communities. Enable communities to connect and utilise their assets.

5. Assess individual strengths when working to improve personal outcomes (through services and personalisation) and provide interventions that release personal assets and build on people's strengths and the assets in their local community.

6. Community budgets and commissioning that builds on existing community assets and provides professional input to enhance assets and provide additional support where needed.

7. Adopt organisational development and service improvement approaches that appreciate and build on what's already working well.

8. Map health assets within and across organisations to understand the internal and external resources, skills and strengths.

9. Share and exchange assets between public, private and community bodies to improve efficient use of resources and give power to communities.

10. Research and monitoring that incorporates the evaluation and development of asset based outcomes, indicators and measures.

In 2012, the Leicestershire JSNA refresh included a chapter on assets in Leicestershire.[3] This report found that overall there are strong feelings of neighbourliness in Leicestershire. However, generally people in the 'rural' areas feel more positive about their neighbourhood, while those people from 'deprived areas' feel less positive about it.

Recommendations

- To adopt an assets based approach across Leicestershire and use this to influence commissioning of public health interventions;

- To increase the measurement and evaluation of assets within the JSNA for Leicestershire to underpin future commissioning decisions and influence the future development of the JHWS.

Improving the health of working age adults

Stopping smoking
The single most important thing you can do to improve your health.
You are up to 4 times more likely to quit if you get help from the NHS Stop Smoking Service. To find your local service call 0800 085 2917 or text LIFE to 80800.
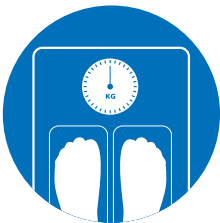
Maintain a healthy weight
Maintain, or aim for, a healthy weight (BMI 20-25). Eating a healthy diet - Eating at least 5 portions of fruit & vegetables each day and cutting down on fat, salt and added sugar is the most effective way to loose weight if you are overweight or obese.

Being physically active
Adults should aim to be active daily. Over a week, activity should add up to at least 150 minutes (2½ hours) of moderate intensity activity in bouts of 10 minutes or more, one way to approach this is to do 30 minutes on at least 5 days a week. Exercise is important for everyone in staying healthy and maintaining a healthy weight.

If you drink, keep within sensible limits
If you drink alcohol, have no more than 2-3 units a day (women) or 3-4 units a day (men), with at least 2 alcohol free days per week. You can use this website to calculate your units and keep track of your drinking: http://www.nhs.uk/Livewell/alcohol/Pages/Alcoholtracker.aspx

Look after your sexual health
This means enjoying the sexual activity you want, without causing yourself or anyone else any suffering, or physical or mental harm. Sexual health is not just about avoiding unwanted pregnancy or sexually transmitted infections - but using a condom will help with both.

Mental Health
Manage your stress levels. Talking things through, relaxation and physical activity can help. Have a good work/life balance. Developing interests outside of work can help reduce stress and improve productivity.

Source: The Picture of Ill-health in Warwickshire, Joint Director of Public Health Annual Report 2012

1. Tobacco control

Tobacco use is the single biggest cause of preventable deaths in England, killing over 80,000 people per year. This is greater than the combined total of preventable deaths caused by obesity, alcohol, traffic accidents, illegal drugs and HIV infections (Figure 4).

Smoking accounts for about half of the difference in life expectancy between those in the lowest and highest income groups.[10] One in every two regular smokers is killed by tobacco, and half of them will die before the age of 70, losing an average 10 years of life.[30]

Figure 4: Comparison of preventable deaths in England
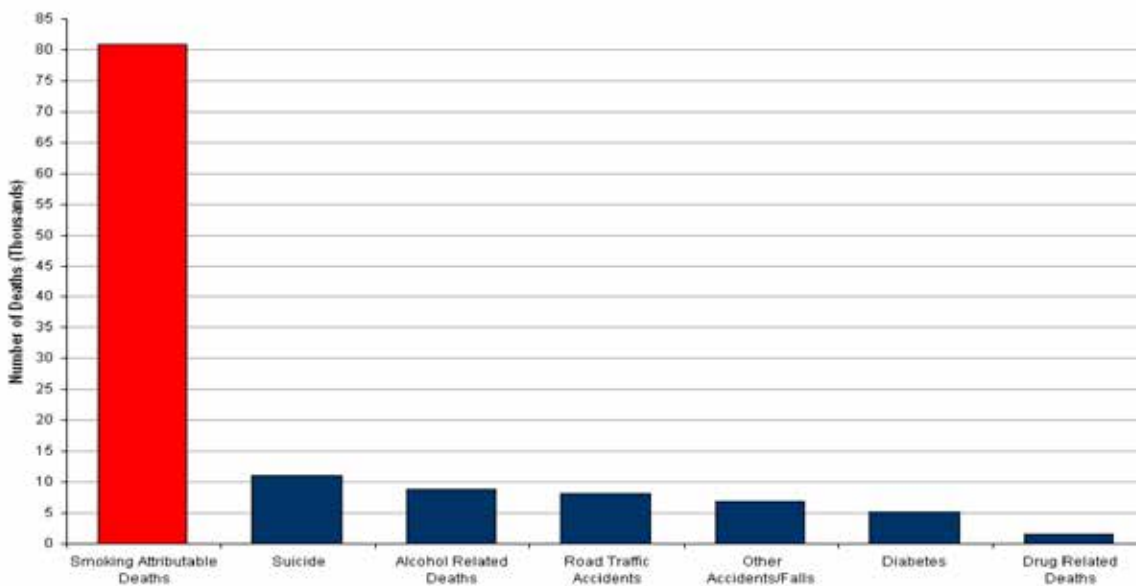
Source: A Smokefree Future, Department of Health, 2010

Key facts

- Approximately 17% of adults in Leicestershire smoke. This equates to approximately 88,300 people;[31]

- Between 2008 and 2010 there were an average of 884 smoking related deaths per year in Leicestershire;[32]

- In 2010/11 there were 5,227 hospital admissions attributable to smoking in Leicestershire.[33]

1.1. What we are doing locally

Tobacco-free Leicestershire and Rutland (TLR) is the local tobacco control alliance and has the agreed mission to reduce the prevalence, power and influence of tobacco through advocacy, education and community organisation. 2013/14 will see continued expansion of the tobacco free young person programme and an increased focus on illegal tobacco enforcement,[c] advocacy and programme evaluation. TLR has been in existence since 2011 and has been **CLeaR** (**C**hallenge, **L**eadership and **R**esults) accredited (a mark of excellence) since May 2012.

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[c] Illegal tobacco includes smuggled, bootlegged and counterfeit tobacco. Smuggled is generally legitimate tobacco that has evaded tax. Bootlegged is tobacco brought into UK illegally and without paying tax. Counterfeit is fake tobacco that is often made abroad and sold cheaply and tax free in the UK

TLR programmes include:

- Step Right Out (designed to encourage people not to smoke in their home or car);

- STOP! (the Stop Smoking service);

- The Tobacco Free Young Person programme (which uses a whole school approach to reduce tobacco use by young people);

- Underage sales test purchasing programme and illegal tobacco sales, both with trading standards.

Leicestershire continues to increase access to stop smoking services, both for the general population and with targeted activities in populations at greatest risk of smoking. This has been enabled by increasing the number of public sector employees trained in brief advice and interventions.

Adults smoking can have a significant impact on the health of their children. Children have the right to be protected from exposure to second hand smoke, which has a significant impact on the health of a child before birth, in childhood, and into adulthood.

