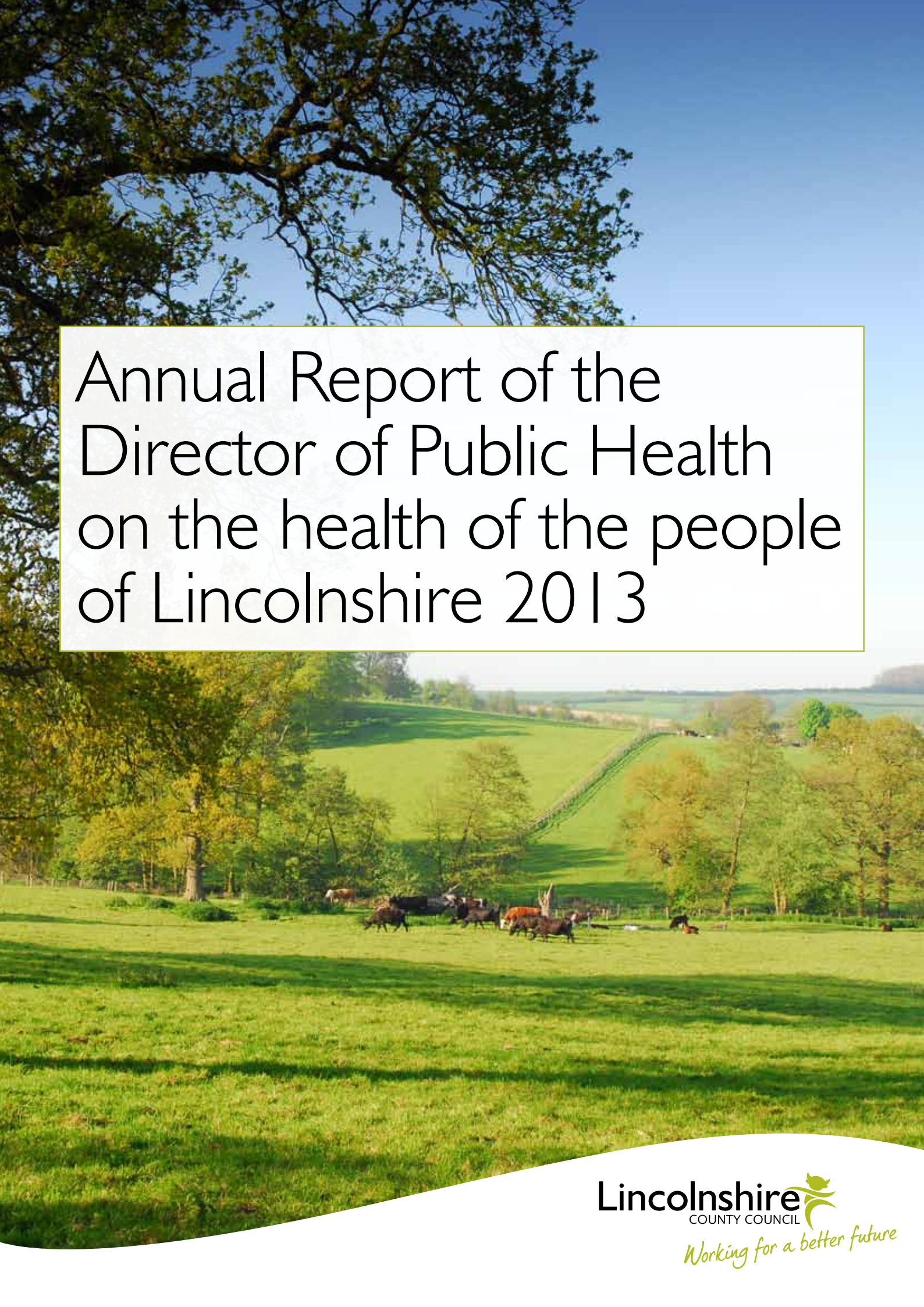


# Annual Report of the Director of Public Health on the health of the people of Lincolnshire 2013

Lincolnshire
COUNTY COUNCIL
Working for a better future

# Introduction

This is my fourth annual report on the health of the people of Lincolnshire, and the first in my new role based in Lincolnshire County Council. I have a statutory duty to make this report, which is not an annual account of the work of the Public Health Team, but an independent professional view of the state of the health of our area, with recommendations on the action needed by a range of organisations and partnerships.

Inevitably, there has to be a range of topics covered in any one year and I have tried to address issues that, in my view, are likely to be priorities or where there is scope and need for action to be taken.

The first chapter considers the health needs of international migrants and outcomes we should be striving for. This is an issue of considerable importance in Lincolnshire.

Tobacco is responsible for a very large proportion of deaths in our population, and this is rightly an important priority in our Joint Health and Wellbeing Strategy. This is not just a responsibility of the County Council or of the NHS. Many others have a part to play and chapter two details some of this.

Part of the rationale for moving local Public Health responsibilities from Primary Care Trusts to Local Authorities was to support those who influence the wider determinants of health. Spatial planning has influence over many factors which strongly influence health and wellbeing. Chapter three describes spearhead work in Lincolnshire and recommends how this could be developed. This links to the development of Public Health skills in the wider work force which is considered in chapter four.

The Director of Public Health not only has some roles and responsibilities in protecting the health of the population, but also has a role "to be assured" that other organisations and professional groups are working well together to protect health. How we do this and the current picture is described in chapter five.

I would like to thank my staff who have been involved in producing this report. As ever, I and they would welcome comments and dialogue with you.

**Tony Hill**
Director of Public Health,
Lincolnshire County Council

# Contents



# Progress on Previous Recommendations

| | |
|---|---|
| 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. | Work has been undertaken to convert the health needs assessment into a more detailed understanding of service needs for now and the future, including social needs.<br><br>This is informing the commissioning plans of the Joint Commissioning Board. |
| 2. Primary care should be encouraged to identify and record all people with learning disabilities. | I am not aware of any action that has been taken on this recommendation. |
| 3. Preventive healthcare and public health activities should be reviewed to ensure provision across Lincolnshire. | All public health services will be reviewed by the end of March 2014, and implementation plans are already in place for some services.<br><br>The county's prevention and early intervention strategy is under review, and will be relaunched early in 2014. |
| 4. All services should provide the opportunity for adults with learning disabilities to access healthy lifestyle initiatives and services. | This has been established as part of the specification for the Wellbeing Service which is currently being procured. |
| 5. All GP practices should be encouraged to provide annual healthchecks for people with a learning disability. | More focus on achieving annual health checks is currently being promoted across community learning disability services and primary care. |
| 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. | I am not aware of any action that has been taken on this recommendation. |
| 7. 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. | NHS Health check performance has been raised at CCG meetings. Distribution of practice performance data has increased from quarterly to monthly – sent to practices and CCGs. We are looking at restructuring the service specification for 2014/15 to increase and stretch target payments to encourage an increase in uptake. |

| | |
|---|---|
| | A pilot is being set up with the Co-op providing health checks for some of the highest risk patients at the four non-participating practices (1st January 2014 to 31st March 2014). This will be evaluated to see if it is a viable alternative service model. |
| 8. 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. | Practices are being encouraged to make and record referrals to lifestyle services through the NHS Health Check. LWCCG have included a target for referrals onto weight management services for patients accessing their NHS Health Check who have a recorded BMI of 30 or above.<br><br>In total, 45 people received Make Every Contact Count (MECC) Train the Trainer sessions in 2012/13. These trainers ranged from across NHS organisations and associated professionals such as pharmacists, to Lincolnshire County Council and District Council Housing teams.<br><br>Over 791 frontline NHS staff were trained to enable them to effectively discuss lifestyle issues with patients, and provide signposting, referral or support for the patient in choosing to make a lifestyle change. |
| 9. All involved with children should raise the profile and implications of childhood obesity with local communities. | Childhood obesity continues to be a problem within our county. However, all key partners are working together to address this issue. Nationally, we received praise for our joint working in the School Food Plan which was a review commissioned by central government. |
| 10. Maternity primary care and children's services should support mothers to effectively breastfeed. | Initiating breastfeeding at birth and prolonging the duration an infant is breastfed continue to be priorities in Lincolnshire. An ongoing training programme for frontline staff has been established in order that women receive consistent messages about the benefits of breastfeeding, and the support to do so, both in hospital and community settings. |
| 11. We should all promote healthy food choices and appropriate portion sizes in the home, nursery and school. | We have worked continually with schools and early years settings to promote the use of appropriate portion sizes. Our Healthy Schools Team has employed 2 specialist consultants to work specifically with early years settings on their food provision. |
| 12. Schools need to increase the numbers of children eating healthy school meals and reduce those eating packed lunches. | The new School Food Plan is at the heart of our way forward for working with schools and caterers on the uptake of healthy school meals. Key partners are working to accommodate the new universal free school meal offer which will provide free school meals to all children under the age of eight as of September 2014. |
| 13. We all need to promote active lifestyles in the home, nursery and school. | Our healthy schools team continues to promote the Healthy Early Years Award, which has seen good uptake in the past 12 months, 39 schools are now enrolled and 26 schools have achieved the award. We are also currently developing a new healthy lifestyles pathway for families with young children, in conjunction with children's centres and early years settings around the county. |

| | |
|---|---|
| 14. 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. | The level and quality of provision of public health advice and support was one of the tests in the authorisation process for CCGs. All four Lincolnshire CCGs are fully authorised by NHS England without conditions.<br><br>A Memorandum of Understanding is in place between Lincolnshire's Public Health Directorate and each CCG which sets out mutual expectations.<br><br>Each CCG has a public health consultant as a member of their Governing Body, to provide advice to them across the three domains. |
| 15. 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. | Each CCG is represented on the Health and Wellbeing Board.<br><br>Each of the five themes of the Joint Health and Wellbeing Strategy has a lead GP, as well as a lead elected member and a lead public health consultant. |
| 16. Around half of the staff time of Lincolnshire's public health directorate be devoted to work on behalf of NHS commissioners. | This is a commitment within the Memorandum of Understanding between Lincolnshire's Public Health Directorate and the four Lincolnshire CCGs. This commitment has been met, and has been reaffirmed for 2014/2015. |
| 17. 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. | Terms of Reference have been agreed for the LHRP in Lincolnshire, with appropriate representation from all NHS organisations.<br><br>A 3 year strategic plan is currently being developed, with agreement on the key priorities during this time period.<br><br>Actions identified during incidents and lessons are agreed and managed through the group.<br><br>The LHRP links into other Local Resilience Forum standing groups to ensure a clear governance structure is in place for emergency preparedness, resilience and response within Lincolnshire. |
| 18. A Health Protection Group is established involving commissioners and providers to assist the Director of Public Health to give advice, challenge and advocacy. | The clarity of the role of this group has now been established, and it will meet for the first time in Spring 2014. |
| 19. The Local Area Team of the NHS Commissioning Board continues with the current coordination arrangements for each of the screening programmes. | The Local Area Team have now assumed responsibility for commissioning national screening programmes. Lincolnshire County Council retains a responsibility to seek assurance of the performance and quality of the local screening programmes, and to challenge and scrutinise as appropriate. Lincolnshire County Council has developed a local health promotion plan which introduces initiatives to increase uptake, reduce missed appointments and address inequalities in screening programmes in Lincolnshire. |

# Chapter 1
# Addressing Health Equity and Health Outcomes for International Migrants

It is essential that commissioners of healthcare and health improvement services understand the changing health needs of their populations and can tailor services to meet specific health needs. Internal and international migration within the UK and within Lincolnshire is an inherent part of modern life. In May 2004, the Treaty of Accession to the European Union (EU) between the existing 15 member states and 10 new states came into force. The new states included eight countries of central and eastern Europe (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia), termed the A8 countries, along with Cyprus and Malta. The expansion of the EU has seen areas with little previous experience of immigration facing unprecedented changes, particularly rural areas, and it is acknowledged that parts of Lincolnshire have seen significant numbers of international migrants coming to live and work. More recently, it has become possible for people to migrate from Bulgaria and Romania but the impact of this group is not considered in this needs assessment. This will be monitored in the future.

