NHS
Leicestershire County and Rutland

Director of Public Health Annual Report 2010

Rutland County Council

Leicestershire County Council

Contents

1.0 FOREWORD

It gives me great pleasure to present my first annual report as director of public health for NHS Leicestershire County and Rutland (NHS LCR). Since I took up post in April 2009 a great deal has happened. Very soon after starting in post the first cases of swine flu, which originated in Mexico, were seen in the UK. A lot of time and effort from the public health team, and many others in NHS organisations, local authorities, the Local Resilience Forum and other partner organisations was taken up managing the consequences of pandemic flu. The response from NHS LCR was extremely effective, and lessons learnt from this experience have helped us to further refine our plans for any future flu pandemic and also for other emergency responses.

Over the last year the public health team has been strengthened with a significant increase in consultant capacity. However, we are now entering a new phase for public health, with functions transferring to a national Public Health Service and local authorities from the NHS. There will be a huge challenge to maintain and improve the health of our population against the backdrop of recession and organisational changes for public health and the NHS, but also enormous opportunities.

Overall the population of Leicestershire County and Rutland (LCR) live longer and enjoy better health than the average for England. However, this good health is not universal. There are significant variations in health experience across our population. These differences, based on poverty, ethnicity, educational status, gender, sexuality and other factors are unfair and unjust. The current recession and associated public sector spending cuts are likely to make these inequalities worse. For this reason I have focused this annual report on health inequalities and what we need to do, across a wide range of organisations, to close the gap between the most and least healthy in our society.

This report contains a significant number of recommendations. To achieve all these in the current financial context will be extremely challenging, but we need to be aspirational. If we do not set ourselves targets that stretch us we will not achieve the reduction in inequalities we all strive for.

Dr Peter Marks
Joint Director of Public Health Leicestershire and Rutland

2.0 INTRODUCTION

This report outlines the key demographic features of the population that are important in the context of health. The report then focuses on health inequalities within LCR and makes recommendations about how current action to tackle these inequalities can be improved.

The World Health Organisation defines health as *"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".* [11]

Inequalities in health arise from inequalities in society: in the conditions in which people are born, grow, live, work and age. The fundamental drivers of these inequalities and disparities are money, power and resources [1].

Our overall health outcomes are better than average as we have a comparatively affluent population. However we have significant health inequalities **within** LCR and this remains a significant challenge in terms of meeting the health needs of our entire population.

Health inequalities are 'the presence of systematic disparities in health (or its social determinants) between more and less advantaged social groups' [1] and are by definition unacceptable in a modern cohesive and caring society.

Health inequalities incorporate differences in how 'healthy' people are and not simply how long they live. Inequalities arise due to complex and interrelated factors such as upbringing, education, employment history, income, and lifestyle choices such as smoking. There is a widely held view that if the causes of health inequalities are social, economic, cultural and political, then so should be the solutions.

This report highlights the key actions that NHS LCR is taking and needs to take in partnership with the local authorities and other partners if we are to maintain progress in tackling unacceptable health inequalities within our population. Throughout this report, reference is made to the Leicestershire Together Health Inequalities Strategy and Action Plan[2]. The strategy and plan acknowledge ***that tackling health inequalities is 'everyone's business***'. The strategy and plan were developed jointly between NHS LCR and key partners and help point the way forward towards sustainable improvement of health of those most in need.

This report also summarises the key health protection issues that arose in 2009/2010.

3.0 CONTEXT

3.1 Demography

Our population

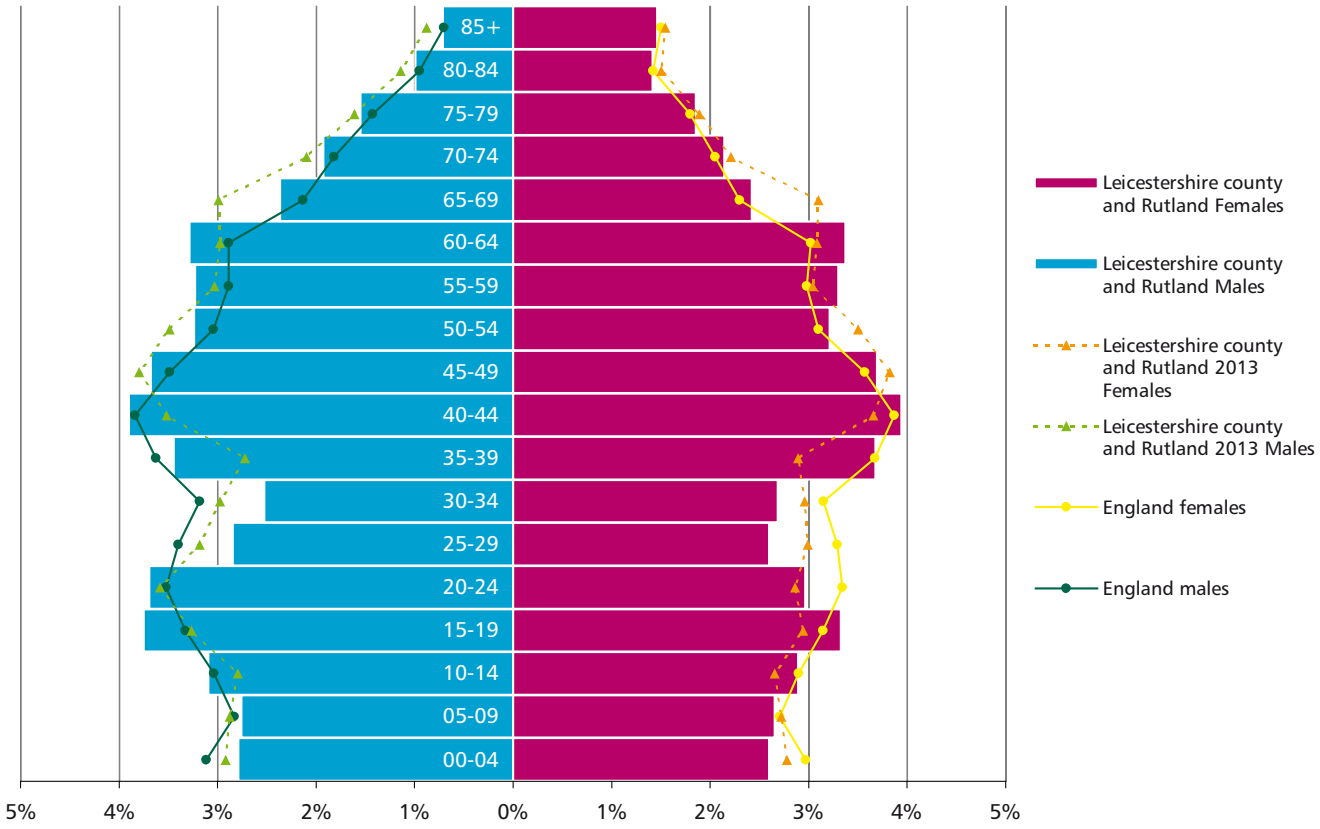
NHS LCR is a primary care trust (PCT) that covers a diverse area, including Leicestershire County Council, seven district councils and Rutland County Council, a unitary authority. In 2008, the resident population of LCR was estimated to be 685,100 [3] with a GP registered population in April 2008 of 666,907 people [4].

The population of LCR is rising. The 2006-based population projections from the office of national statistics show that the population is predicted to rise to 719,400 by 2013 and to 754,200 by 2018 [5]. This is an increase of five per cent between 2008 and 2013 and ten per cent between 2008 and 2018, an average increase of one per cent per year.

Age structure

The population structure is different to the population structure for England (Figure 1). There is a greater proportion of older people and fewer younger adults and younger children than the national average. In addition, whilst the overall population growth is predicted to be 5 per cent by 2013 the numbers of people aged 65 years and over will grow by 18 per cent. This will increase to 34 per cent by 2018. This will have a significant impact on the health needs of the population, particularly long term conditions, and the need and demand for health services.

Figure 1: Population pyramid, NHS LCR 2008, 2013 ; England 2008 [6]



Ethnicity

The majority of the population who live in LCR are white British (89.4 per cent) compared with an England average of 83.6 per cent [7]. The main minority ethnic groups are Asian or Asian British (4.9 per cent) with Indian the most significant part of this group (3.6 per cent) and other white, including Irish (2.6 per cent). It is anticipated that the proportion of people from black and minority ethnic groups will continue to increase through both natural population growth and through migration.

Deprivation, socio-economic status and Mosaic segmentation

The Index of Multiple Deprivation (IMD) covers a range of socio-economic issues which are combined using a number of indicators into a single deprivation score for each local authority area in England. Information from the most recent indices of multiple deprivation 2007 (Table 1) shows that the overall population in LCR is affluent, ranking 146 out of 152 PCT areas nationally (1 = most deprived, 152 = least deprived). However, this affluence is not uniform. North West Leicestershire as a district is affected by higher levels of material deprivation than other areas.

Table 1: Indices of deprivation 2007-rank of all 354 tier 2 local authorities [8]

Local Authority	Average Score	Rank of Average Score
Rutland Unitary Authority	7.49	334 (least deprived = 354)
Blaby Council District	8.41	326
Charnwood CD	11.95	264
Harborough CD	7.08	344
Hinckley and Bosworth CD	10.90	283
Melton CD	10.43	294
North West Leicestershire CD	14.73	219
Oadby and Wigston CD	10.51	293
PCT	Average Score	Rank of Average Score
NHS LCR	10.61	146 (least deprived = 152)

The IMD 2007 also provides deprivation information for small areas using lower level super output areas (areas of around 1500 people). The district level scores give the overall affluence of an area. However, these scores mask the pattern of deprivation within an area and can hide significant populations and individuals that are affected by deprivation. Table 2 demonstrates that 48 per cent of our population live in the most affluent areas of the country. However 1.1 per cent of our population are in the most deprived areas of the country and 13 per cent of our population are affected by material deprivation (the inability of individuals or households to purchase goods and services typical of society at that time).

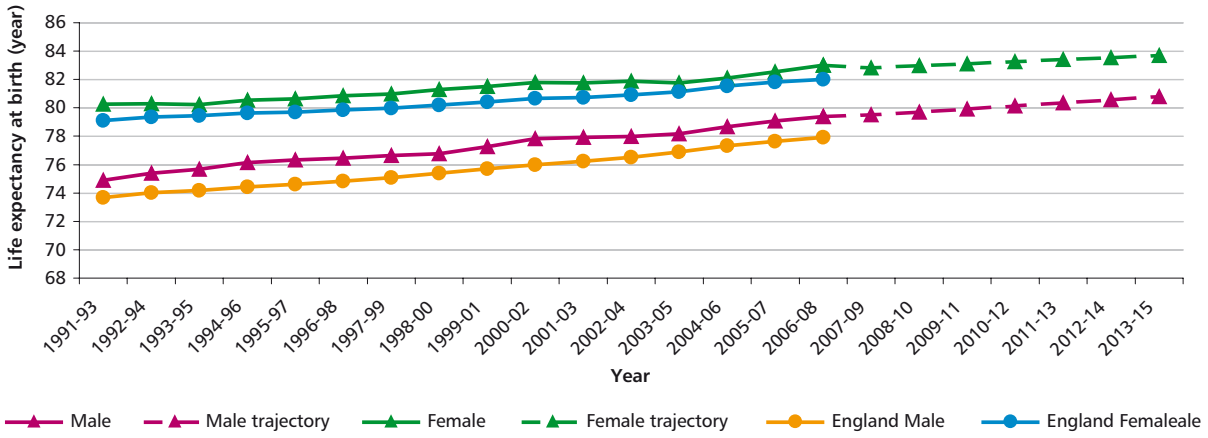
Table 2: Population by decile of deprivation on a national scale [9]

IMD National Decile	Mid 2008 Population	Percent mid 2008 population
Decile 1 - Most deprived	1,456	0.21%
Decile 2	6,266	0.91%
Decile 3	14,460	2.11%
Decile 4	42,065	6.14%
Decile 5	27,699	4.04%
Decile 6	65,416	9.55%
Decile 7	91,069	13.29%
Decile 8	106,899	15.60%
Decile 9	173,321	25.30%
Decile 10 - Least deprived	156,409	22.83%
Grand Total	**685,060**	**100.00%**

Life expectancy

Life expectancy is an important overarching measure of health as it indicates the general state of the health of the population. It is the number of years that a person can expect to live on average in a given population. It is a commonly used summary measure based on death rates of the population in a given year. As the mortality changes over time so will the life expectancy of an area. Figure 2 illustrates increasing life expectancy over the last 20 years and the projected increases in life expectancy over the next five years.

