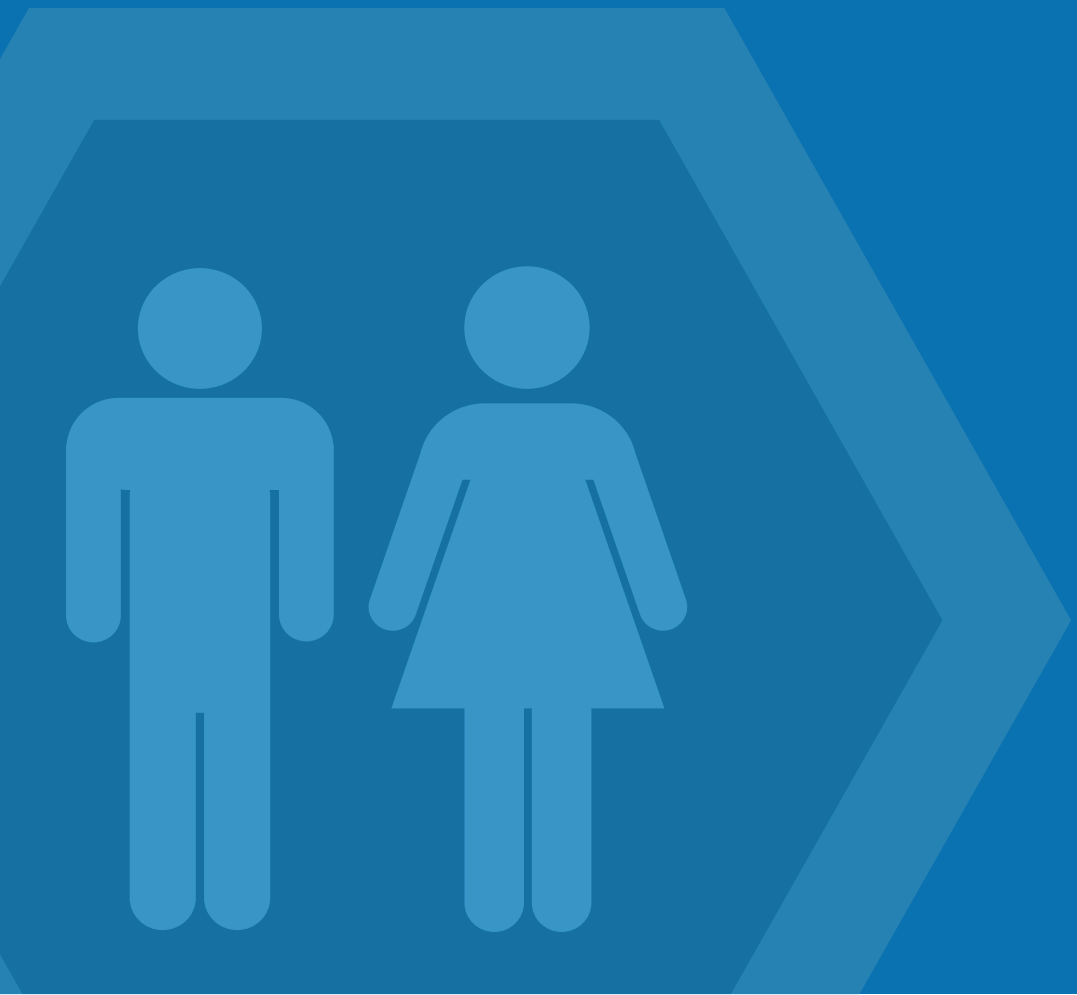
Leicestershire Joint Strategic Needs Assessment 2015

Chapter 4:
Health and Wellbeing of Adults



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CONTENTS

List of Tables

List of Figures

No table of figures entries found.

CHAPTER 4 - HEALTH AND WELLBEING OF ADULTS

This section of the report reviews the health and wellbeing issues affecting adults (people aged 16 years and over), including older adults. Issues that are specific to young people (age up to 24 years) are included in the chapter 3 and issues that are specific to ageing are covered in chapter 5. This section reviews the whole population issues affecting the adult 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.[1] 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.[2] Improving health is also important for increasing employment.[3] 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.[4]

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.[3] Around 172 million working days were lost to sickness absence in 2007, at a cost of over £13 billion to the economy.[3] 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.[5]

Towards the end of a person's working life diseases such as cancer and long-term conditions start to form a significant proportion of all deaths. Many of these illnesses are preventable and are caused by the lifestyle choices that are made earlier in adulthood. Early detection and treatment or management of these illnesses can significantly improve a persons long-term outcomes and quality of life.

Many premature deaths and illnesses could be avoided by improving lifestyles. It is estimated that a substantial proportion of cancers and over 30% of deaths from circulatory disease could be avoided, mainly through a combination of stopping smoking, improving diet and increasing physical activity.[6] [7]

There have been significant increases in overall life expectancy in England in the past decade. However, supporting people to make healthy choices is essential to increasing not just their overall life expectancy, but their healthy life expectancy. This will ensure that people have the greatest opportunity for healthy long lives rather than being affected by preventable ill health and disability in older age. This is detailed in Chapter 1.

The background section of this report sets out the key drivers of premature mortality, the wider determinants of health and NHS health care resource usage.

1. Long-term conditions and cancer

Long-term conditions refer to a group of illnesses that, at present, cannot be cured but can be controlled by medication and other therapies. Once diagnosed with a long-term condition, a patient's life is forever altered. However, by supporting patients with a long-term condition to manage their condition and their risk factors, the NHS and social care can support the patient to attain better health outcomes and quality of life, slow disease progression and reduce disability.

There are a large group of diseases that are considered to be long-term conditions. Within this section there is an overview of the common long-term conditions that are recorded on GP registers.

Cancer is the highest cause of death in England, for both all ages and in under 75 year olds. Mortality rates from cancer are reducing, but to ensure that there continues to be a reduction in the rate of premature mortality from cancer, there needs to be concerted action in both prevention and treatment.[8] Over two fifths of all premature deaths in Leicestershire are due to cancer.[9] Reducing premature deaths from cancer will increase life expectancy and help to reduce health inequalities.

1.1. Evidence of need

Table 1 details the numbers of people that are recorded on GP disease registers with long term conditions. This shows that in 2013/14 there were:[10]

- 97,035 people with hypertension (14.5%);
- 20,928 people with coronary heart disease (3.2%);
- 39,994 people with asthma (6.0%) and 10,994 people with chronic obstructive pulmonary disease (1.6%);
- 34,825 people with diabetes (6.4%);
- 21,825 people with chronic kidney disease (4.1%); and

- 15,157 people with cancer (2.3%).

This demonstrates that there a significant number of people are affected by established long term conditions and cancer that need support to manage their conditions. The prevalence of long-term conditions increases with age and the POPPI data (included in Chapter 5) illustrates that the proportion of people affected by a limiting long term illness age 65 years and over will increase by over 50% - much of this illness will be acquired through adulthood.

Long-term conditions and cancer are the main driver of health inequalities in Leicestershire and drive premature mortality in the population (included in Chapter 1). Public Health England have published an analysis of the main causes of health inequalities in Leicestershire, detailed in Chapter 1. The root causes of health inequalities are cardiovascular disease, cancer and respiratory disease.[11]

Between 2011 and 2013 in Leicestershire for people aged under 75 years there were:[8]

- 1,185 deaths from cardiovascular disease, 785 of these were estimated to be preventable;
- 2,289 deaths from cancer, 1,296 of these were estimated to be preventable;
- 409 deaths from respiratory disease, 204 of these were estimated to be preventable; and
- 255 deaths from liver disease, 229 of these were estimated to be preventable.