Parents must recognise that passive smoking causes ill-health in children and that they have a responsibility not to harm their children. There is a high level of awareness about the impact of second hand smoke (SHS): 92% of adults are aware that exposure to SHS increases a child's risk of chest infections and 86% are aware of an increased risk of asthma.[34] People are less likely to be aware of the risks associated with cot deaths (58%) and ear infections (35%).[34]

The case for investment

- The annual costs of tobacco are estimated at: £146 million in Leicestershire:

Figure 5: The costs of tobacco in Leicestershire
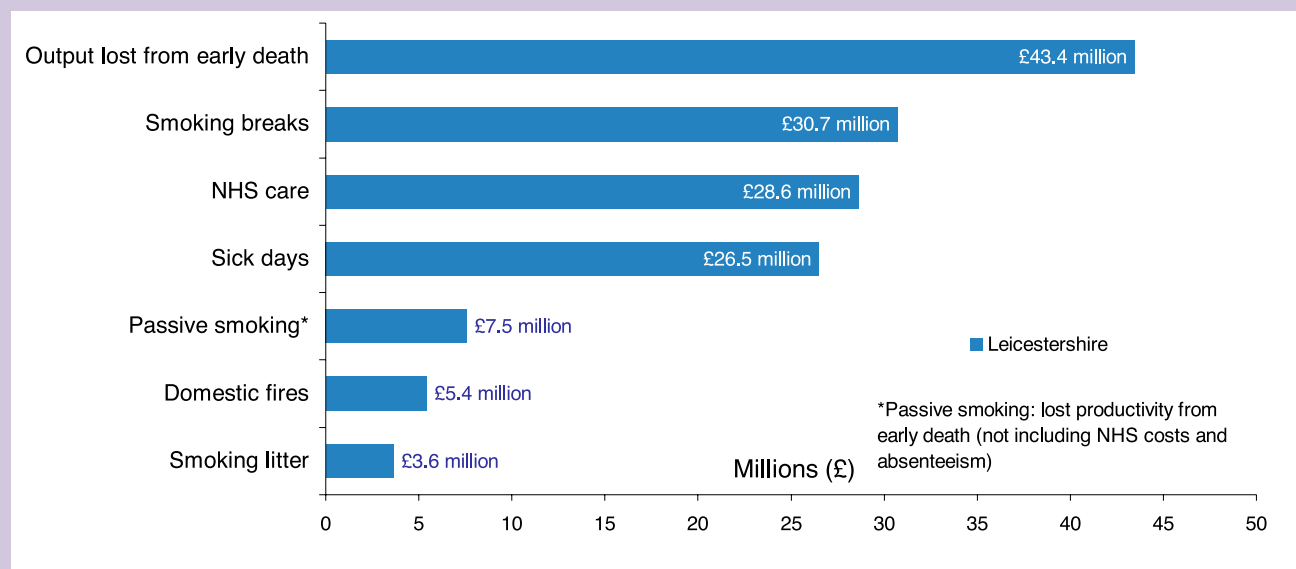
Source: ASH Ready Reckoner

Case study - Stopping smoking during pregnancy

Sarah is 24 years old, lives in Loughborough and is a smoker. She has an 18 month old child and is pregnant with her second child. Her partner also smokes. Her father has mental health problems.

Sarah did not stop smoking in her previous pregnancy as her first attempt led to an increase in symptoms of anxiety and depression. As a result she was really worried about attempting to stop in this pregnancy in case it triggered similar symptoms. However, with encouragement from her midwife she has been using the stop smoking service for four months. The service created a personalised programme for her, which included discussing how nicotine withdrawal can lead to anxiety and what can be done to manage this, such as regular use of nicotine replacement medication (NRT).

Sarah is now managing well as a non-smoker and is no longer using NRT. She says "One of the things that really made a difference was that the stop smoking service would continue to support me when life got really tough. I lapsed when my dad attempted suicide, but my advisor was always there to listen to me and get me back on track. She would text me when I needed advice between appointments. I also got regular tests to show how my carbon monoxide levels were decreasing."

Recommendations

- To help young people to resist taking up smoking and to motivate and support all smokers to quit, including through stop smoking services;

- To lobby the government to maintain support in implementing the *"Under the Counter"* legislation (Tobacco Advertising and Promotion (Display) (England) Regulations 2010) for tobacco products in small shops to begin in April 2015;

- To lobby the government to revisit their decision on standardised packaging of tobacco products.

- To encourage all smokers to Step Right Out and not smoke inside their home or car for the benefit of their loved ones;

- To address the problems of underage and illegal tobacco, through gathering high quality intelligence for trading standards, and increasing awareness and enforcement of the issue.

2. Healthy weight

Healthy weight, particularly tackling obesity, remains a high priority both locally and nationally, with recognition that this is a highly complex issue requiring a comprehensive, co-ordinated and sustained response. Two out of three adults are overweight or obese.[35] Around seven in ten people consume more salt than is recommended[36] (leading to an estimated one in three people with high blood pressure[37]); only three in ten adults eat the recommended five portions of fruit and vegetables a day;[36] only three or four in ten adults say they do the recommended levels of physical activity every week.[35]

Leicestershire County Council is committed to reducing the levels of obesity in the adult working population and is developing a long term strategy to address what is likely to be a major challenge for public health for the next 50 years.

Key facts

- Approximately 24.3% of adults in Leicestershire are obese. This equates to approximately 125,500 people (18+);[32]

- Approximately 30.3% of adults in Leicestershire report following a healthy diet. This equates to approximately 156,500 people (18+); [32]

- Approximately 11% of adults in Leicestershire report following the recommended levels of physical activity. This equates to approximately 58,600 people (16+).[32]

Addressing obesity requires a multi-faceted approach to change behaviours around physical activity, weight management, and food and nutrition. Underlying all of these is the requirement to fundamentally change the obesogenic environment in which we now live. The term 'obesogenic environment' refers to 'an environment that promotes gaining weight and one that is not conducive to weight loss' within the home or workplace. An example would be a sedentary desk-based job at a location that is only accessible by car. The physical environment we inhabit and how Government applies laws and regulations can strongly influence an individual's opportunities, as well as barriers, to eat healthily and be physically active.

The Foresight Report (2007) has mapped out the factors and systems that influence obesity.[38] This is illustrated in Figure 6. The diagram illustrates the complexity of the issues that are facing the population with respect to obesity and the challenges that commissioners face in working with the population and individuals to address obesity.

Figure 6: Foresight Obesity Systems map (FOSM)

Source: Tackling Obesity; Future Choices, Foresight Report. http://www.bis.gov.uk/foresight/our-work/projects/published-projects/tackling-obesities
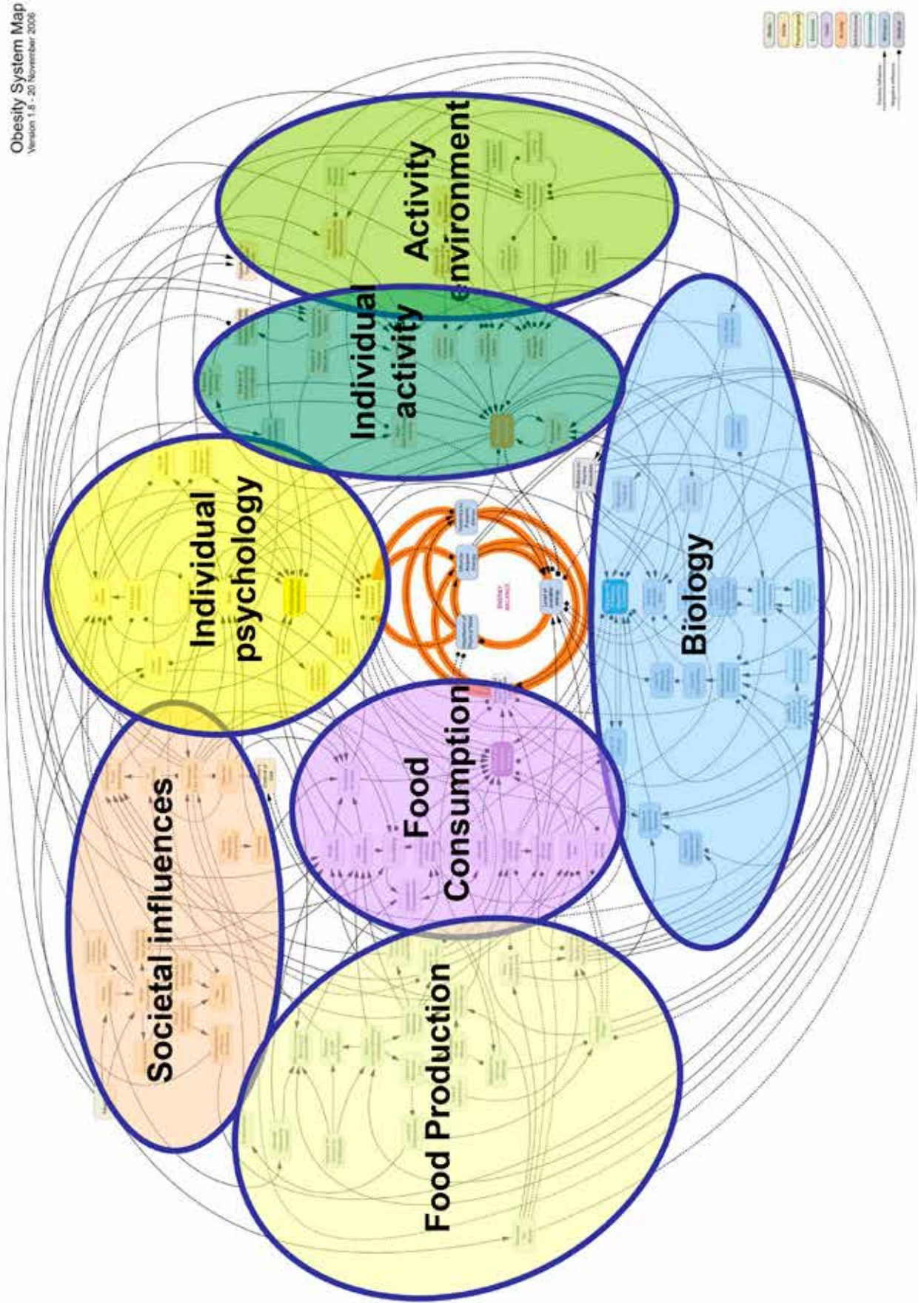
The case for investment