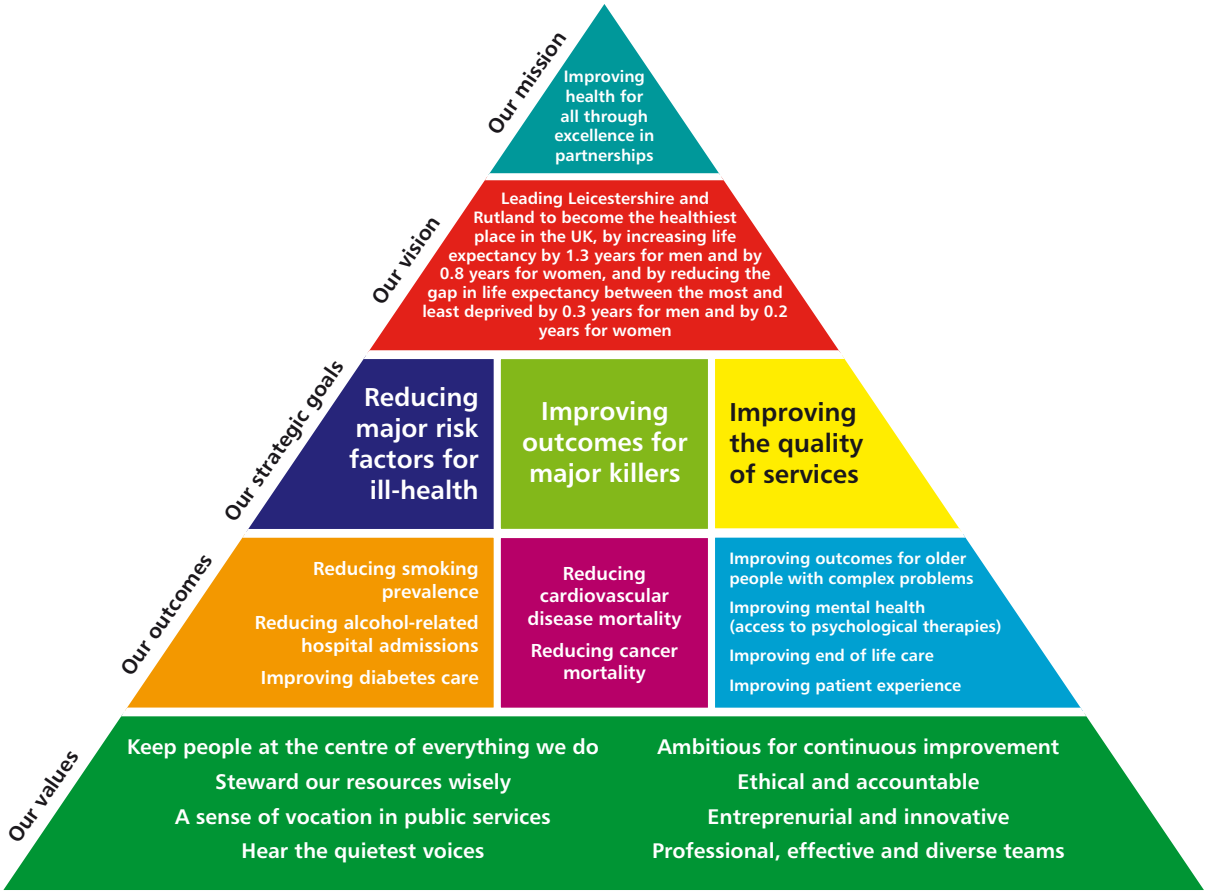
Figure 2: Life expectancy trajectory for NHS LCR [10]



3.2 Our vision and goals

This report acknowledges and incorporates NHS LCR's strategic plan [38], which was refreshed in 2010. This plan sets out our ambitious programme of work to deliver the high quality, value for money services that our population deserve. Its vision and goals are rooted in the Joint Strategic Needs Assessment (JSNA) for Rutland County Council [68] and Leicestershire County Council [69] which provide the analysis of the health and social care needs of our population. The strategic plan also considered the views of our public and patients, clinicians, partners in health and social care and our NHS staff.

Figure 3: Our vision, mission and goals



The strategic plan commits us to measure the achievement of our vision through the use of the slope index of inequalities, the gap between the most and least deprived areas of LCR, and through improvements in life expectancy:

- increase life expectancy by 1.3 years for men and by 0.8 years for women
- reduce health inequalities by reducing the slope index of inequalities by 0.3 years for men and 0.2 years for women

Across our priorities we have set robust, measurable plans to achieve our outcomes whilst recognising the changed picture of public sector finances we must operate in. Over the last 12 months it is recognised that our board, strategic commissioning groups, local clinicians and other stakeholders have helped shape, develop and deliver our strategy. Our plan

embeds the progress we have made so far. It renews our commitment and recognises the changing nature of the social and economic landscape.

3.3 Health inequalities

Drivers of health inequalities

Health inequalities have been defined as 'the presence of systematic disparities in health (or its social determinants) between more and less advantaged social groups' [1].

Although much of the focus on health inequalities centres on differences in premature mortality between different social groups, it is important to remember that health is 'a state of complete physical, mental, and social wellbeing and not merely the absence **of disease or** infirmity [11].

Health inequalities therefore incorporate differences in how 'healthy' people are as well as how long they live.

Inequalities in health and health outcomes are unacceptable. They arise due to many complex and interrelated factors such as upbringing, education, employment history, income, and lifestyle choices such as smoking.

> *"If the causes of health inequalities are social, economic, cultural and political, then so should be the solutions* [*12*]*."*

Many of the factors that underlie health inequalities are deeply rooted in society and may take many years to change. These factors have an influence from very early in life and persist not only into old age but into subsequent generations. Others factors are more amenable to change in the short term.

The Leicestershire Together Health Inequalities Strategy and Action Plan [2] outlines the key actions that partner organisations are currently doing as well as additional actions they need to do if we are to maintain progress in tackling unacceptable health inequalities in our population.

The strategy and action plan have been informed by the Marmot review [12]. This review identified the health inequalities challenge facing England, produced the most relevant evidence to underpinning future policy and action and finally delivered advice and tools to facilitate translating this evidence into practice.

Outline of determinants of health

Figure 4: Factors that influence health [13]

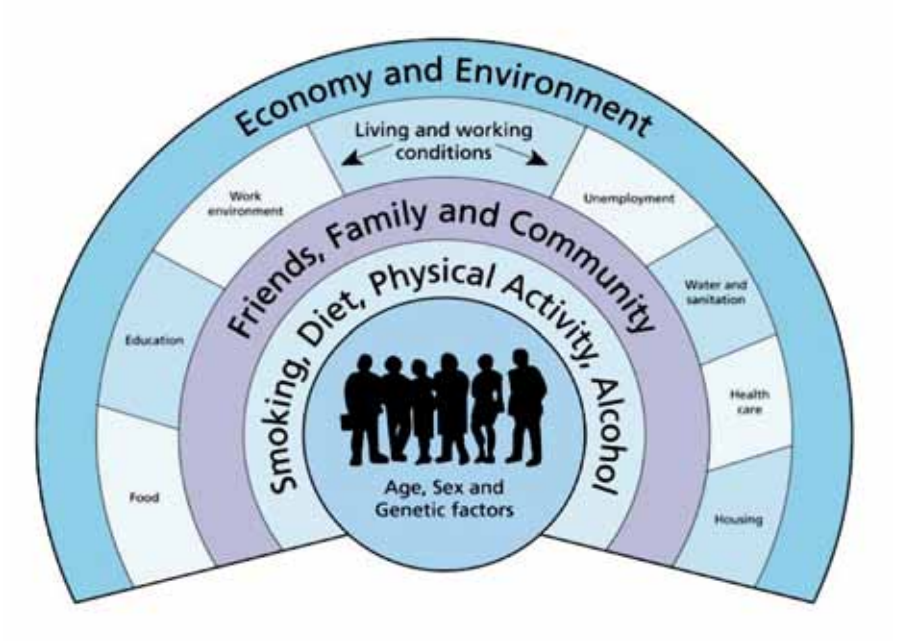


Figure 4 illustrates the different factors/layers that influence health. The layers map the relationship between the individual and their socio-political and physical environment. Individuals are at the centre with a set of fixed factors including genes. Surrounding individuals are influences on health that can be modified.

- The first layer is personal behaviour and ways of living that can promote or damage health eg choice to smoke or not.
- The next layer includes social and community influences, which provide mutual support for members of the community in unfavourable conditions. Individuals are affected by friendship patterns and the norms of their community. Social and community influences can have a positive or negative effect.
- The third layer includes structural factors: housing, working conditions, access to services and provision of essential facilities. These factors all operate within the context of the prevailing economic and environmental circumstances.

Figure 5: What influences health and wellbeing? [14]

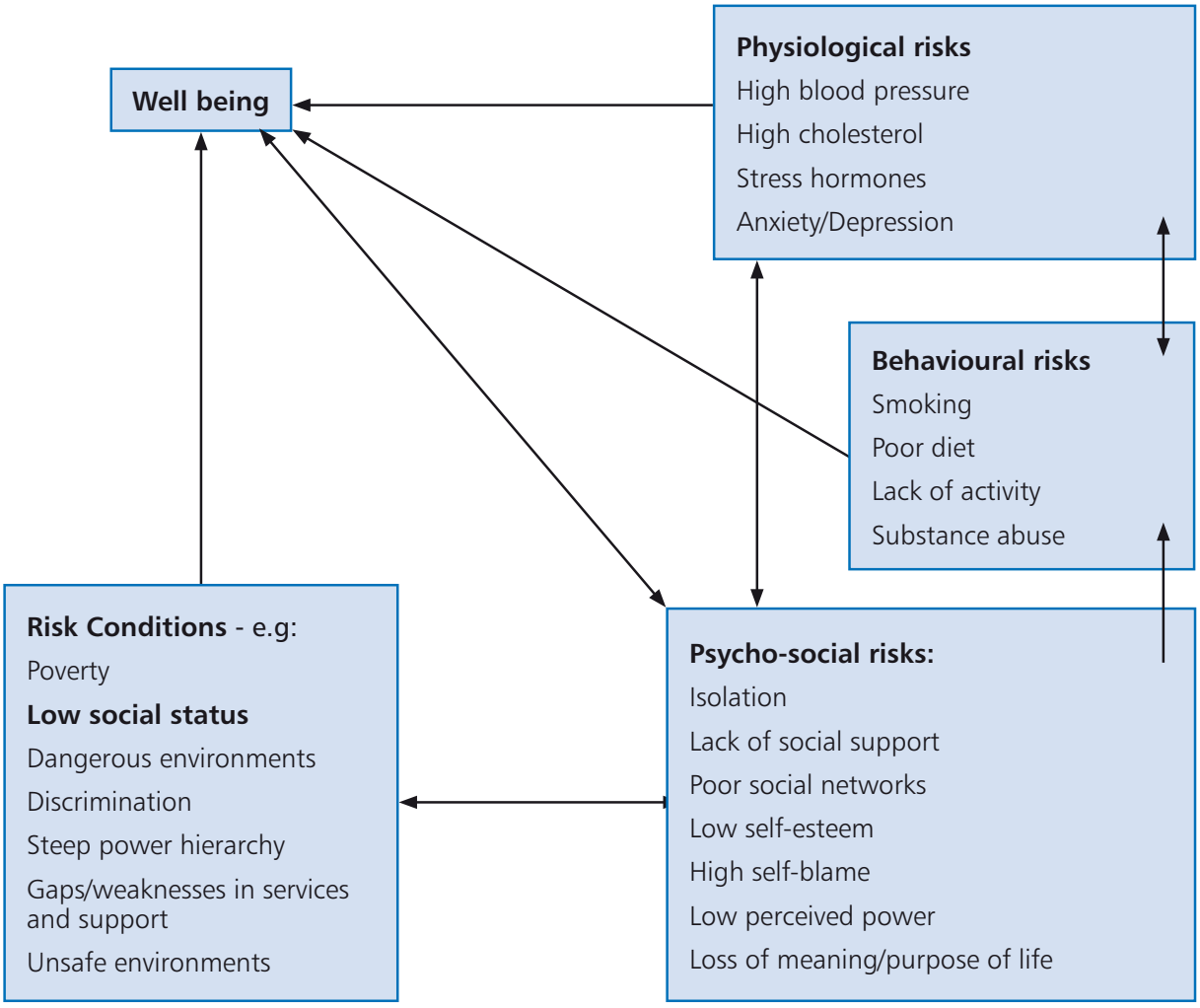


Figure 5 represents how the complex interconnecting factors that determine whether an individual will enjoy good health or not. This diagram which was developed by Labonte [14] adopts a social model of health, and illustrates that an individual's health is affected by physical, social and mental factors.

The risk factors, which prevent people enjoying good health and wellbeing include:

- Behavioural risks - smoking, poor diet, lack of activity, substance abuse
- Risk conditions - poverty, low social status, dangerous environments, discrimination, steep power hierarchy, gaps or weaknesses in services and supports, unsafe environments
- Psychosocial risks - isolation, lack of social support, poor social networks, low self-esteem, high self-blame, low perceived power and loss of meaning or purpose in life

Ultimately these interconnected risk factors feed into physiological risks eg high blood pressure, high cholesterol, stress hormones.

Therefore, it is clear that many determinants of health are outside the direct responsibility of health services and can be influenced by a wide range of partners. These social determinants of health have been described as the 'causes of the causes' [15].

To secure the best possible improvement in the health of the population, all the determinants of health need to be addressed. Many of these determinants require multi-agency partnership working. It is fundamentally important that partner organisations jointly prioritise the actions that must be taken collectively to obtain the greatest health improvement for the investment made and to ensure that services and support are targeted at those most in need.

Health inequalities within LCR

Detailed descriptions of local health inequalities across LCR can be found in key documents including: JSNA and Practice Based Commissioning Health Profiles (These are shown in Appendix 1).

Over the years there have been significant improvements in the health of our local population. On average people are living longer. Fewer people are dying prematurely of the major killers, including cardiovascular disease (CVD) and cancer. However, there is still much room for improvement.

Here are some key things we currently know about health inequalities locally:

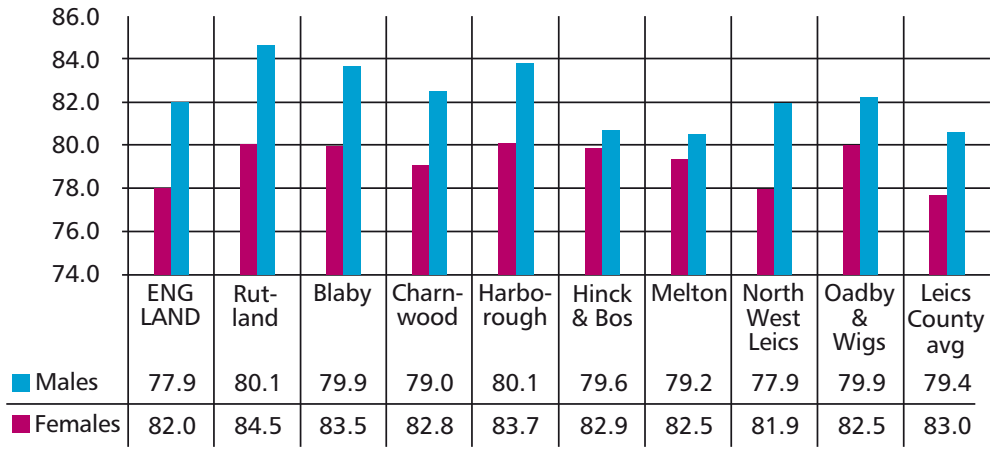
- Health inequalities as measured by the gap in premature mortality between the most and least deprived is widening.
- Health inequalities continue as a symptom of underlying socio-economic inequalities.
- Premature mortality rates for CVD, cancer and respiratory disease account for most of the inequalities in life expectancy between the most and least deprived.
- Morbidity/illness rates for mental illness, CVD, cancer and respiratory disease explain most of the inequalities in day to day health and wellbeing between the most and least deprived.
- Poor access to high quality health care remains an issue for socially disadvantaged groups.
- Although tobacco use has fallen in all socio-economic groups the prevalence remains far higher in lower social economic groups. There are still an estimated 120,100 smokers in LCR. The difference in prevalence of smoking between the most and least deprived groups remains the biggest single cause of health inequalities in premature mortality.
- A significant proportion of ill health and premature death is potentially preventable eg through smoking cessation, tackling obesity, alcohol abuse, improving secondary prevention of CVD.