Migrant workers actively contribute to economic prosperity, are often highly educated, and as they tend to have a younger profile than the resident population, they can help to balance demographics and dependency ratios. In addition to economic migration, around 17% of students in higher education institutions in the UK are from overseas.[1]

The Health and Social Care Act 2012 has resulted in significant change to the health and social care agenda. Understanding the health and other needs of migrants is essential in addressing health inequalities and delivering the policy objectives of the Marmot Review, 'Fair Society, Healthy Lives'.[2]

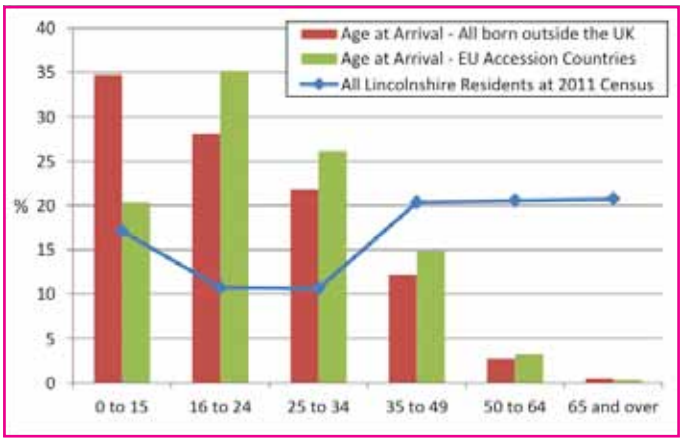
Health (along with employment, education and housing) has been identified as a key indicator of migrants' integration. If migrant workers intend to stay in the UK, even if their stay is temporary but long-term, it is essential that their health needs are routinely considered, along with projected levels of demand for and access to service provision.

## International Migrants in Lincolnshire

Of the 713,653 people resident in Lincolnshire at the 2011 census, just over 7% were born outside of the UK compared to just over 13% across England and Wales. Of these non-UK born residents in Lincolnshire, around 60% were from EU member states and accession countries and 40% were from elsewhere in the world. Increased rates of migration were particularly seen between 2004 and 2009 following the accession of new states to the EU, after which rates again reduced.

International migrants tend to be relatively young, with health needs similar to those of indigenous individuals of equivalent age and sex. Figure 1 shows the age profile of all Lincolnshire residents at the 2011 census compared to the age of arrival for international in-migrants.

*Figure 1.1: Age profile of all Lincolnshire residents at the 2011 census versus age at arrival of international in-migrants*[3]

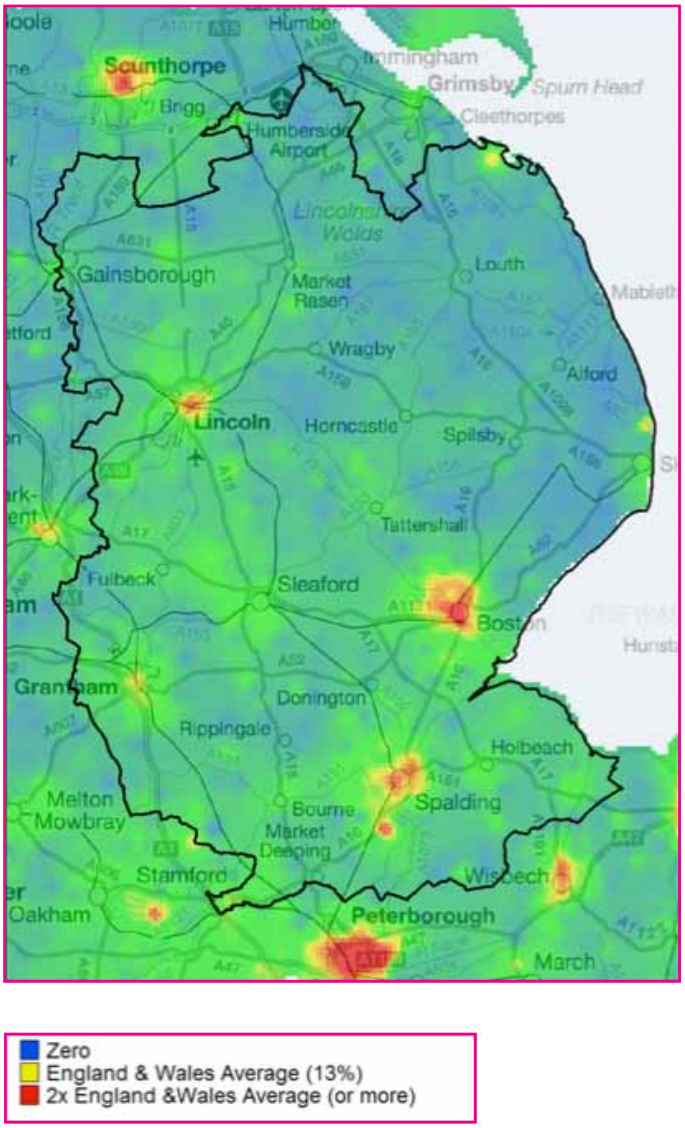



*Source: 2011 Census of Population, Office for National Statistics, 2011*

Figures from the Department for Work and Pensions[4] show that just over 5,300 international migrants in Lincolnshire registered for a national insurance number in 2012/13, with Boston and South Holland seeing the highest numbers of registrants. Since 2004, 34% of national insurance numbers allocated to overseas nationals in the UK have concerned people from A8 countries. In Lincolnshire, the figure is 83%, suggesting the county is more attractive to migrant workers from the A8 countries than to those from other parts of the world. In July 2012, over 15,000 people from the A8 community were recorded as being registered with a Lincolnshire GP, with most recorded as living in the areas of Boston, Spalding, Grantham, Skegness and Lincoln. A large proportion of A8 migrants in Lincolnshire live in areas with high levels of multiple deprivation, they earn the lowest wages compared to other migrant groups, and their employment does not correspond to their educational background and skills.[5]

Information from the 2011 census shows that there are very low proportions of people living across wide areas of the county whose country of birth is outside of the UK in comparison to the England and Wales average. Residence tends to be concentrated on the areas of Boston, Spalding, Lincoln, and to a smaller extent, Grantham, consistent with GP registration data. In addition, there are concentrations of residents born outside of the UK in areas close to the Lincolnshire border, such as in Scunthorpe, Newark and Peterborough, and these residents may also access employment and services within the county.

*Figure 1.2: Proportion of residents whose country of birth is non-UK*[3]




*Source: 2011 Census of Population, Office for National Statistics, 2011*

In England and Wales, in the 10 years between the 2001 and 2011 censuses, the largest increase in people born outside the UK was of those born in Poland. The census also identifies that Polish-born residents are concentrated in West London, Slough in Berkshire and Boston in Lincolnshire. In Boston specifically, around 3,000 people (just over 4% of residents) were born in Poland. In the most recent year of national insurance number registrants (2012/13), A8 migrants to Lincolnshire were predominantly from Lithuania (40%), Poland (34%) and Latvia (19%).

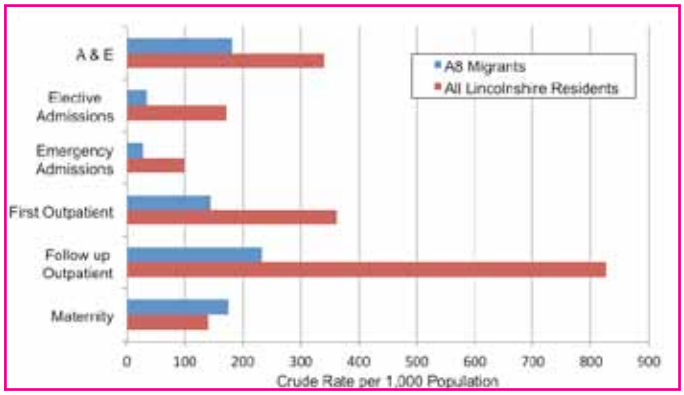
## Health Needs and Service Use of Migrants

Migrants have a range of health needs, partly determined by their individual characteristics (such as age, sex, and ethnicity), their country of origin, the circumstances of their migration and the socio-economic conditions in the host country. The Health Protection Agency (HPA), now part of Public Health England (PHE), identifies several groups of vulnerable migrants living in the UK, including low-paid migrant workers[6]. Work commissioned by the Department of Health also describes the wide determinants of health and well-being for migrants[7].

There is evidence that international migrants are relatively healthy on arrival, and are unlikely to impose a disproportionate burden on health services. This is, to a large extent, due to their young age profile but is also due to the fact that the life changing decision to migrate (usually to work) will tend to be made by those who are already in relatively good health. However, health may deteriorate the longer they stay in the host country. This can be due to a number of reasons, including taking on some of the poorer lifestyle behaviours of the indigenous population where these exist (lower exercise and outdoor activity, alcohol use, smoking, poor eating habits for example), and a combination of changes brought about by their migration. For example, migrant workers from A8 countries frequently live in privately-rented flats or houses, many of which are multiple occupancy and of poor quality[8]. This can tend towards overcrowding, lack of cooking and heating facilities, and property that is badly maintained and/or damp. There are also issues associated with 'cross-border' driving, with road-police officers stressing the need to educate some migrant workers about aspects of road safety. In particular, they are concerned about problems caused by not using seat belts or child seats, and poor driving (driving when tired, speeding and drink-driving)[9].

As migrants begin to settle in the host country their need for health services changes. The rate of hospital service use in all cases is lower for A8 migrants in Lincolnshire than for Lincolnshire residents as a whole, apart from a slightly higher rate for use maternity services. In 2011, 15.7% of all births in Lincolnshire were to non-UK-born mothers and 10% were to mothers from countries that had recently become part of the EU. This is consistent with the health and demographic status of the migrant group.

*Figure 1.3: Use of hospital services by all residents and by A8 migrants, 2011/12*[10]



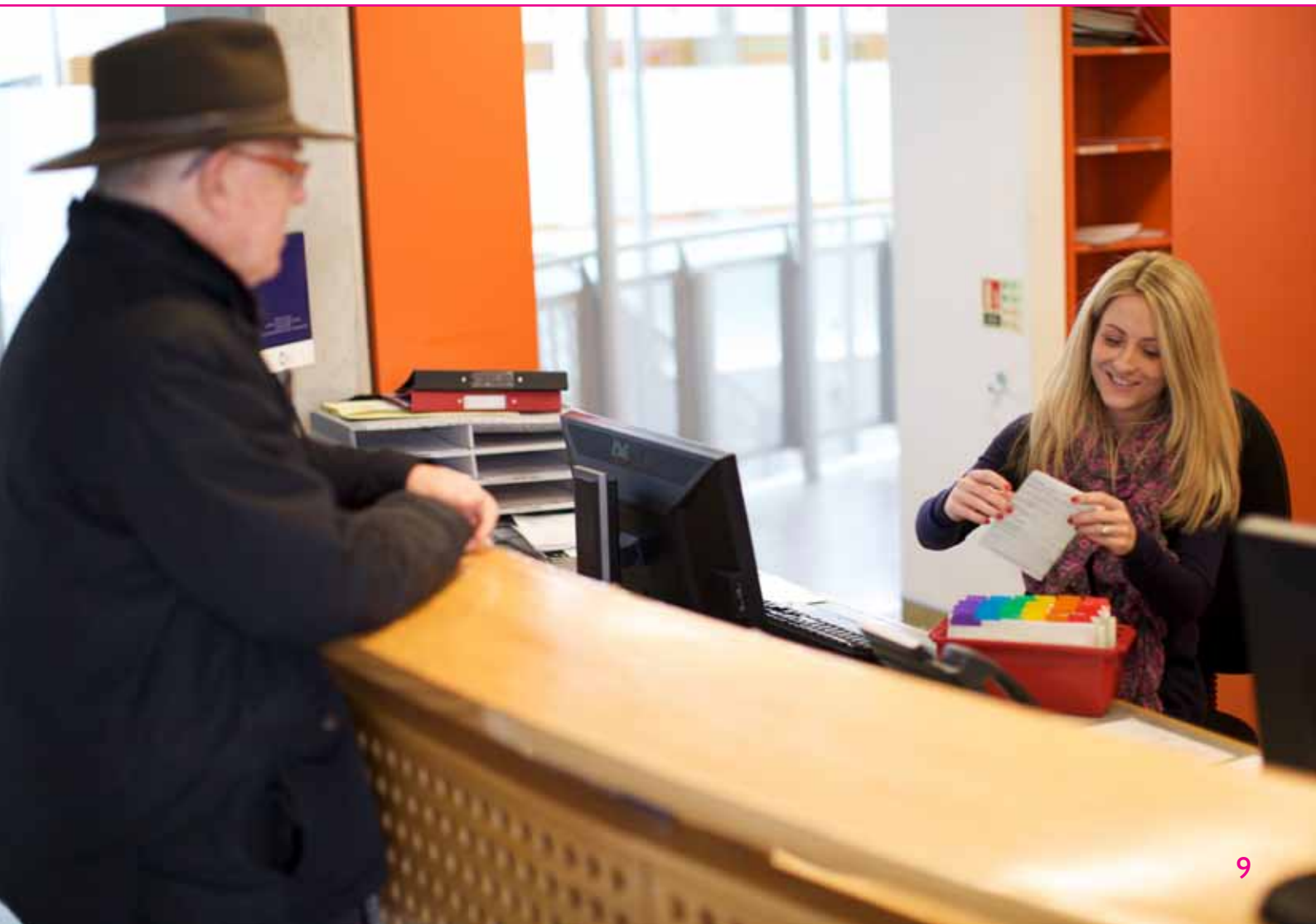

*Source: NHS Secondary Uses Service (SUS) Data, Health and Social Care Information Centre (HSCIC), 2011/12*

Migrants' health may also be affected by their ability to access healthcare services. It is reported that, for various reasons, many migrants do not register quickly (if at all) with a GP. Language difficulties and a lack of knowledge of how the healthcare system in the UK operates are both cited as obstacles to migrants' ability to access health services and health information in the UK. Some migrants return to their home country for healthcare. In an NHS Lincolnshire survey of A8 migrants with 131 respondents, 58% said that they returned to their home country for medical treatment (including predominantly dental treatment), and 51% of those returning home for healthcare said that this was because they found it easier to communicate.