Premature mortality from long-term conditions is reducing for all major causes, apart from liver disease, which is showing a year on year increase, both in Leicestershire and in England. The premature mortality rate from cancer is not decreasing as quickly in Leicestershire as it is for England as a whole – Leicestershire has seen a reduction in premature mortality rates of 6% between 2001-03 and 2011-13, whilst the decrease for England has been 15% (included in Chapter 1).

1.2. **Service review**

Over 50% of healthcare spend in Leicestershire is focussed into the disease areas of mental health, cancer, circulatory disorders, musculo-skeletal disorders and respiratory disease.[12] Services for people with long-term conditions will occur across the whole health and social care pathway, from primary prevention, through to end of life care services. The most important change that can be made is to stop people from developing long-term conditions where this is possible.

The health and social care system across Leicester, Leicestershire and Rutland has recognised the importance of long-term conditions in their five year strategy, “Better

Care Together".[13] The long-term conditions workstream has identified that there is variation in detection and treatment of long-term conditions and too many people are admitted to hospital with conditions that could be managed in the community. The focus for Better Care Together is supporting people to manage their own conditions more effectively and on improving community support to reduce emergency admissions and readmissions.

The JSNA has also identified a need to prevent people from developing long-term conditions where this is possible and the importance of strengthening prevention across the life course, with a particular focus on working age behaviours where life style choices are made that will lead to the development of long-term conditions.

Self-management of long-term conditions is central to primary care and forms a core part of the main GP contract. The GP practices in Leicestershire (East Leicestershire and Rutland CCG and West Leicestershire CCG) achieve very highly against the Quality and Outcomes Framework, the main contractual data set for GPs, with over 97% of all points claimed by local practices.[10] This is higher than the England average of 92.4%.[10] For Leicestershire the GP performance for the Quality and Outcomes Framework (QOF) in 2013/14 is detailed below:[10]

- Overall, over 97% of all QOF points were attained, against an England average of 92.4%.

- Over 96% of clinical points were attained, with 97% of cardiovascular disease points and over 77% of respiratory disease points. The respiratory disease domain is a key domain where performance is worse than the England average of 96%.

- For the high dependency and long term conditions domain Leicestershire practices attained over 95% of available QOF points.

- For both the quality and productivity domain and the patient experience domain, Leicestershire practices attained 100% of QOF points.

The NHS Health Check programme, commissioned by Leicestershire County Council, aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of developing heart disease, stroke, kidney disease and diabetes, and will be given support and advice to help them reduce or manage that risk.[14] In Leicestershire, health checks are delivered solely by GP practice staff.

- By the end of 2013/14 (year 1 of a 5 year rolling programme), 25% of eligible adults in Leicestershire had been offered an NHS health check. This is

significantly better than the England average of 18%.[8] Overall, 12% of eligible adults in Leicestershire have received an NHS health check. This is significantly better than the England average of 9%.[8] There is an aspiration to have delivered health checks to 65% of the eligible population at the end of the first 5 year period in 2018.

In 2011, 67% of people diagnosed with cancer in the NHS West Leicestershire CCG and 70% of people in East Leicestershire CCG survived for a least one year.[15] For England overall the average 1 year survival rate is 68%.[15]

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 Joint Health and Wellbeing Strategy to reflect this. Cancer 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 are smoking, obesity and alcohol.[16]

- In 2014, 83% of eligible women in Leicestershire had been screened for breast cancer in the previous 3 years. This is significantly better than the England average of 76%.[8]

- In 2014, 78% of eligible women in Leicestershire had been screened for cervical cancer in the previous 3½ or 5½ years, according to age group. This is significantly better than the England average of 74%.[8]

1.3. **Gap analysis**

There are gaps in the numbers of people that have been identified through general practice with established long-term conditions and the number of people that are estimated to have these conditions – this represents a significant proportion of people with ill health that are not being support to manage their own conditions effectively:

- It has been estimated that in 2011, Leicestershire had a prevalence of coronary heart disease of 5%.[17] This equates to about 34,000 people. However, GP recorded prevalence for 2013/14 was just 3.2%,[10] or 21,000 people. This means that about 13,000 people may be undiagnosed in Leicestershire.

- It has been estimated that in 2011, Leicestershire had a prevalence of hypertension of 30%.[17] This equates to about 198,000 people. The GP recorded prevalence of hypertension in Leicestershire for 2013/14 of 15%,[10] this means that about 99,000 people may be undiagnosed in Leicestershire.

- It has been estimated that in 2011, Leicestershire had a prevalence of COPD of 2.8%.[17] This equates to about 19,000 people. Given the GP recorded

prevalence for 2013/14 was just 1.6%,[10] or 11,000 people, this means that about 8,000 people may be undiagnosed with COPD in Leicestershire.

- It has been estimated that in 2012, Leicestershire had a prevalence of diabetes of 7.1%.[17] This equates to about 39,000 people. The GP recorded prevalence of diabetes for 2013/14 in Leicestershire was 6.4%,[10] or 35,000 people, it seems that GP recorded diabetes prevalence in Leicestershire may well be complete. Recorded diabetes prevalence has remained stable in Leicestershire since 2012/13.[10] Prevalence for 2030, modelled by Yorkshire and Humber Public Health Observatory, is 8.4% of the population if current obesity levels are maintained, but 9.0% if obesity continues to rise at the current rate.[18]

Premature mortality rates and life expectancy are explored in the background section of this report and these indicate that people that are affected by socio-economic deprivation have a lower life expectancy and a higher rate of premature mortality from the core long-term conditions. These inequalities are unacceptable and more must be done to reduce these health inequalities in the future. The key issues of concern in Leicestershire are:

- The slow reduction in premature mortality rates from cancer. It is believed that this is due to late diagnosis and more must be done to improve this.

- The increase in premature mortality from liver disease.

The Better Care Together five year strategy has identified that there is variation in detection and treatment of long-term conditions and too many people are admitted to hospital with conditions that could be managed in the community. This is symptomatic of geographical variation in the services that are available to people across the county which must be addressed through commissioning.[13]

As well as supporting people with established illness there is a need to prevent people from developing long-term conditions that are linked to lifestyle behaviours.

1.4. **Recommendations**

It is recommended that the plans across health and social care are developed to:

- Support the prevention of long-term conditions through improved primary prevention in working age adults;

- Support people with established illness to manage their conditions more effectively on their own and therefore reduce their need for services;

- Ensure that there is a consistent level of care and support available to all people in Leicestershire regardless of where they live and where they access services;

- Work together to reduce health inequalities across all stages of the health and social care pathway; and

- Provide effective community support to all people with long-term conditions to reduce their need for emergency hospital admissions and readmissions.