Health inequalities due to socio-economic factors

Compared to national averages our population is relatively affluent. Therefore we compare favourably with England averages in our overall life expectancy and general health outcomes. Because of this the focus for addressing health inequalities is about reducing health inequalities within LCR ie concentrating on local communities and individuals with the poorest health.

A boy born in North West Leicestershire can expect to live for 2.3 years less than a boy born in Rutland. For girls the corresponding gap is 3.4 years.

Figure 6: Life expectancy across Leicestershire districts 2005-2007



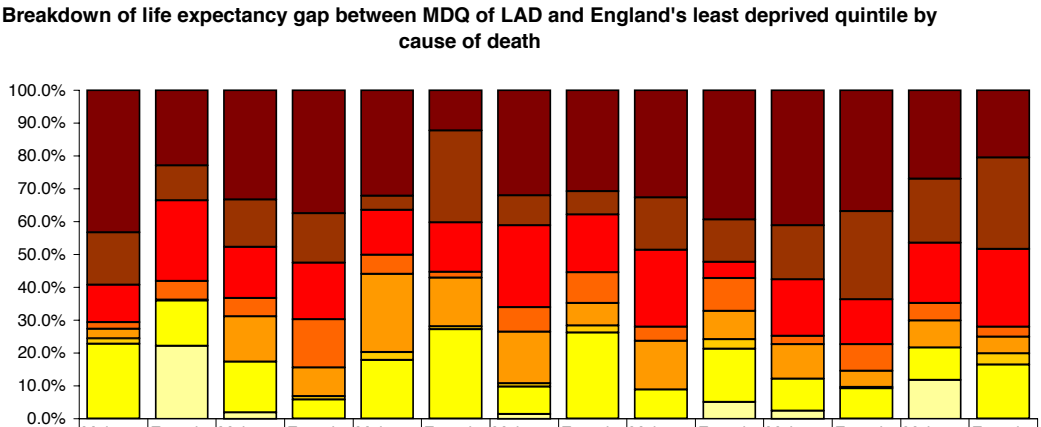
	ENG LAND	Rut-land	Blaby	Charn-wood	Harbo-rough	Hinck & Bos	Melton	North West Leics	Oadby & Wigs	Leics County avg
Males	77.9	80.1	79.9	79.0	80.1	79.6	79.2	77.9	79.9	79.4
Females	82.0	84.5	83.5	82.8	83.7	82.9	82.5	81.9	82.5	83.0

The life expectancy for a district is an average of rates across that district (Figure 6). It masks the differential in life expectancy within districts i.e. the underlying inequalities in small areas within each district.

Causes of life expectancy gaps

The scarf chart (Figure 7) below illustrates the main causes of death that contribute to the inequalities gap for each district, focusing on the average for the district and the life expectancy for the 20 per cent most deprived quartile (MDQ) i.e. deprived parts of the district. This clearly demonstrates that the most significant illness responsible for these health inequalities is CVD. The other diseases that lead to inequalities in life expectancy are respiratory disease and cancer.

Figure 7: Breakdown of life expectancy gap between MDQ of LAD and England's least deprived quintile by cause of death



	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
	Blaby		Charnwood		Harborough		Hinckley & Bosworth		Melton		North West Leics		Oadby & Wigston	
All Circulatory Diseases	43.3%	22.9%	33.3%	37.5%	32.2%	12.3%	32.0%	30.8%	32.6%	39.4%	41.1%	36.8%	27.0%	20.5%
All Cancers	16.0%	10.6%	14.4%	15.0%	4.2%	28.0%	9.2%	7.1%	16.0%	12.9%	16.5%	26.9%	19.4%	27.8%
Respiratory Diseases	11.3%	24.6%	15.6%	17.2%	13.7%	15.0%	24.9%	17.5%	23.4%	4.9%	17.2%	13.7%	18.4%	23.7%
Digestive	2.0%	5.7%	5.6%	14.7%	5.9%	1.8%	7.5%	9.4%	4.3%	10.0%	2.6%	8.1%	5.3%	3.0%
External Causes	3.0%	0.2%	13.8%	8.8%	23.7%	14.8%	15.7%	6.8%	14.8%	8.6%	10.4%	4.9%	8.2%	5.1%
Infectious * parasitic diseases	1.6%	0.2%		1.0%	2.4%	0.9%	1.0%	2.2%		2.9%		0.3%	0.1%	3.5%
Other	22.8%	13.8%	15.4%	5.8%	17.9%	27.2%	8.3%	26.2%	8.9%	16.2%	9.8%	9.3%	9.8%	16.4%
Under 28 days		22.1%	1.9%				1.4%			5.1%	2.4%		11.8%	

In addition to health differences due to socio-economic disadvantage, we have other groups facing significant health challenges. These include:

People from black and ethnic minorities - Men born in South Asia are 50 per cent more likely to have a heart attack or angina than men in the general population. Men born in the Caribbean are 50 per cent more likely to die of stroke than the general population [17]. Young black men are six times more likely to be sectioned under the Mental Health Act for compulsory treatment than their white counterparts [18].

Older people - Marked variation has been highlighted in parts of the UK in access to surgical procedures for the conditions related to old age. This is demonstrated for cataract, hip and knee procedures-the likelihood of older patients being offered surgery varies considerably across the country suggesting that advancing age alone can be used as a barrier for some patients even though they may be clinically suitable for surgery [19].

Mentally ill and people with learning difficulties - People with a diagnosis of severe and enduring mental illness e.g. schizophrenia and bi-polar disorder are at increased risk of a range of physical illnesses and conditions including coronary heart disease, diabetes, infections, respiratory disease and greater levels of obesity [20].

Studies suggest that the health needs of people with learning difficulties are poorly understood and historically have been poorly met [70]. For example, take-up of breast screening is just 26 per cent in women with a learning disability compared with over 70 per cent for other women [21].

Homeless - There is abundant evidence that people who are sleeping, or have slept, rough and/or are living in hostels and night shelters have significantly higher levels of premature mortality and mental and physical ill health than the general population. Several sources show that of deaths that occur in hostels or while registered with homelessness services, the average age at death is low, about 40-44 years [22].

The most common needs of homeless people concern drug dependence, alcohol dependence or mental disorders, and dual diagnosis is common. Additional causes of ill health include injury (due to accidents or violence), poor condition of feet or teeth due to self-neglect, infections or skin complaints. Skin complaints most commonly include infestations or infections though inflammatory skin conditions [23].

Offenders - Offenders have higher than average levels of physical and mental ill health. The percentage of prisoners who suffer from a mental health problem and/or drug dependence has been estimated to be 60–65 per cent [24].

80 per cent of prisoners smoke, 9 per cent of the UK prisoner population suffer from severe and enduring mental health illness, 10 per cent of prisoners have a learning disability. People who have been in prison are up to 30 times more likely than the general population to die from suicide in the first month after discharge from prison. In addition, 40 per cent of prisoners declare no contact with primary care prior to detention. There is commonly poor continuity of health care information on admission to prison, on movement between prisons and on release [25].

Gypsies and travellers - Research from the 1987 Health Status study in Ireland showed that traveller women tend to live 12 years less than settled women. Traveller men live 10 years less than settled men. However, recent research in Leeds indicates that in England the life expectancy gap may be as high as 25 years, with an average life expectancy of about 50 years [26].

The 2004 Health Status of Gypsies and Travellers in England report by Sheffield University showed that infant mortality among gypsy and traveller communities is three times higher than the national average. A gypsy or traveller mother is nearly 20 times more likely to lose her child before their eighteenth birthday, than the rest of the population [27].

Asylum seekers - Asylum seekers and refugees are a particularly vulnerable population with significant, unique health needs. The greatest threat to their health is from diseases: communicable, degenerative and psychological, associated with poverty and overcrowding, and from the trauma they may have suffered [28].

Gay/lesbian/transgender - Gay and bisexual men are seven times more likely to attempt suicide compared with the general population [29].

A report on the mental health and social wellbeing of lesbian, gay and bisexual people in England and Wales by MIND [31] revealed higher levels of reported psychological distress compared to heterosexual people. Higher levels of substance abuse and eating disorders have also been attributed to societal discrimination against this group [30].

Rural people - There are significant pockets of deprivation and disadvantage to be found in rural areas in LCR. Rural deprivation has been described as "a set of economic and social conditions … *which excludes people from the styles of life open to the majority in the countryside….[32].* These rural inequalities often remained hidden because of the way deprivation was measured in the past. In rural areas individuals may be classed as being deprived with or without a low income. Deprivation, as seen in urban areas, has traditionally been tackled in area-based initiatives, but in rural areas many people who experience deprivation live alongside the affluent, making it harder to target resources. Overall there are significant difficulties in collecting small area data and identifying deprivation in sparsely populated areas.

4.0 WHAT WE CAN DO TO TACKLE HEALTH INEQUALITIES

Clearly, NHS LCR and our partners must continue to work together to address and tackle the wider determinants of health including education, employment, income equality and housing and to ensure that health and social care services are of good quality and targeted at those in greatest need.

Tangible impacts can be achieved by the local health community and partners by focusing on four major themes as identified in the NHS LCR health inequalities strategy and action plan [2] as based on tackling health inequalities: a programme for action [34].

- **Supporting families, mothers and children –** to ensure the best possible start in life and break the inter-generational cycle of health.
- **Engaging communities and individuals –** to ensure relevance, responsiveness and sustainability.
- **Preventing illness and providing effective treatment and care –** making certain that the NHS provides leadership on tackling health inequalities and ensuring equitable access to services. This is crucial as inequalities in access are experienced by people of lower socio-economic groups, particular BME communities and other vulnerable groups.
- **Addressing the underlying (wider) determinants of health** eg income/poverty, housing, education, employment.

An integrated approach to tackling health inequalities must be embedded into the mainstream of service delivery across health and social care. There is a growing recognition that "one size does not fit all" and that national standards need to support a mix of local services to meet a diversity of local need. There is also a need to better co-ordinate activity across traditional boundaries, and work in partnership with frontline health and local authority staff, voluntary, community and business sectors, as well as service users.

A visit from the Regional Support Team for Tackling Health Inequalities (RST HI) to NHS LCR and partners in July, 2010 recommended that across the PCT and within wider partnerships ***there needs to be recognition that public health and health inequalities are everyone's business.***

National evidence and recommendations from the National Support Team for Health Inequalities indicate that the greatest short term gains (ie in the next two years) will be achieved through interventions in primary care to prevent deaths in people with CVD and interventions to reduce smoking prevalence. Cardiovascular diseases have a common set of risk factors including poor diet, obesity, lack of physical activity, high blood pressure and smoking. The single most important lifestyle risk factor for addressing our health inequalities in mortality is to reduce smoking. In our deprived areas, smoking behaviours account for up to 50 per cent of the gap in life expectancy. Indeed, smoking status contributes significantly to the three major causes of inequalities: CVD, respiratory disease and cancer.

5.0 SUPPORTING FAMILIES, MOTHERS AND CHILDREN

Background

Academic research repeatedly shows that action targeted at supporting children and families in the early years is essential to break the cycle of deprivation through the generations.

The Acheson inquiry said that 'while there are many potentially beneficial interventions to reduce inequalities in health in adults of working age and older people, many of those with the best chance of reducing future health inequalities… relate to parents, particularly present and future mothers, and children' [35].

More recently the Marmot Review [12] placed a renewed focus on early years. This review's main policy objective was to give every child the best start in life by:

- Reducing inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills
- Ensuring high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient
- Building the resilience and well-being of young children across the social gradient

The Marmot Review's ultimate aims in relation to supporting mothers, families and children are to:

- Close the gap in infant mortality between advantaged and disadvantaged communities
- Improve maternal and child health, and child development including through prevention
- Improve early years support
- Improve educational attainment

Current activity to address need locally

- Teenage pregnancy prevention plan
- Specialist antenatal smoking cessation service
- Congenital anomaly register monitored
- Co-ordinated plans to increase access to child and adolescent mental health service (CAMHS) usage
- NHS LCR childhood immunisation plan and strategy developed
- Monthly monitoring of practice childhood immunisation performance with follow up calls
- Distribution of vitamin supplements in vulnerable children through children's centre

Women reminded that breast is best

Women are being encouraged to learn about the benefits of breastfeeding following the annual World Breastfeeding Week (August 1-7).

NHS Leicestershire County and Rutland is urging local mums to learn more about just how beneficial breast milk is. Breast milk is the best form of sustenance for a baby as it is nutritionally balanced, with the perfect amount of proteins, carbohydrates, fats, vitamins and iron to help a baby grow. It also contains antibodies that help to protect babies from infection, and it changes to suit the differing needs of a baby as it develops.

Article taken from Healthy Times, Autumn 09, Issue 2, page 6

Achievements

- Breastfeeding peer support programme which has so far recruited 88 breast feeding mothers who are supporting other mothers to breast feed
- Certificate of Commitment from UNICEF Baby Friendly Initiative
- County users' forum established for the Maternity Services Liaison Committee enabling women to inform service development for maternity services in Leicester, Leicestershire and Rutland (LLR)
- Above average uptake of childhood immunisations

Recommendations for the future

Improve quality and accessibility of antenatal care and early years support in disadvantaged areas eg building on the lessons of Sure Start Supporting Families

Increase the number of pregnant women with full health and social care needs assessed by the 13th week of pregnancy by:

- Mainstreaming maternity support workers in community midwifery to increase capacity and support early access to midwives
- Promotion of early and direct access to maternity services in the community and within primary care services
- Development of specialist midwifery team for teenage parents to facilitate direct access and specialist support for vulnerable women

Engage women in the strategic development of maternity services using the parents' forum to ensure that women's views and experiences inform the development of services.

Increase breastfeeding rates by implementing Baby Friendly Initiative standards – offering universal support through hospital and community health services and targeted support to vulnerable groups through children's centres.

Develop the breastfeeding peer support programme to help women sustain exclusive breastfeeding and thereby maximise the health benefits for infants.

Improve the uptake of vitamin supplements in vulnerable children through increasing the accessibility of vitamins in children centres, health centres, pharmacies and health visitor clinics. Raising awareness and educating staff and public about the need for vitamin D will be a high priority.

Maintain and build upon partnership work to prevent teenage pregnancy and support teenage parents

Reduce the number of pregnant women who smoke thereby improving maternal and child health

Ensure early access to support services for families experiencing challenging behaviour in their children

Improve uptake of childhood immunisations through fully implementing the childhood immunisation plan and target specific groups with lower uptake levels including travellers

Involve young people in designing services and implement "You're Welcome" in adolescent sexual health services.

