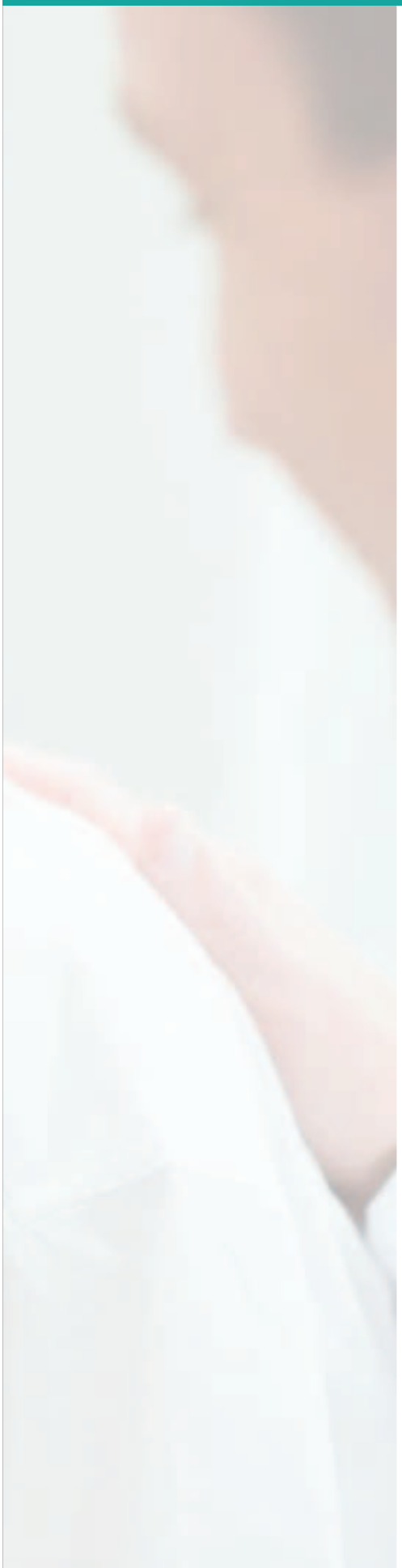
LINCOLNSHIRE PUBLIC HEALTH

Annual Report 2012

NHS Lincolnshire

Lincolnshire COUNTY COUNCIL

Contents



Introduction

This is my third annual report as Director of Public Health for Lincolnshire, and my last to the Board of Lincolnshire Primary Care Trust. It is, however, of more significance to Lincolnshire County Council as it takes on its new public health responsibilities and to the four new clinical commissioning groups in Lincolnshire as they take on their new statutory duties for commissioning health care. The next year will be a challenging one for all of us, with new responsibilities, new partner organisations and a whole new set of opportunities to improve the health and wellbeing of the people of Lincolnshire. This annual report tries to shine a light on some of the changes and their implications to help all of us focus on the ways we need to work together. These changes are a big opportunity to improve the way we join up our work. In the maelstrom of reorganisation we must not miss this opportunity. Chapters four and five are the main ones for this.

Population needs assessment is not highly valued in Lincolnshire, but it is a critical component of the commissioning cycle. Relying on routine statistics and performance data does not measure unmet need and you simply get what you have always had, although it may be better quality or better value for money as a result of the commissioning activity. To identify and meet unmet demand in our communities requires painstaking work to look at the whole of the population. The Joint Strategic Needs Assessment requires some specific and focussed work to support the routinely collected data.

Chapter one gives a summary of a population needs assessment for people with learning disabilities. I hope this needs assessment will play a significant part in shaping new jointly commissioned services for this vulnerable group of people.

The Joint Health and Wellbeing Strategy (JHWS) for Lincolnshire places a great emphasis on addressing issues in systematic ways. A systematic, evidence based approach to, for example, cancer care, heart disease programmes and treatment of stroke has been shown to deliver better care and better outcomes. Continued improvement to these is the objective of theme three in the JHWS. The NHS Health Checks programme is designed to identify those with some long-term conditions earlier than they might be found otherwise, so that these people can benefit from earlier treatment and secondary prevention. Chapter two reports on progress with NHS Health Checks in Lincolnshire.

The JHWS also identifies childhood obesity as a major challenge for Lincolnshire. Chapter three explains why this is, and tries to outline some of the changes that need to happen so that our children in Lincolnshire do not grow up to be obese adults with all the increased risks for cancer, diabetes, heart disease, musculoskeletal disease and others.

The 2011 Annual Public Health Report made fourteen recommendations. I think it is helpful to report back on how much progress has been made against these recommendations.

Improved quality of data on the demography and health status of prisoners – The quality of data has recently improved greatly and further improvements are being implemented.

Prison healthcare provider to maintain disease registers and manage healthcare for prisoners on the registers to the required standard – Disease registers are now in place and disease management is improving using an assessment tool to identify prisoners with a learning disability.

Stress testing of each antenatal and new-born screening programme to be carried out – This has been completed.

Improved quality of data on people who do not attend for screening and target evidenced based programmes to address this – Progress has been made in primary care using mosaic profiling within the cervical cancer screening programme. The service provider of the Diabetic Eye Screening Programme has introduced new pathways for inviting people to try and reduce numbers of the people who do not attend.

Increase screening uptake in areas with lowest coverage – The EPOC programme is now working to increase uptake across all three of the cancer screening programmes in areas with the lowest coverage across all CCG areas as appropriate. They are working with staff from the breast and bowel cancer screening units locally.

Roll out abdominal aortic aneurysm screening across Lincolnshire – This has now been agreed and is under way. The Service Provider is working closely with General Practices and Public Health to provide this service for the Lincolnshire population.

Maintain good access to sexual health services within 48 hours of appointment request – This has proved to be a considerable challenge in a wide rural county and a fundamental review is now under way.

Linking chlamydia screening with wider aspects of sexual health – This has been achieved

Increase HIV testing in high risk groups – Work has commenced with GPs to increase awareness of testing, and with organisations which already, work with the 'at risk' groups.

Linking Teenage Pregnancy work with wider aspects of sexual health – This has been achieved.

Awareness raising in relation to sexual assault and rape – The police and the Sexual Assault Referral Centre have developed a 'no means no' campaign, which has a variety of ways of delivering their key message.

Service redesign of sexual health services to meet population needs –
A fundamental review is now under way.

I would like to thanks staff within the Lincolnshire Public Health directorate who wrote parts of the report, reviewed chapters and proof read. I would welcome your comments on the report.

Dr Tony Hill

Joint Director of Public Health
NHS Lincolnshire and Lincolnshire County Council

Learning Disability Health Needs Assessment

In April 2012, Lincolnshire Public Health published a Health Needs Assessment (HNA) for adults with learning disabilities. This chapter of the Annual Report provides outline information on some of the findings from the HNA.

Introduction

People with a learning disability tend to have worse health than the population as a whole, and they are one of the most socially excluded groups in society. There is evidence indicating greater prevalence of specific diseases amongst people with a learning disability compared with the general population. The learning disability definition used for this HNA is given in the definitions and clinical signs section below.

NHS and Local Authority Commissioners have a responsibility to ensure that mainstream health and social care services address the needs of people with learning disabilities, in addition to ensuring that specialist healthcare is available for people who require it. This HNA aims to support NHS and Local Authority Commissioners and their providers in delivering their responsibilities for the Lincolnshire learning disability population.

Aims of the Health Needs Assessment

The aims of the HNA were to:

- systematically assess the health needs of adults with learning disabilities in Lincolnshire;
- identify gaps in service provision;
- review evidence of effective interventions;
- make recommendations to address unmet health needs and reduce health inequalities.

Methodology

A multi-agency steering group, led by the Public Health team, was established to oversee the HNA. The group used established HNA methodology and approaches to carry out the work. This included:

- Epidemiological – exploring the health status of the learning disability population, and describing the effectiveness of services and interventions.
- Comparative – contrasting local epidemiology or service provision with other geographical areas.
- Corporate – collecting the views of learning disability service users, service providers and other stakeholders.

Findings from the Literature Review

Definitions and Clinical Signs,

For the purpose of the HNA, the learning disability definition in the White Paper, Valuing People: A New Strategy for Learning Disability for the 21st Century[1] is used. This is that learning disability includes the presence of:

a significantly reduced ability to understand new or complex information, or to learn new skills (impaired intelligence), with

- a reduced ability to cope independently (impaired social functioning),
- and which started before adulthood, with a lasting effect on development.

The World Health Organisation International Classification of Diseases divides learning disability into four main categories: mild, moderate, severe and profound, depending on the level of cognitive impairment.

Causes and Risk Factors

The aetiology of learning disability can be subdivided into those conditions that arise at conception, and those that arise during pregnancy, labour and birth. Aetiological agents fall into three main categories: genetic, infective and environmental. However, no known aetiological cause is identified in a high proportion of learning disability cases.