In 2007, the cost to the economy (including the NHS) of people being overweight or obese was an estimated £16 billion. This was predicted to rise to £50 billion a year by 2050, if the conditions were left unchecked.[38] The costs can be further broken down to:

- The direct cost of obesity to the NHS was £2.3 billion and the direct cost of being overweight, but not obese, was estimated as £1.9 billion;[38]

- The cost to society as a whole, including those resulting from unemployment, early retirement and associated welfare benefits were estimated at an additional £11.6 billion;[38]

- The direct costs to the NHS were forecast to increase to £7.1 billion (obesity) and £2.6 billion (overweight) respectively by 2050 and the overall cost to society was predicted to rise to £50 billion (including NHS costs, but not social care by local authorities).[38]

Generally, the upfront costs of most preventive interventions will not be repaid for a number of years. However, these costs will usually be small in comparison with the future health benefits and the long term cost savings from reductions in type 2 diabetes, cardiovascular disease and some cancers.

2.1. What we are doing locally

Tackling obesity is a complex challenge requiring long term and sustained interventions aimed at an individual, family, community and cultural level, over a number of decades. Locally and nationally we are still at the very early stages of developing effective interventions and are still learning which interventions will have the greatest impact. Leicestershire is developing a comprehensive and diverse obesity strategy across three key areas:

- Maintaining a healthy weight;

- Physical activity; and

- Food and nutrition (including food sustainability).

Maintaining a healthy weight

The past two years in Leicestershire have seen the development of a new healthy weight pathway for adults (and a maternal healthy weight pathway for pregnant women), in order to map existing services and identify gaps in provision and inform future commissioning requirements. Following this process, 2013/14 will see significant new investment in number of new and existing programmes:

- Further investment in Lifestyle, Eating and Activity Programme (LEAP), a targeted, community based weight management programme for individuals with a body mass index (BMI) greater than 28 with co morbidities or greater than 30, delivered by the Leicestershire Nutrition and Dietetic Service (LNDS);

- New investment in universal weight management services, delivered in partnership with commercial weight management organisations;

- New investment in maternal weight management services including a new telephone based support service for pregnant women and a pilot physical activity and lifestyle programme for pregnant women.

Physical activity

Increasing levels of physical activity remains a central component of Leicestershire's obesity strategy, both as a mechanism to maintain a healthy weight, and importantly as an effective preventative measure to reduce the incidence and worsening of many chronic health conditions.

In Leicestershire, there is an extensive range of physical activity opportunities for adults delivered by Leicestershire and Rutland Sport and district councils. 'Active Together' is a county wide programme across Leicestershire that aims to encourage everyone to become "more active more often". There are physical activity development officers based at the district councils who are there to help the population become more active. Each district offers a programme of regular and easily accessible activities from walking, yoga, hooping and dance, to Pilates, jogging, Buggyfit and bowls, with the aim of offering suitable activities for people of all abilities and ages.

In addition to generally raising activity levels across the whole population, Leicestershire also has a number of specific strategic aims. The intention is to increasingly target the most inactive and deprived populations, and to shift the focus away from elite sport to the building of routine physical activity into daily life. A number of initiatives currently support this aim including a new and innovative Sport England funded pilot project in Greenhill ward, Coalville. 'Sport 4 health buddies' will use innovative one-to-one mentoring and support to encourage inactive individuals and their families to try walking, cycling and other sports, possibly for the very first time.

The more established and long running community based programmes, 'Exercise on referral' and 'Heartsmart' support patients with existing medical conditions to rehabilitate or recover using one-to-one tailored programmes delivered by trained physical activity instructors. Both programmes will continue to expand in every district in 2013/14, offering an increasing range of activities suitable for those individuals requiring a gentle and monitored introduction to routine physical activity.

Food and nutrition

A number of new programmes will address the underlying knowledge and skills required in order for individuals to eat healthily in a sustainable and affordable manner. The Adult Learning Skills 'basic cookery skills' programme develops ability and knowledge around healthy food, nutrition and preparation, whilst new programmes will support and encourage communities to grow their own fruit and vegetables.

Public health has a central role in reducing the long term impact of the increasingly obesogenic environment facing the population, as it is a key determinant for poor health and unhealthy lifestyles. The department will be building upon programmes started in 2012/13 with a substantial new programme of work in 2013/14 focussing upon food sustainability and food culture, particularly aimed at introducing a positive food culture for children, but also the wider community. Over the next decade, flagship programmes such as "Food For Life", "Master Gardeners", and "Back to Basics" Cookery programmes will positively alter Leicestershire people's relationship with how they purchase, grow, prepare and cook food.

Case study - Smarter Travel for Business

Leicestershire County Council's local sustainable travel plan "Smarter Travel for Business" is an excellent example of a strategic approach to reducing the obesogenic environment, through adaptation and improvement of the local transport infrastructure in order to make walking and cycling more attractive and appealing travel choices. The programme is focussed on the economically deprived areas of Loughborough and Coalville. More generally, since 2000, there has been significant investment in the walking and cycling network across Leicestershire, whilst the county's "Choose How You Move" campaign encourages people to get fit, save money, have fun and help the environment by leaving their cars at home.

Recommendations

- To ensure that future policies and planning decisions reduce the obesogenic environment through county and district council partnership working, and to make physical activity and healthy eating an easier choice.

- To continue to develop population scale weight management services, delivered in creative and innovative ways for example, through partnership with commercial sector providers.

- To continue to build opportunities for routine daily physical activity into people's lives, through programmes for the whole population, as well as through targeted interventions to support the most inactive individuals to increase their levels of activity.

3. Substance misuse

Key facts

- In 2011/12 there were 11,485 alcohol related hospital admission for Leicestershire residents;[39]

- In 2012/13 1,153 adults in Leicestershire were reported in effective drug treatment (structured tier 3 services[d]);[40]

- In 2012/13 1,378 adults in Leicestershire were reported in effective alcohol treatment (structured tier 3 services);[40]

- The Health Profile for Leicestershire 2012 estimates 23% of adults are drinking at an increasing or high risk level. This equates to approximately 123,000 adults (16+) in Leicestershire, based on the 2011 census[32]

Alcohol plays an important role in society and in the economy. However, where it is misused alcohol is a major contributor to a range of harms at considerable cost. These harms include:

- Harms to the health of individuals;

- Crime, anti-social behaviour, domestic violence, and drink-driving and its impact on victims;

- Loss of productivity and profitability; and

- Social harms, including problems within families.

Nearly seven million adults are drinking at levels that increase the risk of harming their health. The same number report 'binge' drinking which, in addition, increases their risk of accidents and anti-social behaviour.[41]

3.1. What we are doing locally

Substance misuse has a far reaching impact on individuals, families, communities and the agencies who provide services to them. To reflect this Leicestershire and Rutland Substance Misuse Partnership Board has agreed a shared partnership vision:

'Working together to make Leicestershire and Rutland a healthier and safer place by reducing the harm and inequalities caused by substance misuse, in a sustainable and cost effective way.'

The board will work with the Police and Crime Commissioner and community safety partners to tackle the direct and indirect impact of substance misuse on anti-social behaviour and crime.