6.0 ENGAGING COMMUNITIES, INDIVIDUALS AND TACKLING SOCIAL EXCLUSION

Background

Health inequalities are part of a pattern that combines social exclusion, low income, poor mental and physical health and poor access to services. The UK government's Social Inclusion Unit's definition of social inclusion is "what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low income, poor housing, high crime, bad health and family breakdown' [36].

Current activity to address need and achievements

- NHS LCR identifies the communities with the lowest life expectancy and poorest health using JSNA and Health Equity audits (HEA) and we use social marketing to target interventions at those in greatest need.
- We have developed a multi-agency public health network across NHS LCR incorporating partners in local authority and the voluntary sector to specifically address the needs of the socially excluded. We also work in partnership with local authority and joint work programmes to reach those most in need through priority neighbourhoods. The membership scheme also organises regular 'Community medicine for members' events and where possible targets them to areas where there are known health inequalities.
- NHS LCR has a comprehensive Communications and Engagement Strategy called 'Be healthy, be heard' [37]. Within this, the engagement team has developed a specific 'Seldom heard' group's strategy [71]. NHS LCR also links to socially excluded people through the NHS LCR membership scheme. Both of these initiatives help create a meaningful dialogue between health professionals and members of seldom heard communities and groups.
- Working agreements also exist between NHS LCR and a range of community and other groups including the third sector, Learning Disability Partnership Board, 'Leicestershire Together', University Hospitals of Leicester (UHL) Equality Panel, Leicestershire Learning Disability Groups, LINKS, Young Advisors, NHS Young Ambassadors, National Empowerment Partnership, Connexions, The Jitty (Leicestershire Young People's forum), Leicestershire Interfaith Forum.

- We also deliver targeted interventions aimed at specific socially excluded groups, including:
  - older people through NHS LCR's older person's strategy.
  - systematic health checks for people with learning disability (LD)
  - work with gypsies and travellers through a designated liaison health worker and using a locally enhanced service in a general practice in Market Harborough practice to deliver specific service aimed at gypsies and travellers,
  - prison health needs assessment tool and engagement with Rural Partnership
- There is a multi organisational diversity and equality hub as a single point of contact across NHS LCR and NHS Leicester City (NHS LC) for services and users which provides interpretation translation services, equality impact assessments and organisational training on the single equality scheme.

Achievements

- Engagement programmes have been carried out with five 'seldom heard' groups over the period 2009/10 which helped inform our commissioning process and deliver key health messages to young people, the frail elderly, gypsies and travelers, people with a learning disability and people from BME populations.
- Jointly with our partners we have successfully bid for three 'Pacesetters' projects bringing focused work on smoking in Bangladeshi communities in Loughborough, early awareness of bowel cancer and bowel cancer screening uptake and exercise referral in patients with learning difficulties.
- We are collaborating with North West Leicestershire and Charnwood District authorities to deliver Your Health Matters clinics (formerly Well Families clinics). These are clinics delivered directly in disadvantaged communities to bring health checks and health information to individuals who don't traditionally engage with mainstream services.

Hundreds have their say on maternity services

During November, NHS Leicestershire County and Rutland asked people, including members, for their views on local maternity services and the care of newborn babies. More than 800 people had their say. The aim was to find out people's attitudes to having their care in hospital or in community-based services. People were also asked how far they would be willing to go for specialist care and how they feel about where that specialist care should be available.

The views will feed into ongoing planning for local maternity and newborn services.
A summary of the views is published on our website **www.lcr.nhs.uk** in the 'get involved' section.

Article taken from Healthy Times, Spring 10, Issue 4, page 10

Recommendations for the future

Consolidate work with a wide range of community and other groups to address health inequalities

Use social marketing techniques to identify and target interventions at socially excluded including tobacco control, alcohol harm reduction, physical activity, antenatal/postnatal care, breastfeeding, sexual health services, screening

Continue to listen, engage and act on reported patient experiences, and include the targeted work of the communications and engagement team and neighbourhood management teams to continue to build relationships with seldom heard groups

Strengthen collaborative work with local authority to address needs of socially excluded through neighbourhood management and public health network

Develop and implement a framework to ensure primary care is able to contribute to reduction of health inequalities. As a priority those practices providing primary care to those residents of the priority neighbourhoods should be actively supported to meet the particular health and social care needs of their disadvantaged communities

Co-ordinate equality and diversity, patient experience and public engagement working strands within the NHS LCR

Continue to gather insight of needs and wants of existing socially excluded groups eg 'Be healthy, be heard group'. Utilise these groups to test messages to ensure that services are meeting the needs of the 'seldom heard' populations

7.0 PREVENTING ILLNESS

The NHS Plan [39] set out the responsibilities of the NHS to provide effective prevention and treatment, and to tackle health inequalities. As a result, there is a more coherent and properly supported prevention programme, stronger and more responsive primary care services, and better access to treatment for the less well-off.

Preventing Illness

Aim: Reduce risk through targeted effective health improvement programme

7.1 Tobacco control (including stop smoking)

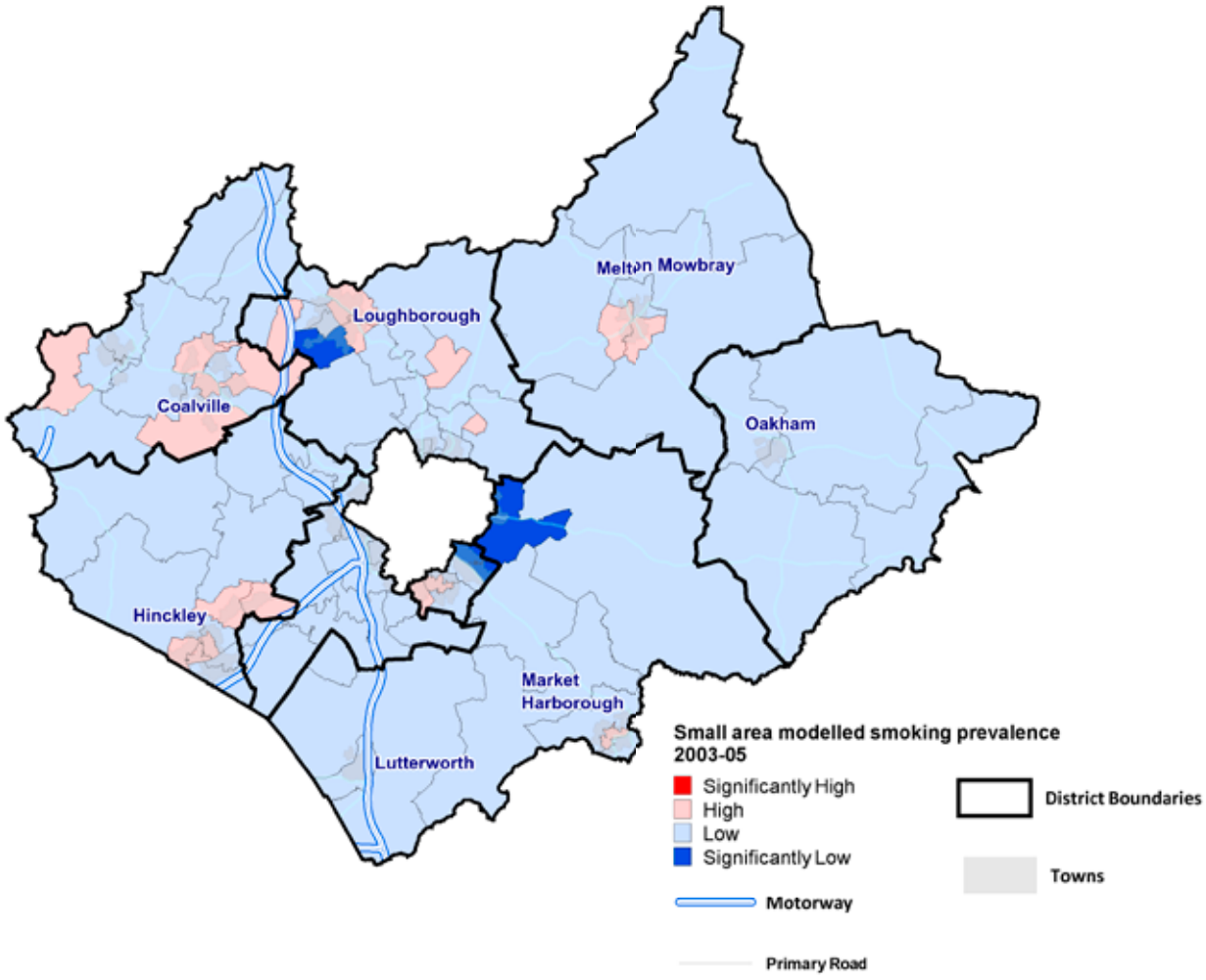
Background

Smoking remains the single greatest cause of preventable illness and premature death in England, killing around 87, 000 people each year [40]. An estimated one in four people smoked in England in 2006, with more men smoking than women. The current level of tobacco use is estimated to cost the NHS around £2.7 billion every year [41]. The NHS Information Centre calculates that in England in 2007/08 there were approximately 440,000 hospital admissions of adults aged 35 and over with a primary diagnosis of a disease that was caused by smoking (about 1,200 admissions per day on average). The decline in the number of smokers over the past decade has led to current annual savings to the NHS of around £380 million.

Although tobacco use has fallen in all socio-economic groups, smoking prevalence remains far higher in more disadvantaged communities. Men living in the most deprived areas of England are up to 1.9 times more likely to smoke than men living in the least deprived areas of England. Women are over twice as likely to smoke if they live in deprived rather than affluent areas.

Around 120,000 smokers (22 per cent of adult population) across LCR remain exposed to major health risks from smoking. The more deprived areas of Loughborough, North West Leicestershire and South Wigston have the highest smoking prevalence, as illustrated in Figure 8. At a district level, Rutland has the lowest smoking prevalence of 17.6 per cent and Melton has the highest smoking prevalence of 24.4 per cent. It is estimated that up to half the difference in life expectancy between the richest and the poorest is associated with smoking. Death rates from tobacco among the poorest are two to three times higher than among the richest.

Figure 8: Synthetic estimates of smoking at ward level, 2000 – 2002 [42]



Since smoking is the main risk factor for diseases contributing the most to health inequalities - CVD, respiratory disease and cancer - reducing smoking prevalence in priority areas and groups is a priority as shown in the strategic plan [38] and in the LSPs Staying Healthy Strategy [45]. The greatest short term gains (i.e. in the next two years) will be achieved through interventions in primary care to prevent deaths in people with CVD and interventions to reduce smoking prevalence.

Smoking remains one of the few modifiable risk factors in pregnancy, and it can cause a range of serious health problems, including lower birth weight, pre-term birth, placental complications and perinatal mortality. Smoking during pregnancy is estimated to contribute to 40 per cent of all infant deaths. The total number of pregnant women setting a quit date for 2007-08 were 354, of which 65 per cent successfully quit at four week follow up.

Significant progress has been made in reducing smoking rates across England. This has been achieved through the effective introduction of smoke free legislation, virtual elimination of tobacco advertising, increasing the age of sale of tobacco from 16 to 18 and the creation of accessible and effective NHS stop smoking services.

Current activity to address need

Our vision is to achieve a smoke free future where communities are free from tobacco-related harm and where people lead longer and healthier lives. We aim to deliver this vision through a comprehensive programme of tobacco control that incorporates a mix of educational, clinical, regulatory, economic and social strategies to:

- Motivate and assist every smoker to quit

The provision of high quality stop smoking treatment and support is a central element of tobacco control policy. The NHS LCR stop smoking service was established in 2000 and currently supports over 8,000 clients every year. One of the largest in England, the service integrates a core specialist team that is underpinned by a range of enhanced GP and pharmacy providers. The service is needs led and targeted in geographical areas of high deprivation and on priority groups, including people in routine and manual occupations, pregnant women, BME communities and prisoners.

In 2009/10, we achieved our target to assist more than 4,800 people to quit smoking through high quality stop smoking services. Through our stop smoking programmes in secondary care, we targeted brief interventions and referrals to acute care patients and smokers admitted for elective surgery. The recruitment of dedicated specialists by the service enhanced capacity to target priority areas and groups. A face-to-face street campaign resulted in over 1000 additional referrals.

- Prevent young people from starting to smoke

The majority of adult smokers say they started smoking regularly before the age of 18 [43]. We have focused on young people through our investment in a programme of school-based interventions. These programmes aim to prevent the uptake of smoking among young people [44] and offer treatment and support to those who smoke. Supporting adults to quit and promoting 'Smokefree' homes are key aspects in encouraging young people not to take up smoking.

- Protect families and communities from tobacco-related harm

Protecting our communities and families from tobacco-related harm depends on partnerships between public, private and third sectors. Through the Local Strategic Partnership (LSP), we secured funding for a new Smokefree Alliance Co-ordinator who will raise the profile of tobacco control and champion our vision to achieve a smoke-free future. Other key partnerships have included work with schools to help young people to quit smoking and with trading standards to tackle cheap and illegal tobacco.

Achievements

- In a study of stop smoking services across the East Midlands, NHS LCR had the second highest success rate in assisting smokers to quit and the highest success rate for pregnant women. Other measures of quality included low loss of clients to follow up and high validation of quit success.
- We were awarded National Pacesetter funding to undertake a project to reduce high levels of smoking in Bangladeshi communities.
- The stop smoking service achieved the overall smoking quitter target and at the same time increased its capacity to target priority groups through the recruitment of dedicated specialists.

Additional successes of the stop smoking service:

(a) Workplaces

Within the last year the workplace programme has been recognised as a successful and groundbreaking model reaching workplaces throughout LCR. Excellent reviews and evaluations have been received from the companies with many repeat requests for further support for their staff.

Standard Soap in Ashby de la Zouch decided to dispense with their smoke shelter and make the entire site smoke free. An event was organised on National No Smoking Day 10 March 2010 resulting in twenty three routine and manual staff signing up to the programme. Twenty people were subsequently validated as quitters.

(b) Lost to follow up

Since quarter 1 2009 a concerted effort has been made at the end of each quarter to contact clients by telephone/text who were reported as lost to follow ups, did not attend or self reported smokers. As a result of this over 400 additional quitters have been verified.

(c) Hard to reach workers/communities

An agreement was negotiated with North West Leicestershire District Council to hire their mobile unit at no cost to the stop smoking service. The unit would be used to get into hard to reach/deprived communities and industrial estates with the planned outcome of running the smoking cessation programme from the unit.