Prevention

Prevention can be divided into primary and secondary prevention. Primary prevention is the implementation of measures to prevent new cases of people with learning disabilities. These occur at various stages, i.e. prior to conception, during pregnancy, during labour and after birth.

Policy Context

Valuing People recognised that people with a learning disability are among the most vulnerable and socially excluded in our society. It has six main priority areas, one of which is to improve the health of people with a learning disability. Valuing People Now[2] further progressed the work of Valuing People, and has an overall objective that all people with a learning disability receive the healthcare and support that they need to live healthy lives.

The Disability and Equality Act 2010[3] gives disabled people important rights of access to everyday services. Service providers have an obligation to make reasonable adjustments to their premises and/or the way that they provide services.

A number of high profile reports have been published in relation to the health of people with learning disabilities. Some of these include Equal Treatment Closing the Gap[4], Promoting Equality[5], Treat Me Right[6], Death by Indifference[7], Six Lives: The Provision of Public Services to People with Learning Disabilities[8] and Healthcare for All[9]. Following a BBC Panorama programme in May 2011 about Castlebeck Care Ltd, the Care Quality Commission (CQC) developed a focussed inspection programme to review the care provided by hospitals for people with learning disabilities.

Health Needs and Inequalities

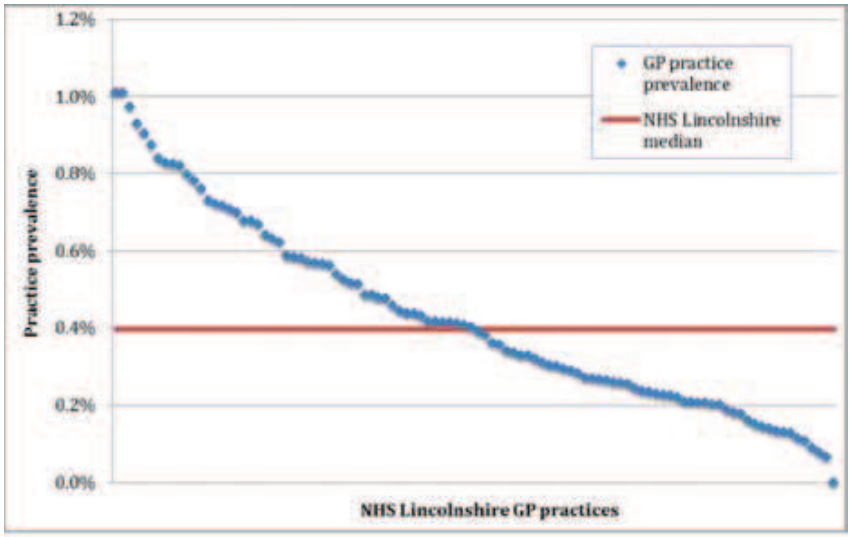
A literature review was carried out to establish the evidence in relation to the mortality and morbidity of people with learning disabilities, and how their health compares with that of the general population. Some of the key findings from the literature review include:

- People with a learning disability, have a shorter life expectancy compared to the general population. The greater the level of learning disability, the greater the reduced life expectancy.
- Difficulties in swallowing are found in people with learning disabilities due to neurological or anatomical problems. In Lincolnshire, 2.7% of adults with learning disabilities are known to have dysphagia, while the overall prevalence is 0.8%.
- Respiratory infections place a significant burden on people with a learning disability, and there is significantly greater risk of mortality compared to the general population.
- The prevalence of epilepsy amongst people with a learning disability is greater than for the general population. In Lincolnshire, 26% of adults with a learning disability have epilepsy, while the overall prevalence is 1.4%.
- Sensory impairments are known to be more prevalent in people with a learning disability.
- People with a learning disability are more likely to have poorer oral health compared to the general population.
- Accidental injuries in the adult learning disability population are known to occur more frequently than in the general population.
- People with learning disabilities are at greater risk of developing mental health and behavioural disorders compared to the general population.

- The prevalence of psychiatric disorders is greater in adults with a learning disability compared to the general population.
- The prevalence of dementia is significantly higher in older adults with a learning disability compared to the general population.
- Adults with a learning disability generally have a poor diet, and a high proportion of adults with a learning disability do not undertake the recommended levels of physical activity.
- Adults with a learning disability are more likely to be obese compared to the general population. Those at greatest risk include women and people with Down's syndrome.
- People with learning disabilities are more frequently exposed to factors that are associated with poor health, such as poverty, poor housing and unemployment.

As part of the Quality and Outcome Framework (QOF), general practices are required to maintain a register of adults with a learning disability. In 2010/11, there were 2685 people in Lincolnshire on the learning disability register. This represents a prevalence of 0.45%, which is close to the England (0.43%) and East Midlands (0.47%) prevalence. Figure 1.1 shows the variation in prevalence amongst the general practices in Lincolnshire, which could be due to the differences in the case mix of general practice lists, as well as the relative completeness of the registers.

Figure 1.1 Age-specific (18 years and over) prevalence of learning disabilities recorded on primary care registers held by GP practices across Lincolnshire, 2010-2011



Source: Primary care registers held by GP practices across Lincolnshire

The national PANSI (Projecting Adult Needs and Service Information) and POPPI (Projecting Older People Population Information) datasets provide information on the predicated number of learning disability cases 10,[11]. Although there are known shortcomings with the evidence on which this data is based, they indicate that there could be in the region of 13000 people with learning disability across Lincolnshire, with 2709 of these being moderate or severe.

In March 2011, 1714 people with learning disabilities were known to Lincolnshire adult social care services. The ratio of males to females was 1.23:1 and 98.4% were of white British ethnic origin. Boston, East Lindsey and West Lindsey had the highest crude rate in their population. The Index of Multiple Deprivation (IMD) 2010 suggests that learning disability service users live in more deprived areas compared to the general population, with more than half residing in the two most deprived quintiles of the county. This may be partly explained by access to services. For example, the distribution of IMD scores for CQC approved care homes is greater in more deprived areas of the county.

POPPI and PANSI project the number of adults with a learning disability from 2011 to 2030. It is estimated that, in Lincolnshire, there will be a 16% increase in the number of cases during this period. It is projected that the proportion of people with profound and multiple learning disabilities will increase, and the greatest increase is anticipated in people aged over 65 years.

Description of Lincolnshire Health Services and Activity

Commissioning arrangements and service provision

People with a learning disability access a wide range of mainstream services that are provided for the general population. NHS commissioning organisations have a responsibility to ensure that these mainstream health services address the needs of people with learning disabilities. Furthermore, specialised learning disability healthcare is commissioned for people who require it. This section of the report provides information on some of the services that are available for the Lincolnshire learning disability population.

Primary Care Services

A wide range of primary care services (general practices, dental practices, opticians and community pharmacies) are available for people with a learning disability. As part of QOF, general practices are required to maintain a register of adults with a learning disability. Annual health checks for people with a learning disability were introduced in 2008 as part of a Directed Enhanced Service (DES).

Community Services

Lincolnshire Community Health Services (LCHS) provide a wide range of health services for the Lincolnshire population, including people with learning disabilities. LCHS provides a Special Care Dentistry Service which addresses oral health for particular individuals and groups in society, such as those with a severe and profound learning disability, who have needs beyond the usual skills and facilities of a general dental practitioner.

Secondary Care Services

United Lincolnshire Hospitals provide a wide range of healthcare from their four main hospitals.

Specialised Learning Disability Service

Lincolnshire Partnership Foundation NHS Trust provides specialist health services for people with a learning disability, for example, an assessment, treatment, and rehabilitation service (Long Leys Court), outpatient clinics and specialist allied health professionals.

Lincolnshire County Council Learning Disability Community Partnership Teams provide integrated health and social care.

East Midlands Specialised Commissioning Group is responsible for commissioning secure (low, medium and high security) mental health and learning disability services for the Lincolnshire population.

Service Activity

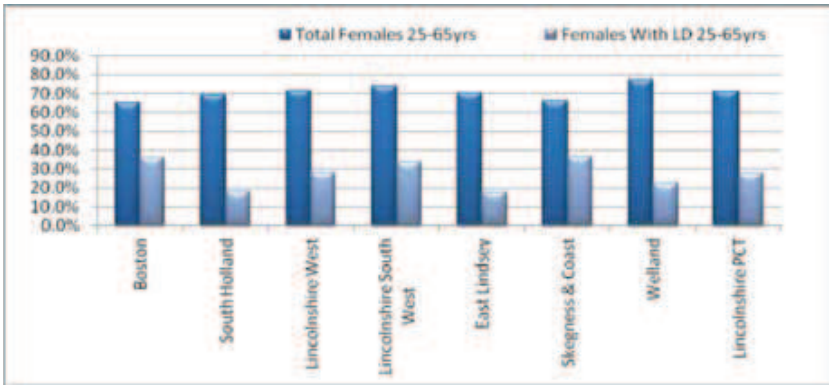
Whilst carrying out the HNA it was difficult to obtain comprehensive information on how far people with learning disabilities are accessing the full range of services that are available to them. This section of the report provides some information about the available data, which, unfortunately, is limited.