Table 1: GP Recorded Disease Prevalence, 2013/14

Area		England	Blaby	Charnwood	Harborough	Hinckley and Bosworth	Melton	North West Leicestershire	Oadby and Wigston	Leicestershire	Rutland
Atrial Fibrillation	Register counts	883,938	1,671	2,685	1,540	1,840	1,020	1,683	1,147	11,586	883
	Raw prevalence	1.6%	1.7%	1.5%	1.8%	1.8%	2.0%	1.8%	2.0%	1.7%	2.5%
Coronary Heart Disease	Register counts	1,854,867	3,187	5,293	2,530	3,363	1,773	3,274	2,078	21,498	1,337
	Raw prevalence	3.3%	3.3%	2.9%	3.0%	3.3%	3.4%	3.4%	3.6%	3.2%	3.7%
Cardiovascular Disease Primary Prevention	Register counts	1,585,442	2,738	4,937	2,613	3,066	2,132	3,369	2,073	20,928	1,322
	Raw prevalence	2.8%	2.8%	2.7%	3.1%	3.0%	4.1%	3.5%	3.6%	3.1%	3.7%
Heart Failure	Register counts	401,729	698	1,469	550	944	438	947	520	5,566	381
	Raw prevalence	0.7%	0.7%	0.8%	0.6%	0.9%	0.9%	1.0%	0.9%	0.8%	1.1%
Hypertension	Register counts	7,735,592	14,519	23,989	11,717	15,523	7,899	14,411	8,977	97,035	5,917
	Raw prevalence	13.73%	15.1%	13.2%	13.8%	15.4%	15.3%	15.1%	15.4%	14.5%	16.5%
Peripheral Arterial Disease(PAD)	Register counts	360,599	411	1,053	380	628	396	618	326	3,812	228
	Raw prevalence	0.64%	0.4%	0.6%	0.4%	0.6%	0.8%	0.6%	0.6%	0.6%	0.6%
Stroke or Transient Ischaemic Attacks (TIA)	Register counts	966,093	1,633	2,826	1,482	1,789	839	1,653	1,107	11,329	748
	Raw prevalence	1.72%	1.7%	1.6%	1.8%	1.8%	1.6%	1.7%	1.9%	1.7%	2.1%
Asthma	**Register counts**	**3,340,484**	**5,445**	**10,522**	**5,171**	**6,118**	**3,090**	**6,167**	**3,481**	**39,994**	**2,063**
	Raw prevalence	**5.93%**	**5.7%**	**5.8%**	**6.1%**	**6.1%**	**6.0%**	**6.5%**	**6.0%**	**6.0%**	**5.8%**
Chronic Obstructive Pulmonary Disease	**Register counts**	**1,004,920**	**1,562**	**2,776**	**1,318**	**1,795**	**759**	**1,846**	**938**	**10,994**	**625**
	Raw prevalence	**1.78%**	**1.6%**	**1.5%**	**1.6%**	**1.8%**	**1.5%**	**1.9%**	**1.6%**	**1.6%**	**1.7%**
Obesity (ages 16+)	Register counts	4,329,858	7,139	12,844	5,702	7,807	4,719	7,664	3,480	49,355	2,920
	Raw prevalence	9.42%	9.0%	8.5%	8.2%	9.3%	11.1%	9.8%	7.2%	8.9%	9.9%
Cancer	**Register counts**	**1,180,841**	**2,307**	**3,380**	**2,167**	**2,488**	**1,237**	**2,242**	**1,336**	**15,157**	**1,064**
	Raw prevalence	**2.10%**	**2.4%**	**1.9%**	**2.6%**	**2.5%**	**2.4%**	**2.4%**	**2.3%**	**2.3%**	**3.0%**
Chronic Kidney Disease (ages 18+)	**Register counts**	**1,786,463**	**2,341**	**4,904**	**3,386**	**3,993**	**1,758**	**3,696**	**1,850**	**21,928**	**1,410**
	Raw prevalence	**4.00%**	**3.1%**	**3.3%**	**5.0%**	**4.9%**	**4.3%**	**4.9%**	**4.0%**	**4.1%**	**5.0%**
Diabetes Mellitus (Diabetes) (ages 17+)	**Register counts**	**2,814,004**	**4,857**	**9,603**	**3,677**	**5,407**	**2,629**	**5,152**	**3,500**	**34,825**	**1,967**
	Raw prevalence	**6.21%**	**6.2%**	**6.4%**	**5.4%**	**6.6%**	**6.3%**	**6.7%**	**7.4%**	**6.4%**	**6.8%**
Hypothyroidism	**Register counts**	**1,836,835**	**2,870**	**5,309**	**2,627**	**3,406**	**1,619**	**3,353**	**2,055**	**21,239**	**1,316**
	Raw prevalence	**3.26%**	**3.0%**	**2.9%**	**3.1%**	**3.4%**	**3.1%**	**3.5%**	**3.5%**	**3.2%**	**3.7%**
Palliative Care	**Register counts**	**152,099**	**384**	**739**	**338**	**493**	**437**	**592**	**236**	**3,219**	**305**
	Raw prevalence	**0.27%**	**0.4%**	**0.4%**	**0.4%**	**0.5%**	**0.8%**	**0.6%**	**0.4%**	**0.5%**	**0.9%**

Area		England	Blaby	Charnwood	Harborough	Hinckley and Bosworth	Melton	North West Leicestershire	Oadby and Wigston	Leicestershire	Rutland
Dementia	Register counts	348,973	661	1,083	472	665	311	577	401	4,170	266
	Raw prevalence	0.62%	0.7%	0.6%	0.6%	0.7%	0.6%	0.6%	0.7%	0.6%	0.7%
Depression (ages 18+)	Register counts	2,912,592	6,674	10,664	5,354	7,436	4,039	6,494	3,083	43,744	1,537
	Raw prevalence	6.52%	8.7%	7.2%	8.0%	9.1%	9.8%	8.6%	6.6%	8.2%	5.5%
Epilepsy (ages 18+)	Register counts	349,898	515	1,083	448	592	311	607	298	3,854	173
	Raw prevalence	0.78%	0.7%	0.7%	0.7%	0.7%	0.8%	0.8%	0.6%	0.7%	0.6%
Learning Disabilities (ages 18+)	Register counts	214,352	255	656	223	366	162	332	195	2,189	127
	Raw prevalence	0.48%	0.3%	0.4%	0.3%	0.4%	0.4%	0.4%	0.4%	0.4%	0.5%
Mental Health	Register counts	483,933	570	1,378	550	706	294	537	502	4,537	235
	Raw prevalence	0.86%	0.6%	0.8%	0.6%	0.7%	0.6%	0.6%	0.9%	0.7%	0.7%
Osteoporosis (ages 50+)	**Register counts**	**79,526**	**91**	**190**	**119**	**156**	**75**	**170**	**64**	**865**	**56**
	Raw prevalence	**0.40%**	**0.2%**	**0.3%**	**0.3%**	**0.4%**	**0.4%**	**0.5%**	**0.3%**	**0.3%**	**0.4%**
Rheumatoid Arthritis (ages 16+)	**Register counts**	**336,321**	**600**	**963**	**467**	**611**	**303**	**589**	**433**	**3,966**	**200**
	Raw prevalence	**1.71%**	**0.8%**	**0.6%**	**0.7%**	**0.7%**	**0.7%**	**0.8%**	**0.9%**	**0.7%**	**0.7%**

2. Avoidable injury

Avoidable injury is an important, often overlooked, public health issue causing significant ill-health, disability and premature loss of life. The term 'avoidable injury' covers a wide range of injury mechanisms, from home-injuries such as burns and poisonings that affect mostly young children, to leisure-related injuries affecting adolescents and young adults, transport injuries, work-related injuries and falls, and fragility injuries in later life. It also includes injuries suffered through intentional acts such as self-harm, assault and neglect.

Given the wide range of causes of injury, interventions need to be targeted to specific settings. The Royal Society for the Prevention of Accidents has published a guide to injury prevention that provides a useful summary of evidence-based interventions for unintentional injury.[19] In brief these measures can be summarised in terms of three-Es: Education, Enforcement and Environment. Education, combined with environmental changes to the home, such as the introduction of safety equipment for children and home adaptations for older people are effective at preventing home injuries. Driver education programmes combined with legislative enforcement such as seatbelt use and environmental traffic calming measures are all effective in reducing traffic-related injuries and leisure and workplace health and safety programmes including legislation has dramatically reduced the occurrence of work and leisure-related injuries.