## Addressing Inequalities in Health and Health Outcomes

Inequalities in health and health outcomes amongst migrant workers are often linked to language barriers and a lack of understanding about access to healthcare and other public services.

A range of guidance is available to support in managing the health needs of the migrant population. NICE (National Institute for Health and Clinical Excellence) guidance sets the standards for high quality healthcare and encourages healthy living. A number of NICE guidelines are specifically relevant to providing healthcare and health improvement for the migrant population. The Migrant Health Guide from the HPA (now part of PHE) also provides a wide range of information in relation to the healthcare of the migrant population. Both of these sources can be used by the NHS, Local Authorities, employers, voluntary groups and anyone else involved in delivering care or promoting wellbeing.



## Recommendations

There are a number of recommendations which could improve the inclusivity and equality of healthcare provision to the migrant populations in Lincolnshire.

- In the provision of any strategy, programme or service, the specific needs of migrants should be considered to understand whether these are any different to those of the general population. Where specific differences are identified in the needs of the migrant populations, these should then be taken into account.

- Commissioners and healthcare providers must be fully aware of, and use, the guidance for providing healthcare to international migrants, including Public Health England and NICE guidance.

- Service providers and intermediaries engaging with international migrants in any capacity should encourage them to register with a GP to enable them to access the full range of primary care services, including screening and other preventative services.

- Staff providing health services should be made aware of the translation services available for people who require them, and ensure that the benefits of English language courses are promoted to all migrants.

- Links should be strengthened between health service providers, other service providers, intermediary and support organisations and employers to ensure that services are better understood by migrants and are more appropriately accessed.

Further information on these recommendations, and the evidence which underpins them, can be found in the report 'Ensuring Inclusive Healthcare' produced by the Public Health directorate of Lincolnshire County Council.[11]

## References


[1] Higher Education Statistics for the United Kingdom 2011/12, Higher Education Statistics Agency

[2] Fair Society, Healthy Lives. The Marmot Review. Strategic review of health inequalities in England post-2010. Marmot M. 2010

[3] 2011 Census of Population, Office for National Statistics, 2011

[4] Department of Work and Pensions statistics.dwp.gov.uk/asd/asd1/niall/index.php?page=nino_allocation. Accessed through stat-xplore.dwp.gov.uk [cited 11/10/2013]

[5] The Migration Observatory at the University of Oxford www.migrationobservatory.ox.ac.uk/briefings/characteristics-and-outcomes-migrants-uk-labour-market [cited 2012 Dec 4]

[6] Public Health England (Health Protection Agency) www.hpa.org.uk/MigrantHealthGuide [cited 2012 Dec 4]

[7] Including migrant populations in Joint Strategic Needs Assessment - a guide, Migrant Health Leads of Yorkshire and the Humber, the North West and the North East, commissioned by the Department of Health, 2011

[8] Health and migration in the North West of England. An overview summary. Manchester: North West RSMP, Ricketts, 2008

[9] Crossing Borders. Responding to the local challenge of migrant workers, Audit Commission, 2007

[10] NHS Secondary Uses Service (SUS) Data, Health and Social Care Information Centre (HSCIC), 2011/12

[11] Ensuring Inclusive Healthcare, Lincolnshire County Council, August 2013. Available from Lincolnshire County Council www.lincolnshire.gov.uk and from the Lincolnshire Research Observatory www.research-lincs.org.uk

# Chapter 2
# Tobacco Control

The Joint Health and Wellbeing Strategy for Lincolnshire 2013 – 2018 identified the need for the development and delivery of a five year Tobacco Control Plan incorporating a broad partnership approach to tackle tobacco control issues. The following information outlines the work done so far and the developments for the future.

## Introduction

Tobacco has been used by people for centuries, but it was the introduction of ready-made cigarettes in around 1884 that led to a global explosion in tobacco use. An estimated 100 million deaths in the twentieth century are attributed to tobacco smoking.[1]

Globally, smoking is the biggest preventable cause of death. Tobacco is unique in that it is the only product that kills when it is used entirely as intended (smoked and inhaled). In doing this, it kills half of its consumers. Smoking causes 50 different conditions and costs the NHS £2.7 billion to treat every year.[2] Tobacco is a leading cause of health inequalities and is responsible for half of the difference in life expectancy between the rich and the poor. Approximately 900[3] adults aged 35 and over die each year in Lincolnshire from a smoking related condition.

Tobacco use and second-hand exposure to tobacco smoke increase the risk of death from lung and other cancers, heart disease, stroke, chronic respiratory disease and other conditions.[4] A burning cigarette spends over 90% of the time smouldering. The smoke contains toxic chemicals (approximately 4,000) which are released into the air for others to breathe. There are approximately 70 cancer causing chemicals contained within each cigarette.[5] In England, deaths from smoking are more numerous than the next six most common causes of preventable death combined (i.e. drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse).[6]

*Figure 2.1 What is in a cigarette?*[7]


In an effort to address this issue, the government introduced legislation that prohibited smoking in virtually all enclosed public places and workplaces throughout the United Kingdom. The smokefree law in England forms part of the Health Act 2006 and followed similar laws that were implemented in Scotland (March 2006), and Wales and Northern Ireland (April 2007). Smoking is no longer permitted in enclosed and "substantially enclosed" workplaces, as well as in work vehicles if they are used by more than one person at any time. The legislation has enforcement offences specified and compliance enacted through local authorities.

The health of the public has been significantly improved since the introduction of this piece of legislation, which suggests it is one of the most significant Public Health measures since the introduction of seat belts in the 1980s.

The Chief Medical Officer, Sir Liam Donaldson, commissioned the report 'Smokefree England – One Year On' to determine the success of the implementation of the legislation. 81% of businesses agreed that smokefree legislation is 'a good idea' and 40% of businesses reported a positive impact on the company. In addition, compliance was high with 98.2% of premises and vehicles smokefree and 89.3% displaying the correct no smoking signage.[8] This public support is not surprising as in in 2004 the East Midlands undertook a region wide survey titled 'Big Smoke Debate', which asked the public to respond on whether smoking should be allowed to continue in enclosed public places. There was huge interest from the public to the debate with over 24,000 responses collated, 87 per cent indicating that they would prefer public places to be completely smokefree and 82 per cent stating that they would support a law that would make all workplaces smokefree. The Big Smoke Debate was rolled out across the country where public interest continued to grow. Later that year the Government published Choosing Health 'Making Healthier Choices Easier' which outlined a range of initiatives that included a move for smokefree public places.

In 2010 the coalition government launched their Plan, 'Healthy Lives, Healthy People: A Tobacco Control Plan for England', which identified three key ambitions for the next five years. They are to:

- reduce smoking prevalence among adults in England. To reduce adult (aged 18 and over) smoking prevalence in England to 18.5% or less by the end of 2015, equating to around 210,000 fewer smokers a year.
- reduce smoking prevalence among young people in England. To reduce rates of regular smoking among


15 year olds in England to 12 % or less by the end of 2015.

- reduce smoking during pregnancy in England. To reduce rates of smoking throughout pregnancy to 11 % or less by the end of 2015 (measured at time of giving birth).

## Lincolnshire's Smoking Prevalence

The majority of smokers start smoking as children or adolescents, before they fully understand the risks of tobacco use, quickly becoming addicted to the nicotine which is as addictive as heroin or cocaine; smoking is a way of feeding that powerful chemical dependence[9] rather than it being a matter of choice.

Nationally, two-thirds of current smokers say that they want to quit smoking, with three-quarters reporting that they have attempted to quit smoking at some point in the past.[10] Market research conducted in July 2012 by the local stop smoking service asked 47 people how they felt about quitting smoking, each of them having different motivations for quitting e.g. cost or health reasons. The responses were varied, with many of these smokers acknowledging that it would be a difficult process. However, equally as many were confident that they could kick the habit.

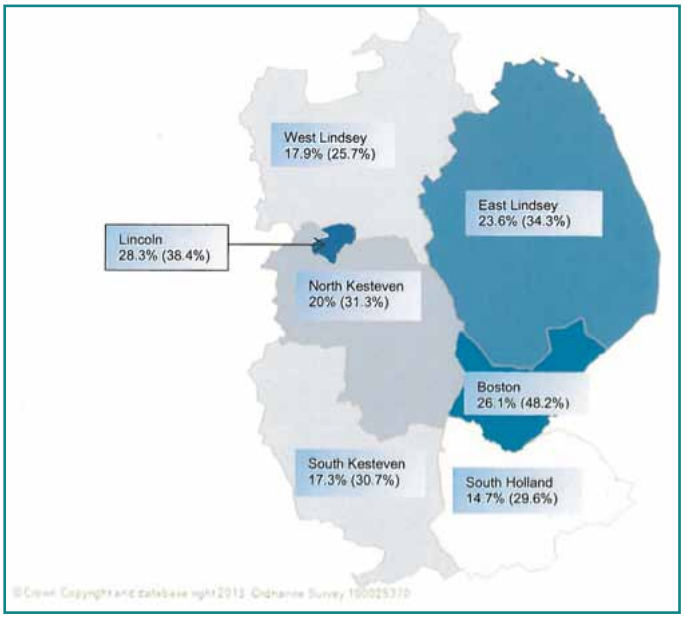
Smoking prevalence continues to fall decade by decade, but Lincolnshire's smoking prevalence of 21% is still higher than England and the East Midlands' average of 20%. Within Lincolnshire's routine and manual (R & M) occupational groups, smoking prevalence is higher still at 33.5% compared to 30.3% and 29.5% respectively. The figure 2.2 shows the difference across the districts, (the bracketed figures relate to R & M groups).[11]

Smoking prevalence is higher in areas such as Lincoln City, Boston and East Lindsey, areas with higher deprivation and greater health inequalities than other parts of the county. These are further exacerbated by smoking and associated ill-health. Targeted activity to focus on these areas of highest need is pursued and monitored closely, but more work is needed to identify health champions who can support their communities by signposting to services and aiding access to specialist support.

Smoking in pregnancy was identified as an area of concern which prompted the development of a working group. Consisting of commissioners, Phoenix NHS stop smoking service, midwives and others, they meet to tackle the disproportionally high smoking prevalence in this target group. Reported at 18.1% in 2011/12 the prevalence has recently been reported to have fallen to 13.7% in 2012/13 in line with the England average. It is difficult to align this fall in reported smoking at time of delivery (SToD) directly with the work of the group. However, the consistent approach used by our midwives in engaging constructively in

conversation about the effects of carbon monoxide (CO) and smoking on their unborn baby may be having an effect. Routine CO testing throughout the women's pregnancy; changing the access into the service by having a stronger physical presence in the hospital; and an earlier antenatal pathway to smoking cessation may be playing a part. As part of their initial work, the group have been able to use provisional data supplied by United Lincolnshire Hospital Trust (ULHT) to identify the smoking prevalence for each of the three hospital sites in Lincolnshire, which showed that Boston's Pilgrim Hospital had the biggest issue with pregnant women smoking, with figures in 2011/12 showing prevalence at 29%. However this too appears to be improving with latest figures for Boston in 2012/13 reported as 23.6%.

*Figure 2.2 Lincolnshire's Smoking Prevalence*




*Source: LRO. Crown Copyright and database right 2013 Ordinance Survey 100025370*

## Areas of Activity – Six Strands for Tobacco Control

Lincolnshire's "Smokefree Lincs Alliance" sets out to achieve the government's ambitions through the development of a five-year strategy, using the six internationally recognised strands for tobacco control and mirroring global aims:

- Reducing exposure to secondhand smoke.
- Helping tobacco users to quit.
- Effective communication for tobacco control.
- Stopping the promotion of tobacco.
- Making tobacco less affordable.
- Effective regulation of tobacco products.