Key actions for tackling substance misuse are set out in the action plan for the JHWS. These include:

- Integrating into children and family services, work to prevent substance misuse and intervene early when issues arise;

- Training programmes to support frontline staff in key organisations to deliver information and brief advice, particularly relating to alcohol;

- Sharing more of the treatment of substance misuse between specialist community services and GP practices;

- Understanding trends in substance misuse and the resources that exist within communities to support recovery and reintegration;

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[d] Structured tier 3 services are community services provided by community drug teams, drug dependency units and day treatment

- Ensuring the safe transfer of substance misuse treatment in criminal justice settings to the new provider of services.

Over recent years there has been an increase in the number of people with drug related problems entering into treatment and support. In response to local need there has been an increase in access and treatment for people with alcohol related problems. By making this a priority, there has been a shift from 80% drug users and 20% alcohol users in treatment in 2009/10, to 57% drug users and 43% alcohol users in treatment in 2012/13. The number of both drug using clients and alcohol using clients has continued to rise every quarter.

One of the key priorities relating to alcohol use/misuse is to reduce the proportion of the population that are admitted to hospital for alcohol related causes. Locally, there are a number of initiatives that are aimed at reducing the health harms of alcohol. These include the delivery of brief alcohol interventions in primary care settings, increasing the capacity of the alcohol specialist nurses within hospital emergency departments (ED) and reducing the number of alcohol frequent attenders at ED.

Whilst continuing the success in increasing the number of people entering treatment, the national and local focus is to ensure people recover from their dependency and successfully move out of treatment. There has been an increase in local access to mutual aid support groups (for example, Alcoholics Anonymous, Narcotics Anonymous, Self-Management and Recovery Training (SMART Recovery)). However, to ensure people are able to reintegrate into their communities and gain employment they will require the support of other partners.

Each year the public health team reviews local needs and services and identifies any changes or gaps in service provision. Whilst the number of opiate users entering treatment is levelling out, there are different trends emerging both locally and nationally. Over the past few years Novel Psychoactive Substances (NPS), sometimes known as 'legal highs' have made local, national and international news, and been linked to hospital admissions and 42 deaths across the UK.[42] Local services have identified a rise in individuals seeking help for recreational substance misuse and in particular the use of mephedrone. For this reason a specific campaign has been launched across Leicestershire and Rutland.

The case for investment

Data submitted by the Department of Health to the Health Select Committee[43] estimate the costs of alcohol misuse as follows:

- NHS in England – £3.5 billion per year (at 2009/10 costs);

- Crime in England – £11 billion per year (at 2010/11 costs);

- Lost productivity in the UK – £7.3 billion per year (at 2009/10 costs);

- The submission estimates that the total cost to society is about £21 billion per year (this does not include the impact of alcohol misuse on families and communities).

The National Institute for Health and Clinical Excellence (NICE) (2009) estimated that screening for, and giving people brief advice on, alcohol problems could save social services and the NHS more than £124.3 million in care and treatment services over a 30 year period.[44]

Case study - Novel Psychosocial Substances (NPS) are also known as 'Legal Highs'

The "Legal Highs Lethal Lows" campaign aims to highlight the risks and harm these substances can cause through initiatives aimed at young people and young adults. Through the campaign individuals or concerned friends and family members can access advice, help and support.

Phase 1 of the campaign was launched in December 2012, and included a new website www.legalhighslethallows.co.uk, a digital phone application, a poster campaign in taxis across Leicestershire, a poster campaign displayed in licenced premises over Christmas and New Year, and advertisements on local radio. The campaign attracted local and national press interest with a number of articles being published and partnership support for the campaign. Over 3,000 individuals visited the campaign website and there were a number of direct requests for help on legal high use directed to our services.

Phase 2 of the campaign has now been launched to run over the summer months and is aimed at those attending local festivals, alongside a specific campaign during university freshers' week in September.

Case study – Alcohol related frequent attendees initiative

There are individuals that regularly attend hospital with specific alcohol related issues known as alcohol high impact users (AHIU). This cohort is responsible for a disproportionally high number of bed days within hospitals at a high cost.

The initiative involves alcohol liaison staff at the University Hospitals of Leicester identifying these high impact users and working closely with both the individual and the specialist treatment service (Swanswell) to ensure referral into specialist support. Once engaged within the specialist service users receive intensive support. Initial results show a significant reduction in representation and readmission to hospital of the high impact users, and, due to the higher visibility of the alcohol liaison nurses a general increase in referrals to specialist treatment services of those alcohol users who do not meet the high impact user threshold.

Overall this is supporting our aim of reducing alcohol related hospital admissions

Recommendations

• To integrate into children and family services work to prevent substance misuse and intervene early when issues arise;

• To build the capacity of frontline staff in key organisations to deliver information and brief advice, particularly relating to alcohol;

• To share more of the treatment of substance misuse between specialist community services and GP practices;

• To focus on supporting recovery and reintegration, with an emphasis on understanding the resources that exist within communities to help to deliver this;

• To ensure the safe transfer of substance misuse treatment in criminal justice settings to the new provider of services.

4. Sexual Health

Key facts

- In 2012, there were 1,166 abortions in women aged 20 years and over in Leicestershire.[45]

- The rate of abortions (all ages) in Leicestershire is lower than the England average (12.7 per 1,000 compared with 16.6).[46]

- Significantly fewer NHS abortions (67% West Leicestershire, 69% East Leicestershire and Rutland) than the England average (78%) are performed at 10 weeks or less gestation.[47]

- LCR has a significantly higher rate of GP prescribed Long-Acting Reversible Contraception (LARC) 62% than the England average of 52% (2011/12).[48]

- In 2011, there were 18,883 attendances to Genitourinary Medicine (GUM) for sexually transmitted infections (STI) by Leicestershire residents (all ages).[49]

- For diagnoses of acute STIs, each district of Leicestershire has a rate significantly lower than the England average.[48]

- Human immunodeficiency virus (HIV) prevalence across LCR is low with 243 people accessing HIV related care in 2011.[50]

Good sexual health is important to individuals and society. Needs vary according to age, sexuality and ethnicity, and groups such as gay and bi-sexual men and some black and ethnic minorities are more at risk of poor sexual health. The National Framework for Sexual Health Improvement[51] identifies the ambition that all adults have access to high quality services and information. It is important that people understand contraceptive options and where they are available, can provide guidance to their children about relationships and sex and have information and support to access testing and early diagnosis to prevent transmission of HIV and STIs.

As people get older their need for sexual health services may reduce but they should not be overlooked. STI rates in the over 50s are low but increasing. Physical health problems that affect sexual health become an increasing issue.

Achieving good sexual health is complex and there are variations in need for services and interventions for different individuals and groups. Prevention work is important to help people to make healthy decisions and to reduce prejudice, stigma and discrimination that can be linked to sexual ill-health.

The case for investment

- For every £1 spent on contraception, £11 is saved in other healthcare costs;[52]

- LARC is more cost effective than condoms and the pill for reducing the risk of pregnancy;[53]

- Early testing and diagnosis of HIV reduces treatment costs by over £10,000 per person per year;[54]

- Early access to HIV treatment significantly reduces the risk of onward transmission;[55]

- Some STIs, if left undiagnosed, cause long term and life threatening complications, including cancers.

4.1. What we are doing locally

In April 2013 the responsibility for commissioning sexual health services moved to a number of different agencies. Local authorities became responsible for a range of sexual health interventions and services as part of their public health responsibilities.

Leicestershire County Council, Rutland County Council and Leicester City Council are jointly commissioning a new integrated sexual health service to improve access and allow more people to visit one clinic for all of their sexual health needs. This service will commence on 1 January 2014. The service will operate across Leicestershire, Leicester and Rutland offering a more consistent, high quality and cost effective service. There will be increased opening times and additional sites in Leicestershire for young people's clinics so offering more choice for patients. This new service will bring together current local sexual health provision into one service. Across Leicester, Leicestershire and Rutland this includes the Chlamydia Screening Service, GUM and contraceptive services (family planning).

The integrated service model will enable:

- Clear and unified management arrangements;
- Innovative service models and approaches;
- Clear clinical leadership and accountability across the entire provision;
- A seamless experience for the user; and
- A value for money service.

Work continues to provide women with accessible contraceptive choices by improving provision of LARC from general practice and specialist sexual health services.

A variety of prevention programmes and services are delivered to hard to reach populations at higher risk of poor sexual health including men who have sex with men, people in African communities, commercial sex workers and people affected by HIV.

Case study - Leicester, Leicestershire and Rutland sexual health services website

The introduction of the website www.leicestersexualhealth.nhs.uk which assists people of all ages to get information about sexual health issues and local services, including an online booking facility for GUM services. The website will continue to be developed and updated. It will include information for practitioners as well as for the public in the future.