2.1. Evidence of Need

- In 2011-13 in Leicestershire, 31 people per 100,000 were killed or seriously injured on the roads – significantly better than the England average of 40 per 100,000. However, this is 619 preventable deaths.[8]

- The rate of people killed and seriously injured on Leicestershire's roads has fallen from 38 per 100,000 in 2009-11, to 31 per 100,000 in 2011-13. The rates for England as a whole are also falling, although less quickly than in Leicestershire

- In 2012, there were 181 pedestrian casualties in Leicestershire: a rate of 28 per 100,000 population. This is lower than the England value of 42 per 100,000 population.[20]

- The rate of pedestrian casualties per 100,000 population has generally been falling in Leicestershire, since 2002.[20] In 2013, 34 pedestrians were killed for every billion pedestrian miles travelled, in Great Britain. This can be compared to 34 cyclists and 2 car drivers for every billion miles travelled.[21]

- In 2012/13 Leicestershire had a directly standardised rate of hospital admissions for self-harm of 123 per 100,000 population – significantly better than the England average of 188 per 100,000.[22]

2.2. **Service Review**

Injuries affect people across the life-course and in a range of settings. Injuries can have lasting physical and psychological effects and can impact on education attainment, employment and caring responsibilities, resulting in significant costs to the healthcare system and the wider economy also. Accidental injury at different stages of the lifecycle are addressed throughout the different sections of the JSNA.

Road safety

The Department of Transport has estimated the total cost to society of all reported road traffic accidents in Great Britain in 2011 to be £15.6 billion.[23] Every person killed in a road traffic accident represents a cost to society of over £1.6 million, and each person seriously injured almost £190,000.[23]

Reducing the number of casualties on all roads in Leicestershire is a priority in the current Local Transport Plan 3 adopted in April 2011. The plan identifies four main ways to do this:[24]

- providing a safer road environment, using national road injury data to target road and junction improvements and informing the planning of significant urban extensions;
- managing speed through the use of advisory 20 mph zones and traffic calming measures;
- education, training and publicity, including driver education courses for drivers caught speeding; and
- improving safety for vulnerable road users through a number of schemes.

Gap Analysis

Whilst overall the number of people affected by transport injuries is decreasing, less is known about injury inequalities within Leicestershire and this needs more exploration. Similarly, the emerging partnership between Public Health and local authority Planners and the County Council's Environment and Transport department is welcome and should continue to develop.

2.3. **Recommendations**

It is recommended that:

1. There is a consistent approach to injury prevention across the life course and across settings, informed by a detailed injury health needs assessment that maps out injury inequalities by deprivation.

2. Public Health, Environment and Transport and local Planning departments to continue to work in partnership to ensure that injury prevention is at the heart of Leicestershire's built environment.

3. Injury prevention interventions continue to be targeted to communities at highest risk using both health (hospital admission) and police (Stats19) data to inform this.

4. The work of the Better Care Fund plan on falls prevention is effectively supported, helping to develop specific strategies and programmes, which have been shown to reduce falls.

3. Work and health

There is strong evidence to suggest that work is good for physical and mental health and wellbeing.[3] The 2006 report, *"Is work good for your health and wellbeing?"* found that work is usually good for health and work is also known to be the best route out of poverty.[2] Work generally:

- Makes people healthier;
- Helps people with a health condition get better; and
- Improves the health of people returning to work from unemployment

In the 2011 Census, 342,139 (71%) of people aged 16-74 years in Leicestershire were economically active. This is similar to the England average of 70%.[25] Unemployment can have a detrimental impact upon health. Those who have been long-term unemployed or those who have never worked are two to three times more likely to have poor health than those in work.[2]

Sickness absence levels have generally been falling over the last decade a report commissioned by the government, published in 2011 indicated that 140 million working days were lost due to sickness in England.[26] The workplace is an important setting for health and wellbeing. Most employers recognise the contribution that protecting and improving the health of their workforce can make to their business and that a healthy workforce is a productive workforce. Employers are well placed to support their workforce to lead healthier lives. Evidence suggests creating health and wellbeing programmes jointly with staff are effective and workplaces provide the opportunity to reach people who do not always access health interventions elsewhere.

3.1. **Evidence of Need**

The labour force survey provides self-reported information on the number of working days lost due to sickness absence during the previous week:

- According to the Labour Force survey 2010-12, 2.1% of workers in Leicestershire took a day off due to ill-health in the previous week. This is similar to the England figure of 2.5%.[8]

- In 2010-12, in Leicestershire, 1.3% of working days were lost due to ill-health. This is similar to the England average of 1.6%.[8]

3.2. **Service Review**

Injuries and ill health in workers in Great Britain resulting largely from current working conditions cost an estimated £14.2 billion in 2012/13 (£1.1 billion in the East Midlands region).[27]

A Leicestershire workplace health and wellbeing group undertook a review of existing workplace programmes in 2012. As part of this, a mapping exercise identified a wide range of workplace health programmes in Leicestershire run by a broad range of organisations. These include: Fit4Work, local authorities, Leicestershire and Rutland Sport, Leicestershire Stop Smoking Service and Loughborough College. Work is currently underway to promote the adoption of the national Workplace Wellbeing Charter Standards in Leicestershire, initially on a self-assessment basis.

The Fit4Work service has been commissioned to provide a healthy workplaces programme to support small and medium size employers (SME) in Leicestershire. This was extended to include the development of a website to promote and collate data on specialist programmes available locally.

3.3. **Gap Analysis**

People with established illness, disability or a long term condition are more likely to be unemployed than the general population:

- In Leicestershire there is a gap of 4.1% in the rates of employment for people with a long-term condition, compared with the overall employment rate. This is lower than the gap for England of 7.1%.[8]

- There is a gap in the employment rate for people in contact with secondary mental health services and the overall employment rate. Supporting people with mental health problems into employment is important and can contribute to improvement in their wellness. The Leicestershire gap is 67.3%. This is slightly higher than for England which is 64.7%.

- Sickness absence rates vary considerably between organisations, sectors and manual and non-manual roles. In 2012, nationally, private sector annual absence levels were 6.4 days for manual workers and 4.2 days for non-manual workers. This compared with 8.1 days for public sector manual workers and 6.8 for non-manual. Average absence costs are estimated at £975 per employee per year.

- Nationally, in 2012, the most common causes of long-term absence (four weeks or more) were stress, acute medical conditions (for example stroke, heart attack and cancer), mental ill health, musculoskeletal injuries and back pain.[28]

3.4. **Recommendations**

It is recommended that:

- Commissioners promote use of the national Workplace Wellbeing Charter Standards with local employers to ensure good employment practices are widespread.

- Commissioners support and promote the roll out of the new national Fit for Work service which will support employees to stay in and return to work. From autumn 2015 this free service will provide occupational health assessment and general health and work advice to employees, employers and GP's.

- Commissioners work with employers to implement the recommendations of the NICE 'Workplace policy and management practices to improve the health and wellbeing of employees 'published June 2015.

- The council works with local agencies to develop and promote schemes which enable people to develop new skills and support their return to both paid and voluntary work.

4. Tobacco Control

Tobacco use is the single greatest 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.[29]

Two-thirds of smokers say they began smoking before the age of 18 and nine out of ten started before the age of 19 (Statistics on Smoking England 2014 HSIC). Smoking accounts for about half of the difference in life expectancy between those in the lowest and highest income groups[30]. 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.[31]

4.1. **Evidence of Need**

- In 2013, the smoking prevalence in Leicestershire was 18.0%, similar to the England average of 18.4%.[8]

- There were 2,760 deaths in Leicestershire between 2011-13 attributable to smoking, giving a rate of smoking attributable mortality of 244 per 100,000 population. This is significantly better than the England rate of 289 per 100,000 population.[8]

- In 2010/11, the rate of smoking attributable hospital admissions in Leicestershire was 1,164 per 100,000 population. This is significantly better than the England average of 1,420 per 100,000 population.