Primary Care Activity

Cervical Cancer Screening

The screening uptake amongst women with a learning disability is considerably lower than for the general population. In 2010/11, the uptake amongst the general population was 71%, compared with 28% for the learning disability population (Figure 1.2). Nearly half (48%) of the eligible learning disability population have declined/been 'exception reported' (compared to 12% of the general population), and consequently will not routinely receive invitations for screening.

Figure 1.2 Cervical screening uptake (2010/11)

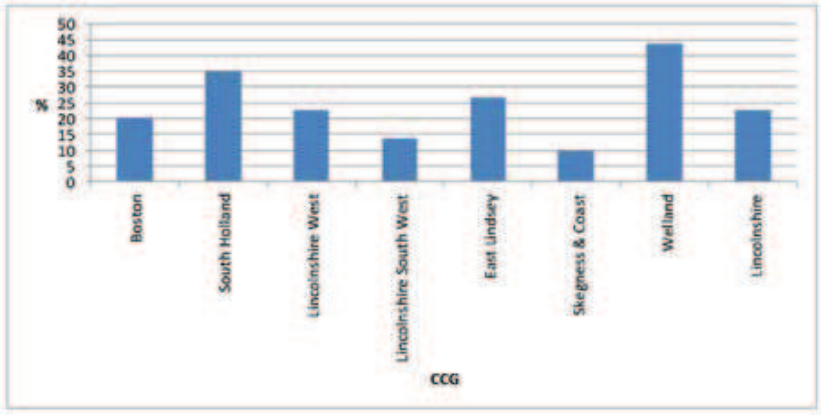


Source: Learning Disability Audit, NHS Lincolnshire

NHS Health Checks

Eighty-two general practices in Lincolnshire provide this service. Figure 1.3 shows the proportion of people with a learning disability who have received an annual health check, both in Lincolnshire as a whole and for each of the initial CCGs.

Figure 1.3 People with a learning disability receiving a health check



Source: Learning Disability Audit, NHS Lincolnshire

Hospital Activity

There was analysis of the levels of inpatient hospital activity for the general population compared to the learning disability population during 2010/11. Because of the relatively small learning disability population, any comparison of the two population groups should be treated with caution. Nevertheless, the analysis does provide some information on the differences in activity between the two groups. Some of the key findings are:

- The emergency hospital admission rate for the learning disability population is over twice that of the general population.
- Injury and poisoning account for 23% of the emergency admissions in the learning disability population compared to 12% in the general population.
- Diseases of the nervous system account for 11% of the emergency admissions for the learning disability population compared to 2% for the general population.
- Mental disorders account for just over 5% of the emergency admissions for the learning disability population compared to less than 2% for the general population.
- The accident and emergency admission rate is almost twice as high amongst the learning disability population compared to that of the general population.

Barriers to Services

The National Primary Care Research and Development Centre[12] carried out a review on access to healthcare for people with learning disabilities. It identified a number of findings in relation to barriers to accessing healthcare. Some of these include:

- problems identifying and communicating health needs.
- problems with carers recognising signs and symptoms.
- physical access difficulties.
- lack of knowledge amongst professionals of how to address the specific health needs of people with learning disabilities.

Effectiveness of Services and Interventions

The literature on the effectiveness of treatments, interventions and service models for people with learning disabilities is mainly limited to descriptive and uncontrolled research studies. Some guidance on how to meet the needs of people with learning disabilities has been produced by the various Royal Colleges. For example, the Royal College of General Practitioners has produced resources to support general practices in delivering high-quality health checks[13]. The Royal College has also been involved in producing commissioning guidance for CCGs[14], in order to achieve better health outcomes for people with learning disabilities. The Royal College of Nursing has produced guidance to support nurses in delivering high-quality healthcare for people with learning disabilities[15].

Corporate Assessment and Qualitative Analysis

A range of approaches was used to gain the views of service users, service providers and commissioners, and other stakeholders:

- Service users. Five small discussion groups for people with learning disabilities, which represented 30 service users, were consulted.
- Service providers/commissioners. An online survey was developed for service providers and commissioners and 19 responses were received.
- Other stakeholders. An online survey was developed and three people responded.

Service users reported that, in general, they are happy with general practices and dental services, and they were very positive regarding some of the specialised learning disability services. Service providers gave feedback on how communication could be improved across agencies to enhance joint working, and on how further training for generic staff could help meet the specific needs of people with learning disabilities.

Recommendations

The HNA report includes approximately 50 recommendations covering a number of themes. Although the full set of recommendations cannot be provided in this chapter, some of the most significant recommendations (with the theme provided in brackets) are listed below:

- The Joint Commissioning Board should ensure joint plans are in place to meet the needs of service users, including increased demand from more adults with learning disabilities (strategy and policy).
- Primary care should be encouraged to identify and record all people with learning disabilities (identification of adults with learning disabilities).
- Preventive healthcare and public health activities should be reviewed to ensure provision across Lincolnshire (prevention of learning disabilities).
- All services should provide the opportunity for adults with learning disabilities to access healthy lifestyle initiatives and services (healthy lifestyle initiatives).
- All GP practices should be encouraged to provide annual health checks (primary care).
- Frontline staff should receive training on learning disability awareness in order to develop their clinical skills, so that they are equipped to meet the health needs of this group (action across healthcare services).

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The full Learning Disability HNA report is available on the Lincolnshire Research Observatory website www.research-lincs.org.uk.

NHS Health Checks

What is the NHS Health Check Programme?

Everyone is at some risk of developing vascular disease. The risk increases with age, and other increases in risk are attributable to being overweight, smoking, not exercising regularly and a poor diet.

The 'NHS Health Check' Programme, offers preventative checks to people aged 40-74 years to assess their risk of vascular disease (heart disease, stroke, diabetes and kidney disease) followed by appropriate management and intervention, e.g. medical intervention and/or referral onto lifestyle services such as weight management.

The NHS Health Check is a 5-year rolling programme, which means that people are invited for a health check every five years. Patients leave the programme if they are diagnosed with vascular disease and therefore will be treated appropriately, or once they reach the age of 75.

In Lincolnshire, those at most risk are being invited for their health check first. Risk is calculated by a software risk tool which uses indicators such as age, gender, BMI, family history of vascular disease and previous blood pressure and cholesterol measurements to give a risk percentage. Where information is not available, for example a cholesterol test has not been conducted in previous years, the software calculates an estimated reading on which to base the risk score. Once a person has been invited and assessed, a new, more accurate, risk score is calculated with the up-to-date information. If any undiagnosed underlying disease is detected, then this can be treated and managed, and general risk can be reduced by discussing where improvements in lifestyle can be made.

The prevention or early identification of vascular disease with this assessment and management programme will lead to a higher uptake of preventative interventions (including statins, anti-hypertensives, brief exercise interventions, weight management and smoking cessation), reduce risk of vascular disease, and increase early detection and treatment of kidney disease and diabetes. The intended effect will be a reduction in vascular disease morbidity and mortality across the population.

Background

Vascular diseases are the biggest cause of death in the UK, and the NHS Health Check programme could, on average, prevent 1,600 heart attacks and strokes and save at least 650 lives, each year. The vascular checks programme could prevent over 4,000 people a year from developing diabetes, and detect at least 20,000 cases of diabetes, or kidney disease earlier, allowing individuals to be better managed and improve their quality of life. (Information from Putting Prevention First, Vascular Checks: Risk Assessment and Management)[1].

Over the past decade there have been significant improvements in the treatment of vascular disease through the National Service Frameworks on coronary heart disease, renal services and diabetes. Nationally there has been a 40% reduction in deaths from cardiovascular disease in people under 75 between 1996 and 2008[1]. During the same period, Lincolnshire had a 43% reduction. However, it remains a major cause of disability and poor health.

A focus is now needed on how vascular diseases can be prevented earlier in life. This will enable people to make informed choices about improving their health, and help them live longer and healthier lives. Vascular disease currently affects the lives of over 4 million people in England. It is responsible for 36% of deaths (170,000 a year in England) and accounts for a fifth of all hospital admissions. It is the largest single cause of long-term ill health and disability, impairing the quality of life for many people[1].

Evidence shows that it is possible to identify the risk factors for these diseases, and also to act to change them. Early intervention to reduce risk can prevent, delay, and, in some circumstances, reverse the onset of vascular disease[1].