Recommendations

- To ensure prevention of sexual ill-health is prioritised and developed in line with the latest evidence;
- To ensure information about sexual health and services is widely available;
- To continue to improve access to sexual health services for Leicestershire residents, and develop robust care pathways across sexual health and other relevant services such as alcohol and drug misuse services.

5. NHS Health Checks

Key facts

- In 2013/14 there are an estimated 205,000 residents of Leicestershire eligible for a health check;[56]

- In 2012/13, approximately 56,500 people were invited and approximately half of these people actually had an NHS Health Check (LCR);[57]

The NHS Health Check programme is a national prevention programme to identify people at risk of developing vascular diseases: heart disease, stroke, diabetes, kidney disease or vascular dementia. Vascular diseases are the leading cause of early deaths in England and everyone is at risk of developing them. However, these diseases can often be prevented, even if you have a family history.

Everyone in England aged between 40 to 74 years will be invited for a NHS Health Check once every five years if they do not have a previous diagnosis of vascular disease. The checks are designed to assess a patient's risk of developing vascular disease and give them personalised advice on how to reduce it. It is estimated that one in five people who go for a NHS Health Check will be highlighted as at risk of developing a vascular disease in the near future.

The case for investment

National figures suggest that each year NHS Health Checks:[58]

- Prevents 1,600 heart attacks and saves at least 650 lives;

- Prevents over 4,000 people from developing diabetes;

- Detects at least 20,000 cases of diabetes or kidney disease allowing people to manage their condition and prevent complications.

5.1. What we are doing locally

NHS Health Checks became the mandatory commissioning responsibility of local authorities in April 2013. Locally they are delivered through GP practices. In addition, the national programme has also been developed to include vascular dementia awareness and alcohol consumption risk.

GP practices are required to invite 100% of people who meet the eligibility criteria and are encouraged to achieve an uptake of 65%. There are over 205,000 residents of Leicestershire who are eligible for a NHS Health check once in the next five years. At least a fifth of those eligible (41,000) should be invited for a NHS Health check each year, over the next five years.

In 2012/13, GP practices in LCR exceeded this target figure for numbers of invites sent for NHS Health Checks. 51% of people across Leicestershire County and Rutland invited, attended and received a check. These figures suggest that practices are inviting all eligible patients but are struggling to deliver the NHS Health Check because of attendance issues.

Public Health are working with CCGs to develop and implement a standardised template for NHS Health checks to make data collection simpler, improve data collection quality and consistency. This will be implemented in October 2013.

Case study - Health checks make a big difference

Beck Tomlin and her team of Health Care Assistants at Long Lane Surgery in Coalville, deliver NHS Health Checks to their eligible registered patients. As Beck explains, NHS Health Checks' really can help people live healthier and for longer.

"…a chap came for his NHS Health check in June and we realised he had a very high risk of developing cardiovascular disease if he didn't change his lifestyle (QRISK of 21.6% and total cholesterol 6.1). People who have such a high risk are often put onto statins to reduce their risk of developing CVD.

At his NHS Health check we also identified areas in his diet and lifestyle to improve and agreed to meet up to check his progress.

Three months later, he had lost a stone in weight and significantly reduced his cholesterol. His risk of developing CVD had reduced so much that there was no longer any need to consider statins.

This just shows how much of a difference we can make to peoples physical and mental wellbeing through NHS Health checks."

Recommendations

- To commission a NHS Health Check programme that includes the new dementia awareness and alcohol auditing components;

- To ensure that all GP practices support the NHS Health Check programme;

- To develop a media campaign to increase uptake for NHS Health Checks;

- To consider other models and services for delivery of NHS Health Checks for hard to reach groups (such as pharmacies or health centres).

6. Health and work

Key facts

In the 2011 Census, for people aged 16-74 years in Leicestershire:[12]

- 342,139 people were economically active[e] (71%), including

  » 70,396 employed part time (15%)
  » 195,058 employed full time (41%)
  » 47,062 self-employed (10%)
  » 14,534 unemployed (3%)
  » 15,089 were full time students (3%)

- 137,323 people were economically inactive[f] (29%), including

  » 73,264 retired (15%)
  » 29,200 students (6%)
  » 15,363 looking after home of family (3%)
  » 12,666 long term sick or disabled (3%)
  » 6,830 other (1%)

There is growing evidence on how closely health, work and wellbeing are connected. The 2006 report, *"Is work good for your health and wellbeing?"*[59] found that work is usually good for health and work is also known to be the best route out of poverty. Work generally:

- Makes people healthier;

- Helps people with a health condition get better; and

- Improves the health of people returning to work from unemployment.

'Workplace health' refers to the combined efforts of the employer and the workers to encourage and support healthy lifestyle habits, making healthy choices the easy choices. Creating a health and wellbeing programme in workplaces can boost productivity and help staff to be happier and healthier at work and at home. Evidence suggests that early interventions to improve health in the workplace are effective.

Workplace sickness absence levels are substantial. From 2010 to 2011, approximately 26.4 million working days were lost due to workplace injury and ill-health. Stress and back pain are the two biggest causes of absence from work; while about 10.8 million working days were lost because of work related stress, depression and anxiety.[60]

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[e] A person aged 16 to 74 is described as economically active if, in the week before the census, they were in employment, as an employee or self-employed; not in employment, but were seeking work and ready to start work within two weeks; or not in employment, but waiting to start a job already obtained and available. Full time students who fulfil any of these criteria are classified as economically active.

[f] A person aged 16 to 74 is described as economically inactive if, in the week before the census, they were not in employment but did not meet the criteria to be classified as 'Unemployed'. Students who fulfil any of these criteria are also classified as economically inactive.

Unemployment is also a major determinant of health and wellbeing. About a quarter of the working age population are not in work. Of these, approximately 20% are unemployed but actively seeking work. The remainder have a variety of reasons for being out of the labour market, only one of which is ill-health. According to Labour Force Survey data, 28% of those who are economically inactive are so because of sickness, injury or disability.[5] Those who have been unemployed long term or those who have never worked are two to three times more likely to have poor health than those in work.[59]

Families without a working member are more likely to suffer persistent low income, poverty and poorer health outcomes. Parental ill-health and worklessness increases the risk of childhood stress, behavioural problems and poor educational achievement.[61]

Moving into adulthood is a key milestone for all young people. In England, 10% of 16 to 18 year olds are classed as NEET. Since 2000, the number of young adults (those under the age of 25) who have been on incapacity benefits for five years or more has more than doubled from 21,000 to 54,000.[5] Those who have few or no qualifications or experience of working need particular support to help them back on the path to success.

Dame Carol Black's 2008 review of the health of Britain's working age population, *"Working for a Healthier Tomorrow"*, recognised the beneficial impact that work can have on an individual's state of health and set out a vision based on three principles:[5]

• Prevention of illness and promotion of health and wellbeing;

• Early intervention for those who develop a health condition; and

• An improvement in the health of those out of work.

The report also highlighted the £100 billion cost of ill-health in our workplaces due to 175 million working days lost to sickness absence each year and the 2.6 million people not working and receiving benefits because of a health issue and other factors. The numbers receiving incapacity benefits reveal that the proportion with mental health conditions has increased dramatically over the last decade, from 26% in 1996 to 41% in 2006. Dame Carol Black also noted the impact of specific health issues in people of working age including obesity, smoking, reduced mental wellbeing and physical inactivity. In addition there is a growing body of evidence that workers with health issues such as obesity and depression are less productive.[62]

In response to the report, the National 'Health and Work Advice and Assessment Service' is being launched in Spring 2014. This will ensure that employers receive bespoke, independent advice for cases of sickness absence lasting more than four weeks.

The case for investment

- Sickness absence in Britain costs the economy an estimated £15 billion per year. This includes lost productivity and output, time spent on sickness absence management and healthcare costs;[63]

- Approximately 5 million people of working age receive out of work benefits – about half of this group receive incapacity benefits.[64] Health related benefits cost the state £13 billion a year;[63]

- On average, employers lose 9.1 working days per employee per year in the public sector, 8.8 days in the non-profit sector and 5.7 days in the private sector to sickness absence;[65]

- The NICE business case tool for promoting mental wellbeing at work estimated that mental ill-health costs UK employers almost £1 million per year. For an organisation with 1000 employees, the annual cost of mental ill-health was estimated to be more than £835,000. Identifying problems early, or preventing them in the first place, could result in cost savings of 30%. This is equivalent to cost savings of more than £250,000 per year.