- There are variations in smoking rates in different populations, with people from lower socio-economic groups more likely to smoke than the overall population. In 2013, for routine and manual populations, the smoking prevalence rose to 28.0%, also similar to the England prevalence of 28.6%.[8]

4.2. **Service Review**

Tobacco-free Leicestershire and Rutland (TLR) is the local tobacco control alliance, led by Leicestershire Public Health Department, and has the agreed mission to reduce the prevalence, power and influence of tobacco through advocacy, education and community organisation. Future Tobacco Control (TC) activity will be working towards shaping a tobacco free generation with activity and services designed to reduce modelling and uptake, and increase cessation opportunities and long-term cessation success. This includes evidence-based and accessible stop smoking services, a web-based smoke free environments campaign, increased advocacy activity and continued tackling of illicit tobacco.

TLR programmes currently include:

- Quit 51 (the Stop Smoking service) – this is a new service that commenced on the 1st April 2015;

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

- the Alcohol and Tobacco Enforcement Programme (ATEP) (Enforcement programme focused on reducing underage and illegal alcohol and tobacco sales, both with trading standards);

- a regional alcohol and tobacco enforcement officer; and

- Step Right Out (Web based Smokefree Homes and Cars campaign)

In 2013/14, the rate of successful quitters at 4 weeks in Leicestershire was 3,972 per 100,000 population, significantly higher than the England average of 3,524 per 100,000 population.[32]

Smoking is responsible for a significant level of spend across public services:

- The Ash Ready Reckoner estimates the local cost of tobacco in Leicestershire, with an estimated cost to society of approximately £156.6 million per year.[33]

- In 2010/11, the cost per capita of smoking attributable hospital admission in Leicestershire was £17.70. This is lower than the England average of £36.90, but still represents a significant spend.

- In 2014, in Leicestershire County Council, £3.64 was spent per head on stop smoking services and interventions. This is higher than the England average (median) spend of £2.46.[34] £0.48 was spent per head on wider tobacco control. This is higher than the England average (median) spend of £0.16.[34]

- The majority of cigarette filters are non-biodegradeable and must be disposed of in landfill sites. The ASH Ready Reckoner estimates this amounts to approximately 75 tonnes (442m filtered cigarettes) of waste in Leicestershire per annum. Of this, more than 17 tonnes is discarded as street litter that must be collected by local government street cleaning services.

4.3. **Gap Analysis**

Leicestershire continues to increase access to evidence-based stop smoking services, both for the general population and with targeted activities in populations at greatest risk of smoking. However, nearly one in five of the Leicestershire population continue to smoke and this drives a significant amount of related ill health and premature mortality.

Adults smoking can have a significant impact on the health of their children and parents, guardians and carers must recognise that passive smoking causes ill-health in children and that they have a responsibility not to harm 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. In addition to the obvious health effects of smoking and second-hand smoke, there is an increased risk that young people living with one or more smokers will smoke as well and there is an increased risk of fire in homes with a smoker.

4.4. **Recommendations**

It is recommended that commissioners work together to further develop a comprehensive programme of evidence-based tobacco control that moves Leicestershire towards a tobacco free generation by:

- Providing accessible, effective evidence based stop smoking services to all smokers.
- Effectively tackling illicit tobacco through increased public awareness and intelligence.
- Increasing public awareness of the harms of second-hand smoke and encouraging smokers to *Step Right Out* to decrease that risk. Alongside that, increasing awareness and compliance in ***no smoking in cars*** legislation effective October 2015.
- Working with schools to empower young people to use their voice and say no to tobacco.
- Working with care homes and other partners to reduce smoking among staff and resident Children in Care.

5. Healthy Weight

Obesity is a major contributor to ill health, premature death and health inequalities and has other impacts on society and the economy. The importance of reducing obesity has been recognised by the Health and Wellbeing Board in Leicestershire.

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.

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.

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.

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.[35]

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.

5.1. **Evidence of Need**

- In 2012, 65.4% of adults in Leicestershire were overweight or obese. This is similar to the England average of 63.8%.[8]

- In England, there has been a marked increase in the proportion of adults with excess weight from 58% in 1993 to 67% in 2013 for men, and from 49% to 57% for women.[36] In 2007, the Foresight report estimated that by 2025, 47% of men and 36% of women (aged between 21 and 60) could be obese, in England.[36] This projection is likely to be replicated in the population of Leicestershire.

- In 2013, 58% of adults in Leicestershire achieved the recommendation of 150 minutes of physical activity per week, significantly better than the England average of 56%.[8] In contrast, 26% of adults in Leicestershire in 2013 were considered inactive i.e. achieving less than 30 minutes of physical activity per week, significantly better than the England average of 28%.[8]

- In 2013, Leicestershire had a density of 66 fast food outlets for every 100,000 people, significantly lower than the England average of 86.[37]

5.2. **Service Review**

- In 2014, in Leicestershire County Council, 88 pence was spent per head on adult obesity services and interventions. This is the same as the England average (median) spend and higher than the median spend across English counties of 73 pence.[34]

- In 2014, in Leicestershire County Council, £1.19 was spent per head on adult physical activity services and interventions. This is higher than the England average (median) spend of 35 pence and higher than the median spend across English counties of 25 pence.[34]

Leicestershire's strategic approach to reducing obesity is addressed through four critical areas of work:

- physical activity;

- weight management;
- food and nutrition; and
- improving the obesogenic environment.

Physical activity: increasing levels of physical activity is a central component of Leicestershire's "Healthy weight" strategy, both as a mechanism to maintain a healthy weight, and 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 district councils and Leicester-shire Rutland Sport (LRS). Each district offers a programme of regular and easily accessible activities 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 targeted interventions to increase physical activity in specific populations.

Weight Management: over the past three years, there has been a steady growth in the accessibility and range of weight management programmes in Leicestershire. Weightwatchers now offers a free 12 week programme to over 1,000 residents per year, through 100 local groups. The NHS Dietician led LEAP and FliC programmes have been available in every district since 2013 and doubled the number of clinics run in the past 2 years. New weight management programmes will be developed in 2015/16 to support overweight pregnant women, men and South Asian communities.

Food and Nutrition: 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. A major focus for Leicestershire has been to begin to develop a coherent long-term strategy to address society's increasingly unhealthy relationship with food, which includes developing programmes which aim to change social norms and attitudes to food and food culture. 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. Leicestershire County Council Adult Learning Team's 'Basic cookery skills' programme develops skills and knowledge around buying and preparing healthy food, particularly on a low income, whilst the Master Gardeners programme supports and encourages communities to grow their own fruit and vegetables. Leicestershire's flagship schools programme "Food For Life", will not only transform food culture in many primary schools, but also aims to inform and influence healthy behaviour in staff, parents, grandparents and the wider community. Participating schools host parent cooking sessions, grandparent gardening days, and farmer's markets for example.

Obesogenic Environment: Leicestershire Public Health Department is in the early stages of developing an approach to systematically influencing the wider

determinants of health including the built environment, transport and housing to help create health promoting places and enable healthy choices.

5.3. **Gap Analysis**

Obesity levels in the population are rising both nationally and across Leicestershire and physical activity levels are falling. If there is not a sustained effort to address this, the levels of ill-health and disability caused by overweight and obesity will increase for the whole population.

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.

5.4. **Recommendations**

It is recommended that:

- Partners work together to ensure that future policies and planning decisions reduce the obesogenic environment and to make physical activity and healthy eating an easier choice.