How we have performed

NHS Lincolnshire was required to start commissioning the programme from 2009/10, and has done so with a Local Enhanced Service (LES) currently in place with 96% of GP practices. This has prioritised people who are at the greatest risk of vascular disease so they are invited first.

There is a requirement to have the programme rolled out fully by 2012/13, and the programme is a national 'must be done'. Local Authorities will be expected to ensure NHS Health Checks continue as part of the mandatory responsibilities laid out in the Health and Social Care Act, 2012.

Not everyone aged 40-74 years old is eligible for an NHS Health Check. Only those who have not been diagnosed with a vascular disease will be invited.

From full roll out in 2012/13, where one-fifth of the eligible population in Lincolnshire will be invited, 45,046 patients will be eligible for their NHS Health Check each year. The Department of Health produced an economic modelling document which showed that, of all the options considered to deliver the programme in the most clinically effective and cost effective way, a starting age of 40 was the optimal, with vascular checks every five years[2].

Table 2.1 shows the number of eligible people who have been invited for an NHS Health Check, and the number receiving a health check. The Department of Health requested that PCTs were 'seen to be doing something' in 2009/10. From 2010/11 formal trajectories have been agreed and in 2010/11 NHS Lincolnshire was one of only 2 East Midlands PCTs to meet these SHA targets.

Table 2.1: NHS Health Check Target and Actual Uptake in Lincolnshire, 2009-2014

Year	Number to be Invited & (Number to be Assessed)	Actual Number Invited & (Assessed)	% Uptake to be Achieved	Actual % Uptake Achieved
09/10	No target set	13,530 (6,323)	No target set	47%
10/11	21,287 (10,003)	27,151 (12,886)	47%	47%
11/12	32,840 (17,734)	32,897 (22,075)	54%	67%
12/13	45,046 (25,676)		57%	
13/14	45,046 (27,028)		60%	

Data source: Integrated Performance Measures Returns (IPMR) NHS Lincolnshire

Outcomes

Specialist software was introduced in 2010/11 to assist practices in identifying eligible patients, and to enable full reporting of the data set required by the Department of Health.

Since the beginning of the programme (1st August 2009 to 30th September 2012) 50,599 people have received an NHS Health Check in Lincolnshire.

Table 2.2 shows the number of first letter invitations sent to eligible patients, and the number attending as a result of this from the start of the programme.

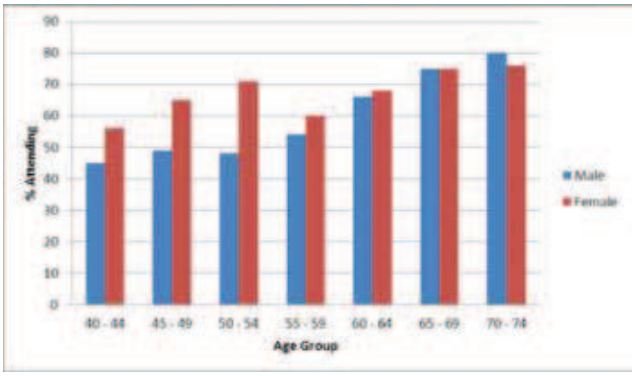
Table 2.2: NHS Health Check Attendance by Gender, 2009-2012

Gender	Number Invited to Attend	Number Attending	% Attending
Male	45,537	26,756	59%
Female	35,020	23,843	68%

Data source: TCR NHS Health Check Database

Figure 2.1 shows the percentage of eligible patients attending for their NHS Health Check after being invited, by gender and age group.

Figure 2.1: NHS Health Check Attendance by Gender and Age Group, 2009-2012



Data source: TCR NHS Health Check Database

Table 2.3 shows the disease diagnosis from the start of the programme, as a direct result of a patient having their NHS Health Check.

Table 2.3: NHS Health Check Disease Diagnosis, 2009-2012

Disease	Number of Cases Identified	
Diabetes Type II	415	1 in every 122 patients seen
Hypertension	1281	1 in every 40 patients seen
Chronic Kidney Disease	207	1 in every 244 patients seen
Familial Hypercholesterolaemia	50	1 in every 1,012 patients seen
Atrial Fibrillation	41	1 in every 1,234 patients seen
Peripheral Vascular (Arterial) Disease	13	1 in every 3,892 patients seen

Data source: TCR NHS Health Check Database

The risk tool used to calculate an individual's overall risk of developing vascular disease is called QRISK2. This calculates the risk of having a fatal or non-fatal heart attack or stroke in the next 10 years. A 20% risk in, say, a 50-year old man, means that he has a 1 in 5 chance of having a major vascular disease event before he is 60 years old.

Table 2.4 shows the number and percentage of those estimated (by the risk tool) to be at high risk, the numbers invited for an NHS Health Check and those attending.

Table 2.4: NHS Health Check Attendance by High Risk Patients, 2009-2012

	>20 RISK	Number Invited	Number Invited as a %	Number of NHS Health Checks Completed on these High Risk patients	Number of NHS Health Checks Completed as a %
Male	13,601	9,332	69%	7,511	81%
Female	3,539	2,679	76%	2,321	87%
Total	17,140	12,011	70%	9,832	82%

Data source: TCR NHS Health Check Database

It is encouraging to see that, as we enter the first full year of roll out in 2012/13, already 70% of those estimated at high risk have been invited, and 82% have chosen to attend for their NHS Health Check. The uptake rate in this group is much higher than the general uptake rate, even the high 67% achieved in 2011/12.

Where someone has been identified as being at a high risk of developing vascular disease, but no underlying disease has been detected, they are placed on a high risk register. This allows their GP to monitor them with an annual check up, and provide advice on reducing this risk with lifestyle improvements and referrals on to lifestyle services where appropriate.

Identification of undiagnosed disease, which people are often unaware of, is only one half of the NHS Health Check. The other half concentrates on offering people tailored lifestyle advice to equip them with the knowledge to manage their risk of developing vascular disease. There is also assistance in the form of lifestyle, services, such as weight management, smoking cessation, 'exercise on referral', healthy walking clubs and many more, which people can be referred to.

Quotes from GP practices providing the service:

''There is no doubt that the Health Check service has, on many occasions, highlighted potential problems with patients who, because they have been diagnosed early are on treatment early, and thus any serious effects have been avoided. The patient group that are being called in are usually the ones that do not come to the GP very often, so having the ability to give them a full MOT is invaluable.

The patient satisfaction with the service has been excellent, and our nurses who undertake the checks have found them interesting to do from a clinical point of view.

We, as a practice, hope the funding for this vital service will continue."

"The NHS Health Check has identified a number of patients with diabetes who may otherwise have gone undetected. Where the patient is identified in the early stages of diabetes type II, lifestyle changes have been made and the symptoms reduced or alleviated completely.

Having an NHS Health Check has encouraged some patients to make a concerted effort to lose weight. One patient has managed to lose two stone and five inches from around his waist. His cholesterol (LDL) has dropped from 5.7 to 4.8 and in, his own words has 'turned his life around'".

The future of the NHS Health Check Programme

The Public Health White Paper: Healthy Lives, Healthy People[3] highlights that the NHS Health Check remains a priority, and will continue in its current format as a national 'must be done'.

The roll out of the Health Check Programme in Lincolnshire met agreed trajectories for 2011/12. The LES was written in consultation with GP practices and the Local Medical Committee. There are currently 4 GP practices out of 102 which are not signed up to the LES; this will impact on the planned full roll out for the current year (2012/13). As a LES is agreed with each individual practice, currently, practices are not obliged to take part. Each individual practice decides whether they wish to provide the service to their patients.

The inclusion of the NHS Health Check on the NHS Lincolnshire corporate dashboard; quarterly reports written and sent to senior managers, including the Accountable Officers of the newly formed Clinical Commissioning Groups (CCGs); Public Health Assistant Directors raising the profile of the programme with their respective CCGs; and the backing of Lincolnshire County Council's Health Scrutiny Committee, have all had a positive impact on the number of GP practices which have signed up to the LES in 2012/13. We hope by continuing to raise the profile of the programme and reporting on the positive outcomes for patients, that the few remaining practices will see the advantages of offering this service to their patients.

Conclusion

The benefits of the NHS Health Check include:

- enabling more people to be identified at an earlier stage of vascular change, therefore offering a better chance of putting in place positive ways to substantially reduce the risk of premature death or disability;
- preventing the development of diabetes in many of those at increased risk of this disease;
- sustaining the increase in life expectancy and reduction in premature mortality that are under threat from the rise in obesity and sedentary living;
- offering an opportunity to make significant inroads into health inequalities, including socio-economic, ethnic and gender inequalities;
- reducing the number of secondary care admissions due to cardiovasular disease events.