(d) Special projects

In 2009/2010 the stop smoking service participated in a face to face campaign. This resulted in acquiring the services of a professional marketing company that is level 1 smoking cessation trained. Members of the public in major towns in LCR ie Loughborough, Melton, Hinckley, Coalville were consulted regarding their smoking habits and asked if they required further support. A total of 1200 enquiries were received in total. Each person was then contacted and an appointment booked/advice/support given.

Recommendations for the future

We must continue to:

- Stop the inflow of young people recruited as smokers
- Motivate and assist every smoker to quit
- Protect families and communities from tobacco-related harm

by

raising awareness of NHS stop smoking services and the harm caused by smoking through a mixed programme of social marketing and communications, including promotion of lung age tests and drop-ins.

Increasing referrals into stop smoking services through engagement with primary care, brief interventions in secondary care, street campaigns and direct mail-outs.

Continuing to build on the quality and efficiency of stop smoking services by rolling out a new electronic information system and increasing access to evidence-based interventions.

Increasing accessibility to priority groups by using new tools to audit health equity and aligning services to meet needs.

Extending programmes to prevent young people from starting to smoke, including school project and tackling underage and illicit sales.

Achieving the ambitious targets we have set (reduce smoking prevalence in NHS LCR to 19 per cent by 2013, and increase the rate of smoking quitters from 848 per 100,000 in 2009/10 to 936 per 100,000 in 2013/14, deliver 4,947 successful smoking quitters (measured at four weeks) in 2010/11)

Making tobacco control everybody's business by rolling out brief intervention training and working together with our key partners through a re-energised Smokefree Alliance.

7.2 Tackling obesity

Background

In England, obesity is associated with social and economic deprivation across all age ranges and is becoming increasingly common [46]. Obesity increases the risk of a number of diseases including type II diabetes, hypertension, CVD and some cancers [47]. Obesity in Britain has reached epidemic proportions with almost two thirds of adults and a third of children being either overweight or obese and the ongoing Health Survey for England highlights the trend towards an increase in the prevalence of overweight and obesity.

In NHS LCR, it is estimated that 24.8 per cent of adults are obese; a higher prevalence than the England average. Furthermore, this is predicted to rise further by 2015 and it is estimated that 36 per cent of men and 28 per cent of women in England will be obese, rising potentially to 60 per cent of men and 50 per cent of women by 2050 [47].

Although fruit and vegetable consumption is steadily increasing, it is estimated that only 26.3 per cent of the population in England eat the recommended five portions a day. Local

estimates suggest that North West Leicestershire has the lowest consumption of fruit and vegetables at 24.2 per cent, and Rutland the highest at 32 per cent [47].

Between 2007/8, the second Active People Survey showed that nationally 21.3 per cent of the population nationally exercise at least 3 times a week for 30 minutes at moderate intensity. This is 23 per cent of the population in LCR [47].

Current activity to address need and achievements

There has been continued countywide progress in delivering the 'Healthy weights healthy lives' programme and ongoing positive activity around delivering childhood obesity and physical activity programmes.

The developing obesity strategy is bringing together a complex array of commissioning organisations and diverse providers, in order to provide a co-ordinated and effective approach to creating long term reductions in the number of people who are overweight or obese. An obesity steering group is being established to align with an action plan and risk assessment in order to track progress. This will incorporate the existing childhood obesity strategy that has been adopted by Children's and Young Peoples Executive.

a) Activity to address childhood obesity/physical activity

- Supporting breastfeeding particularly targeted support to at risk families
- Promoting and school based activities including increasing uptake of healthy school meals and physical activity sessions
- Leicestershire Nutrition and Dietetics Service runs the Family Lifestyle Clubs programme to support overweight children aged 4-8, and their families, through tailored specialist dietician advice, and active games for children lead by the physical activity co-ordinator in each locality

A range of initiatives encourage increased physical activity for school-age children

- Promoting physical activity is part of the NI57 delivery plan [72]. This requires 80 per cent of Leicestershire schools to have two hours curriculum time for physical education and sport. There is a longer term aim to increase this to five hours per week.
- Broader strategies such as the implementation of school travel plans encourage walking to school, rather than using cars and buses
- A number of sport orientated projects also encourage increased physical activity in young people e.g. 'Step into Sport' which offers a range of active volunteering opportunities for young people and their families. 'Sport Unlimited' is a youth sports programme which cascades funding to local communities via the county sports partnerships network. Using funds from this source, Leicestershire and Rutland Sport is working with its partners in schools and clubs to develop new opportunities for sport and physical activity. This will be targeted at youngsters who may have some interest in sport, but aren't particularly engaged with community or club sport. Their annual target is to achieve 7000 5 - 19 years olds attending at least 6 out of 10 sport and physical activity sessions.

b) Activity to address adult obesity/physical activity

For adults, the 'Active Together' programme has been developed through the Leicestershire Local Area Agreement and continues to make good progress towards very challenging targets to increase the number of adults (aged 16 years plus) participating in at least 30 minutes of moderate physical activity on three or more days of the week.

c) Exercise referral scheme

The exercise referral scheme is a well established programme run by all the district councils in Leicestershire, funded jointly by each council and NHS LCR. The programme provides tailored support for patients with health conditions that would benefit from increased physical activity. Patients can be referred onto the programme by their GP or other health professionals.

Following a Public Health Department review of the programme in 2009, a number of potential improvements in the programme were identified. It was noted that all districts ran the scheme in a slightly different manner and public access to the scheme varied widely across the county. A two year development programme was then produced in consultation with district co-ordinators, supported by a small increase in funding for the period 2009-11.

The two-year development programme aims to increase both the quality of the programme and the number of patients using the scheme.

Recent activities include:

- The appointment of a new co-ordinator within the Community Health Services health improvement team
- An audit of district based qualified instructors and the subsequent funding of new instructor training to increase numbers across all districts
- Standardising of systems and paperwork across all districts to reduce administration costs and improve monitoring and data collection
- The development of a core programme of activities offered within each district, starting with 'Natural England' Healthy Walking schemes in 2010-11.

Recommendations for the future

Create and sustain a wide range of physical activity opportunities to ensure every adult has the opportunity to take part in at least 30 minutes of physical activity at least 5 days a week

Develop and sustain a comprehensive physical activity referral programme targeting 'high risk' individuals/groups whose health will benefit from taking part in physical activity

Promotion of 'life course' approach – ensuring good infant feeding and nutrition during pregnancy and working with adolescents towards healthy physical development of future mothers

Promote initiation and support continuation of breastfeeding

Develop Healthy Early Years programme to encourage healthy eating and energetic play in all early years settings

Increase number of workplace and school travel plans

Provide universal community based weight management services for children and adults

Support 2012 Olympic legacy opportunities to increase physical activity

Encourage workplaces to promote healthy eating and physical activity with public sector acting as exemplar

7.3 Substance misuse including alcohol and illicit drugs

This section covers the misuse of substances, specifically alcohol and illicit drugs such as cannabis, opiates and amphetamines. Substance misuse harms the health of individuals, contributes to health inequalities and impacts on society, for example through crime and disorder, road traffic accidents and productivity in the workplace. The financial costs of substance misuse, particularly alcohol, are substantial. Working with other organisations to reducing the harm and costs related to substance misuse is a priority for the NHS LCR.

Drug and Alcohol Action Teams (DAAT) for NHS LCR were established to commission and then oversee the provision of drug services. In conjunction with the DAATs, the PCT and Local Authorities also commission alcohol provision across the two counties.

Background - Alcohol

Alcohol is an important part of British culture with many people enjoying alcohol as part of family life and social occasions. However, excessive alcohol consumption amongst individuals and some sections of the population is a cause for concern shared by both public sector organisations and members of society.

Excessive alcohol consumption increases a person's risk of ill health and the harm that this causes is entirely preventable. As well as the extreme harm that results in alcoholic liver disease and associated conditions, excess alcohol consumption increases the risk of hypertension and cardiovascular disease and has wider social impacts including domestic violence, mental illness and sexually transmitted infections.

Reducing the levels of alcohol consumption in our population will reduce the burden on primary, secondary and community care and will have a direct impact on life expectancy and health inequalities.

- Across NHS LCR there are an estimated 96,286 binge drinkers, 111,960 hazardous drinkers and 22,952 harmful drinkers
- The harm caused by alcohol is entirely preventable and it is estimated that every £1 spent on alcohol treatment could release £5 to the public sector
- In 2008/09, there were 10,962 hospital admissions attributable to alcohol in LCR, an admission rate of 1,319 admissions per 100,000 population
- Alcohol attributable admission rates in LCR almost doubled between 2002/03 and 2008/09
- It is essential that there are effective services in place to prevent the harm caused by alcohol within the population and that resources are protected and targeted towards greatest need and effective interventions.
- The actions to reduce the harm caused by alcohol require a co-ordinated effort across a wide partnership of public and community sector agencies

Current activity to address need - alcohol

The current approach centres on three main strands:

1. Raising awareness of alcohol related harm (including reducing binge drinking)

2. Improve access to treatment for alcohol dependency

3. Partnership working to improve outcomes and release resources by joining up commissioning arrangements for both drugs and alcohol and re-commission substance misuse services

- Increased provision of alcohol-related advice, screening, simple brief interventions and referral through a local enhanced service with GPs (piloted in 2009, rolling out in 2010).
- Recruitment of three whole time equivalent community-based alcohol workers to provide assessment and treatment services. Posts will be operational by the end of 2010.
- Specialist alcohol nurses in the emergency department at University Hospitals Leicester to assess patients admitted with alcohol problems and deliver brief interventions. Additional posts will be operational by end of 2010.
- The 'System Change' pilot project aims to co-ordinate cross agency work across the sub-region, in order to improve outcomes and patient experience and increase efficiency by delivering a fully integrated end to end treatment service. Joint working will be facilitated by pooled budget and host commissioning arrangements.
- The Total Place programme aims to reduce alcohol-related harm through more effective working across organisational barriers. Implemented in 2010, the programme aims to:

  - Reduce substance related crime

  - Reduce substance misuse related ill health and premature death

  - Reduce costs by optimising cost efficiency of all interventions and services delivery

Background - drugs

The Leicestershire Drug and Alcohol Action Team is responsible for overseeing the delivery of the National Drugs Strategy within Leicestershire. They also work closely with the neighbouring DAATs in Leicester City and Rutland as they share a number of drugs service providers and strategic partners across the sub region.

Drug misuse is a complex issue which can affect not just individuals, but their families, friends, communities and society. Effective treatment is important for tackling the harm that drugs can cause. It offers individuals the opportunity to manage their addiction and get on the road to recovery, and gives communities a break from drug-related crime and antisocial behaviour.

There is a strong positive association between the prevalence of problematic drug users aged 15 – 64 years and the level of socio-economic deprivation. There is similar social gradient in admission rates for drug specific conditions.

- For every £1 spent on drug treatment there is a saving of £9.50 to society as a whole
- 99 per cent of drug users are receiving treatment within three weeks of being assessed
- Drug misuse in LCR is lower than that seen nationally (9.9 per 1000 population).

The DAATs lead on the commissioning and performance monitoring of drug treatment services across NHS LCR. Their aim is to ensure that services are available, accessible and appropriate to meet the needs of drug users locally, so that they may have the opportunity to rebuild their lives, and reintegrate with their families and communities.

In 2009, the NHS LCR DAATs began a review of current drug and alcohol service provision across the two counties. The outcome of the review was to re-commission an integrated substance misuse treatment system that reflected current needs and priorities. Following consultation with partner organisations, clients and public, the new service will commence from July 2011.

Current activity – drugs

- There has been a considerable decrease over time in the number of service users recorded as currently injecting drugs. There were 19 per cent injecting in 2009/10 versus 28 per cent the previous year.
- Treatment Outcomes Profile (TOP) was developed by the National Treatment Agency (NTA) and has been used since 2007. TOP helps commissioners to monitor performance and make improvements where necessary in the local treatment system, encouraging an emphasis on the outcomes of treatment.
- NHS LCR DAAT has recorded good improvements in TOP performance, with all DAAT commissioned services currently achieving the NTA required target of 80 per cent compliance in all areas.
- There were 1,353 adults recorded in effective drug treatment in Leicestershire as of Q1 2010/11, which is stable from the previous quarter and exceeding the target of 1,254.

Recommendations for the future

NHS LCR and partners to commission a more integrated system for drug and alcohol treatment, in line with the outcomes of the current service review and redesign

The new substance misuse service, which will commence in July 2011 needs to guarantee access across the counties to the range of provisions in the treatment system

NHS LCR and partners to work towards a fairer share of resources between drug and alcohol services, following a historical focus on illicit drug use that has not reflected population need or impact on society

Increase the capacity of open access extended brief interventions for alcohol, which are likely to be more cost effective than specialist treatment and will provide early advice and treatment to current hazardous and harmful drinkers (currently these services are provided in Loughborough and Coalville only)

Moving towards a treatment system that supports recovery, abstinence and social integration, with broad outcomes including improved quality of life, housing and employment status

Informed by annual needs assessment, NHS LCR and DAATs to continue to address the under-representation of certain groups within the treatment system, including BME communities, and ensure that services are accessible and responsive to their needs

7.4 Sexual health

Background

The consequences of poor sexual health can have a long lasting and severe impact on peoples' lives. Poor sexual health can lead to unintended pregnancies and abortions, high teenage pregnancy rates, poor psychological consequences and sexually transmitted infections (STI).

Illnesses include HIV, pelvic inflammatory disease (which can cause ectopic pregnancies and infertility), cervical and other genital cancers, hepatitis, chronic liver disease and liver cancer [48]. There are links between social deprivation and poor sexual health with unequal distribution of sexual ill health across the population. The greatest burden is borne by young adults, women, gay men and minority ethnic groups. Reducing these inequalities is very important. Similarly, the links between teenage pregnancy and particular socio-economic groups are well established.

The government has set the following targets:

- Chlamydia screening available across England with 35 per cent of 15-24 year olds taking up a screen in 2010/11
- Maintain access to GUM clinic within 48 hours of contacting a service
- Reduce under 18 conception rate by 2010

There is also a national drive to improve access to the full range of contraceptive choices.

Prevalence and local picture

Since 2000, Chlamydia has become the most commonly diagnosed STI locally, as for England.