- The council undertakes a review of the commissioning and delivery of physical activity in order to unify commissioning priorities and funding across the partnership, to develop a combined commissioning strategy.

- Commissioners ensure better use of community assets including community venues, parks and green spaces, private and publicly owned leisure facilities and active travel infrastructure to promote physical activity and reduce inactivity.

- Commissioners develop a more streamlined and comprehensive physical activity care pathway, to link specialist clinical rehabilitation services (e.g. cardiac, pulmonary, mental health, falls, diabetes) with local community support and maintenance programmes (e.g. exercise referral).

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

- Commissioners continue to build opportunities for the population to access affordable, healthy food through programmes for the whole population, as well as through targeted interventions to support the most disadvantaged individuals to increase their levels of healthy eating.

6. Substance misuse

Alcohol misuse is the third greatest overall contributor to ill health, after smoking and raised blood pressure.[38] Nearly 7 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.[39]

Drug misuse is widespread with 2.7 million adults reporting using an illegal drug in the past year,[40] and 1.2 million affected by drug addiction in their families, mostly in poor communities.[41]

Drug misuse damages physical health and mental health contributing to liver damage, poor vein health, blood borne viruses, cardiovascular disease, arthritis and immobility.[42] As well as impacting on individual health and wellbeing, drug misuse harms families and communities. Parental drug use is a risk factor in 29% of all serious case reviews.[43]

Preventing people from misusing alcohol and drugs and treating these people leads to better public health outcomes including:

- reducing hospital admissions;
- reducing premature mortality;
- reducing premature mortality from liver disease;
- preventing suicide and self- harm;
- reducing drug related deaths; and
- reducing HIV, heart disease, respiratory disease, liver disease and cancers.

6.1. Evidence of Need

- In 2012/13 there were 3,718 alcohol related hospital admissions for adults in Leicestershire, an admission rate of 573 per 100,000 population which is significantly better than the England average of 637 per 100,000 population.[8]
- Alcohol-specific mortality rates were 10.3 per 100,000 persons for 2011-13. This is significantly better than the England average of 11.9 per 100,000.[44]
- Premature mortality from liver disease has increased by 43% between 2001-03 and 2011-13 in Leicestershire (**Error! Reference source not found.**).[8]
- In 2011/12 it was estimated that 4.4 per 1,000 16-54 year olds (1,851 people) in Leicestershire used opiates and/or crack cocaine (OCU) in the previous 12

months, this is almost half of the national rate of 8.4 per 1,000 15-64 year olds.[45]

- The rate of adult drug-related hospital stays for 2006/07 – 2008/09 was 58.4 per 100,000 population (approximately 270 admissions per year). This is significantly better than the East Midlands average.[46]

- The drug-related death rate for 2009-11 was 1.9 per 100,000 population (approximately 7 drug-related deaths per year). This is significantly better than the East Midlands average.[46]

6.2. **Service Review**

- In Leicestershire County Council, £3.60 was spent per head of population on adult alcohol misuse services and interventions. This is similar to the England average (median) spend of £3.27.[34]

- In Leicestershire, £5.14 was spent per head of population on adult drug misuse services and interventions. This is lower than the England average (median) spend of £10.57.[34]

- In Leicestershire, £0.37 was spent per head of population on drug and alcohol misuse services and interventions for young people. This is similar to the England average (median) spend of £0.64.[34]

Currently support for people with substance misuse problems are provided across Leicestershire by a number of services:

- Swanswell provide services from a range of different venues across Leicestershire for adults and young people with problems with alcohol and/or drugs. Support includes providing advice and information, assessment, counselling and psychosocial support, and specialist treatment, all with the aim of supporting people to recover from their substance misuse problem.

- LiFT provides support for adults with drug and/or alcohol problems who are involved in the criminal justice system.

- Alcohol nurse specialists based within local hospitals provide advice, treatment and referral to people attending hospital for alcohol related issues.

- Specialist in-patient detoxification services are provided in a dedicated unit just outside of the Leicestershire border.

- Screening and brief advice for alcohol is provided by a majority of GP/primary care practices and pharmacists across Leicestershire. These services can also refer people to specialist services where this might be appropriate.

- In 2012/13, the rate of adults in treatment for substance misuse (per 1,000 population) was: [46]
    - 2.6 per 1,000 adults in alcohol treatment (1,201 people). This is similar to the East Midlands average.[46]
    - 3.1 per 1,000 adults in structured drug treatment (1,431 people). This is similar to the East Midlands average.[46]
- In 2013, the proportion of adults successfully completing drug treatment was:[8]
    - 10.7% for opiate users, this is significantly higher than the England average.[8]
    - 36.8% for non-opiate, this is similar to the England average.[8]
- The rate of young people in drug or alcohol treatment in 2012/13 was 1.9 per 1,000 population (134 people). This is significantly lower than the East Midlands average.[46]

6.3. **Gap Analysis**

- The increase in premature mortality from liver disease, both in England and locally, reflects the increasing levels of medium and high risk drinking.
- For our substance misuse services, in 2012/13, 10.4% of adult drug users in Leicestershire were not in effective drug treatment.[46] Of the adults in structured drug treatment, 22% had an unplanned exit.[46]

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 48% drug users and 52% alcohol users in treatment in 2014/15. The number of both drug using clients and alcohol using clients in treatment has continued to rise.

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, and we support and encourage Asset Based Community Development (ABCD) opportunities to support recovery initiatives such as recovery cafes, allotments, and activity groups.

Each year the public health team reviews local needs and services and identifies any changes or gaps in service provision. This work has identified specific areas of concern, the addiction to medicines and the increasing use of novel psychoactive substances (NPS). These trends are also nationally identified as of increasing concern. Over the past few years NPS, sometimes known as 'legal highs' have made local, national and international news, and been linked to hospital admissions and 68 deaths across the UK in 2012. Local services have identified a rise in individuals seeking help for recreational substance misuse and in particular the use of cannabis and NPS.

6.4. **Recommendations**

It is recommended that the council/commissioners:

- Build the capacity of specialist substance misuse services to address newer trends in substance misuse, including the use of NPS.
- Build the capacity of frontline staff to identify and refer substance misusers into appropriate services.
- Develop the role of primary care, in particular to address addiction to medicines(ATM's), and alcohol treatment
- Support and encourage Asset Based Community Development (ABCD) opportunities to develop recovery initiatives
- Undertake a system review and redesign to extend the model of integrated recovery orientated substance misuse provision

7. Sexual health

Good sexual health is important to individuals and society. Needs vary according to age, sexual orientation 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 identifies the ambition that all adults have access to high quality services and information.[47]

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 human immunodeficiency virus (HIV) and sexually transmitted infections (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.

For every £1 spent on contraception, £11 is saved in other healthcare costs. [48] LARC is more cost effective than the combined pill for reducing the risk of pregnancy even at 1 year of use.[49]

Early testing and diagnosis of HIV reduces treatment costs by over £10,000 per person per year.[50]Early access to HIV treatment significantly reduces the risk of onward transmission.[51] Some STIs, if left undiagnosed, cause long-term and life threatening complications, including cancers.