The NHS Health Check programme has been generally well received in Lincolnshire, with an encouraging sign up from GP practices and a 67% uptake rate in 2011/12 by those people sent an invitation.

Now at full roll out in 2012/13, the small service gap of practices choosing not to participate will have some impact on us being able to reach the number of people we would have hoped to, but, on a positive note, we have met our trajectories in previous years, and practices have assessed over 50,000 people and diagnosed over 2000 cases of vascular disease as a result.

The programme is now in its fourth year, and we need to place a real emphasis on promoting the huge part that lifestyle plays on a person's risk of developing vascular disease. As those at highest risk are being seen, those at a lower estimated risk will be getting calls for their assessments, and may feel that the lack of underlying disease means that they will not develop vascular disease in the future. Everyone is at some risk, and this risk can be reduced considerably by making, often quite small, changes in behaviour. For example, if you are overweight or obese, a 5% reduction in weight can bring real health benefits. If you do no exercise, then starting to do just 'some' will bring improvements in health, and stopping smoking can reduce your risk considerably.

Lincolnshire has lifestyle services in place, such as weight management, smoking cessation and 'exercise on referral', to support those wishing to improve their health and lower their risk of developing vascular disease in the future. In 2012/13 we have increased the number of weight-management places available, and will continue to manage these services so that they are best suited to meet the needs of the people of Lincolnshire.

Recommendations

The commissioners, public health teams and providers work together to increase the number of NHS Health checks offered, increase the uptake rate and agree a way to cover the service gaps.

The commissioners, Public Health teams and providers work together to ensure that every eligible individual is offered high quality lifestyle advice and when appropriate, a referral to a lifestyle service.

Appendix - Disease Outlines

Diabetes – Diabetes occurs when the level of glucose (sugar) in the blood becomes higher than normal. There are two main types of diabetes - type 1 diabetes and type 2 diabetes. Type 2 diabetes used to be known as maturity onset, or non-insulin-dependent diabetes. It develops mainly in people older than the age of 40 (but can also occur in younger people). In the UK, about one in 20 people aged over 65, and around one in five people over 85, have diabetes.

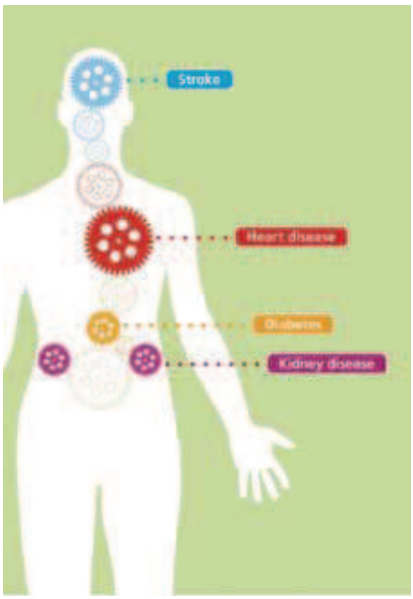
Hypertension – High blood pressure is one of several 'risk factors' that can increase an individual's chance of developing heart disease, stroke, and other serious conditions. As a rule, the higher the blood pressure, the greater the risk. Treatment includes a change in lifestyle risk factors where these can be improved - losing weight if you are overweight, regular physical activity, a healthy diet, cutting back if you drink a lot of alcohol, stopping smoking, and a low salt and caffeine intake. If needed, medication can lower blood pressure.

CKD (Chronic Kidney Disease) – Chronic kidney disease means that your kidneys are not working as well as they once did. Various conditions can cause CKD. Severity can vary, but most cases are: mild or moderate, occur in older people, do not cause symptoms and do not progress to kidney failure. People with any stage of CKD have an increased risk of developing heart disease or a stroke. This is why it is important to detect even mild CKD, as treatment may not only slow down the progression of the disease, but also reduces the risk of developing heart disease or stroke.

FH (Familial hypercholesterolaemia) - Familial hypercholesterolaemia is an inherited condition, in which the level of low-density lipoprotein (LDL) cholesterol in the blood is higher than normal from birth. The condition may be discovered at a routine health check, or by noticing some of the features, such as fatty lumps on the skin or around the eyes.

AF (Atrial Fibrillation) – Atrial fibrillation causes a fast and erratic heartbeat. It is a complication of various diseases. Medication can slow the heart rate back to normal, and ease symptoms. In some cases, treatment can restore the heart back to a normal rhythm. In addition, a drug such as warfarin is usually advised to reduce the risk of having a stroke.

PVD (Peripheral Vascular Disease) - Peripheral Vascular Disease is narrowing of one or more arteries (blood vessels). It mainly affects arteries that take blood to the legs. The condition is also known as peripheral arterial disease. It is also sometimes called hardening of the arteries of the legs.



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3. Healthy Lives, Healthy People: our strategy for public health in England – DH November 2010

Childhood Obesity

What is childhood obesity?

Overweight and obesity are terms used to describe an excess of body fat, which results from an energy imbalance where more energy is taken in compared to what is consumed.

Within the UK, overweight and obesity are assessed among adults using the Body Mass Index (BMI). For children, there are no clearly defined BMI criteria, as weight and height vary considerably depending upon age and stage of development. Instead, overweight and obesity are defined for children using the British 1990 growth reference charts, where the weight status of the child is classified according to their age and sex. Children with a weight at or above the 95th centile are classified as obese, and children between the 85th and 95th centiles are classified as overweight. Because this method of measurement takes into account the age and gender of the child, and matches it with measurements taken from British children before the current high levels of obesity were observed, it is widely acknowledged to be the most accurate way to identify weight problems in children under 12 years of age.

Classification	BMI Centile
Underweight	≤2nd centile
Healthy Weight	2nd centile – 84.9th centile
Overweight	85th centile – 94.5th centile
Obese	≥95th centile
Atrial Fibrillation	41
Peripheral Vascular (Arterial) Disease	13

Classification of children's BMI

Children who are overweight or obese early in life are at greater risk of developing serious health problems. The World Health Organisation states;

'Overweight children are likely to become obese adults. They are more likely than non-overweight children to develop diabetes and cardiovascular diseases at a younger age, which in turn are associated with a higher chance of premature death and disability.'[1]

Being obese or overweight brings significant risks at a range of different points throughout life (NHS Information Centre 2011). The health risks for adults who do not maintain a healthy weight status are somewhat concerning. Evidence from the Department of Health[2] suggests that, when compared with an adult healthy-weight male, an obese male is:

- five times more likely to develop type 2 diabetes;
- three times more likely to develop cancer of the colon;
- more than two and a half times more likely to develop high blood pressure, which is a major risk factor for stroke and heart disease.

Similarly, an obese woman, compared with a healthy weight woman, is:

- almost thirteen times more likely to develop type 2 diabetes;
- more than four times more likely to develop high blood pressure;
- more than three times more likely to have a heart attack.

Antenatal and postnatal risks

Obesity in pregnancy is associated with an increased risk of serious adverse outcomes, including miscarriage, foetal congenital anomaly, thromboembolism, gestational diabetes, pre-eclampsia, dysfunctional labour, postpartum haemorrhage, wound infections, stillbirth and neonatal death. Obese women also tend to contribute to a higher caesarean section rate and lower breastfeeding rates compared with women with a healthy BMI.

The Government's Foresight Project Report, Tackling Obesities: Future Choices[3] highlights the 'generational dimension' of obesity, claiming that children of parents who are overweight or obese are also more likely to have difficulty maintaining a healthy weight.

How do we know what the picture of obesity looks like in Lincolnshire? The National Child Measurement Programme (NCMP).

The NCMP takes place annually between September and June during the school academic year. The children involved are those in reception year (aged 4/5 years of age) and year 6 (aged 10/11 years of age).

Over the past four years, the percentage of children taking part in this process has improved, and we now have a robust set of measurements to give us a snapshot of the numbers of overweight and obese children within the targeted age groups in Lincolnshire.

The numbers of overweight children in both reception and year 6 have demonstrated a slight increase (not statistically significant) over the past 12 months.

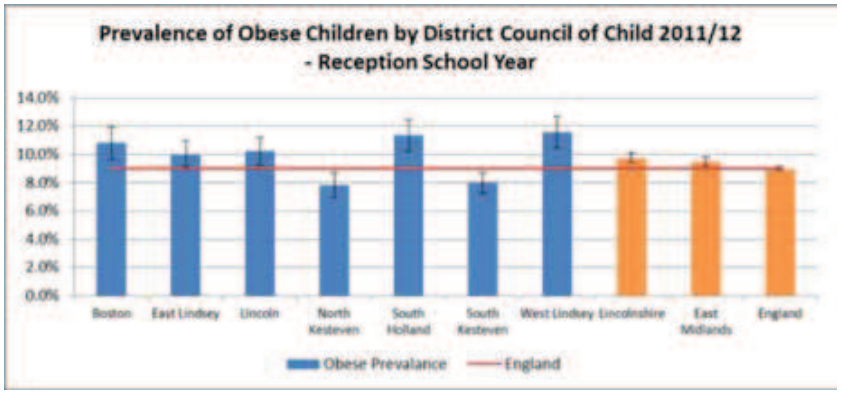
Despite showing a slight decrease over the past 12 months, the numbers of year 6 children identified as obese has remained around 19% of the population. It is clear, looking at these figures for each school year, that there is a consistent doubling of the numbers of obese children during their first seven years of school (Figure 3.1).