HIV prevalence in England is increasing as a result of both rising numbers of HIV diagnoses and decreasing HIV related deaths since the introduction of effective combination anti-retroviral therapy. HIV continues to be one of the most important communicable diseases in the UK. It is an infection associated with serious morbidity, high costs of treatment and care, significant mortality and high number of potential years of life lost. Highly active antiretroviral therapies have resulted in substantial reductions in AIDS incidence and deaths in the UK [48]. There was a total of 235 HIV positive residents seeking treatment in 2009, a 69 per cent increase from 2005. As HIV now tends to be a chronic disease, the number of residents seeking treatment will continue to steadily increase. Early diagnosis and treatment are important in improving health outcomes and reducing onwards transmission [48].

Teenage conception rates in NHS LCR (31.2 per 1,000 females age 15-17) are significantly below the England average of 40.4. However it is unlikely that the 2010 national target is met. (45% reduction by 2010 from the1998 baseline.)

We are falling short of meeting the recommended target of 70 per cent of all NHS funded abortions within 9 weeks of gestation. In 2008, 66.7 per cent of all NHS funded abortions were under 10 weeks gestation. This is an improvement on 2007 but is still 5.5 per cent lower than the national average.

GP prescribing of long-acting reversible contraception is significantly higher than England. In 2008/09 the rate was 49.7 per 1000 females aged 15-44, 8.3 per cent above the national rate.

Current activity to address need

Patients from NHS LCR access a significant proportion of their genitor-urinary medicine (GUM) services from UHL clinic and a smaller proportion from Loughborough hospital clinic. Both clinics maintained high levels of access within 48 hours from March 2008.

- Contraceptive services are available from a range of providers including community contraceptive services (often called family planning), general practice, young people's community sexual health services and pharmacies. Different providers offer different levels of service. Action to improve service quality and accessibility through improved.
- A range of voluntary sector projects undertake sexual health and HIV prevention work focusing on priority groups.

Achievements

- In 2009/10 we screened 21,498 people aged 15-24 for Chlamydia as part of the Chlamydia screening programme (23 per cent of the population) [48].
- Research has been undertaken to better understand the knowledge and attitudes of young people in relation to contraceptive choices.

- Training has been delivered to a range of practitioners to increase provision of long-acting reversible contraception and to increase awareness of contraceptive choice and where it is available.

Recommendations for the future

Maintain access to GUM clinic within 48 hours of contacting a service

Develop integrated model of delivery of sexual health services

Chlamydia screening: target resources available at those most at risk to ensure we identify as many positive cases as possible

Ensure all patients with a positive diagnosis of Chlamydia (and their sexual partners) receive adequate treatment

Improve appropriate access to abortion services and contraceptive services

Improve sex and relationship education

8.0 PROVIDING EFFECTIVE TREATMENT AND CARE

Improve early detection, intervention and treatment of major illnesses

Improving access to effective treatment including prevention

Aims:

- Reduce risk through targeted effective health improvement programmes
- Improve early detection, intervention and treatment of major illnesses
- Improving access to effective treatment including prevention

Evidence suggests that the most effective way to reduce the gap in life expectancy in the short term is to improve the management of CVD and its risk factors - especially smoking (which is also the main risk factor for lung cancer and chronic obstructive pulmonary disease), high blood pressure, raised cholesterol levels and diabetes

8.1 Cardiovascular disease (CVD) including ischaemic heart disease, heart failure and stroke

Background

A particular challenge for us is the need to reduce inequality in CVD outcomes and variability in service provision across NHS LCR. Variability in CVD mortality accounts for more than half of the health inequality seen. Though the significant variation in the quality of CVD care in the primary setting does not systematically relate to the level of deprivation, there is a broader challenge for addressing quality issues including targeting those practices in areas of deprivation. It is now possible to use the extensive data on population health need now available as part of social marketing and Association of Public Health Observatory tools to model the gap between expected and observed prevalence of CVD indicators in primary care.

In April 2009 a comprehensive analysis and benchmarking exercise identified the following issues that we should focus on to have greatest impact on CVD mortality:

- The recorded prevalence for all major CVD groups is less than those of respected estimates eg for hypertension only 57 per cent of patients are currently on disease registers.
- In primary care, certain drugs including beta blockers which show significant benefit in a variety of CVD conditions are not always prescribed for eligible patients.
- Appropriate treatment pathways, such as referral to the Transient Ischemic Attack (TIA) one stop clinic, are not always followed.
- 'Time to thrombolysis' remains a major issue in acute myocardial infarction.
- The per centage of patients who receive a scan within 24 hours of having a stroke remains low.
- Lack of clarity persists over the configuration of thrombolysis and acute stroke services in the area.

- Stroke re-admission rates are high compared to the national and SHA average.
- There is a need to further develop community based heart failure support services.
- Rehabilitation services for stroke, ischaemic heart disease and heart failure are at sub-optimum levels

Current activity to address need

The key elements of our CVD commissioning strategy are:

- Supporting healthier lifestyles.
- Strengthening treatment pathways to tackle vascular risk, for example hypertension, arterial fibrillation and high cholesterol to ensure that our CVD risk is mitigated.

The NHS Health Checks Programme is a key initiative around primary prevention and was introduced in December 2009. It involves inviting patients who are estimated to be at the highest risk of developing CVD within the next ten years. In quarter one of 2010/11, 850 patients were screened of whom 700 were identified as being high risk. These patients have all now been offered advice, support and medication where necessary, to help modify their overall risk factor. We commissioned 12,000 checks to be carried out in 2010/11.

A statin prescribing incentive scheme (statins lower blood cholesterol and lipid levels thereby reducing the risk of developing ischaemic heart disease) has also been launched to ensure that good practice is followed and this links with the NHS Health Checks Programme and monitored on a quarterly basis.

We are also working with our acute provider to relocate and streamline local stroke pathways. This has included moving the stroke unit and TIA clinic on to the same site as Accident and Emergency at Leicester Royal Infirmary in August 2010. Other developments include strengthened treatment pathways for hyper acute and acute stroke as well as access to the TIA one stop clinic.

Heart and stroke services

More than 300 people responded to engagement work carried out in December to gather views on existing heart and stroke services.

People gave their views through questionnaires that looked at issues around transport, specialist care and communications.

There were expectations of a rapid response from the emergency services with on-site diagnosis and initial treatment. People expected the paramedics to be trained and knowledgeable and wanted the views of carers and relatives to be considered.

Article taken from Healthy Times, Spring 10, Issue 4, page 10

Recommendations for the future

Improve the management of CVD and its risk factors (especially in primary care) using:

Risk stratification methods to identify patients at increased risk of vascular disease including heart attack or stroke

Systematic control of blood pressure, cholesterol in people at increased risk of heart disease

Co-ordinated approach between public health, primary care and quality and medical directorates to address performance of GPs in relation to secondary prevention of CVD-includes 'balanced scorecards'

Quality and Outcomes Framework (QOF) data to enhance prevalence reporting - comparison of QOF scores against deprivation, systematic review of disease registers

Clarification as to the level of 'exemptions' from the QOF system. Patients not currently achieving target levels of control will often be those with the most vulnerability and complexity and therefore at most risk of premature mortality. Therefore the exemptions should be reviewed by the PCT and further action taken to reduce levels if appropriate

Local incentives to raise the ceiling of achievement on clinical outcomes beyond those in the national QOF programme

Performance monitoring of local enhanced services that are already in place for smoking, NHS health checks and diabetes

Further develop the role of Medicines Management in CVD secondary prevention

Commission cardiac rehabilitation services for all who need it

Further redesign of stroke care pathway to improve health outcomes including commissioning a redesigned rehabilitation pathway of care, incorporating a community pathway

Increased the numbers of eligible patients receiving thrombolytic treatment

8.2 Diabetes

Background

Diabetes is a chronic and progressive disease that impacts upon almost every aspect of life. It can affect infants, children, young people and adults of all ages, and is becoming more common. Around 1.3 million people are currently diagnosed with diabetes and in addition, many hundreds of thousands of people in England have type II diabetes without knowing it.

People from Asian, African or Caribbean origins (particularly women) are three to five times more likely to develop diabetes than are people from a European background. Asians are more likely than Europeans to develop diabetes with comparatively small increases in BMI [49].

Obesity is closely associated with type II diabetes. Therefore the burden of ill health caused

by the rising prevalence of diabetes falls disproportionately on the poor (who are more likely to be obese) and those from ethnic minorities.

In England 26,300 deaths between the ages of 20 and 79 years in 2005 can be attributed to diabetes. This equates to 11.6 per cent of all deaths in this age group.

In NHS LCR recorded prevalence is similar to national and regional levels of around 4.7 per cent, 25,687 people.

- Prevalence of diabetes is projected to rise to around 6.3 per cent in 2025, the equivalent of 46,840 people in Leicestershire county and Rutland.
- In Leicestershire county and Rutland, there were 291 excess deaths among people with diabetes aged between 20 and 79 in 2005 – around 10 per cent of all deaths in this age group.

Current activity to address need

Our plans to improve the risks associated with diabetes are linked with empowering patients and helping improve their ability to self manage. Three areas will be concentrated on as a priority:

- Implementation of a diabetes strategy for our population
- Development of services within general practice including staff education, patient education, insulin and management of complex patients
- Increased capacity for the delivery of the DESMOND programme, a structured patient education programme for people with type II diabetes

Recommendations for the future

Strengthened capacity for early detection and optimum treatment of diabetes including:

Better identification and management of patients with impaired glucose tolerance

Improved community-based care for people with diabetes

Enabling GPs to start and manage insulin therapy for patients with diabetes, as appropriate

Strengthened support for self-care for people with diabetes

Development of registers to facilitate appropriate intervention

Commissioning and procurement of a fully integrated Community Diabetes Service

Implementation of the HI NSTI ‘high impact’ changes on diabetes

8.3 Cancer

Background

The relationship between deprivation and cancer is complex and multifaceted. Certain types of cancer – such as lung, mouth and oesophagus – are more common in the most deprived groups. For other types of cancer – such as breast and prostate – death rates are higher among the most deprived despite the fact that incidence rates are lower [50].

Much of the inequality in cancer outcomes relate to higher smoking prevalence among the most deprived populations. Smoking is the biggest single preventable risk factor for cancer, and it disproportionately affects those already disadvantaged by poverty. It is less well known that a poor diet is the second largest risk factor for cancer. Increasing fruit and vegetable consumption is the second most effective strategy to reduce the risk of cancer, after reducing smoking [51].

Inequalities in cancer can relate to different areas such as genetics, information and awareness, lifestyle, screening and treatment. These factors, either individually or through interaction with each other, contribute to the different cancer incidence and outcomes experienced by different socio-economic groups.

Research has shown that the following communities and groups experience inequalities in cancer either through increased incidence or poorer access to treatment:

- those from lower socioeconomic groups
- BME communities
- those with mental illness
- those with learning disabilities
- those with physical disabilities
- rural communities
- lesbian, gay, bisexual and transgender communities
- older people
- men
- those from certain religions or with particular religious beliefs

Figure 9: Variations in cancer mortality rates for all ages by quintile of deprivation [52]

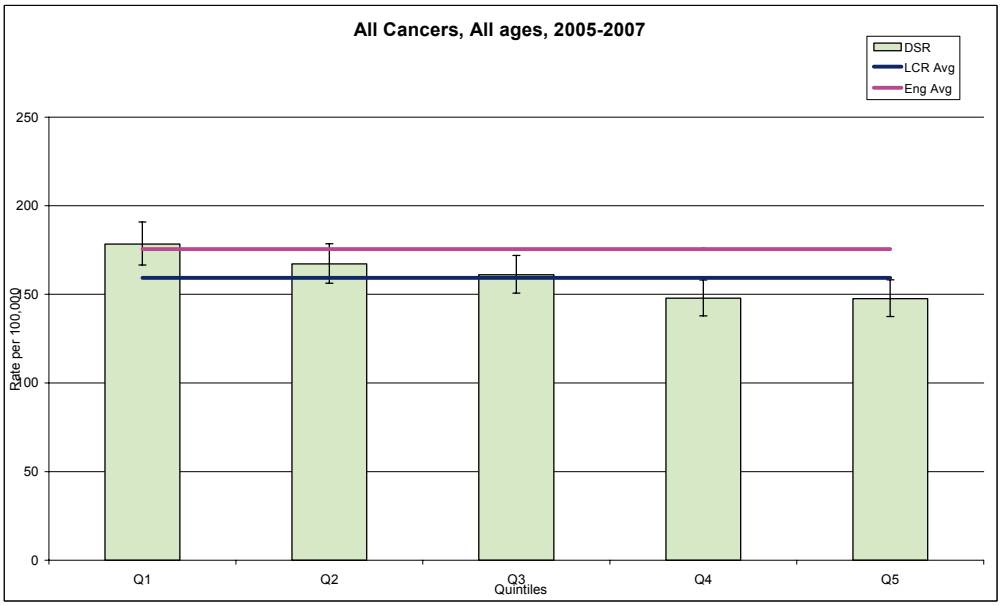


Figure 9 illustrates the differential premature mortality rates experienced by quintile of deprivation. Quintile splits the population into fifths according to the level of deprivation, quintile 1 is the most deprived and quintile 5 is the least deprived. People in the most deprived areas of are over 30 per cent more likely to die prematurely from cancer than people living in the least deprived areas.

Current activity to address need and achievements

- Development of cancer health equity audit and needs assessment in 2010 leading to targeted action
- Strong GP leadership resulted in a high uptake of national primary care cancer audit in 2010. The findings and recommendations have resulted in improvements in primary care aimed at increasing earlier diagnosis of cancer. Going beyond the original focus of the national audit, practices were also asked to provide NHS numbers with patient data to facilitate linking findings to deprivation
- Year on year improvements in uptake of cancer screening: cervical, breast and bowel cancer screening programmes being expanded in line with national policy
- Pacesetters funding secured to establish project to improve early symptom awareness and understanding of bowel cancer screening in BME population in Charnwood/NW Leicestershire
- £100,000 grant secured from the National Awareness and Early Diagnosis Initiative for the improvement of outcomes in bowel cancer in deprived and disadvantaged communities
- Macmillan dietetic project

Cancer talk draws crowd

Members turned out in force to find out more about women's cancers at an event held in January.

The talk was part of our 'Community Medicine for Members' events; a series of bi-monthly discussions on different health topics, giving members a chance to learn more from experts and to ask questions.

Held on 25 January at the Pavilion, in Huncote, Leicester, the talk was attended by more than 30 people, including some men, who learned how to check properly for breast lumps, what symptoms to look out for with ovarian cancer and why it is so important to have smear tests.

Andrea Clark, NHS Leicestershire County and Rutland's head of engagement and involvement, said: "I am delighted that so many people chose to find out more about cancers – including breast cancer, which can affect men too.