NICE has produced a series of guidelines for early interventions to improve health in the workplace (http://guidance.nice.org.uk/PHG/Published). The guidance demonstrates that improved productivity is associated with effective management of long term sickness absence, and with smoking cessation.

Presenteeism refers to loss in productivity caused by employees working when ill and therefore performing at a lower level because of their illness and is a significant problem facing businesses. Presenteeism accounts for 1.5 times as much working time lost as absenteeism and is more common among higher paid staff. [66] The Sainsbury Centre for Mental Health calculated that presenteeism from mental ill-health alone costs the UK economy £15.1 billion per annum, while absenteeism costs £8.4 billion.[67]

6.1. What we are doing locally

The Leicestershire and Rutland workplace health and wellbeing group was established in 2011 to review the existing workplace programmes across both counties. A mapping exercise identified a wide range of workplace health programmes run by a broad range of organisations including Fit4Work, local authorities, Leicestershire and Rutland Sport, Leicestershire Stop Smoking Service and Loughborough College. At the same time work is underway to develop tools to support the roll-out nationally of the workplace charter in the East Midlands region.[68]

The Leicestershire and Rutland Workplace Health Group has undertaken a programme of work to develop a new "integrated pathway" in order to join up the various local programmes to encourage universal adoption of workplace charter standards and the systematic cross referral of clients between programmes and better coordination of activity across the variety of specialist provider services. As part of this, commissioners in Leicester, Leicestershire and Rutland have extended the remit of the Healthy Workplaces Programme (see case study) to develop as an expert hub for Leicestershire workplace programmes, with the first task of developing a website to promote and collate data on the specialist programmes available locally.

Case study - Healthy workplaces

This is a project delivered by the Leicestershire Fit for Work team aimed at supporting small and medium enterprises (SMEs) in relation to workplace health. 98.5% of businesses based within Leicestershire employ fewer than 100 people and the Chartered Institute of Personnel and Development (CIPD) estimates that SMEs of this size could be losing up to £119,900 per year in staff health issues, increasing the likelihood of serious financial instability for these companies.

The team engages and works with SMEs to improve the health of their employees by identifying the health needs of their workforce and by developing actions to address these needs to ensure maximum health and cost benefit through workplace interventions. These interventions aim to deliver a workforce that is healthier, happier and more productive. This provides protection against financial hardship and promotes a better quality of life by allowing people to make the most of their potential.

Leicestershire Fit For Work service is part funded by Leicestershire County Council and Leicestershire CCGs. It provides expertise and services to improve the health of the working age population and to address health inequalities by supporting people at risk of becoming unemployed due to ill-health. Clients receive one-to-one support from a dedicated case manager in the early stages of sickness absence, with the aim of making access to work and access to the support services readily available. The service works with local GPs and their patients to achieve a quicker return to work, reduce sickness absence, flow onto benefits and by supporting individuals who develop illness to remain in or return to work.

Recommendations

- To deliver on the recommendations of Dame Carol Black's review, Working for a Healthier Tomorrow, through collaborative working with partners;

- To improve promotion of health and wellbeing and prevention of illness in the workplace;

- To improve provision of early interventions for those at work who develop a health condition;

- To address the additional health needs of those who are out of work;

- To help people who have not yet found work, or have become workless, to enter or return to work, with a special emphasis on 16 to 18 year olds who are classed as NEET.

7. Mental Health

Key facts

- In Leicestershire 64,923 people aged 18-64 in 2012 were predicted to have a common mental health disorder.[16,g] Approximately 1% of adults have a serious mental illness such as schizophrenia or bipolar disorder;[69]

- An estimated 30 per cent of all people with a long term condition also have a mental health problem;[70]

- In 2010 there were 39 deaths from suicide and injury undetermined in Leicestershire;[71]

- It is estimated in 2012 there were 9777 adults in Leicestershire between 18-64 years of age with a learning disability.[16] The number of working age adults with learning disabilities is expected to increase due to individuals with learning disabilities living longer.

Mental health is more than the absence of mental illness. The World Health Organisation defines mental health as:

"A state of wellbeing in which the individual realises his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community".

In this positive sense, mental health is the foundation for individual wellbeing and the effective functioning of a community.

Everyone has mental health needs. Mental health is a significant public health issue with mental illness being the largest single source of burden of disease in the UK.[72] No other health condition matches mental illness for the combined extent of its prevalence, persistence and breadth of impact. One person in four will experience some kind of mental health problem in the course of their lifetime and one person in six per year.[73]

Mental illness is consistently associated with deprivation, low income, unemployment, poor education, poorer physical health and increased health-risk behaviour.

Mental health promotion is about building on the existing strengths, assets, skills, resources, networks, social and community supports, and relationships that enhance our sense of competence and belonging. It is about giving people the opportunity to experience control over their lives through activities that lead to increased self-esteem, quality of life, and social connectedness.

Mental health promotion and prevention should be central to the agendas of local authorities and partners. A public health approach to mental health and wellbeing recognises the importance of addressing the wider determinants across the life course to both prevent mental illness and promote wellbeing. People with higher wellbeing have lower rates of illness, recover more quickly, remaining well for longer and generally have better physical and mental health. Protection of mental health and wellbeing includes tackling a range of social determinants. Some preventative actions include:

- Strengthening the social inclusion and participation of working age adults, particularly the unemployed;

- Increasing physical activity levels to the recommended 30 minutes a day of moderate physical activity on five or more days of the week;

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g Common mental disorders (CMDs) are mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety, and include obsessive compulsive disorder.

- Addressing violence in the community with a particular focus on domestic violence and child abuse;

- Ensuring healthy standard of living for all by tackling homelessness and improving the quality of housing available;

- Increase employment opportunities;

- Improve access to resources and services which protect mental wellbeing, for example increasing benefit uptake and increasing opportunities for physical, creative and learning activities.

Both a population and targeted approach are required to effectively promote mental health and wellbeing in children and young people, adults and older people. It also requires the participation of a wide range of stakeholders. The early detection of those with mental illness is important for maximising the positive outcomes of treatment.

People with learning disabilities

The life experiences of working age adults with learning disabilities are unique and variable due to the disability severity. It is estimated that over four in five (83%) of individuals with learning disabilities who are of working age are unemployed. People with learning disabilities who live in private households are more likely to live in areas of high social deprivation compared to individuals living in supported accommodation. Working age adults with multiple learning disabilities are less likely to participate in leisure and community activities compared to individuals with mild or moderate learning disabilities.[74] These issues should be addressed by the relevant services to ensure individuals with learning disabilities are able to play a full role in society and fulfil their potential.

The case for investment

Mental illness often begins in childhood and continues through life resulting in substantial human, social and economic costs. Mental illness has significant economic costs including estimated wider costs in England of £105 billion a year. Research shows that should mental health care and treatment arrangements remain at their current levels, there will be a substantial increase in the impact of mental health problems on the economy in the future.[80]

The Department of Health commissioned a study to identify and analyse the costs and economic pay-offs of a range of interventions in the area of mental health promotion, prevention and early intervention:[81]

- Early diagnosis and treatment of depression at work programme to have an economic pay-off of £5.03 per £1.00 expenditure, split between the NHS, public sector and non-public sector;

- Workplace health promotion programmes were found to have a pay-off of £9.69 per £1.00 of expenditure;

- Attempting to address social determinants of mental health through debt advice services, the economic pay-off was £3.55 per £1.00 of expenditure.

Overall many of the mental health related programmes were found to have economic pay-offs for the NHS, other public sector services, and for non-public sector services.

7.1. What we are doing locally

Leicestershire's JHWS has identified improving mental health and wellbeing as a key priority, with a key action to

'promote positive mental health promotion and the early detection of mental health problems across the age ranges'.

The council is working on a multiagency mental health strategy linked to the priorities in the JHWS.

This will identify actions to:

- Promote positive mental health and wellbeing;

- Continue to improve the early detection and management of people with common and severe and enduring mental health needs.

The 2013-16 Leicester, Leicestershire and Rutland (LLR) Suicide Prevention Strategy is being progressed by the LLR Suicide Audit and Prevention Group which is made up of partners across the NHS, local authority, police and voluntary sectors.

Other priorities include working with key stakeholders to address wider health inequalities and social determinants of health, for example, housing, social exclusion and income inequality and the potentially negative impact of benefit changes and other economic changes linked to the economic downturn.