**Reducing Exposure to Secondhand Smoke** The majority of smokers start smoking as children or adolescents and it is recognised that children who grow up in a smoking environment are three times more likely to take up smoking themselves. It is also known that children who grow up in an environment free from smoke are more likely to remain smokefree. Evidence suggests that people who live in the most deprived areas on limited income are more likely to smoke and be heavier smokers. Lincolnshire Smokefree Homes programme, established in 2004, targets the most deprived areas of the county. Working through children's centres it targets young families who are at most risk of living in a smoking household. With over 23,500 homes across Lincolnshire registered, protecting just over 24,000 children, this is the biggest and one of the most effective programmes across the country, and has been cited in a number of national reports, including the government's 'Healthy Lives, Healthy People' paper.

**Helping Tobacco Users to Quit** The Phoenix NHS stop smoking service has undergone a number of changes over recent years. Although numbers accessing the service have recently declined, the success rate of smokers once into the service continues to remain high with over 54% still not smoking when measured at four weeks. 12,076 smokers have successfully quit smoking using Phoenix in the past two years, with 22,108 attempting to quit and setting a quit date. Based on current population figures, Lincolnshire has in excess of 130,000 adult smokers and yet the service only reaches a small proportion of these. Smokers are four times more likely to quit smoking if they access help from a stop smoking service rather than trying to quit on their own, and the Phoenix quit rate of 54% is in excess of national expectations. Services need to understand why most smokers choose not to use them and instead opt for a less effective form of quitting smoking. Armed with this information services can begin to target smokers more effectively.

**Effective Communication for Tobacco Control** Significant investment by the Department of Health (DH) over the last decade has raised awareness of the dangers associated with smoking and secondhand smoke. Information on how young people are targeted through marketing and their ease of access to tobacco, has resulted in a range of legislative changes to the advertising of tobacco products, age of sale for tobacco, smokefree workplaces and enclosed public places, and the sale of tobacco from vending machines. Because of the complex nature of some of the legislation, this has created a need for additional support for workplaces - specifically small to medium enterprises (SMEs) - that do not have the capacity to interpret the finer legislative details required to ensure their compliance. This has resulted in the development of a workplace toolkit that is circulated upon request which has been circulated to over 1,000 local businesses.

**Stopping the Promotion of Tobacco** The growing issue of children smoking, particularly young girls, has led to the development of a young persons' programme, 'Teens in Charge of Tobacco (Tic Toc)'. The programme is led by a young persons' specialist who works predominantly with

groups that support more disaffected children. However, this support has also been sought by schools experiencing issues with smoking. Many schools exclude children who are caught smoking on their premises, which impacts on the child's education and social well-being. In response to this increasing demand for support, a policy guidance document (Clean Air Award) has been produced. It conforms to all legislative requirements and helps organisations produce policies and initiatives that support healthier choices by young people. This has led to the production of a range of educational tools that can be used in primary, secondary and higher education, including lesson plans and modules that lead to a qualification in tobacco control (equivalent to an NVQ level 1 or Grade D GCSE). The specialist has also looked at ways to reduce the number of exclusions for tobacco offences. Working with partners these tools have expanded to an online professional development module aimed at people working with children who smoke.

**Making Tobacco Less Affordable** Illicit and counterfeit tobacco has been an increasing problem across areas of Lincolnshire. Local awareness campaigns have resulted in a growth of local intelligence reports which have helped Lincolnshire Trading Standards target their work more effectively and has culminated in recent joint operations with Lincolnshire Police and the UK Border Agency, making significant inroads in disrupting the supply chain.

**Effective Regulation of Tobacco Products** Lincolnshire's partnership approach has been the major factor for the breadth of successful outcomes, including criminal action being brought against traders in illegal products. Most recently a trader in Boston was fined £5,000 and given 270 hours of community service under product safety regulations. 'Jin Ling' a tobacco product with no legal trade in the UK and which is not regulated against any standards, had previously been found at a major house fire in the county that resulted in the death of its occupant. Legislation that came into force in November 2011 stated that all cigarettes sold in the European Union should be compliant with 'Reduced Ignition Propensity' regulations. 'Jin Ling' does not comply with this legislation.

## Challenges

In 1974, the adult smoking prevalence was 40%[12] falling steeply to 25% by the early 2000s due to public awareness campaigns, publication of evidence and the introduction of a variety of legislation to restrict the advertising, sale of tobacco and where smoking may occur. This has resulted in a further reduction in national smoking prevalence to the current rate of 20%. The majority of smokers have got the message and have quit or attempted to quit. Of the smokers that remain, 70% of them want to quit. However, these smokers tend to be the more entrenched and highly addicted smokers. Our challenge is to find the balance between reaching and engaging with these smokers, without making them feel vilified and further victimised for their addiction.

Despite best efforts, young people are still taking up smoking. 207,000[13] children aged 11 – 15 start smoking every year in the UK. The challenge is how to deter today's young people from smoking.

Some success over the past two years has been seen following illicit and counterfeit public awareness campaigns in the county. Intelligence reports to Lincolnshire Trading Standards increased by 80% as a result of the campaign when compared with the previous year. However we need to continue to raise the profile of illicit and counterfeit products to encourage a better understanding of the problems they cause, both in terms of the link with criminal activity and also a change in social attitudes. The use of illicit and counterfeit tobacco has significant detrimental social and economic impact on society, and for the smoker can seriously damage their long-term health.

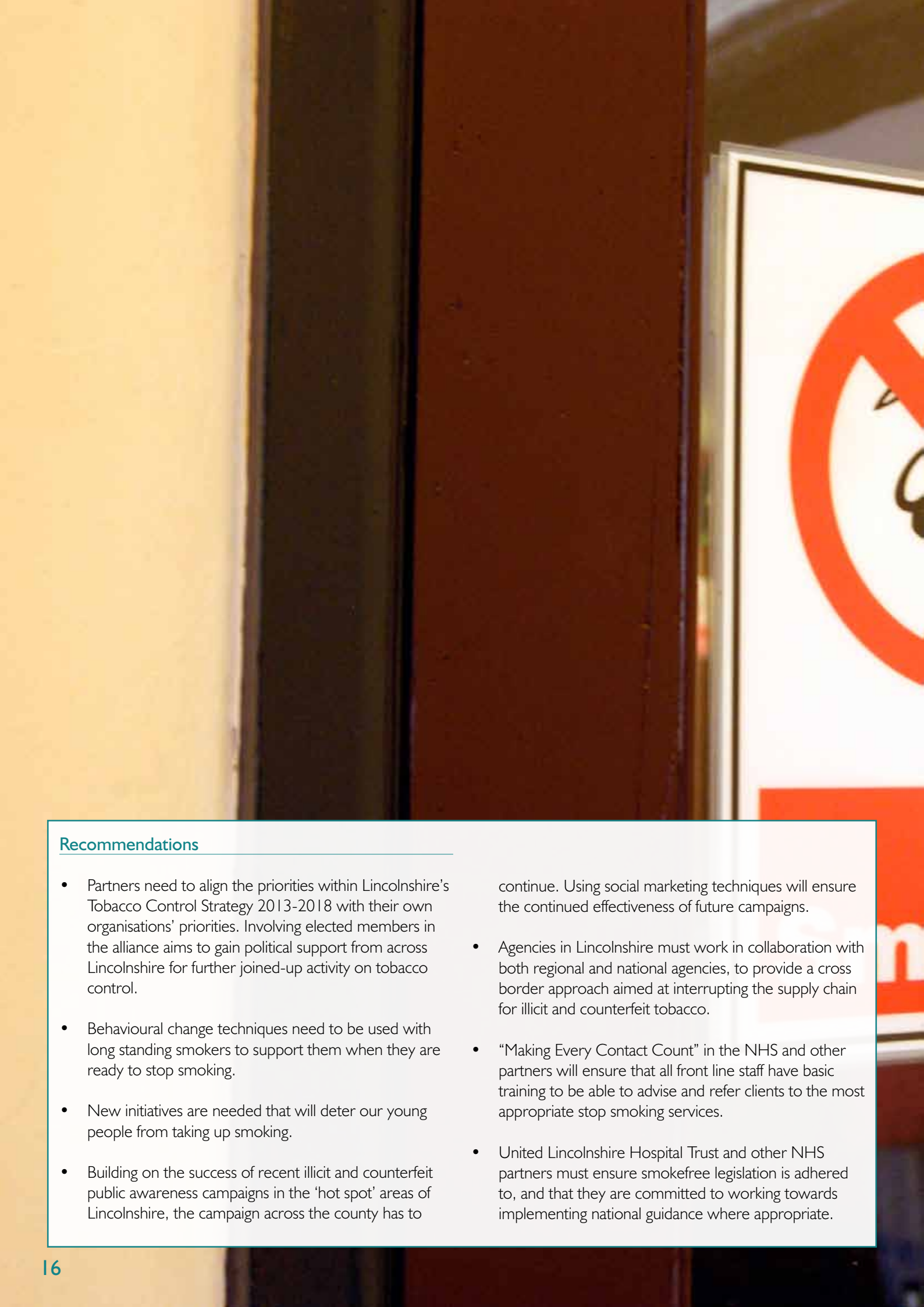
Despite success in disrupting the illicit market through joint operations between Lincolnshire Trading Standards, Lincolnshire Police and UK Border Agency, the ease of supply of illicit and counterfeit tobacco to smokers continues to be a problem. We need to build better links with regional and national colleagues working across borders to disrupt and, if possible, take out the supply chain to our communities.

All front-line staff, particularly in the NHS, need to have the confidence and skills to discuss smoking and be able to provide brief advice and refer effectively.

The implementation of the Health Act 2006, which prohibited smoking in enclosed public places and workplaces, has been viewed as a success in Lincolnshire with few instances of non-compliance. It is important that partners in enforcement roles are proactive in supporting this piece of legislation. NHS colleagues must address the particular challenges of smoking on hospital sites.

## Conclusion

Lincolnshire has had many successes over the years in the field of tobacco control. In 2013, the partnership's work contributed to a million smokers quitting and winning an award for the fourth year running in the British Heart Foundation's No Smoking Organiser of the Year competition. Additionally, their work has been cited in major reports and documents. The past decade has seen significant positive change in the public attitudes and behaviour around smoking and this has led to the implementation of a much broader range of legislative restrictions than would have been thought possible just 15 years ago. Public support has been essential in ensuring the success of tobacco control activities. The value of supporting people with resources and information to make an informed choice, is evidenced by the reduction in Lincolnshire's smoking prevalence from 25.8%[14] in 2001-03 to 20.98% in 2011-12, in line with national figures.



## Recommendations

- Partners need to align the priorities within Lincolnshire's Tobacco Control Strategy 2013-2018 with their own organisations' priorities. Involving elected members in the alliance aims to gain political support from across Lincolnshire for further joined-up activity on tobacco control.
- Behavioural change techniques need to be used with long standing smokers to support them when they are ready to stop smoking.
- New initiatives are needed that will deter our young people from taking up smoking.
- Building on the success of recent illicit and counterfeit public awareness campaigns in the 'hot spot' areas of Lincolnshire, the campaign across the county has to continue. Using social marketing techniques will ensure the continued effectiveness of future campaigns.
- Agencies in Lincolnshire must work in collaboration with both regional and national agencies, to provide a cross border approach aimed at interrupting the supply chain for illicit and counterfeit tobacco.
- "Making Every Contact Count" in the NHS and other partners will ensure that all front line staff have basic training to be able to advise and refer clients to the most appropriate stop smoking services.
- United Lincolnshire Hospital Trust and other NHS partners must ensure smokefree legislation is adhered to, and that they are committed to working towards implementing national guidance where appropriate.


## References


[1] Department of Health, A Smokefree Future (February 2010)

[2] Callum, C., Boyle, S and Sandford, A. (2010). "Estimating the cost of smoking to the NHS in England and the impact of declining prevalence" in Health Economics, Policy and Law. Cambridge Journals Online, Cambridge University Press, Cambridge.

[3] Office for National Statistics (ONS) Mid Year Population Estimates for 2009, Lincolnshire 35+ data and www.tobaccoprofiles.info/tobacco-control

[4] Annual report of Chief Medical Officer, 2011, www.dh.gov.uk/health/2012/11/cmo-annual-report

[5] International Agency for Research on Cancer (IARC). IARC Monographs on the evaluation of carcinogenic risks to humans Volume 83 Tobacco smoke and involuntary smoking. IARC. France 2004.