"Health awareness is very important and through our membership scheme we are determined to lead Leicestershire and Rutland to become the healthiest place in the UK."

Article taken from Healthy Times, Spring 10, Issue 4, page 10

Recommendations for the future

Improve the early detection (including screening) and subsequent treatment of cancer:

Increasing awareness of symptoms and signs, and supporting earlier presentation and diagnosis, building on the findings of the GP audit, Pacesetters and National Awareness and Early Diagnosis Initiative projects

Implement recommendations of Regional Support Team visit to help expand screening for cancer and improve uptake and ensure patients with cancer receive optimum treatment:

Develop of an overarching cancer plan to use for managing progress. The plan should be based on the Cancer Reform Strategy Framework.

Identify a local cancer team in order to both develop the plan and take it forward, with agreed frequency of reporting, through the governance system

Establish clear lines of engagement with the Cancer Network and the Cancer Registry including regular sharing of board and other reports

Continuously review commissioning arrangements for cancer services to ensure services match need

Share the Health Needs Assessment and the Health Equity Audits already undertaken with clinical colleagues and user groups to ensure their experience of the system is able to influence the approach being developed

Consider how best to take advantage of all information from user groups and NHS LCR to enable cancer servicers to be more sensitive to the communities and the geography of the area

Develop local plans to deliver home based chemotherapy services

- Implement HI NST high impact changes on cancer
- Continue quarterly surveillance of cancer screening uptake rates and, if uptake falls, action taken to address this.

8.4 Chronic Obstructive Pulmonary Disease (COPD)

Background

COPD is heavily associated with smoking and is therefore a key contributor to health inequality in the local population.

- Estimated prevalence of COPD in LCR is 14,244 people or 2.6 per cent. There is a gap of around 6,000 undiagnosed patients (just over 1 per cent of the population)
- The estimated prevalence is predicted to rise to 2.9 per cent by 2025 (15,865 people)
- Between 2004 and 2006 there were 644 deaths from COPD. 31 per cent of these were premature (ie under 75 year olds).
- Admission rates are at a level approaching the national norm.

Current activity to address need

NHS LCR is in the process of developing a network for COPD called MnGED clinical network. This is happening alongside a new pathway of care that has been co-produced with clinicians spanning acute, community and primary care based services. The model of care is changing to an integrated community based service from 2010. The service will engage primary care in the more proactive identification and management of COPD patients and support practices with tools and education to deliver care closer to home. Pulmonary rehabilitation is an important element of this pathway and is part of the Practice Based Commissioning (PBC) Improvement Scheme. This also incorporates work to improve the recording of COPD, and to improve the use of spirometry. Other elements include the use of medicines management monitoring and self management/education of patients in order to ensure appropriate referral for pulmonary rehabilitation.

These initiatives are helping identify new pathways to help reduce hospital admissions for COPD. The overall vision for care is to reduce hospital attendances by:

- Early disease identification and stratification
- Promotion of patient self management including better access to psychological support
- Ensuring quality of spirometry
- Using community facilities both inpatient and outpatient

- Extending pulmonary/cardio rehab in the community
- Developing end of life strategies to keep people at home

The work streams that fall under the strategy are as follows:

- Oxygen services
- Development of community services
- PBC COPD Improvement Scheme
- Hospital services
- End of life

Achievements

- The roll out of pulmonary rehabilitation delivered in the community. This is much valued by patients and functional outcomes are similar to those achieved in the hospital setting. The numbers of referrals are not as high as might be anticipated and further work is taking place to publicise the service and potential benefits to patients.
- The development of the Practice Based Commissioning (PBC) COPD Improvement Scheme (CIS) which delivers:
- Targeted screening to identify those with COPD who do not yet have a diagnosis
- A structured review for all existing patents with COPD
- A small educational grant to be spent on either training or equipment

In order to participate in the CIS, practices were required to become accredited to provide spirometry. Initially only 30 per cent were performing quality assured spirometry but this is now 100 per cent of practices in the scheme.

Recommendations for the future

To consolidate the gains of the CIS and to build on that. The PBC scheme, which is currently optional needs to be made an integral part of the CIS

Practice re-accreditation needs to be developed and maintained every one or two years

Develop a community infrastructure to facilitate early discharge and avoid unnecessary admissions

Fill educational and skills gap to optimise care in the community

Rationalise prescribing

Tele-health solutions need to be developed including re establishment of a dedicated COPD help line manned for 16 hours per day

9.0 ADDRESSING THE UNDERLYING (WIDER) DETERMINANTS OF HEALTH

The Acheson inquiry report [35] emphasised the need for effective interventions to address the wider influences on health inequalities. Again this was forcibly reinforced in the Marmot Review [12].

Government departments need to continue to contribute to addressing these determinants, such as improving educational attainment and tackling low basic skills, improving the quality of poor housing, improving the accessibility, punctuality, reliability and use of local transport, tackling unemployment and inactivity, and improving access to social and community facilities and services.

9.1 Poverty

Background

The link between poverty and adverse health outcomes is indisputable [53]. The poorest of the poor, around the world, have the worst health. Those at the bottom of the distribution of global and national wealth, those marginalized and excluded within countries, and countries themselves disadvantaged by historical exploitation and persistent inequity in global institutions of power and policy-making present an urgent moral and practical focus for action. But focusing on those with the least, on the 'gap' between the poorest and the rest, is only a partial response. In fact the relation between socioeconomic level and health is graded. People in the second highest quintile have higher mortality in their offspring than those in the highest quintile. This is called the social gradient in health [54].

Current activity to address need

As societies become wealthier, the levels of income and resources that are considered adequate also increase. The proportion of the UK population living in poverty remains above the European Union average [12].

The index of multiple deprivation (IMD) (which covers a number of socio-economic issues) shows Leicestershire county and Rutland to be one the most affluent regions, ranking 146 out of 152 [where 1 = most deprived, 152 = least deprived] [38]. However this affluence is not uniformly distributed, with areas such as North-West Leicestershire being affected by higher levels of deprivation than other areas.

Figure 10: IMD Map for Leicestershire and Rutland [55]

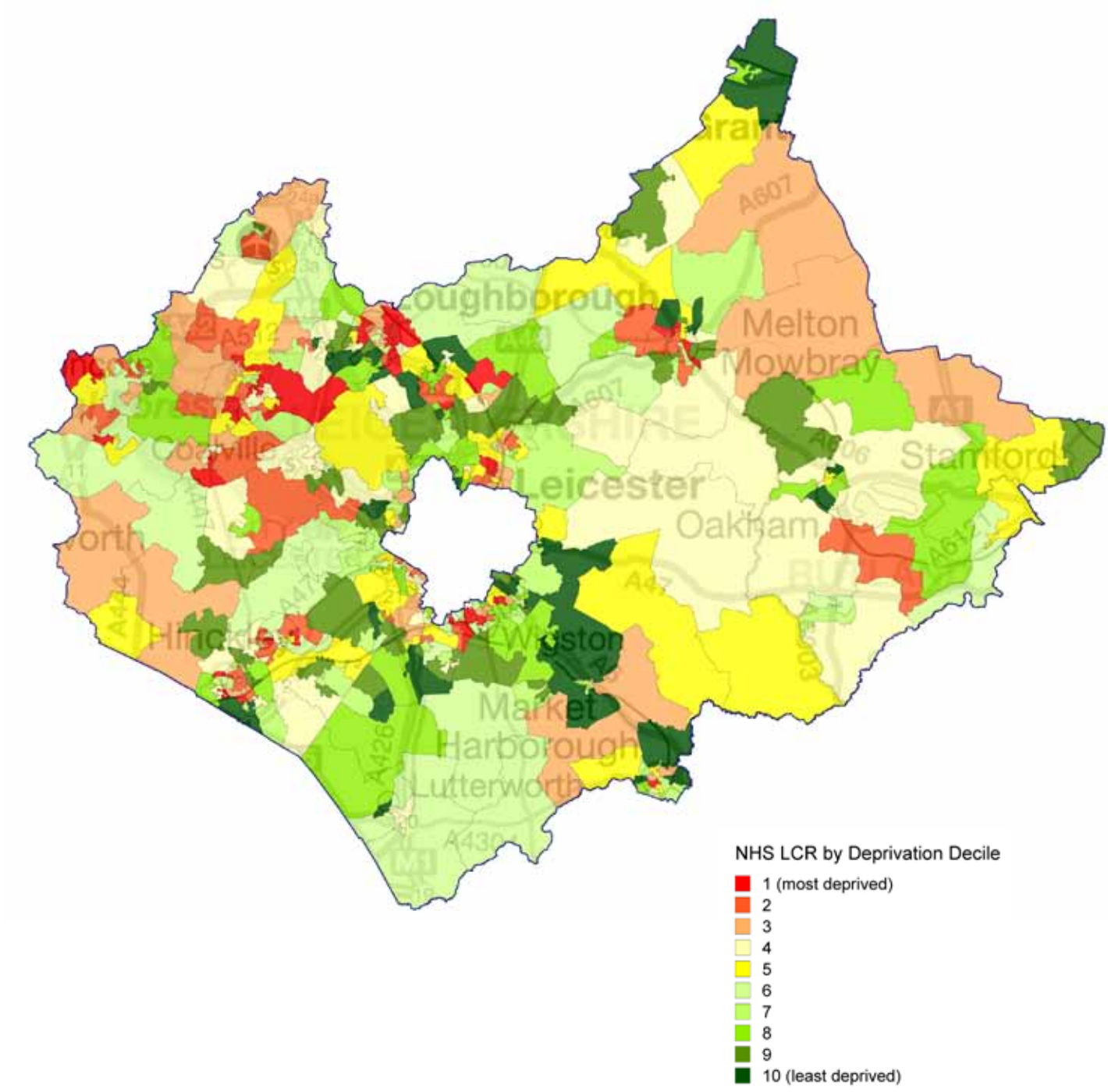


Figure 10 above highlights the top 10 per cent of most deprived neighbourhoods (in purple) and the least deprived neighbourhoods (in green). The most deprived areas are predominantly urban areas. When looking at all the districts in England (354 in total) the IMD 2007 shows that the difference between the most deprived district (within LCR), North West Leicestershire, and the least deprived, Harborough, is 125 places (down from 140). This is a sizable gap.

We know that tackling poverty will reduce health inequalities. Although LCR is one of the wealthier regions, health inequalities remain present. The 'First Contact Scheme' is being rolled out across Leicestershire and Rutland and enables residents aged 60 or over who contact police, fire and rescue service, east midlands housing association, district councils and other partner organisations to be referred to a single point of contact for various services including help with fuel poverty and other benefits advice [56].

Other advice available through First Contact includes advice on falls prevention, home safety and security advice – fitting of free smoke detectors and security devices, housing advice, repairs and adaptations, advice on living a healthier lifestyle, information on groups and activities.

It is clear that the NHS and partners could do more to help address the impact of poverty through signposting patients in relation to finances eg debt and benefits advice.

Recommendations for the future

Use every opportunity to signpost eligible families and individuals to advice on managing debt and how to access appropriate benefits.

Consider employing benefits, debt and jobs advisers in NHS settings including primary care.

9.2 Education

Background

The Marmot review [12] re-confirmed the previously identified strong correlation between poor health and lack of educational attainment. Educational qualifications determine what opportunities a person can have access to within the working world. Poor education may affect housing, income and other material resources [35]. This will lead to an overall poorer quality of life.

According to the Marmot Review [12] children from disadvantaged backgrounds are more likely to begin primary school with lower personal, social and emotional development and communication, language and literacy skills than their peers. These children are also at significantly increased risk of developing conduct disorders that could lead to difficulties in all areas of their lives, including educational attainment, relationships and longer-term mental health. There are clear socioeconomic gradients in all these factors.

Current activity to address need

The task of improving education skills and training in Leicestershire rests principally with the local authority. We will work with the local authority via the Children's and Young People Board.

Recommendations for the future

Collaborate with local agencies to help deliver higher educational, training and skills levels

Collaborate with local agencies to help deliver greater employment opportunities

Consider employing benefits and jobs advisers in NHS settings including primary care

9.3 Housing

Background

There is a need to manage urban development to ensure greater availability of affordable housing [53]. The latest Leicestershire JSNA [69] noted that there is an extensive housing need within the county due to problems with affordability of houses. These problems have arisen due to high property prices and housing costs and are currently affecting most parts of the UK.

In the UK in 2008, 7.4 million homes (around 33 per cent) were non-decent, including 4.8 million homes with potentially serious hazards under the housing health and safety rating system. The majority of homes in poorer neighbourhoods tend to be non-decent [58]. Leicestershire has identified the need to look at the condition and suitability of properties occupied by vulnerable people.

Poor quality housing is associated with health problems. The link between housing and health may run both ways – with housing affecting an individual's health and their health impacting on their housing opportunities [58]. Damp homes have poorer average health, with strong associations found between damp and higher prevalence of respiratory disorders [58].

Be healthy… Stay warm and well this winter

Each year there are an estimated 30,000 additional deaths in winter linked to the cold weather – and more than half are the over 65s.

Excess winter deaths are defined by the Office of National Statistics as the difference between the number of deaths during the four winter months (December to March) and the average number of deaths during the preceding autumn (August to November) and the following summer (April to July). In 2007/8 there were more than 2000 excess winter deaths in the East Midlands.

Although it is unusual for exposure to the cold to directly kill people, it can have a major impact on those with respiratory (breathing) or cardiovascular (heart) conditions. Overall, deaths are from heart attacks, strokes, bronchial and other conditions, and may often occur several days after exposure to the cold.

Spending too long in the cold will lower body temperature which can often aggravate circulatory diseases, which can lead to strokes and heart attacks or respiratory illnesses such as bronchitis or pneumonia.

Dr Tim Davies, deputy director of public health at NHS Leicestershire County and Rutland, said: "Older people with existing health problems are more at risk, so they need to take extra care when it is cold. Older people are less able to judge if they are warm or cold, meaning they may not put on an extra jumper or put on the heating before they get too cold. Many older people tend to live in older houses with inefficient heating systems and/or no insulation. This makes it harder to heat their homes.

"Older people will often try to cut their energy bills by reducing the amount of heating they use and many fail to take advantage of their winter payment which aims to cover the increased heating costs.

"We know that older people on low incomes spend up to 30 per cent less on food than is needed for a healthy balanced diet. This could make them more vulnerable to the cold.

"We can all do our bit by helping to spread the message to older neighbours, friends and family and help them prepare and stay warm and well this winter."