Figure 3.1: Prevalence of Overweight and Obese Children in Lincolnshire 2008/09 to 2011/12

Indicator		2008/9	2009/10	2010/11 2011/12	2010/11
Reception (age 4-5 yrs.)	Overweight	15%	15%	14.4% 15.4%	38445
	Obese	9.9%	10.8%	9.4% 9.7%	3625
	Overweight or obese	24.9%	25.8%	23.8% 25.1%	34820
Year 6 (age 10-11 yrs.)	Overweight	**16%**	**15.5%**	**15.1% 15.7%**	**34199**
	Obese	18.5%	19.5%	20.2% 19.4%	25840
	Overweight or obese	34.5%	35%	35.3% 35.1%	99.0%
		87.5%	79.9%	89.4%	75.6%
		11.8%	10.7%	7.7%	9.4%

Source: NHS Lincolnshire Dataset

Figure 3.2: Reception Year Prevalence of Childhood Obesity by District Council 2011/12

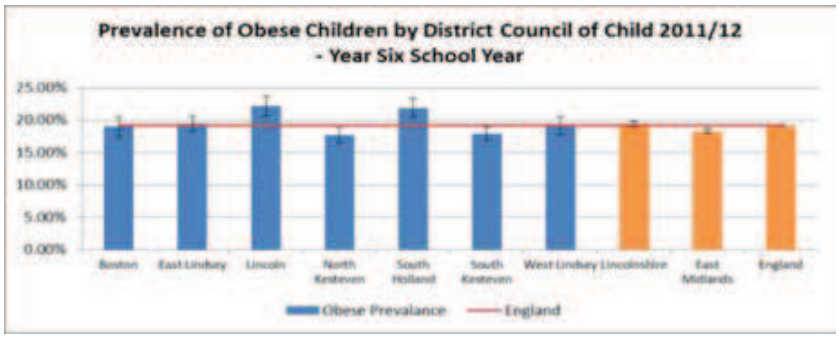


Source: NHS Lincolnshire Dataset

Figure 3.2 shows that reception year children in Lincolnshire exhibit higher levels of obesity than the England and East Midlands average.

The only district councils in Lincolnshire which demonstrate statistically significantly lower numbers of obese reception year children compared to England as a whole are North and South Kesteven.

Figure 3.3: Year 6 Prevalence of Childhood Obesity by District Council 2011/12



Source: NHS Lincolnshire Dataset

The prevalence of obesity in year 6 children continues to be above the England and East Midlands averages.

Two areas of the county, Lincoln and South Holland, demonstrate significantly higher levels than England (figure 3.3). Lincoln and South Holland also have statistically significantly higher prevalence of obesity compared to the Lincolnshire average.

The obesity data for reception and year 6 in 2011/12 continues to demonstrate a doubling of the numbers of children measured as being obese in these year groups.

Nevertheless, in some areas of the county the outcomes exceed this average increase. Lincoln City increased from 10.2% to 22.2%, North Kesteven from 7.8% to 17.7% and South Kesteven from 8.0% to 17.9%.

Childhood obesity and gender

Similar to national trends, the analysis of local Lincolnshire data demonstrates that the prevalence of obesity is higher among boys than girls. In 2011/12, 9% of reception-age girls were obese compared to 10.5% of boys.

The numbers of year 6 girls who are being identified as obese has continued to rise year on year since 2006: reaching 17.7% by 2011/12. Nevertheless, this is lower than the prevalence in year 6 boys which was 21.1% in 2011/12.

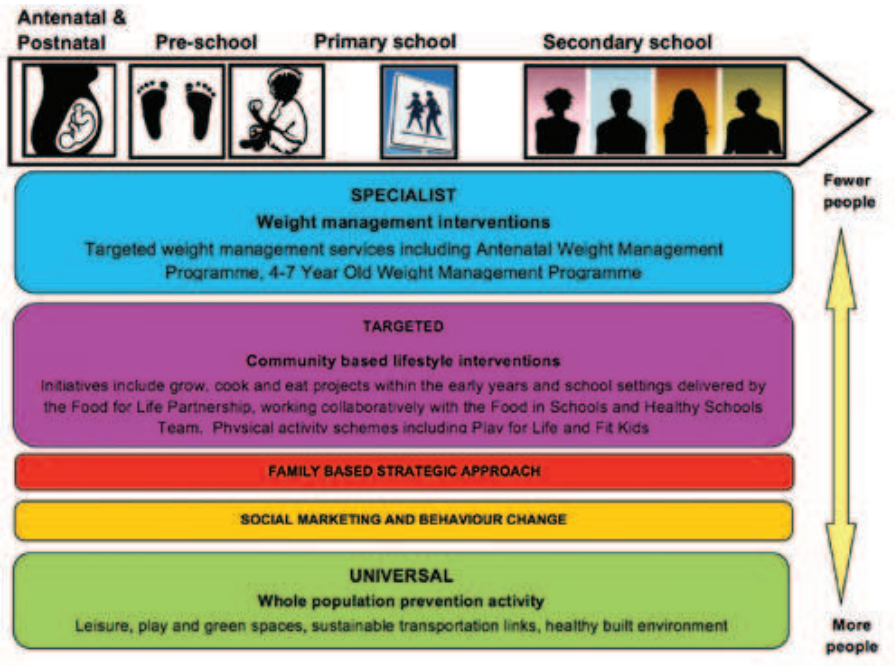
Childhood obesity and deprivation

The prevalence of obesity varies with deprivation. The Index of Multiple Deprivation (IMD 2010) quintile one indicates those who are most deprived, and quintile five those least deprived. The Lincolnshire data demonstrates a correlation between deprivation and overweight/obesity levels. Those in the most deprived groups have a statistically significantly higher prevalence of overweight and obesity compared to those in the more affluent quintiles for both reception and year 6 pupils.

Implementing a 'life course approach' to reduce childhood obesity

The 'life course approach' recognises that there are important stages in peoples lives where they are more likely to change their behaviour or come into contact with health services. We have taken this evidence-based approach as one of the key themes for tackling childhood obesity in Lincolnshire, to ensure we provide a comprehensive map of interventions to target children and their families across their life stages. Figure 3.4 shows the life course approach in Lincolnshire, where a range of interventions are implemented at different tiers (universal, targeted and specialist).

Figure 3.4: Description of the Life Course Approach to reducing Childhood Obesity in Lincolnshire



Conclusion

The health, social and personal costs associated with the consistent increase in the numbers of children and adults who are not maintaining a healthy weight are high. If we don't start to reduce the numbers of overweight or obese children and adults in Lincolnshire, this will undoubtedly overwhelm services, and not just health services, in the future.

Over the past four years, we have observed that the proportion of children identified as being obese at year-6 is double that of reception year pupils. Therefore, the necessity to understand what is affecting our children's ability to maintain a healthy weight during these informative early school years is imperative.

To reverse the childhood obesity crisis in Lincolnshire, we must support families to make healthier food choices, give portion sizes appropriate to the child's age and keep physically active and healthy. It is necessary to do this at home, in pre-school nursery and at school.

We are providing interventions across each area of the child's lifetime: during pregnancy, early years and throughout their school years. This is supported by the following recommendations:

- Raise the profile and implications of childhood obesity with local communities
- Support mothers to effectively breastfeed
- Promote healthy food choices and appropriate portion sizes in the home, nursery and school
- Increase the numbers of children eating healthy school meals and reduce the numbers of those eating unhealthy packed lunches
- Promote active lifestyles in the home, nursery and school
- Increase customer insight and media use to raise the profile of childhood obesity e.g. 'me-sized' plates

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2 The Department of Health, Facts & Figures on Obesity; http://www.dh.gov.uk/health/2012/04/obesityfacts/ accessed 17/12/12
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Public Health Support to Clinical Commissioning Groups

Introduction

For over one hundred years, responsibility for public health was a statutory function of local authorities, but since 1974 has been located within the NHS, most recently within Strategic Health Authorities and Primary Care Trusts (PCT). During this time, specialist public health staff have assumed the lead for three major responsibilities on behalf of the NHS and local communities:

- Health improvement eg lifestyle factors and the wider determinants of health;
- Health protection eg preventing the spread of communicable diseases, leading the NHS response to major incidents, and screening programmes;
- Population healthcare eg input to the commissioning of health services, evidence of effectiveness, care pathways.