[6] Department of Health analysis of Office for National Statistics, death registrations, 2007

[7] Artwork from stop smoking wales website, and facts taken from ASH fact sheet 'what's in a cigarette'

[8] Department of Health, Smokefree England – One Year On, 2008

[9] Nicotine Addiction in Britain. A report of the Tobacco Advisory Group of the Royal College of Physicians. London, RCP, 2000.

[10] NHS Information Centre. Statistics on Smoking: England, 2010. NHS Information Centre, Leeds.

[11] Integrated Household Survey, ONS (experimental statistics) Adult smoking prevalence 18+ 2011 - 2012

[12] General lifestyle Survey 2008

[13] Nicholas S Hopkinson, Adam Lester-George, Nick Ormiston-Smith, et al. Child uptake of smoking by area across the UK, Thorax published online 4.12.13 thorax.bmj.com/content/early/2013/11/25/thoraxjnl-2013-204379.full.html

[14] Health and Social Care Information Centre © Crown Copyright, Source of data: Health Surveys for England - National Centre for Social Research 2001 - 2003

# Chapter 3
# Public Health and Spatial Planning

*'Too often we intervene too late in the pathway to ill health and forget that health starts where we live, learn, work and play. Research has shown that the key to foster good health is to build preventative services which address these wider determinants of health and take care of our families, our schools, our workplaces and our playgrounds and parks.'*

*'Intervening in the Social Determinants of Health to Improve Priority Public Health Conditions and Reduce Health Inequalities.'* Institute of Health Equity, p3, 2012.[1]

Keeping people healthier for longer should be a core priority for all public services. One of the opportunities afforded by the current NHS reorganisation is with their new resources and skilled staff, for local authorities to focus on public health and work to achieve beneficial outcomes, across different service areas and responsibilities. Nowhere is this more apparent than in the links between spatial planning and public health.

## A new beginning? Health & Planning through the ages...

Although the connection is not commonly realised today, the two professions of public health and spatial planning share common foundations, statutes and goals. They were inextricably linked from the 19th century onwards where the practice of public health and modern urban planning arose from the same stimulus, that of the appalling conditions and devastating death rates in the Victorian city.[2]

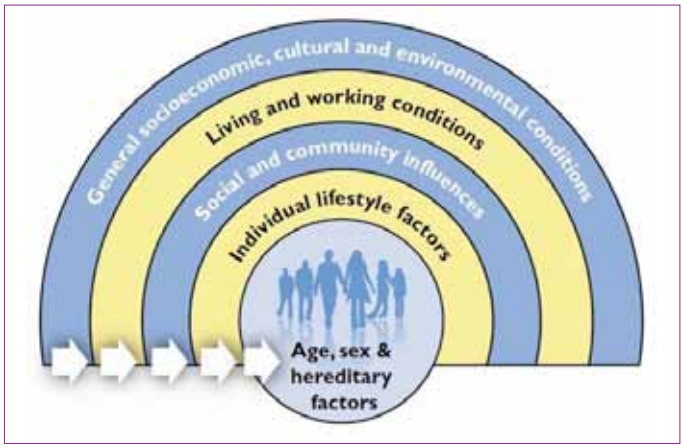
This alliance was to make a far greater contribution than medicine to improving health and increasing life expectancy over the following century. Indeed, most of the fundamental public health challenges of the time were solved by a combined approach of the two, exemplified by the 1875 Public Health Act. This enforced laws about slum clearances, provision of sewage systems and clean water and as a result started to make significant inroads in dreadful childhood and adult mortality levels and suffering from disease. The symbiosis continues today. Many of the issues for which spatial planners are responsible interact with human health, and can, if we get them right, contribute to improving our physical and mental health, and diminish inequalities in health, in Lincolnshire. The infections, respiratory disease and malnutrition of the 19th century have been replaced by heart disease, cancer and obesity today.

Unfortunately, the two professions became distanced from each other and drifted apart throughout the 20th century. Whilst both planners and Public Health professionals today still share a common goal, often this remains unwritten and unrecognised, despite planning policy having shifted from land use designation to one where the full interaction of people and places is brought into account. Spatial planning has at its heart the attempt to manage those very same determinants of health - employment, housing, transport, education and environment. You might expect it to be at the forefront of the challenge to improve health and wellbeing, but this is often not the case. There is strong evidence of a poor level of mutual understanding and weak integration between planning and health professionals and their respective interventions.

## A new approach

The core relationship between health and the environment has continued to be explored and shown by research. This is most famously realised by the Social Determinants of Health Model developed in the 1990s by the academics Dahlgren and Whitehead as shown in Figure 3.1.

*Figure 3.1: Health Determinants Model*




*Source: Dahlgren and Whitehead, 1991*

In its simplest sense this states that health depends on a person's socio-economic and environmental circumstances, as well as hereditary and personal influences. Individuals are at the centre, with a set of fixed genes. Surrounding them are influences on health that can be modified, such as their housing, education, lifestyle and diet. Recently, the Government has provided more of a legislative and policy base to underpin efforts to reunite the two disciplines:

**The National Planning Policy Framework (NPPF)** The NPPF was adopted in March 2012 and is the national government guidance for local planners in making plans and assessing development proposals. It requires planners to promote healthy communities, use evidence to assess health and wellbeing needs and work with public health leads and organisations.

The NPPF states that the purpose of planning is to 'contribute to the achievement of sustainable development'. This includes:

- Making it easier for jobs to be created in cities, towns and villages,
- Replacing poor design with better design,
- Improving the conditions in which people live, work, travel and take leisure,
- Widening the choice of high-quality homes.

The NPPF requires planners to consider health in a range of different ways. The framework's presumption in favour of sustainable development highlights the importance of achieving social, economic and environmental objectives. Health cuts across all three. It has a whole section on promoting healthy communities, which states that the planning system can play an important role in facilitating social interaction and creating healthy, inclusive communities. This will include measures aimed at reducing health inequalities, improving access to healthy food and reducing obesity, encouraging physical activity, improving mental health and wellbeing, and improving air quality to reduce the incidence of respiratory diseases.

There are other useful hooks to health in the framework, including promoting sustainable transport, delivering a wide choice of high-quality housing and requiring good design. A core planning principle in the NPPF is for plan making and planning decisions to take account of and support local strategies to improve health, social and cultural wellbeing, and to deliver sufficient community and cultural facilities and services to meet local needs.

The NPPF also requires local planning authorities (LPAs) to work with public health leads, local communities and health organisations to develop a robust evidence base that takes into account future changes and barriers to improving health and wellbeing. In Lincolnshire, the Public Health lead will be located at county level, while most of the planning responsibilities will be delivered by district councils.

**The Health & Social Care Act 2012** The Act transferred responsibility for Public Health to Lincolnshire County Council from April 2013. It also required the creation of health and wellbeing boards to bring together key commissioners from the local NHS and local government to plan local health and social care services strategically.

As well as, creating the boards, the Act requires an assessment of the relevant health and social care needs of the area through a Joint Strategic Needs Assessment (JSNA) and formulating these needs along with views gained from the local Lincolnshire community into the Joint Health and Wellbeing Strategy (JHWS – see right).

Health and wellbeing boards are responsible for:

- Assessing the current and future health and social care needs of the local community in the JSNA and develop strategies to meet those needs and reduce inequalities in the JHWS.
- Promoting integration and partnership working between the local NHS, local government and other local services.
- Improving democratic accountability for the planning of local health services.
- Bringing oversight and strategic planning to major service redesign.

**The Localism Act 2011** This Act gives more power to neighbourhoods, including provisions for neighbourhood planning. The Act also introduced a raft of other changes that have implications for improving health.

The aforementioned NPPF links with this localism agenda through specifying the importance of responding to local views and for consultation/ engagement to occur with local communities.

The role of local planners to establish local housing needs is more critical now that there is a decentralised system of housing needs assessment and allocations through the local plan (previously these were allocated through regional strategies).

Taken together these reforms strengthen the argument for recognising and valuing the influence that planning, housing and other environmental functions have on improving health and wellbeing and reducing health inequalities.

## Lincolnshire Joint Health & Wellbeing Strategy 2013-2018 (JHWS)

The first Lincolnshire JHWS has a specific theme on tackling the social determinants of health (Theme 5). This has as an outcome improving people's health and well-being through addressing wider determining factors of health that affect the whole community. This includes proposed action on local housing to ensure that people have access to good quality, energy efficient, 'decent' housing that is both affordable and meets their needs.

A home is defined as 'decent' if it meets certain standards, including a reasonable degree of thermal comfort, a reasonable state of repair and reasonably modern facilities. The percentage of private rented and owner occupied homes in Lincolnshire estimated to be considered as "non-decent" has increased between 2007 and 2009 by 15%. The increase ranges from 19% in Boston to 8% in West Lindsey. The highest percentage of homes estimated as non-decent in 2009 was in East Lindsey (52%).

## The Public Health Outcomes Framework

The Public Health Outcomes Framework sets out a vision for public health, desired outcomes and the indicators that will help us understand how well Public Health is being improved and protected.

The Public Health Outcomes Framework sets the context for our county to decide what public health interventions they will make. It sets out two overarching outcomes:

- Increased healthy life expectancy.
- Reduced differences in life expectancy and healthy life expectancy between communities.

The framework has four domains with supporting indicators, as shown in Table 3.1; the influence of planning cuts across all four domains.

*Table 3.1: Public Health Outcomes Framework domains*

| Domain | Indicators relevant to planning |
|---|---|
| Improving the wider determinants of health | • Killed or seriously injured casualties on England's roads<br>• Utilisation of green space for exercise/ health reasons<br>• Fuel poverty<br>• Older people's perception of community safety (this is a 'placeholder' indicator, which means that major work is still required to develop the rationale and technical information) |
| Health Improvement | • Excess weight in 4-5 and 10-11 year olds<br>• Excess weight in adults<br>• Proportion of physically active and inactive adults<br>• Self–reported wellbeing |
| Health Protection | • Air pollution<br>• Public sector organisations with board-approved sustainable development management plan |
| Healthcare public health and Preventing premature mortality | • Mortality from respiratory diseases |

*Source: Public Health England, 2013*

## Practical steps to progress - What planners and Public Health specialists can do

To recap, public health and planning were closely associated a century or so ago. It remains true that much of the role of planning is to promote health and wellbeing, even if that has not been made so explicit in recent decades. So, although not new territory for either profession, there is still much that can be gained by working together and working within the new systems and structures.

Table 3.2 lists some of the key actions that both planners and Public Health specialists can undertake to progress this area of work. This is taken from a document from the Town and Country Planning Association.

*Table 3.2: Practical steps to reunite health and planning*

### What planners can do:

- Review the local plan for compliance with NPPF health policies
- Engage Public Health on major planning applications
- Involve health in infrastructure planning
- Conduct health impact assessments (HIAs)
- Measure planning's influence on health and wellbeing outcomes

### What Public Health specialists can do:

- Focus on topics that matter locally
- Understand the role of elected members
- Engage with a variety of stakeholders

### What planners and Public Health specialists working together can do:

- Encourage your directors
- Help elected members to understand the links between planning and public health
- Develop a collaborative evidence base
- Engage clinical commissioning groups (CCGs)
- Improve how you communicate

*Source: Reuniting Health with Planning – Healthier Homes, Healthier Communities, TCPA, July 20123*

## Local action in Lincolnshire

The Public Health directorate in Lincolnshire has been and is very active in continuing to promote and drive the health and planning agenda in the county. Although we remain very keen to work with our planning colleagues across all 7 of the district councils in Lincolnshire we have, by necessity of resources, been attempting to trail blaze and create a robust and practical operational model with the Central Lincolnshire Joint Planning Unit (JPU) which develops joint planning policy for West Lindsey and North Kesteven District Councils and City of Lincoln Council with Lincolnshire County Council.

Initially, both Public Health locally and the JPU worked on developing an integrated impact assessment methodology. The integrated impact assessment (IIA) expands the scope of a (statutory) sustainability appraisal to include local health and equality impacts. Officers from the JPU have undertaken the IIA on draft policies. These assessments have then been reviewed by an independent IIA panel established by the JPU, which as well as including a representative from the neighbouring area of South East Lincolnshire (South Holland District and Boston Borough Councils), has also included, for the first time, a Consultant in Public Health from Lincolnshire County Council and a member from the equalities teams at West Lindsey District, North Kesteven District and City of Lincoln Councils.

The IIA approach has been welcomed by all partner agencies in the county as a first step for improving health considerations in the planning process. The Central Lincolnshire Joint Strategic Planning Committee – which includes councillors from the county council and the three district councils – feels it is more user friendly compared with receiving multiple impact reports, and is a more efficient use of officer time.