The council will continue to work with NHS and other partners to improve the management of people with common and severe and enduring mental health problems (SMI) by identifying their needs and addressing risk factors for premature mortality in people with SMI.

Case study - Books on prescription

A campaign aimed at optimal management of mental illness and promotion of mental health through availability of 'self-help' books and other resources in libraries.

Case study - Time to change

The 'time to change' campaign is a local multi-agency campaign aimed at reducing the reduce stigma and discrimination relating to mental illness.

Recommendations

- To work with partners to prioritise mental health and to deliver on the emerging mental health strategy;

- To strengthen mental health and wellbeing for all, thereby recognising that good mental health is more than the absence of mental illness;

- To address wider determinants of health and to enable individuals to fulfil their potential through partnership working across departments and agencies;

- To protect investment in prevention and tackle the wider determinants of health as the return on investment per pound spent in this area is good.

Health protection

1. Infectious diseases

Health protection covers a wide range of "threats" to health. These include many diverse areas such as infectious diseases, "superbugs", flooding, radiation, poisons and food safety. It is important that the health, safety and protection of the population from all external threats to health is rigorously maintained.

1.1 Food borne disease

The largest number of notifiable infections both nationally and locally continues to be food-borne disease (food poisoning). Nationally the Food Standards Agency (FSA) estimates that there are around a million cases of foodborne illness in the UK each year, resulting in 20,000 hospital admissions and 500 deaths. Locally during 2012 there were 692 reported cases.[75] However the majority of cases go unreported and this can be seen to be the tip of the iceberg.

Table 6: Leicestershire County and Rutland reported cases of foodborne disease to Health Protection Unit East Midlands South 2008 to 2012

	Leicestershire and Rutland				
Disease	2008	2009	2010	2011	2012
Food Poisoning (Campylobacter/ Salmonella /Non-specific Gastroenteritis)	696	726	849	772	692

Source: East Midlands Health Protection Unit 2013.

The responsibility for enforcement of food safety legislation lies with environmental health officers within district councils. They work closely with Public Health England to investigate cases of food poisoning and to ensure that food business operators work according to the legal standards determined by European and national regulations. As a significant number of foodborne diseases occur in the home we also ensure through work in schools and communities that we have education and awareness raising activities that promote food safety and reduce the huge burden of food borne disease.

1.2 Pertussis (whooping cough) in pregnancy

There has been a considerable increase in pertussis since the middle of 2011. This increase has occurred across England and Wales. The highest rates are in infants less than three months of age who are at the greatest risk of complications and death. Babies under eight weeks are too young to gain protection from the childhood immunisation schedule.

A temporary programme of immunisations for pregnant women after 28 weeks of pregnancy began in September 2012. The purpose is to boost antibodies in the vaccinated women so that pertussis antibodies are passed from mother to baby. This aims to protect the infant before routine immunisation can be started at eight weeks of age.

1.3 Tuberculosis (TB)

Tuberculosis is caused by the bacteria Mycobacterium tuberculosis. It can cause disease in the lungs as well as other sites such as the lymph nodes and bones.

TB, although curable with antibiotics, has re-emerged as a major public health problem and is the leading cause of death worldwide from a curable infectious disease. In England cases fell progressively until the mid-1980s but started to rise again in the early 1990s.[76]

Case numbers in the UK are at their highest for nearly thirty years and now exceed 9,000 per year. Much of this rise affects disadvantaged communities including certain ethnic minority groups and those with social risk factors such as homelessness and drug and alcohol misuse. This concentration in particular sections of the community provides unequivocal evidence for a need to strengthen efforts to control the disease through a range of measures targeted at key risk groups and in particular those living in urban areas. NICE have recently issued guidance on the management of TB in hard to reach groups. TB is a disease associated with poverty and specific groups of the population are at heightened risk:

- Close contacts of infectious cases;

- Those that have lived in, travel to, or receive visitors from places where tuberculosis is still very common;

- Those with immune systems weakened by HIV infection or other medical problems;

- The very young and the elderly as their immune systems are less robust;

- Those with chronic poor health and malnutrition because of lifestyle problems such as homelessness, drug abuse or alcoholism.

Between 2009 and 2011 there were an average of 41 new cases of TB reported per year. The incidence rate per 100,000 population of 6.3 in Leicestershire (95% CI 4.5-8.5) is significantly lower than the England average of 15.4 (95% CI 15.1-15.6).[77] Public Health England are currently undertaking a full health needs assessment of TB across Leicester, Leicestershire and Rutland.

1.4 2013/14

From 2013 as a result of the Health and Social Care Act 2012 Leicestershire County Council has acquired some new responsibilities with regard to protecting the health of their populations. Specifically the local authority is required, via its Director of Public Health (DPH), to assure itself that relevant organisations have appropriate plans in place to protect the health of the population and that all necessary action is being taken. In order to discharge these responsibilities, a Health Protection Board has been established as a sub-group of the three health and wellbeing boards for Leicester, Leicestershire and Rutland. The Health Protection Board is the way the health and wellbeing boards will be assured that the health protection agenda is being adequately addressed and considered in sufficient detail. It will also provide a reporting route should a health and wellbeing board have specific health protection concerns.

Emerging issues of relevance to working age adults include:

- Multi-drug resistant organisms such as multi-drug resistant TB;

- Pandemic 'flu and other emerging diseases such as Middle East Respiratory Syndrome Coronavirus.

2. Screening

Screening is a process of identifying apparently healthy people who may be at increased risk of a disease or condition. They can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition.

The NHS in England operates a number of screening programmes that are offered to people of working age. The relevant programmes are:

- Breast cancer screening;

- Cervical cancer screening;

- Bowel cancer screening; and

- Diabetic eye screening.

The purpose of screening is to identify a disease, or in some cases a risk factor, in such a way that the chance of a better health outcome is increased. This latter part of the statement is important; there is no point in going through screening and getting an earlier diagnosis of a problem if treatment at that stage is not going to confer an advantage for the individual.

Screening programmes do not usually provide a clear diagnosis. The purpose of a screening programme is to separate those who are unlikely to have a particular condition from those who have a higher chance of having the condition based on the screening test undertaken. The latter group will then be asked to attend for further diagnostic tests to see if they really have the condition in question or not. If the answer is yes, then treatment will be offered.

As screening programmes are offered to the whole population at risk they can be very costly. In order for the population to gain significant benefit from a screening programme it is important that a high percentage of the population makes use of them. The costs of a screening programme are to a large extent fixed. If only half of the eligible people take up a service the cost will be less, but probably not very much less, than if 80 or 90% of people take it up. With only 50% uptake we will only see around 50% of the potential benefit for the population, so the cost per life saved will increase dramatically if uptake is low.

2.1. Breast cancer screening

Screening for breast cancer is offered to all women aged 50-70 years on a three yearly cycle. The basic test is an x-ray of the breast called a mammogram. The advent of digital mammography has led to an extension of the age range on a trial basis so in Leicestershire women are now invited from age 47 to 73 years. Women who are over this age can continue to have breast screening if they request it but they will not be routinely called.

The national minimum standard for coverage (the number of people eligible who attend for the service) is 70% with the achievable standard being 80%. In Leicestershire and Rutland the performance for April 2011-March 2012 was 84.4%, the best in the East Midlands and one of the best in the country.[78]

Table 7: NHS Breast Screening coverage of women aged 53-70 as at 31 March 2011 and 2012

	As at 31 March 2011	As at 31 March 2012
England	77.2%	77.0%
East Midlands	81.8%	81.3%
Leicestershire County and Rutland	84.9%	84.4%

Source: Compendium of Clinical Indicators, Health and Social Care Information Centre

2.2. Cervical cancer screening

Cervical screening is not a test for cancer. It is a method of preventing cancer by detecting and treating early abnormalities which, if left untreated, could lead to cancer in a woman's cervix (the neck of the womb). The first stage in cervical screening is taking a sample using liquid based cytology.

Cervical cancer screening is offered to all women aged from 25 to 64 years. The screening interval for those aged 25-49 years is three yearly and for 50-64 it is five yearly. There is currently a national trial of using a test for the human papilloma virus (HPV) which is done on the smear specimen as part of the screening process. This process is currently in use in the service that covers Leicestershire.