Under the Health and Social Care Act 2012, on 1st April 2013 primary responsibility for health improvement and health protection will transfer at the national level from the NHS to Public Health England, and at local level from PCTs to upper tier local authorities. Responsibility for strategic planning and commissioning of NHS services will transfer to the NHS Commissioning Board and to Clinical Commissioning Groups (CCGs). Around 60 Public Health staff currently employed by NHS Lincolnshire will transfer to Lincolnshire County Council in April 2013, together with an annual budget of around £27 million.

There will be four CCGs in Lincolnshire:

- Lincolnshire East CCG (East Lindsey, Boston and Skegness)
- Lincolnshire West CCG (nearly all of West Lindsey, City of Lincoln and the northern half of North Kesteven)
- South Lincolnshire CCG (South Holland, Bourne, Stamford and the Deepings)
- South West Lincolnshire CCG (Grantham and Sleaford and surrounding areas)

CCGs will be responsible for improving the health of the population and reducing health inequalities within their area, and the commissioning of many NHS services - effectively, all health services except primary care, public health and specialised services - from NHS and private sector providers. The four Lincolnshire CCGs will, between them, spend around £900 million per year.

CCGs will not directly employ Public Health specialists. Rather, each CCG will obtain its public health advice and support from staff employed by the relevant local authority. The Department of Health has mandated local authorities to provide this support, funded from the ringfenced Public Health grant that they will receive. The Department of Health has indicated that around 40-50% of public health staff time should be allocated to work for CCGs.

In Lincolnshire, a Memorandum of Understanding has been agreed with each of the four CCGs, which sets out in detail what support will be provided for each of the three main areas of public health work: health improvement, health protection and population healthcare. This document will be reviewed annually.

Health Improvement

The Health and Social Care Act 2012 gives Lincolnshire County Council a statutory duty to improve the health of the population of Lincolnshire and reduce health inequalities, from April 2013. Clinical Commissioning Groups will be required to secure continuous improvement in health, and to reduce inequalities in the outcomes achieved by health services. This will require action along the entire care pathway from prevention to tertiary care. In addition, the NHS will only be able to remain within budget in future years if there is successful implementation of preventive measures to reduce the burden of disease that results from, for example, smoking, alcohol, obesity and falls.

Lincolnshire County Council and Lincolnshire's Clinical Commissioning Groups therefore have a collective interest in health improvement. The expectations for 2013/2014 are that:

Lincolnshire County Council's Public Health Directorate will:

- Refresh current strategies and action plans to improve health and reduce health inequalities, with input from Clinical Commissioning Groups.
- Lead on the commissioning of cost effective, equitable lifestyle services based on local needs and evidence of good practice.
- Ensure that lifestyle services are evaluated and monitored, and that they support CCGs in their role of improving health and addressing health inequalities.
- Work with all areas of service of Lincolnshire County Council, and with the seven district councils in Lincolnshire, to embed ownership and leadership of health improvement across the county.

- Lead media campaigns on lifestyle issues, and provide staff who can give media interviews.
- Support primary care to improve health - for example, by offering training opportunities for staff, and through targeted health information campaigns.
- Facilitate partnership working between Clinical Commissioning Groups, local partners and residents to integrate and optimise local efforts for health improvement and disease prevention.

Lincolnshire Clinical Commissioning Groups will:

- Contribute to strategies and action plans to improve health and reduce health inequalities.
- Work with constituent practices to help maximise their contribution to disease prevention – for example, by taking every opportunity to address smoking, alcohol, and obesity in their patients and by optimising management of long-term conditions.
- Ensure that primary prevention and lifestyle services are considered within the commissioning process, and are an integral part of all care pathways.
- Play a full part in the work of the Lincolnshire Health and Wellbeing Board.

Health Protection

The Health and Social Care Act sets out that the Secretary of State for Health is responsible for taking steps for the purpose of protecting the health of the population. Regulation-making powers will be used to require local authorities (through the Director of Public Health on their behalf) to ensure that plans are in place to protect the health of the local population from threats ranging from relatively minor outbreaks to full-scale emergencies, and to prevent as far as possible those threats arising in the first place. The scope of this duty will include local plans for immunisation and screening, as well as the plans acute providers and others have in place for the prevention and control of infection, including those which are healthcare associated.

Thus, as with health improvement, Lincolnshire County Council and Lincolnshire's Clinical Commissioning Groups have a collective interest in ensuring that the arrangements for health protection within the county are robust. The expectations for 2013/2014 are that:

Lincolnshire County Council's Public Health Directorate will:

- Assure that strategic plans are in place for responding to the full range of potential emergencies – for example, pandemic flu, fuel crises, flooding, and other major incidents.
- Assure that these plans are adequately tested.
- Assure that Clinical Commissioning Groups have access to these plans and an opportunity to be involved in any exercises.
- Assure that any preparation required – for example, training, access to resources - has been completed.
- Assure that the capacity and skills are in place to co-ordinate the response to emergencies, through strategic command and control arrangements.
- In conjunction with Public Health England provide specialist advice to Clinical Commissioning Groups and constituent practices on health protection issues.
- Monitor the effectiveness of national screening programmes within Lincolnshire.

Lincolnshire Clinical Commissioning Groups will:

- Familiarise themselves with strategic plans for responding to emergencies.
- Participate in exercises when requested to do so.
- Ensure that any provider contracts they have responsibility for include appropriate business continuity arrangements.
- Work with constituent practices to develop business continuity plans to cover action in the event of the most likely emergencies.
- Assist with co-ordination of the response to emergencies, through local command and control arrangements.
- Ensure that resources are available to assist with the response to emergencies, by invoking provider business continuity arrangements, and through action by constituent practices. Staff employed by CCGs will be made available to assist in the response to emergencies.

Population Healthcare

The Health and Social Care Act establishes Clinical Commissioning Groups as the local commissioners of NHS services, and gives them a duty to continuously improve the effectiveness, safety and quality of services. The Lincolnshire Health and Wellbeing Board has been established to identify the needs of the population, and ensure that these needs are addressed through Clinical Commissioning Groups, public health and social care commissioning plans and activities, and the commissioning plans of the NHS Commissioning Board.

The expectations for 2013/2014 are that:

Lincolnshire County Council's Public Health Directorate will:

- Provide specialist public health advice to Clinical Commissioning Groups.
- Lead the work of the Lincolnshire Health and Wellbeing Board.
- Continuously refresh the Joint Strategic Needs Assessment (JSNA), to specify the needs of the population and ensure that this is relevant at the level of each Clinical Commissioning Group. The production of the JSNA will be complemented by a programme of targeted needs assessments and profiles for each CCG.
- Ensure that insight data, such as Mosaic, is used to help target services appropriately.
- Lead implementation of the Joint Health and Wellbeing Strategy.
- Work on care pathways, including review of the evidence of effectiveness, and work with clinicians.
- Provide specialist support in relation to named patient funding requests.
- Respond to media requests for interviews on topical healthcare issues.

Lincolnshire Clinical Commissioning Groups will:

- Consider how to incorporate specialist public health advice into decision making processes, in order that public health skills and expertise can inform key commissioning decisions.
- Ensure that their commissioning plans are underpinned by the Joint Strategic Needs Assessment, and support the implementation of the Joint Health and Wellbeing Strategy.

Level of Public Health Support to CCGs

Lincolnshire's public health directorate has recently been restructured to ensure that we can meet the needs of our CCGs for public health support. Currently, at a senior level, we employ a Director of Public Health and 5.6 wte consultants in public health, plus trainees and staff at a more junior level.

Three teams will provide public health support to Lincolnshire CCGs, i.e. one for Lincolnshire West CCG, one for Lincolnshire East CCG, and one for South Lincolnshire CCG and South West Lincolnshire CCG. Each team will be led by a Public Health consultant who will normally be a member of the Governing Body and Executive Committee, and input from the team will, as a minimum, consist of:

- Three days per week from Public Health consultants
- One day per week from a Public Health programme manager
- Share of the work of Public Health trainees and other Public Health Directorate staff

Recommendations

1. That Lincolnshire County Council's Public Health Directorate and the four Clinical Commissioning Groups in Lincolnshire cooperate fully to improve health, and reduce health inequalities, across the three domains of Public Health practice: health improvement, health protection and population healthcare.
2. That Lincolnshire's Clinical Commissioning Groups continue to play a full part in the production of the Joint Strategic Needs Assessment, and the implementation of the Joint Health and Wellbeing Strategy.
3. That around half of the staff time of Lincolnshire's Public Health directorate be devoted to work on behalf of NHS commissioners.