In the longer term, the aim is to introduce a scheme, currently running in other areas across the UK that requires developers of schemes/projects over a certain threshold to more formally assess the impact (positive or negative) on the population's health and wellbeing through an enhanced Environmental Impact Assessment (EIA) or a separate Health Impact Assessment (HIA).[3]

Lincolnshire Public Health has also continued a fruitful relationship with the Town and Country Planning Association (TCPA). Local contribution was keenly welcomed for their initial national publication on this issue ('Healthier Homes, Healthier Communities' TCPA, July 2012) this is now being followed up throughout this year with more detailed work with key organisations and councils across the county. In September, a joint event was held with the TCPA at North Kesteven District Council which achieved good support, buy-in and dialogue from partners with an aim to build on this in the future.

Public Health England (PHE) have also been taking an interest in health and spatial planning nationally, and have recently set up a professional working group with planning colleagues and PH professionals to develop this agenda. Lincolnshire Public Health colleagues and their ideas are at the forefront of driving this group with lead discussions at PHE Chief Executive level, workshops, seminars and a role in shaping what local support from this body might look like.

Additionally, links with colleagues in Public Health in the West Midlands and their healthy urban development centre. This has resulted in the creation of, again in collaboration with PHE, a wider 'Midlands' learning and sharing network which is open to all professionals in Lincolnshire as another way of developing links and learning.

Finally, Public Health has a role in advocating the formal links between Development Management planners and our[4] four Clinical Commissioning Groups (CCGs) now they are firmly established. Under Local Planning Regulations (2012), both CCGs and NHS England are statutory consultees in local development proposals, and it is therefore vital these links are robustly developed and maintained in Lincolnshire.

These developments, although welcome, are only the first step in the process of reuniting the two professions more fully and achieving the outcomes for health and wellbeing this will bring. We still have a long way to go to meet or exceed the national exemplars in this area such as South Cambridgeshire, Essex or Bristol City, where planning and public health departments overlap, albeit in a unitary authority system, to achieve a seamless transition and added value of the two.

With the two-tier council structure in Lincolnshire, Public Health is both physically and operationally separated from local planning departments in the district councils and therefore good communication and partnership working will be vital in this area. There is still much to be done in promoting and working with our local district councils and, so far, it has been difficult to engage district council planning colleagues in the south-west and coastal areas of the county.

## Recommendations

- CCGs and district councils need to develop good communications so that they can work in a timely, thorough and linked way over local planned developments.
- Organisations in Lincolnshire, with responsibility for health and planning need to continue to work regionally and nationally to remove barriers to improving health through spatial planning.

## References


[1] Intervening in the Social Determinants of Health to Improve Priority Public Health Conditions and Reduce Health Inequalities. Institute of Health Equity, p3, 2012

[2] Why public health and town planning share an unbreakable bond. Guardian Professional, N Blackshaw, 5 January 2012

[3] Reuniting Health with Planning – Healthier Homes, Healthier Communities. TCPA, A Ross et al, July 2012

[4] The Town and Country Planning Regulations 2012, Department for Communities and Local Government, 2012

# Chapter 4
# Public Health Skills Training

The Health and Social Care Act 2012 set out significant changes to the Public Health system, with the goal of transforming Public Health in this country and achieving a stepchange in outcomes for the population. It is recognised that the transformation cannot be achieved without the right workforce, in the right place, with the right skills. Delivering the government's Public Health aspirations requires a well skilled and competent workforce, which includes not just Public Health specialists and practitioners but also the wider Public Health workforce across health and local government. There is a consensus that success depends on everybody recognising that Public Health is their business, and that a good place to start is by developing the workforce to value their own health and to be developed to support the public in achieving the same goals.[1]

'Healthy Lives, Healthy People: a public health workforce strategy' defines the vision for the public health workforce (Figure 4.1).

*Figure 4.1 The vision for the Public Health workforce*

### The public health workforce will be known for its:

- **Expertise.** Public Health staff, whatever their discipline and wherever they work, will be well-trained and expert in their field, committed to developing and maintaining that expertise and using an evidence based approach to practice.
- **Professionalism.** They will demonstrate the highest standards of professional conduct in their work.
- **Commitment to the population's health and wellbeing.** In everything they do, they will focus on improving and protecting the health and wellbeing of their populations.
- **Flexibility.** They will work effectively and in partnership across organisational boundaries.

There is no better time to join in the effort to promote and protect population health. From growing rates of obesity to bio-terrorism and the advent of new diseases Public Health issues appear regularly on the front pages of our newspapers.

## What is Public Health?

Public Health is defined as:

*"The science and art of preventing disease, prolonging life, and promoting health through the organised efforts of society."*[2]

Unifying principles of public health are its essentially "public" nature and the fact that it is mainly focused on the health of the whole population.

Public Health looks at the causes of ill health and disease in populations and it is at the forefront of tackling the social determinant factors that influence health and lead to health inequalities, such as differences in life span or infant deaths. Public Health practice depends on good evidence. Evidence-based practice builds on epidemiological analysis to help us understand what makes an effective policy, programme or intervention, in terms of its impact on people's health and wellbeing.

In the nineteenth century, the emphasis was on introducing legislative measures to improve sanitation and poor housing. In the twentieth century, this changed to tackling infectious diseases and introducing widespread immunisation and vaccination programmes. The focus in the early twenty-first century is on tackling inequalities in health and promoting healthier lifestyles.

## What do we mean by Public Health workforce?

The Public Health workforce in England is best described in terms of:

### The Public Health Specialist workforce

This group includes consultants in Public Health medicine and specialists in Public Health who work at a strategic or senior management level or at a senior level of scientific expertise to influence the health of a whole population.

Public Health consultants must look at 'the bigger picture' and then take action to promote healthy lifestyles, prevent disease, protect and improve general health, and improve healthcare services. At this level, an ability to manage change, lead Public Health programmes and work across organisational boundaries is crucial as are technical skills in epidemiology, health promotion and healthcare evaluation.

The Faculty of Public Health oversees the quality of training and professional development of Public Health consultants in the UK, and maintains the professional standards in the discipline.

## The Public Health Practitioner workforce

Members of these professional groups spend all or a major part of their time in Public Health practice. They work in multi-professional teams and, in addition to those working within defined Public Health directorates supporting the senior staff, they also include those that work with groups and communities and with individuals, such as health visitors, environmental officers and community development officers.

Particular capabilities for this workforce include effective partnership working and education competencies to develop the skills of the wider workforce so that they can support people in making healthy lifestyle choices and information analysis.

## The wider workforce

This group includes those who have a role in health improvement, protecting health and reducing inequalities but who would not necessarily regard themselves as part of the Public Health workforce. Many people make a contribution to the health and wellbeing of others in their daily lives without realising it. This may be, for instance, as a carer, a volunteer, or as part of a workforce not traditionally directly associated with health and wellbeing such as teaching or spatial planning. For example, town planners can have a significant impact on the whole population, since urban design has been shown to influence the type and extent of exercise that people take. Voluntary organisations too are often involved with groups in society who have the worst deprivation and health inequalities.

Barton and Grant and the UKPHA strategic interest group (2006) developed the health map[3] based on Dahlgren and Whitehead's earlier model (Dahlgren and Whitehead 1991) which shows how individual determinants, including a persons age, sex and hereditary factors, are nested within the wider determinants of health which include lifestyle factors, social and community influences, living and working conditions and general socio-economic cultural and environmental conditions.

Figure 4.2 shows an adaptation of Barton and Grant highlighting samples of workforces that have a potential to influence determinants of health and which are considered part of the wider Public Health workforce.

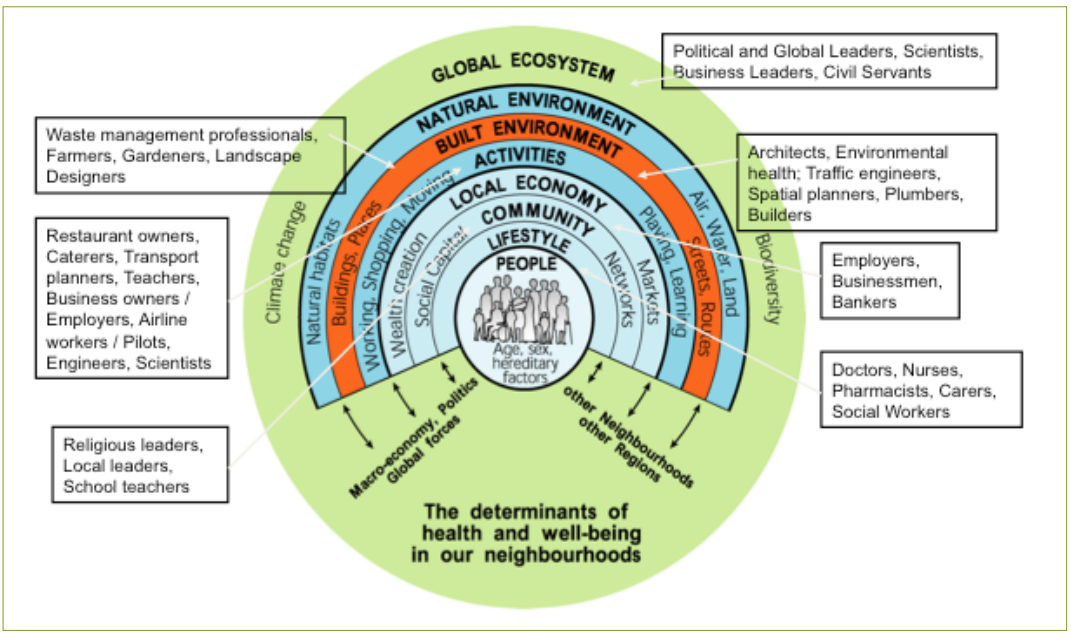
It is now accepted that improving Public Health requires strengthening both the capacity and the capability at the levels of the wider workforce, Public Health practitioners and Public Health specialists.

## Public Health Skills and Knowledge Framework

Much of the current work in Public Health workforce development nationally has been based on the original Public Health Skills and Career Framework (PHSCF)[4] which was launched in 2008. As there have been considerable changes in Public Health and the Public Health workforce, the Department of Health recently commissioned a refresher of this framework, the result of which is the new Public Health Skills and Knowledge Framework (PHSKF).[5]

The new framework applies to the whole of the Public Health workforce, in whatever sphere they may be working or however they may be making a contribution to the public's health. It outlines in simple language the skills and knowledge that the workforce need in order to make a difference and it provides a unifying context for a workforce that is dispersed across many organisations such as health and social care organisations, local authorities and the third sector.

*Figure 4.2 A sample of Workforce with the potential to influence the determinants of health*




*Source: The Health Map, Barton & Grant 2006 based on a Public Health concept by Whitehead and Dahlgren. The Lancet 1991.*

Skills and knowledge are split across the four core areas of Public Health practice, which anyone working in the field of Public Health will need to have, as well as the five specific areas of practice within which individual practitioners will develop and work.

| Core Area | Non-core (defined) areas |
|---|---|
| 1. Surveillance and assessment of the population's health and wellbeing | 5. Health improvement |
| 2. Assessing the evidence of effectiveness of interventions, programmes and services to improve population health and wellbeing | 6. Health protection |
| 3. Policy and strategy development and implementation for population health and wellbeing | 7. Public Health intelligence |
| 4. Leadership and collaborative working for population health and wellbeing | 8. Academic Public Health |
| | 9. Health and social care quality |

*Figure 4.3 Public Health Skills and Knowledge Framework (2013)*

The framework consists of nine levels from level 1 where people have little previous knowledge, skills or experience in Public Health to level 9 where people will be setting strategic priorities and direction and providing leadership to improve population health and wellbeing. The diagram in Figure 4.3 captures this.