Coverage for the year 2011/12, calculated as the percentage eligible having had a smear within the last five years, is shown below. As can be seen, uptake in LCR is higher than the national average. Coverage specifically for those aged 25-49 years is calculated on the percentage eligible having had a smear within the last three years. This figure of 78.3%, which is higher than the national and regional average, would benefit from being over 80%.[79]

Table 8: Cervical cancer coverage 2010/11 and 2011/12

	2010/11 (%)			2011/12 (%)		
	25-49	50-64	25-64	25-49	50-64	25-64
England	73.7	78.0	78.6	73.5	77.8	78.6
East Midlands	76.9	80.4	81.4	76.5	79.8	81.0
Leicestershire County and Rutland	79.2	81.6	83.2	78.3	81.2	82.7

Source: NHS Cervical Screening Programme Statistical Bulletin 2011-12

2.3. Bowel cancer screening

Bowel cancer screening started in LCR in 2007. It is offered to men and women aged 60-69 and from June 2012 the service has been rolled out for men and women up to the age of 74 years.

A screening kit is sent in the post to eligible people every two years. The kit requires people to submit a very small specimen of faeces on a specially designed card. The specimen is then tested in a laboratory for the presence of very small quantities of blood. The test is referred to as faecal occult (meaning hidden) blood, or FOB.

A positive test may suggest the presence of a polyp or of bowel cancer. People with a positive screening test will be offered further diagnostic tests and treatment as necessary.

Probably because of the nature of the test the acceptability of this programme has been harder to achieve with the population. The uptake rates for LCR for the last two calendar years, 2011 and 2012, have been 58.5% and 64.8% respectively compared to a national standard of 60%.[82]

2.4.   Diabetic eye screening programme

People with diabetes run the risk of a number of complications of which sight threatening retinopathy is one. Everyone with diabetes from the age of 12 is invited to have an annual photograph of their retinas to assess the presence and extent of any changes that may threaten their sight. If changes are found it may be necessary offer laser therapy to the back of the eye and there is also now the option of injections into the eye following recent guidance from NICE.

Table 9: NHS diabetic eye screening coverage 2010/11 and 2011/12

	2010/11	2011/12
England	91.6%	91.9%
East Midlands	92.3%	92.2%
Leicestershire County and Rutland	93.3%	92.4%

Source: Public Health England Immunisation and Screening Team

Recommendations

- To establish and operate a Health Protection Board that seeks to provide assurance to the local authorities in LLR about the adequacy of prevention, surveillance, planning and response with regard to health protection issues.

- To continue to assure that NHS England maintain high coverage and uptake of national immunisation and screening programmes.

Feedback from actions for 2012

In March 2012 the Leicestershire Together (LT) Board agreed 4 priority outcomes for Leicestershire, including (in response to the increasing ageing population) that "Services are designed to mitigate the impacts of an ageing population and enable older people to live independently for longer".

This recommendation was further reinforced by recommendations included in the DPH Report 2: Older People, published in September 2012.

Work in response to this LT priority outcome included carrying out a peer review based on the following hypotheses and exploring issues of strategy, governance, and accountability across Leicestershire.

Hypotheses

- As the population of over 50s in Leicestershire increases, the demand on services will be unaffordable based on current service delivery;

- Some services are delivered in silos, meaning the customer is potentially receiving disjointed and uncoordinated services, impacting on the quality of care they ultimately receive;

- Some organisations operating models are focussed more on reactive service delivery and less on the delivery of early intervention or preventative services;

- By re-designing how we support older people in Leicestershire, acknowledging the changing needs at different ages and life events, we can improve the lives of older people and reduce the costs to the public and voluntary sector.

Sandra Whiles, Chief Executive at Blaby District Council, led the peer review team which included Matthew Lugg, Director of Environment and Transport at Leicestershire County Council, Senior Officers from public health in Leicester City, Warwickshire County Council, a senior elected member from Nottinghamshire and the Chair of the Older Peoples Engagement Network (OPEN). The team interviewed 52 commissioners/providers as well as elected members representing the county council and district councils.

The following link is to a succinct and thought provoking animation (5 minutes in length) that sets the context of the review and reminds those involved of the emotional impact of ageing. Charlie and Marie: A tale of ageing (http://vimeo.com/21592651)

The interim findings of the peer review are shown below.

Peer review findings

We need to:

- Change how we think. Create a whole system approach focussing on striking the right balance between providing the right services and enabling individuals and communities to support themselves;

- Enable People. Supporting people to ensure they recognise the impact of their lifestyle choices from an early age, and ensure that we provide services and support that are person centred, not condition based;

- Empower Communities. Work with communities to create a culture of sustained self support and address the assumed dependency on universal public sector services;

- Better Insight, better decisions. More regular and robust evidence to inform the design and delivery of effective solutions.

The next stage of the programme is to capture the views of patients, carers and service users. A stakeholder event held in May identified a range of groups to contact in order to fully understand the needs, wishes and aspirations of older and ageing individuals in the county. As a result a detailed engagement plan is being prepared across the partnership to engage with these groups.

On completion of this exercise, the views expressed by patients, carers and service users will be put together with the views expressed in the peer review in order to define future services in Leicestershire.

It had been anticipated that the definition of new commissioning and delivery plans for Leicestershire would be completed by this autumn. However, activity has focussed on the wider health and local government integration initiatives, following recent announcements by Government. Government is incentivising local areas who demonstrate innovation in integration of health and local government and Leicestershire partners are keen to play a key role in this.

Whilst this shift in focus has resulted in a three to six month delay in progressing the ageing well programme, the focus and desired outcomes of both programmes are very much aligned. The findings of the ageing well peer review and subsequent stakeholder engagement activity will feed into the integration activity and, as a result, help drive through the transformation of services required.

Appendix A: The new public health system

Public health in Local Authorities

On the 1st April 2013, Local Authorities took over responsibility for public health services for their local communities. Leicestershire County Council has a new duty to promote the health of the population. The council is also responsible for ensuring that robust plans are in place to protect the local population and in providing public health advice to NHS commissioners (West Leicestershire CCG and East Leicestershire and Rutland CCG).

Leicestershire County Council is now responsible for commissioning the following services:

- Children's public health
- Sexual health
- Public mental health
- Obesity programmes
- Drug misuse
- Alcohol misuse
- Tobacco control
- Nutrition
- NHS Health Check Programme
- Reducing and preventing birth defects
- Health at work
- Accidental injury prevention
- Seasonal mortality

Public Health England

Public Health England (PHE) was established on 1st April 2013. It will carry out nationwide and specialist functions for public health. Locally public health will be led by local authorities.

Public Health England's three main functions will be:

- Delivering services to national and local government, the NHS and the public. This includes health protection services, public health intelligence services, development of evidence and nationwide communications strategies;

- Leading for public health; and

- Supporting the development of the specialist and wider public health workforce.

Public health services commissioned by NHS England

In addition to Local Authority Public Health and Public Health England, NHS England will commission the following public health services:

- Public health services for children from conception to age 5;

- Immunisation programmes;

- National screening programmes;

- Public health care for people in prison and other places of detention; and

- Sexual assault referral services.

Leicestershire's Health and Wellbeing Board

Leicestershire's Health and Wellbeing Board was formally established on the 1st April 2013. This statutory board builds on the work of the Shadow Health and Wellbeing Board that was in place from April 2011.

The Health and Wellbeing Board has a fully operational sub structure with supporting boards leading work on:

- Integrated Commissioning;

- Staying Healthy;

- Substance Misuse; and

- Health Protection.

The main focus of the work of Leicestershire's Health and Wellbeing Board in 2012 has been to:

- Refresh and publish the Joint Strategic Needs Assessment (JSNA) for Leicestershire and engage with a wide range of stakeholders in this process;

- Identify and agree local priorities from this assessment;

- Develop and publish our first Health and Wellbeing Strategy and engage with a wide range of partners in this process;

- Oversee the delivery of work plans from the substructure groups; and

- Prepare for statutory status of the Board with effect from April 2013.

The Health and Wellbeing Board has also covered a number of other important topics this year, for example:

- Local CCG commissioning strategies and authorisation;

- The vision for local Healthwatch;

- Local emergency planning arrangements;

- The implications of the Adult Social Care White Paper;

- Cancer mortality rates in Leicestershire;

- The Annual Report of the Director of Public Health, which focused on older people;

- Future Special Educational Needs provision for Children;;

- The Better Care Together programme - planned changes in healthcare services across the sub-region;

- The introduction of the NHS 111 telephone number (a national development).

Further information about the Health and Wellbeing Board is available from www.leics.gov.uk/healthwellbeingboard.htm

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