Health Protection

Health Protection is one of the three component parts of Public Health. Through this part of our work we seek to prevent or reduce the harm caused by communicable diseases, minimise the health impact of environmental hazards, including chemicals, radiation and physical threats, and identify early disease. We do this in a wide variety of ways, and almost always in partnership with other parts of the NHS or with other agencies. This chapter aims to set out some of this work, and make recommendations on the way forward as these public health responsibilities move from the NHS to upper tier local authorities.

Communicable Diseases

Currently, responsibility for the surveillance and control of communicable diseases is split. Much of the statutory responsibility lies with the Primary Care Trust (PCT), although district councils have responsibilities under a number of statutes. The day-to-day work on surveillance and management of single cases or outbreaks of infections such a salmonellosis, legionella and hepatitis is undertaken by staff within the Health Protection Agency, supported by environmental health officers and community nursing staff. Healthcare acquired infections, such as MRSA, Clostridium difficile and E. coli are a shared responsibility between the Public Health Team and the organisation treating the person affected. This works well with NHS providers, but requires much more Public Health input with primary care and social care providers.

The Director of Public Health has a key role in coordinating and leading this work. The Department of Health wants this coordination role to continue, and has set out in guidance that "the local leadership of the Director of Public Health will play an important part in ensuring the local authority and local partners are supporting preventative services that tackle key threats to the health of local people". One of the key areas we need to tackle in Lincolnshire is raising awareness of the risks of infectious diseases. This would include blood-borne and sexually transmitted viruses, such as Hepatitis B and C, where excellent vaccines are available, which are not used as much as they should be, and tuberculosis where high risk groups, such as migrant workers and the homeless present a particular risk.

At present Public Health staff lead the development of health protection plans for outbreaks of communicable disease and the prevention and control of infection, and this will continue.

Responsibility for commissioning immunisation programmes will move from the PCT to the NHS Commissioning Board, but the Director of Public Health will have a role in "supporting, reviewing and challenging local plans for, and delivery of, immunisation programmes". This will particularly consider inequalities in uptake rates and whether the programmes are meeting local needs. Where we identify issues that need addressing we will provide "advice, challenge and advocacy". This will utilise leadership skills within public health and good relationships with clinicians and Clinical Commissioning Groups (CCGs). Other channels for resolving difficulties will include the DPH annual report and reports to the Health and Wellbeing Board.

The Public Health Team will continue with its role in community infection control, and will continue to give advice on healthcare acquired infection to CCGs.

Environmental Issues and Hazards

The Public Health Team currently has a role in giving advice on the health aspects of environmental issues and hazards. This is both in terms of trying to reduce the health risks in the environment through advice to planners, the Environment Agency and others, and in supporting the multiagency response to a wide range of incidents. These might be air pollution, water pollution including drinking water, chemical leaks, fires, floods and so on. Most of these require multiagency planning and exercising in preparation.

The local authority, through their Director of Public Health will take over responsibility for local initiatives to reduce the public health impact of environmental risks. The position of the Public Health Team within the local authority gives added opportunities to influence environmental issues.

The future of health input to emergency planning and managing emergency situations is more complex. Many of these require specialist Public Health advice, and this will continue to be available through the Director of Public Health and Public Health England. The responsibility for the NHS contribution to emergency planning, and for preparing NHS plans, will now be with the NHS Commissioning Board. The interdependence of these two contributions is the reason why the local Director of Public Health and a director from the Local Area Team of the Commissioning Board will co-chair a new executive level partnership to oversee health emergency planning and link with the multiagency planning. This will be called the Local Health Resilience Partnership.

Screening Programmes

The NHS currently commissions a range of screening programmes, which were described in some detail in chapter 3 of the 2011 Annual Public Health Report. These include a number which relate to pregnancy and very early childhood – screening the mother for Hepatitis B, HIV and syphilis; and new-born hearing screening; some programmes to pick up early cases of cancer – breast, cervix and bowel; and some adult screening programmes for other conditions – diabetic retinopathy and abdominal aortic aneurysm. The actual programmes to be commissioned across the whole country are decided by the National Screening Committee, which is part of the National Institute of Health and Clinical Excellence.

Responsibility for commissioning screening programmes is not transferring to local authorities as part of their public health functions but to the NHS Commissioning Board supported by staff from Public Health England. What is transferring is a role for the Director of Public Health to have an oversight of screening programmes. This role is similar to that with immunisation programmes – ensuring that programmes meet local needs, especially in relation to inequalities, advice to commissioners and providers, and advocacy. There will be a particular role if a serious incident occurs, where the Director of Public Health and the rest of the Public Health Team may need to lead the overall health community response to the incident.

Next Steps

These programmes often involve a large number of provider organisations. For example, cervical screening involves the organisation providing the NHS register for call and recall; GPs, practice nurses, and sexual health services to take the test; pathology services; Public Health staff and voluntary organisations raising awareness; and hospital services. Add to this mix an increased number of organisations involved in commissioning and coordination, and it can be seen that these changes lead to a considerable level of uncertainty in the delivery of some of the most critical public health programmes.

This makes the local Public Health role critical to the safety and success of these programmes. In Lincolnshire we are putting in place a team of experienced staff, led by Public Health consultants to ensure that we deliver these outcomes.

Recommendations

1. That all NHS organisations in Lincolnshire ensure that they have a high-level executive input to the Local Health Resilience Partnership, and give serious consideration to its decisions and recommendations.

2. That a Health Protection Group is established involving commissioners and providers, to assist the Director of Public Health to give advice, challenge and advocacy.

3. That the Local Area Team of the NHS Commissioning Board continue with the current coordination arrangements for each of the screening programmes.

Conclusions and Recommendations

This report highlights some really beneficial improvements which could be made in services for people with learning disabilities. This type of health needs assessment offers objective guidance on the unmet needs of the population which can be used to reconfigure existing services. Very often, meeting these needs now will avoid costly requirements in the future, as well as improving quality of services, and life.

A similar opportunity exists with the NHS Health Check Programme. For example, with a population in this country which is considerably overweight, one difficulty is that being overweight becomes the norm, and people may not even realise that they need to lose weight. Identifying a need to lose weight now, and giving modest help to achieve this, will result in less heart disease, fewer people with diabetes and fewer older people with immobility requiring social and healthcare, amongst other benefits. You can see that this gives better quality of life for many people in Lincolnshire, and better use of the collective resources of organisations in the county.

The NHS reforms present us with many opportunities, and the recommendations below seek to maximise those opportunities and address the potential risks. I hope organisations in Lincolnshire will take these recommendations and use them to improve our collective health.

1. The Learning Disability Joint Commissioning Board should ensure joint plans are in place to meet the needs of service users, including increased demand from more adults with learning disabilities.
2. Primary care should be encouraged to identify and record all people with learning disabilities.
3. Preventive healthcare and Public Health activities should be reviewed to ensure provision across Lincolnshire.
4. All services should provide the opportunity for adults with learning disabilities to access healthy lifestyle initiatives and services.
5. All GP practices should be encouraged to provide annual healthchecks for people with a learning disability.
6. Frontline staff should receive training on learning disability awareness in order to develop their clinical skills, so that they are equipped to meet the health needs of this group.
7. Commissioners, Public Health Teams and providers should work together to increase the number of NHS Health Checks offered, increase the uptake rate and agree a way to cover the service gaps.
8. Commissioners, Public Health teams and providers should work together to ensure that every eligible individual is offered high quality life style advice and, when appropriate, a referral to a lifestyle service.
9. All involved with children should raise the profile and implications of childhood obesity with local communities.
10. Maternity primary care and children's services should support mothers to effectively breastfeed
11. We should all promote healthy food choices and appropriate portion sizes in the home, nursery and school.
12. Schools need to increase the numbers of children eating healthy school meals and reduce those eating packed lunches.
13. We all need to promote active lifestyles in the home, nursery and school.
14. Lincolnshire County Council's Public Health Directorate and the four Clinical Commissioning Groups in Lincolnshire should cooperate fully to improve health and reduce health inequalities, across the three domains of public health practice: health improvement, health protection and population healthcare.
15. Lincolnshire's Clinical Commissioning Groups should continue to play a full part in the production of the Joint Strategic Needs Assessment, and the implementation of the Joint Health and Wellbeing Strategy.
16. Around half of the staff time of Lincolnshire's Public Health Directorate should be devoted to work on behalf of NHS commissioners.
17. All NHS organisations in Lincolnshire should ensure that they have a high-level executive input to the Local Health Resilience Partnership and give serious consideration to its decisions and recommendations.
18. A Health Protection Group involving commissioners and providers should be established to assist the Director of Public Health with the duties of giving advice, challenge and advocacy.
19. The Local Area Team of the NHS Commissioning Board should continue with the current coordination arrangements for each of the screening programmes.

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