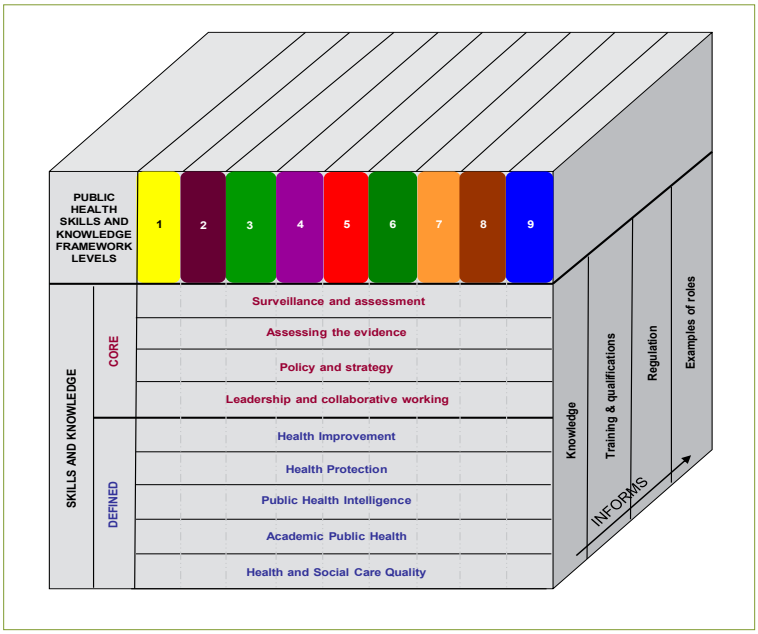
The framework is there to support Public Health development and should be used in conjunction with other frameworks specific to different organisations and employers to help inform where Public Health skills and knowledge can enhance delivery of Public Health outcomes and where additional training of staff may be of benefit.

The most comprehensive information about Public Health skills and careers for all levels (including examples of career stories) is currently found at www.phorcast.org.uk.

## Developing the wider Public Health workforce

Effectively addressing social determinants of health requires multisectoral action across government and society. This includes strengthening the wider Public Health workforce and engaging citizens, politicians, service providers, policy-makers, the media, planners and commissioners of health and social care. Also, the importance of community resilience, the quality of social networks and strengthened participation in decision-making for health and wellbeing is increasingly recognised.

Current Public Health challenges require a paradigm shift in the way we live. We need to create an environment which positively influences health and wellbeing, supporting behaviour change in the wider workforce (see pictures overleaf).




*Source: PHORCaST.org.uk (2013) and adapted from original PHSCF (2008)*

*We need to create an enviorment which positively influences health and well-being*

*Supporting behaviour change in the wider workforce*

*We need to change our norms...*

*from this* → *to that*

The health map of Barton & Grant in Figure 4.1 illustrates why the social determinants are of such relevance to local government. The majority of local government services impact upon or can influence the conditions in which people live and work and, to a certain extent, the life chances of individuals.[6]

Examples of how local government, the NHS and the third sector can contribute to the wider Public Health workforce:

**Local government:**

- as the commissioner of children's services, makes a huge contribution to the social, mental and physical wellbeing of young people. It provides them with vital skills and social capital which lead to better life chances as they grow up.

- as a planning authority, can do a great deal to plan for healthy environments; not just those which promote physical activity but also those that promote mental wellbeing by including green space and opportunities to interact with others.

- as a provider and commissioner of leisure and cultural services, can influence health not simply through offering activity and promoting healthy lifestyle but also in the way culture shapes an area and the communities within it.

The health sector also has a big role to play. For instance, nurses have a long history of contributing to the Public Health agenda, but it is generally recognised that the Public Health role of nurses need strengthening. Until now, it has been predominantly those working within community settings who have been acknowledged as key contributors to Public Health. However, all nurses can participate in improving health.

Third sector organisations are often involved with groups in society who have the worst deprivation and health inequalities and very often their activities can lead to great health benefits. Their role in raising awareness of healthy lifestyles, helping navigate through services and championing wellbeing is crucial. Supporting them in their wider Public Health role and equipping them with the right skills is essential.

## Developing the wider Public Health workforce in Lincolnshire

In addition to our internal directorate programme that helps and supports our specialists and practitioners to develop and maintain the behaviours, competencies and technical skills, much of our work in the directorate has an impact on the development of the wider workforce. An example is illustrated in chapter three of this report (Public Health and Spatial Planning).

The blue print from the Lincolnshire Sustainable Services Review (LSSR) puts prevention at the heart of the review:

*"A health and care system that works in a joined up way, focuses on the prevention of ill health, coordination of care and improves clinical and personal outcomes and goals, with quality driving efficiency."*[7]

The Lincolnshire Health and Wellbeing Board is in an unique position to influence the wider determinants of health and help build the wider Public Health capacity needed to improve outcomes and services for the local community.

Public Health is everybody's business and not just the role of our Lincolnshire Public Health team. Both as workers and as citizens we all have a part to play in health improvement (Figure 4.4).

*Figure 4.4 Key transferable skills relevant to our entire workforce:*

- Assessing your own health behaviour.
- Communicating health information fairly and effectively.
- Respecting people's right to make their own decisions.
- Recognising and using opportunities to promote your own and other people's health and wellbeing.
- Recognising and using opportunities to assist your organisation in becoming healthier.
- Recognising and preventing adverse effects on people's health and wellbeing.

## Recommendations

- "Prevention is better than cure" must remain one of the core principles that will drive the implementation of the Lincolnshire Sustainable Services Review blueprint going forward. The understanding of the entire Lincolnshire health and social care workforce of their contribution to 'make every contact count' is crucial if we are to be successful at improving integrated health and social care outcomes across Lincolnshire.

- Develop an approach that recognises that the whole of the public sector workforce are potential contributors to Public Health and increases awareness across all workforces and making sure they have the skills to inform decisions and choices.

- Every local authority chief executive and every director of a council department should regard themselves as having as much responsibility for the health of the population they serve as they do for their own named service area, be it transport, environmental services, children's services, urban or rural planning or sports and cultural services.

- Develop the role of the Public Health practitioner as educator of the wider workforce so capacity for promoting healthy lifestyles is optimised.

- Introduce health improvement courses for partners in health (including local authority colleagues, NHS and voluntary sector) that will provide the participants with the knowledge, skills and language to promote health within their organisation roles and ideally to be delivered as part of the council's corporate training function.

- Shift culture across health and local authority workforce so improved support is offered to citizens to take greater responsibility for their own healthcare and wellbeing.

## References


[1] UK Department of Health. Healthy lives, healthy people. A Public Workforce Strategy, London. April 2013

[2] Public Health in England. The report of the Committee of Inquiry into the Future Development of the Public Health Function. London, HMSO, 1988

[3] Adapted from The Health Map. Barton, H. and Grant, M. (2006) "A health map for the local human habitat." The Journal of the Royal Society for the promotion of Health, 126(6) pp. 252-253)

[4] Department of Health. Public Health Resource Unit. Skills for Health. UK Public Health Skills and Career Framework (UK PHSCF). London 2008

[5] Department of Health, PHORCaST Team, Public Health Skills and Knowledge Refresher, 2013

[6] The social determinants of Heath and the role of local government, I&DeA, London, Fiona Campbell, 2010

[7] The Lincolnshire Sustainable Services Review, Blueprint, page 15

# Chapter 5
# Protecting the Health of the People of Lincolnshire

The Health and Social Care Act 2012 has fundamentally changed the way the NHS in England is organised and run. The driving force behind these changes focuses on quality and improving the quality of care for service users. The NHS is organising itself around a single definition of quality: care that is effective, safe and provides as positive an experience as possible.

This relentless focus on quality means a persistent emphasis on how we can positively transform the lives of the people who use and rely on Lincolnshire services. In contrast, a failure to focus on quality and to make it a primary concern can result in lasting emotional and physical damage, even death, to service users. The failures at Mid-Staffordshire NHS Foundation Trust and at the independent hospital, Winterbourne View, provide stark reminders that when we fall short on our responsibilities in respect of quality, the consequences can be catastrophic.

## Health Care Associated Infection (HCAI)

Healthcare Associated Infections (HCAIs) are infections which develop as a direct result of healthcare interventions. HCAIs can be acquired from any place where healthcare is delivered e.g. hospitals, care homes, dental surgeries, and general practice surgeries, including patients' own homes if healthcare is delivered there. HCAIs can result in prolonged hospital stays, long-term disability, increased resistance of microorganisms to antimicrobials, additional costs for health systems, high costs for patients and their families, and unnecessary deaths.

Two of the most common HCAIs are Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (commonly known as C diff). MRSA is a common bacteria carried by around one in three healthy people; usually on their skin or in their nose. In most cases, it is not harmful but MRSA can cause local infections such as boils and abscesses and may cause wound infections, particularly at surgical sites and where catheters and drips have been put in place. In some cases, it can cause more serious blood stream infections (bacteraemia) which can be life-threatening. C diff is one of the 'normal' bacteria in the gut in up to 3% of healthy adults and is usually kept at bay by all the other bacteria there. With vulnerable people, such as older people and those with a long term illness, it can cause severe diarrhea and in some people, inflammation of the bowel. Prescribing antibiotics in these vulnerable groups can upset the balance of the gut bacteria and when this happens, the C diff bacteria can rapidly multiply, causing complications. Both infections can be spread by hands, equipment and the environment.

Tackling preventable HCAIs is one of the Government's key priorities. From the current financial year there is a zero tolerance of MRSA blood stream infections.

## Progress with reducing HCAIs in Lincolnshire

Within Lincolnshire, the number of C diff infections reported each year has reduced from 296 cases in 2008/9 to 131 cases in 2012/13; a decrease of 56%. This is a greater reduction of cases than that achieved by the East Midlands as a whole (52%), but a slightly lower reduction than that achieved by England as a whole (59%).

Locally, the number of MRSA bacteraemias reported each year has reduced from 32 cases in 2008/9 to 8 cases in 2012/13; a decrease of 75%. This decrease is slightly less than that seen across the East Midlands as a whole (80%), but a greater decrease than that achieved by England as a whole (69%).

Progress in this area is good but the consequences of HCAIs are still being felt by our patients and residents.

## Responsibility

The Director of Public Health (DPH) has a statutory responsibility 'to be assured' that infection prevention and control systems and processes across the health and social care economy are safe and effective. The patient/service user journey can move across primary, secondary, tertiary care and social care, and could include contact with multiple professionals. It is a collective endeavour, requiring collective effort and collaboration at every level to share information, address concerns and raise standards across Lincolnshire.

Through the Public Health core offer, the Health Protection Team provides specialist advice to Clinical Commissioning Groups (CCGs). It is also responsible for the community infection prevention and control (IPC) service. Under the Health and Social Care Act 2012 this is a statutory responsibility of the Secretary of State, which has been delegated to local authorities and Directors of Public Health.

## Assurance

The assurance of IPC across Lincolnshire is obtained from commissioners and providers of health and social care through a number of routes which provides greater reliability and a process to 'confirm and challenge'. When assessing the actual standard and level of compliance, all evidence is taken into consideration and a report is

produced that best summarises the findings from that evidence.

The key methods of assurance gathering are:

- Quarterly reports from commissioners of health and social care services with evidence of systems and processes for IPC including areas of non-compliance and concern.
- Monthly reporting by key health providers on compliance with the Care Quality Commission (CQC) IPC standards and surveillance of reported HCAIs.
- Looking for common issues from Post Infection Reviews (PIR) and Root Cause Analysis (RCA) reports for HCAIs so that we can learn and improve IPC processes.
- Findings from CQC visits, IPC team visits and audits.
- Issues raised by a commissioner of health and social care services and complaints or concerns raised by members of the public.

## The way forward

An assurance framework and IPC delivery plan is in place. However, IPC remains a significant area of concern, particularly within the social care and residential/nursing home setting. IPC expertise across the health economy needs boosting, even in hospital sites. Across the social and residential/nursing care setting, expertise in this area is extremely limited and I remain unconvinced that providers give it the priority required. Whilst some care home settings have very robust plans and processes in place, there are many that are falling short of the minimum standards required. This puts both patients, clients and staff at unnecessary risk. Consequently, my priorities over the next year are to:

- work collaboratively with IPC colleagues across healthcare settings to increase IPC capacity;
- implement the assurance framework to identify areas for priority action;
- continue to work proactively with colleagues within adult social care and children's services to ensure that IPC is embedded into contractual frameworks and the delivery of social care.

## Emergency Preparedness, Resilience and Response

Health Protection sits as one of the three pillars of Public Health with a key aim to prevent or reduce harm caused by communicable diseases and minimise the health impact from environmental hazards such as chemicals and radiation. Within the health community part of this work is referred to as emergency preparedness, resilience and response (EPRR) and ensures that a wide range of incidents with the potential to impact on health or patient care are planned for and responded to.

Prior to 1st April 2013, primary care trusts had the responsibility to co-ordinate a local NHS response to a major incident, taking the lead for the health community including representation at the Local Resilience Forum (LRF) in Lincolnshire. The LRF is a multi-agency partnership involving all organisations required to both prepare for, and respond to emergencies within the county.

These EPRR responsibilities for the NHS now fall to NHS England and the CCGs. As a non-departmental public body of the Department of Health (DH), NHS England was established to design and deliver the commissioning of primary care services using a single operational model, and to lead on some national based functions previously undertaken by the DH.