7.1. **Evidence of Need**

- In 2013, the rate of GP prescribed Long Acting Reversible Contraception (LARC) in Leicestershire was 61.5 per 1,000, this is significantly better than the England rate of 52.7 per 1,000 population.[52]

- In 2013, the rate of abortions in Leicestershire was 12.1 per 1,000 population, significantly better than the England rate of 16.6 per 1,000 population.[52] The proportion of abortions performed under 10 weeks gestation was 71% in Leicestershire, this is significantly worse than the England average of 79%.[52]

- The rate of cervical cancer registrations in Leicestershire was 10.1 per 100,000 between 2009-11. This is similar to the England average of 8.8 per 100,000 population.[52]

- Of all girls aged 12-13 in Leicestershire, 94.5% received all 3 doses of the HPV vaccine in 2013. This is significantly better than the England percentage of 86.1%.[52]

- In 2013, 271 residents in Leicestershire were diagnosed with HIV. The HIV diagnosed prevalence rate in Leicestershire was 0.7 per 1,000 aged 15-59, significantly better than the England rate of 2.1 per 1,000 aged 15-59.[52]

- The HIV diagnosed prevalence rate in Leicestershire has increased year on year from 2010 to 2013, while still remaining significantly better than the England rate throughout this time. This increase in prevalence is reflected the trend in England. [52]

The 2013 diagnosis rates for other STIs in Leicestershire are indicated below:[52]

- Genital herpes - 49.2 per 100,000 population, which is significantly better than the England rate of 58.8;

- Genital warts- 109.3 per 100,000 population which is significantly better than the England rate of 133.4;

- Gonorrhoea - 25.7 per 100,000 population which is significantly better than the England rate of 52.9; and

- Syphilis - 1.5 per 100,000 population which is significantly better than the England rate of 5.

7.2. **Service Review**

In Leicestershire, in 2014, the spend on sexual health by Leicestershire County Council is presented below:[53]

- £5.86 was spent per head on STI testing and treatment (prescribed functions). This is below the England average (median) spend of £6.35 but similar to the average spend across the East Midlands.

- £1.32 was spent per head on contraception (prescribed functions). This is below the England average (median) spend of £2.80 and below to the average spend across all peer comparators.

- £0.22 was spent per head on advice, prevention and promotion (non-prescribed functions). This is below the England average (median) spend of £1.22 and below to the average spend across all peer comparators.

Leicestershire County Council, Rutland County Council and Leicester City Council have jointly commissioned an integrated sexual health service to improve access and allow more people to visit one clinic for all of their sexual health needs. This service commenced on 1 January 2014. The service operates across Leicestershire, Leicester and Rutland offering a more consistent, high quality and cost effective service. Opening times have increased and there are two additional sites in Leicestershire for young people's clinics so offering more choice for patients. This service brings together a range of local sexual health provision into one service including the Chlamydia Screening Service, genitourinary medicine (GUM) clinics

and contraceptive services (family planning). This service has been in place for a year and review is ongoing to continue to develop the service to meet local needs.

7.3. **Gap Analysis**

In April 2013 the responsibility for commissioning sexual health services moved to a number of different agencies (including Clinical Commissioning Groups and NHS England). Local authorities became responsible for a range of sexual health interventions and services as part of their public health responsibilities.

The changes in commissioning responsibilities have caused some fragmentation of sexual health and associated services across the system. Therefore a strategic approach is required, working with local partners to deliver seamless patient pathways and ensure that gaps in service are addressed.

Sexual health information and data sources now provide more detail at local level. A refresh of the sexual health needs assessment is in progress to reflect the latest available data and to inform the strategic direction for commissioning across the sexual health system.

7.4. **Recommendations**

It is recommended that:

- There is a need to create a sexual health system that works across Leicester, Leicestershire and Rutland, in partnership with local partners and commissioners. This will be informed by the sexual health needs assessment and a three year sexual health strategy across Leicester, Leicestershire and Rutland.

- Prevention of sexual ill-health is prioritised and developed in line with the latest evidence.

- Information about sexual health and services is widely available.

- Access to sexual health services for Leicestershire residents continues to improve with the development of robust care pathways across sexual health and other relevant services such as alcohol and drug misuse services.

8. **Carers**

A carer is someone who looks after a person who is not able to care for themselves. This could be because the person has a long-term illness, disability, mental health problem, is of old age or as a result of alcohol or substance misuse. This caring is unpaid. A carer can be a parent, son, daughter, brother, sister, wife, husband, partner, any other relative, friend or neighbour.

A young carer is someone in a caring role under the age of 18 and some of the issues for young carers vary from those who are older carers. Many young carers are disadvantaged in terms of their educational, personal and social development as a result of their caring role.

Carers provide a significant amount of care that would otherwise be the responsibility of health and social care services. With the growth of the older people's population, and the accompanying resource pressure on health and social care services, supporting carers is becoming increasingly fundamental to the health and social care agenda. As illustrated by Forder,[54] the intensity of care packages increases by almost fifty per cent if the customer lives alone and carer loss/ carer strain can be a significant tipping factor leading to an escalation in the level of support required for people suffering from dementia.

Carers play a major role in terms of providing community based support and the demands of the caring responsibility can be considerable. The impact on carers lives varies depending on the amount of caring time provided, the age of the carer and the individual needs of the person cared for.

Carers UK estimated that the care provided by informal carers to ill, frail or disabled relatives was worth around £119 billion a year in 2011.[55] This amounted to £2.3 billion per week or £326 million per day which mean that the contribution by carers exceeds the total cost of the NHS (£9.8 billion per year in 2011).[55]

8.1. **Evidence of Need**

- The 2011 Census found over 70,700 carers in Leicestershire, providing from 1 hour per week to over 50 hours per week of unpaid care. Over 11% of the population provide some unpaid care.[25]

- Over 48,000 people provided less than 20 hours per week; a further 8,000 people, provided between 20 and 50 hours per week; and over 14,000 people provided over 50 hours of unpaid care per week.[25]

- Caring is age differentiated. Over one fifth of the population aged between 50 and 64 provides some hours of unpaid care, and around 15% of those aged 65 and over also provide some care. Less than an eighth of people in younger age group provide any unpaid care.[25]

- Over 1,100 children under 15 (0.9% of children under 15) () provided some unpaid care in Leicestershire in 2011. Of these, almost 200 were providing care for 20 hours or more each week (0.17% of children this age). Both figures are significantly lower than the England averages of 1.1% and 0.20% respectively.[56]

The number of carers in Leicestershire is increasing and projected to rise further:

- In the 2001 Census 10.4% of Leicestershire's population considered themselves to be providing some unpaid care. In the 2011 Census, the prevalence had risen to 11.1%. Given the ageing population, this rate is only likely to rise further.

- Projecting Older People Population Information has calculated the number of older carers based on the 2011 Census rates and the population projections – they calculate that there are 21,340 carers aged 65 and over in Leicestershire in 2015, and that by 2030, this figure will be around 30,000.[57]

Nationally it is anticipated that by 2017, a tipping point will be reached when the numbers of older people needing care will outstrip the numbers of working age family members currently available to meet that demand.[58]

8.2. **Service Review**

- A strategic review of carer support services was undertaken in Leicestershire between May 2013 and January 2014. This review concluded that carer support forms part of the wider early intervention and prevention offer.

- The newly commissioned carer support services have been developed in order to meet the increased demand and need for carer support, to offer equitable access (both demographically and geographically), to have a focus on positive outcomes for carers, to give value for money and to ensure that the County Council complies with the Care Act 2014.[59]

- The Care Act 2014 was introduced in April 2015 places a statutory duty on Local Authorities to provide a carer who is assessed as having eligible support needs with their own support plan, setting out how these needs will be met. This may include a personal budget for the carer putting them on par with the person they are caring for. [59]

The table below denotes the number of carers for whom assessments or reviews were completed or declined during 2013/2014 by age group of carer. There is an expectation that the demand for carer support from adult social care will rise significantly; our current estimates of the number of carer assessments that will be undertaken in 2015/16 is approximately 4,900.