The local authority still has a responsibility to contribute to health EPRR and this is discharged through the DPH, who as well as taking steps to ensure adequate plans are in place to protect the health of the population, also involves appropriate escalation of any concerns.[1] Recognising the importance of this role for the populations' health protection, the DPH, together with the Director of Operations and Delivery from NHS England, co-chairs the Local Health Resilience Partnership (LHRP). The group provides a strategic forum for local organisations to facilitate the health sector in its preparedness and planning for emergencies. It then links into wider multi-agency emergency planning work, ensuring that the health needs of the population are fully considered at the Local Resilience Forum level.

The DPH has a personal statutory responsibility "to be assured" that health EPRR is effective. This is carried out through a variety of mechanisms. The LHRP produces a three year strategic plan in line with national EPRR priorities for the health sector. Delivery of this plan will be carried out through the operational sub-group who report as a standing agenda item at each meeting.

A set of NHS Core Standards for EPRR have been developed, with guidelines for measurement against standards. All NHS providers are required to demonstrate compliance with these standards, and a national assurance programme is being introduced. For the fiscal year of 2013-14, this programme is limited to acute, community and ambulance trusts. Full inclusion of NHS providers will take place after April 2014.

Opportunities to test the ability of the health sector to respond to emergencies, and to identify any gaps in planning or training are achieved through regular exercising of these arrangements, and 2013 has seen Lincolnshire host two multi agency exercises focusing on different aspects of EPRR.

Exercise Georgiana gave partners the chance to test the county's ability to respond to a major transport accident, one of the enduring risks identified in the community risk register.[2] The exercise simulated a train crash on the east coast main line, and provided the opportunity for all organisations to work together at a local, regional and national level.

With Exercise Georgiana being carried out in May 2013, it offered the ideal platform for the new emergency response arrangements within the health community to be fully tested. Communication procedures, capability and capacity of both new and existing organisations were challenged and new commanders in the health community given the opportunity to test new roles, policies and procedures.

Local authority Public Health staff and Public Health England worked together during the exercise to provide comprehensive Public Health advice and guidance to the community in Lincolnshire.

The exercise gave the DPH assurance that in the event of a major incident, such as a train crash, the health community in Lincolnshire is able to respond in a timely and co-ordinated manner.

Many learning points relating to EPRR arrangements were identified throughout the two days, and a comprehensive action plan has been compiled with realistic time frames and identified lead organisations. This is then reported through the LHRP ensuring appropriate progress is being made. Equally as important as response work is the ability for the county to recover from an incident, often a long and complex process.

Exercise Lazarus, carried out in November of 2013, focused on county's ability to recover from an east coast flooding incident. The DPH co-ordinated the health, social care and education response, identifying key issues and developing action plans to address them.

Again the learning from this exercise has proved invaluable in further developing the health, social care and education recovery plan, and fully understanding how this fits in with multi-agency recovery work. This exercise was unfortunately put into live operation shortly afterwards following coastal flooding in the county on 5 December 2013. The health cell was invoked and demonstrated both a pro-active and dynamically reactive approach to the 'health' response.

Every incident and exercise offers many learning opportunities, whilst providing local assurance on the ability of the health care community to respond when required. Further recommendations include:

- Clarity on the command and control structure for the health response.
- Clear communications strategy for the health community promoting the single clear message before, during and after the emergency.

## Sexual Health

Good sexual health is important not only for individuals but also for wider communities. People are entitled to a safe, healthy relationship free of coercion with access to good quality services for contraception and sexual health issues. Communities want to ensure controls are in place to prevent transmission of infection and that the issue of positive relationships and pleasure are as central as the negative aspects of infection, dysfunction, sexual violence and unintended pregnancy. According to the World Health Organisation,[3]

*"The ability of men and women to achieve sexual health and well-being depends on their access to:*

- *comprehensive good-quality information about sex and sexuality;*
- *knowledge about the risks they face and their vulnerability to the adverse consequences of sexual activity;*
- *their access to sexual health care;*
- *an environment that affirms and promotes sexual health."*

It is therefore important to have access to the right services in the right places supported by a programme of prevention to ensure population needs are met.

In April 2013 the way in which sexual health services were commissioned in England changed. The Health and Social Care Act 2012 mandated Local Authorities, rather than the NHS, to commission comprehensive open access sexual health services. Responsibility for a few services has remained with CCGs and NHS England, such as the sexual assault referral centre and HIV treatment, alongside general contraception within primary care.

There are three indicators within the Public Health Outcomes Framework 2013-1016 which recognise the importance of good sexual health, these are:

- under 18 conceptions;
- chlamydia diagnoses in the 15-24 year age group;
- late diagnosis of HIV.

Lincolnshire has a comprehensive programme which supports continued progress against these areas as well as other features felt locally to be key including reducing rates of undiagnosed STIs, sexual health promotion and access to a wide range of contraception.

## Teenage Pregnancy

Teenage pregnancy rates both locally and nationally are at the lowest level since 1969. However, reducing the under-18 conception rate remains a high priority as highlighted in the Public Health Outcomes Framework (2013-16)[4], the Sexual Health Improvement Framework, 2013[5] and the Child Poverty Strategy.

National: 2011 data for England shows the under-18 conception rate is 30.7 per 1000 females aged 15-17, a fall of 10.2% from 2010. The reduction from the baseline year in 1998 of the Teenage Pregnancy Strategy is now 34%.

Regional: The East Midlands rate is now 31.3 per 1000 showing a 36% decrease from the baseline year.

Local: The rate for Lincolnshire is now 32.3 per 1000 indicating a decrease of 35.53% since the baseline year and a 6.1% decline in the last year. The percentage of teenage conceptions leading to abortion in Lincolnshire is 42.1%. Huge improvement has therefore been made locally but there is still work to be done and maintained.

The work needs to continue because *"a teenage pregnancy prevention strategy that seeks to reduce conception rates by a substantial margin cannot concentrate on high risk groups alone. Although certain girls are at much greater risk of conceiving and giving birth as teenagers than others, the majority of girls that conceive do not share these risk factors."* (Teenage Pregnancy in England DfE research report 2013).

We are still only two thirds of the way towards levels experienced by young people in similar Western European countries. The majority of under-18 conceptions are unplanned, with a high percentage leading to abortion and the outcomes for young parents and their children remain disproportionately poor.

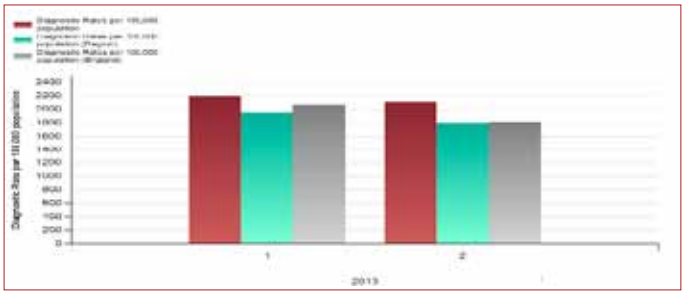
Evidence[6] shows that the most effective ways to reduce the rates is to provide young people with a comprehensive sex and relationships education programme and access to young people-friendly contraception and sexual health services. There is also added value in giving positive messages to young people and open and honest conversations about relationships and sexual health help young people make well informed choices.

## Chlamydia Screening

Chlamydia is the most common sexually transmitted infection (STI) in the UK, with sexually active young people at highest risk. As chlamydia often has no symptoms and can have serious health consequences (e.g. pelvic inflammatory disease, ectopic pregnancy and infertility), screening remains an essential element of good quality sexual health services for young adults.

In order to reduce the amount of chlamydia infection in the community it is important to diagnose and treat as many people as possible. The public health outcome indicator for 2013/2016 is to achieve 2,300 diagnoses per 100,000 15-24 year olds.

*Figure 5.1 Quarterly Chlamydia Diagnostic Rates for Lincolnshire vs.Midlands and East of England (Jan-Dec 2013)*



*Data source: CTAD surveillance, Public Health England*

During the first half of 2013 Lincolnshire has achieved a diagnosis rate that exceeds the regional and national figures.

General practice has a key role in offering chlamydia screening alongside contraceptive and sexually transmitted infections advice. The 3Cs & HIV Programme is a Public Health England initiative to support general practices to make a basic sexual health offer during routine consultations:

- '3Cs' – offering a chlamydia screen, signposting or provision of contraceptive advice and free condoms to young adults (15 – 24 years old).
- HIV – offering testing to adults (≥ 16 years) in line with current clinical guidelines.

An initial pilot has been shown to increase general practice screening test rates by 76% and chlamydia diagnoses by 40% according to new research on sexually transmitted infections. 20 practices across Lincolnshire have signed up to the programme so far in order to improve services to young people.

## HIV

There are thought to be 77,610 people in the UK diagnosed with HIV but a further 21,900 remain undiagnosed by the end of 2012.[7] 47% of HIV diagnoses nationally were diagnosed late and this is associated with an increased risk of death and AIDS. In the over 50s, more than 1 in 10 of individuals diagnosed late die within 12 months. Late diagnosis was highest among heterosexuals, with two-thirds of men and over half of women diagnosed late. The latest data for Lincolnshire (2009 – 2011) indicates that 34.1% of HIV diagnoses are late.[8] This is lower than the England rate of 50% and the lowest in the East Midlands, but is not a reason to be complacent. Early diagnosis prevents onward transmission of infection by reducing the levels of the HIV virus in patients, providing earlier partner notification (so that they can also be tested) and earlier behaviour change counselling. These are essential components in the reduction of HIV transmission.

## Sexual Health

According to PHE data for England[9], young people under 25 have the highest rates of acute STIs, with females recording higher than males. In the older age groups however males have a higher diagnosis rate. The rates of many STIs have steadily risen between 2009 and 2012, with chlamydia being the most common. Syphilis diagnoses are significantly lower than other STIs although the rates in men for 2012 are ten times that seen in women.

*Figure 5.2 PHE Statistics (2012 data) NB 95% confidence intervals apply to all statistics:*

| Rate of Acute STIs – per 100,000 population | England | Midlands and East | Lincolnshire |
|---|---|---|---|
| All STIs | 863.7 | 683.4 | 512.3 |
| Chlamydia (all ages) | 371.6 | 324.8 | 298.1 |
| Gonorrhoea | 45.9 | 31.4 | 15.1 |
| Herpes | 58.4 | 50.4 | 29.9 |
| Syphillis | 5.4 | 2.6 | 2.5 |
| Warts | 134.6 | 120.8 | 97.8 |

*Data Source, HPA, Public Health England, 2012*[10]

Usually patients can be offered an appointment within 48 hours for STI testing and treatment by contacting either Lincolnshire Community Health Services clinics via a countywide central booking line or one of two primary care led services in Louth or Spalding.

Services across Lincolnshire currently include a range of community and primary care led genito-urinary medicine clinics, contraception services (long-acting contraception as well as other types including emergency hormonal contraception), a dedicated sexual assault referral centre and psycho-sexual counselling services. Pharmacies are able to provide signposting and many services for young people including a condom scheme. Working with the community sector has enabled outreach and health promotion services to be commissioned alongside services to support those infected with and affected by HIV. More is being done to ensure all services address gaps and needs; making sure people know what is available and where and ensuring strong links are made with those who are most at risk and vulnerable.

## Recommendations

- Maintain access to all services across the county to reach a geographically spread community.
- Services should work collaboratively to avoid fragmentation of service delivery.
- Services should work across the wider health and social care system to ensure integrated delivery and planning with a range of other key areas, such as drugs and alcohol, children's services, adult social care and sexual exploitation and violence.
- Service providers must maintain a trained workforce to ensure services are comprehensive.

## References


[1] NHS Commissioning Board Emergency Preparedness Framework 2013

[2] www.lincolnshireprepared.co.uk

[3] WHO, 2010 Developing Sexual Health Programmes, A Framework for Action. Accessed at: whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.22_eng.pdf

[4] Improving Outcomes and Supporting Transparency - The Public Health Outcomes Framework for 2013-2016. Accessed at www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

[5] A Framework for sexual Health Improvement in England, 2013 accessed at: www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england

[6] A Framework for sexual Health Improvement in England, 2013 accessed at: www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england

[7] www.nat.org.uk/HIV-Facts/Statistics/Latest-UK-Statistics.aspx

[8] www.phoutcomes.info/public-health-outcomes-framework#gid/1000043/par/E12000004

[9] www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1204619474055

[10] www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIV/HIVData/

Reference: LCC302
Published: February 2014

Lincolnshire
COUNTY COUNCIL
Working for a better future