Table 2: The number of carers in Leicestershire for whom assessments or reviews were completed or declined during 2013/2014 by age group of carer

	Number of carers assessed or reviewed separately	Number of carers assessed or reviewed jointly with the client	Number of carers declining an assessment
Under 18	1	5	0
18 -64	327	1035	1
65 -74	110	432	3
75 and over	102	611	3
Total all ages	540	2083	7

8.3. **Gap Analysis**

- There is a need to increase the identification of carers in primary care and improve the integration between health and social care provision for carers. The GP carer health and wellbeing service is being extended throughout the county to deliver this. The service will increase identification of carers within primary care, offering support, advice and information to carers who have not as yet identified themselves as a carer or who, as a carer, require support.

- There is currently no reliable data detailing equitable access to carer support services by different groups of carers, such as male carers, young carers and carers within BME communities. There is a need to reach out and support those groups of carers who remain hard to identify in order to prevent their own health and wellbeing deteriorating.

8.4. **Recommendations**

It is recommended that:

- Commissioners continue to build upon the newly developed carer support pathway to ensure continued equity of support for all groups of carers.

- Commissioners work together through the Better Care Together delivery to

improve integration between health and social care. It is important that we maximise the potential for integration in order to deliver the major changes required within the health and social care economy.

9. Autism

The term “autism” is used to refer to all diagnoses on the autism spectrum. This includes Asperger syndrome, high functioning autism, Kanner or classic autism. Autism affects social communication, social interaction and social imagination. It is a lifelong developmental disability which may also present alongside other impairments such as learning disability.

It is estimated that more than half a million people in England have autism. This is equivalent to more than 1% of the population and similar to the number of people that have dementia. Autism is neither a learning disability nor a mental health problem, although mental health problems can be more common among people with autism. It is estimated that one in three of adults with a learning disability also have autism.[60]

The Autism Act of 2009 was the first ever piece of legislation designed to address the needs of one specific impairment group: adults with autism.[61] The publication brought the challenges faced by adults with autism to the fore front. The Act required each local authority area to develop a local autism strategy for the provision of health and social care services for people with autism (aged 14 years and older). A key role of the strategy is to facilitate the development of services to meet the needs of people with autism, including identifying a local lead to oversee service provision.

The Act was created in response to increasing evidence that a significant proportion of adults with autism, across the whole autistic spectrum, are excluded both socially and economically. Estimates suggest that only 15% of adults diagnosed with autism are in employment,[62] health outcomes are worse than for the population at large, and a large number of adults with autism continue to live with their families rather than independently in their own homes. This led Government to set out its focus to transform the lives of and outcomes of adults with autism in *Fulfilling and Rewarding Lives:*[63]

> ‘All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents.’

Revised statutory guidance was published in March 2015 which outlined the requirements of Local Authorities and NHS organisations to support the implementation of the Adult Autism Strategy.[64]

9.1. Evidence of Need

- In 2014, 3,994 adults (18+) were estimated to have autistic spectrum disorder in Leicestershire. In 2030, 3,980 are predicted to be affected.[65]

- 107 young people aged 14-17 have been identified and are receiving assistance for autism (year end March 2014).[66]

9.2. Service Review

- In the UK, the lifetime societal costs of an individual with autism without learning disability is estimated at £3.1 million and of an individual with autism and learning disability £4.6 million.[67]

- The substantial societal cost of autism in adults requires provision of effective interventions that will improve the quality of life of people with autism and their carers. It will reduce the costs borne by the health and social care services, the people with autism and their families, and the wider society. These interventions should aid people to live independently, support them in work and while at work and identify their health needs earlier.

- In 2013/14, 120 people in Leicestershire received a diagnosis of autism spectrum condition. Of these diagnoses, 81 were recorded as a primary diagnosis and 39 as a secondary diagnosis.[66]

- 4961 adults in Leicestershire were assessed as being eligible for adult social care services and are in receipt of a personal budget. Of these individuals, 21 (0.4%) had autism but not a learning disability, while 51 (1.0%) adults had both a diagnosis of autism and learning disability.[66]

9.3. Gap Analysis

- Working together to improve outcomes for people with autism crosses many departments; from health and social care to employment, education and criminal justice.

- Consistent approaches to making reasonable adjustments to enable people with autism to access public services.

- There is a gap in the number of people that are estimated to have an autism spectrum disorder and the number of people that are receiving services – more work needs to be undertaken locally to understand the needs of people with autism who are not accessing services.

- Detailed local information on the demographics of people with autism in Leicestershire, particularly the needs of women, people from BME

communities and older people with autism is needed to support commissioners to plan services.

9.4. Recommendations

It is recommended that:

- Commissioners undertake a detailed needs assessment for people with autism, which includes housing and employment needs.
- Commissioners work together to develop best practice guidance for making reasonable adjustments to support people with autism to access public services.
- Commissioners look to find ways to support employment and wider work related support services for people with autism.

10. Offender health

In this section, the term ‘offender’ refers to an individual who is convicted in a court of law as having committed a crime, violated a law or transgressed a code of conduct. There is a distinction made between community offenders and those accommodated in prison. The term ‘youth offender’ is used to refer to those under the age of 18 who offend.

Offending behaviour is damaging for not just offenders and their victims, but also their families and the wider community. It is closely linked with deprivation, drug and alcohol misuse, mental health, loss of accommodation and employment as well as affecting outcomes for families and children. Improving the health of offenders reduces the chance of their re-offending, which in turn reduces the future impact on both victims and the families of offenders.[68] [69]

Offenders in prison and in the community have different health needs to the general public. They are likely to have poorer physical, mental and social health than the general public and suffer from poor lifestyle choices associated with offending, such as substance misuse.

10.1. Evidence of Need

There are 2 prisons in Leicestershire:

- Gartree Prison, in Market Harborough, has an operation capacity of 707, and houses adult male prisoners serving life sentences; and
- Glen Parva Young Offenders Institute, in Wigston, has an operation capacity of 808 and holds a mixture of sentenced, unsentenced and remand male

prisoners aged between 18 and 21.[70]

There were 3,789 offenders being supervised in the community in Leicester, Leicestershire and Rutland at the end of December 2012.[71]

10.2. **Service Review**

There are currently four offender health commissioning bodies:

- NHS England, who commission health services for prisons;
- NHS England Specialised Commissioning who commission Medium and Low Secure Services;
- the National Offender Management Service (NOMS) who commission some specialist probation services on behalf of the Secretary of State for Justice; and
- Clinical Commissioning Groups (CCGs) who jointly or individually commission the generic community mental health support team.

10.3. **Gap Analysis**

Significant health inequalities exist amongst offenders and ex-offenders, these are detailed below:[72]

- It is estimated that up to 30% of offenders have a learning difficulty/disability.
- Among children and young people in custody over 75% have serious difficulties with literacy and numeracy; over 30% have a diagnosed mental health problem; more than 30% have experienced homelessness; over 30% of young women; and over 25% of young men report a long-standing physical complaint.
- About a quarter of prisoners with a drug problem are injecting drug users. Of these, 20% have hepatitis B and 30% have hepatitis C.
- Among female prisoners, 40% have a long-standing physical disability, and 90% have a mental health or substance misuse problem.
- Less than 1% of ex-offenders living in the community are referred for mental health treatment.
- In prisons, the smoking rate is as high as 80% – almost four times higher than the general population.

- Hazardous drinkers is common for 63% of male prisoners and 39% of female prisoners are.

- Before being in custody, 58% of prisoners are unemployed and 47% are in debt.

10.4. **Recommendations**

It is recommended that:

- NHS England, NHS England Specialised Commissioning, the National Offender Management Service (NOMS) and CCGs need to inform each other's work and be aware of other services before making commissioning decisions.

- Commissioners develop clear pathways and referral processes that enable offenders leaving custody to access community drug and alcohol services.

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