Tips for keeping warm and well

It is essential that you keep warm during the winter. You can do this by:

- dressing appropriately
- keeping active
- eating good meals
- if possible, do not switch off the heating to save on fuel bills, ensure you get your winter fuel payment if you are eligible

The Department of Health's *Keep Warm Keep Well* booklet is packed with advice on how to stay healthy this winter. You can download it direct at **www.lcr.nhs.uk**

Alternatively you can download Age Concern's top tips to keep warm this winter at **www.ageconcern.org.uk** or call their information line on 0800 00 99 66.

Articles taken from Healthy Times, Spring 10, Issue 4, page 10

Affordable housing includes social rented housing and should be provided for households whose needs could not otherwise be met by the current housing market (due to financial constraints). With current supply levels, approximately 2,700 more affordable housing units will be needed each year in LCR. Extra provision will also be needed to cater for older persons, people with learning disabilities and those with mental health problems

Current activity to address need

Local housing strategies have identified a number of issues concerning the housing needs of vulnerable people relating to the standard of accommodation, higher demand for adaptations in the private sector, lack of move accommodation and tenancy support, and the increasing need for smaller housing units for and an increase in low level care for older people.

'Improved life chances for vulnerable people and places' is one of the seven themes of the Leicestershire Sustainable Community Strategy [59].

Recommendations for the future

Reduce the number of severely overcrowded families on housing register

Improve the energy efficiency and warmth of properties of vulnerable people eg through referral for affordable warmth grants

Increase the number of decent homes in the private sector

Work to ensure all local authority and private homes meet the Decent Homes standard

9.4 Employment

Background

Employment plays a crucial role in society. People are often defined, and define themselves, through what they do for a living [35]. Having good employment is protective of health and conversely, unemployment contributes to poor health [12]. Poor employment is associated with generally poorer mental and physical health.

Unemployment tends to be highest amongst groups where opportunities are more limited – people with few skills/qualifications, people with disabilities and ill health, minority groups, lone parents, older workers and young people [57]. When these groups do gain access to employment, it is usually jobs of a lower pay and quality.

Current activity to address need

Leicestershire has a relatively successful economy. Wage levels are higher than the national average, with relatively low unemployment. In March 2009, 79.5 per cent of Leicestershire's working age population were in employment (national average = 74 per cent) [57]. However, significant numbers of people in LCR are either unemployed or unable to work because of disability. Being out of work results in increased mortality and morbidity, financial problems, distress, anxiety and depression and change in health behaviours. There are also impacts on subsequent generations.

People on long term incapacity benefit/employment and support allowance (IB/ESA) have two to three times the average levels of both morbidity and mortality. The number of people with 'minor mental health' problems ending up on long term benefits is increasing. It is estimated that 40 per cent of people who end up on incapacity benefit could have been prevented if they had an earlier resolution of their (often non medical) problem. These people often end up as the patents that GPs feel they cannot help.

Projects such as the "fit for work" scheme (currently being rolled out) aim to reduce the amount of time that people spend away from work due to health reasons. Collaborations such as this where both local businesses and primary care are involved aim to limit the impacts of health on employment, and the subsequent impacts of lack of employment on health.

What is the Fit for Work Service?

Leicestershire Fit for Work Service is a new service that enables people who are on or at risk of long term sickness absence to remain in employment. It offers individual personalised case managed support and interventions enabling employed people to overcome barriers and remain in work.

The service is part of the governments £13 million national programme to support the Work and Wellbeing services jointly funded by the Department of Health and Department of Work and Pensions. The scheme in Leicester and Leicestershire is a partnership between the two local authorities, two PCTs and Job Centre Plus in Leicester City and Leicestershire and is one of 11 national pilots aimed at retaining people with health problems in work.

Who is eligible for the FFWS?

To be eligible for the Fit For Work Service the client must be:

- Employed or self-employed

- Signed off sick from work by their GP, or at risk of long-term sickness absence

- Registered with a GP surgery in Leicester City or Leicestershire County

How is the service accessed?

The service takes referrals from GPs and practice therapists. Clients are contacted by the service within 24 hours of referral to arrange their first appointment with their case manager.

What support can the Fit For Work Service offer?

Support is tailored to the individuals needs. In addition to one to one case management, the service has dedicated occupational health advisors and a GP, and access to services such as musculoskeletal therapies, psychological therapies, debt management advice, legal advice, career counselling, and employer liaison and mediation.

Case Study

Jane (not her real name), a thirty one year old female had been off sick for five months with depression. She is employed as a learning support assistant at a Special School dealing with four year old children. A diagnosis of chronic fatigue syndrome was mooted. She has needed mid morning sleeps due to feeling tired after four hours of work. She often felt the need to have to sleep during the day time. She has also had high levels of sickness absence due to 'stomach bugs' and infections. She was keen to go back to work but on a phased return, which was being denied by the head teacher. Jane had already been in touch with Unison and a meeting has been arranged.

After referral to the Fit For Work scheme, Jane was directed to the occupational health advisor within the Fit For Work Service for an assessment. The occupational health advisor suspected chronic fatigue syndrome (yet to be confirmed and clarified). Jane is now back to work on a phased return (8.45am – 12.45pm five days a week) with a view of going back full-time at the beginning of the next school term. Jane is very happy with the Fit For Work Service and commented that the case manager and the occupational health advisor were very helpful. She is 'amazed' how quickly her issues have been dealt with and resolved. She has already made other positive improvements to her life eg she has now enrolled at her local swimming baths and is going for long walks including making herself walk up hills. She is also taking positive steps to stop smoking. As she is being more active, she is no longer sleeping during the day time. She appears buoyant, positive and happy.

Recommendations for the future

Collaborate with local agencies to help deliver greater employment opportunities

Build on the success of Fit For Work to reduce the risk of long term sickness absence from work

9.5 Transport

Background

Transport facilitates access to jobs, education, markets, leisure and other services as well as playing a vital role in the economy [35]. Leicestershire currently has excellent transport links with access to the M1 and M6 and well as high speed trains to London running through it.

Public transport must continue to improve, becoming more available to those who are more are more likely to have limited access women, children, minority groups, older people.

Current activity to address need

With the growing impact of climate change on the environment, Leicestershire County Council's (LCC) Environment and Transport department is currently developing a 15-year Local Transport Plan (LTP3).This plan sets out aims of allowing the transport network to support economic growth whilst limiting its impact on the environment [60].

Recommendations for the future

Develop a NHS LCR transport policy and provide input into Health Impact Assessments in relation to transport

Work to create opportunities that allow and encourage walking and cycling as methods of transport. These will reduce the burden of car traffic whilst having a positive impact on the health of the population. This can only be done by collaborating with local government and other agencies

10.0 HEALTH PROTECTION

Background

We work closely with East Midlands Health Protection Agency (HPA), South Division to protect the local population against microbiological, chemical, physical and radiation threats. The HPA has two types of work - proactive and reactive.

Proactive work is about preventing health incidents from happening, such as:

- Working with health partners to provide effective immunisation programmes
- Helping prevent healthcare associated infections eg MRSA and Clostridium Difficile
- Advising immigration authorities on travel related health issues

Reactive work involves minimising the risk to the general public once an incident happens and includes:

- Advising on how to stop infectious diseases such as meningitis, hepatitis or measles from spreading
- Carrying out risk assessments to find out how outbreaks occurred, and recommending ways to prevent them happening again
- Tracing people who may have come into contact with, or be carrying an infectious disease or be contaminated with chemicals or radiation
- Compiling statistics on notifiable diseases eg mumps and measles.

Achievements

- Development of NHS LCR childhood immunisation action plan
- Uptake of the first and second doses of the MMR vaccine by five years of age was amongst the highest in the country in 2008/09 but need to be improved further to reach the World Health Organization's target of 95 per cent and keep the rate of measles cases low [61].
- Uptake of all three doses of the HPV (Human Papillomavirus) vaccine in girls aged 12-13 years in LCR was amongst the highest in the country in 2008/09. This vaccine is offered to reduce the risk of acquiring the virus, which can cause cervical cancer [61].
- The rate of people living with HIV in LCR in 2007 was lower than the national average. This may be a reflection of the local population, which may have a low per centage of people in at risk groups, such as men who have sex with men and people who have recently emigrated from countries with high rates of HIV [63].

10.1 Flu Campaign

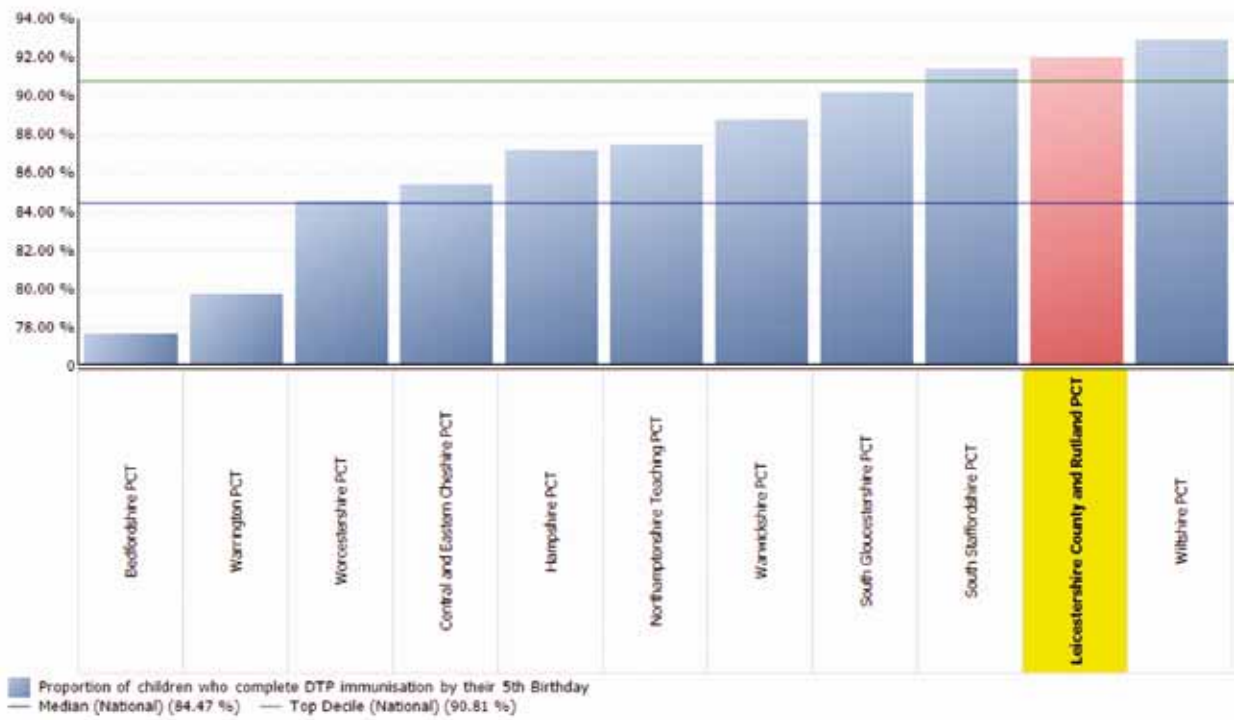
In 2009 we dealt with the swine flu pandemic. The response by NHS LCR and partners proved extremely effective. At a debrief session in January 2010 many areas of good practice were noted including the commitment and flexibility of staff in delivering new tasks and roles at short notice, good communications to staff and to primary care and rapid availability of appropriate IT solutions. The lessons learnt will be used to help us to further refine our plans for any future flu pandemics and indeed other major emergencies.

An update on this learning was presented to the NHS LCR trust board in September 2010 and this helped take account of national, regional and local targets across the local health economy and to ensure that appropriate governance, statutory and regulatory frameworks are in place. [33]

10.2 Immunisation Targets

2008/09 Immunisations – NHS LCR had 89 per cent eligible children immunised against MMR by second birthday [65] – This ranks NHS LCR as the best out of the nine PCTs in East Midlands. This placed us in the top 'decile' nationally i.e. in the top 10 per cent nationally (out of 150 PCTs): Uptake of Diphtheria, Tetanus and Pertussis (DTP) immunisation by 5th birthday is well above the national average as shown in Figure 11.

Figure 11: Proportion of children who complete DTP immunisation by their 5th Birthday [66]



What are we doing in LCR to further improve uptake of childhood immunisations?

Whilst we have above average performance for childhood immunisations we have aspirational targets to achieve even higher rates. To support us with this we have:

- Established a programme of work with GP practices in which we send them their individual performance data each month and this includes information on children that need to be contacted by the practice
- The practices with poorest performance are visited and supported
- Immunisation conference held in June 2010 with 170 delegates from primary care across LLR. Speakers from National Support Team, HPA and PCTs. Good practice guidance is being produced as a result.
- Work is ongoing to assess whether there are waiting lists for immunisation in general practices
- Development of a communications strategy for children's immunisations - articles in Leicestershire Matters and membership newsletters about immunisation
- Specific childhood immunisations page on our website with links from many local councils and GPs website
- Advert being commissioned for television in antenatal clinics at UHL promoting the importance of immunisation. Message is in English and Punjabi

- Further media releases planned for specific times of year eg July for pre-school booster
- HPV routine to Year 8 girls – HPV vaccine is given over an academic year (each girl needs three doses over six months). Dose three performance was 91 per cent against 50 per cent target
- The HPV catch up for years 10 and 11 means we have gone for an accelerated schedule for the year 8s in order to get them completed this academic year

10.3 Notification data

Under Health Protection legislation, the HPA is informed (notified) of cases of infection. The table in Appendix 2 shows the notification data for NHS LCR and compares it with the figures for Leicestershire, Northamptonshire and Rutland as well as data for the East Midlands. The table shows infections that have been reported to the HPA.

Doctors report when they suspect that a patient may have an infection. So for example there are far more cases of measles (i.e. 49 cases) reported and only 12 tested positive. Similarly with mumps, 352 cases were reported and 92 tested positive. This is appropriate and for surveillance purposes it is important that infections are reported without confirmation to enable investigation and public health management at an early stage.

In summary, LCR experiences fewer infections than in the East Midlands generally. For example there are fewer cases of TB in the counties compared with Leicester city or other areas of the East Midlands. Infections such as Cryptosporium, Giardia and Escherichia coli 0157 that are commonly found in rural areas are not significantly higher in LCR compared to the rest of East Midlands.

11.0 KEY CHALLENGES FOR 2010/11

11.1 Financial context zero growth

NHS LCR commissions and provides services for the population of LCR to the value of approximately £850m. We hold contracts ranging from small grants to £271m with our main acute provider University Hospitals of Leicester (UHL).

In the medium term, we will face unprecedented pressure on NHS finances due to a number of factors:

- The impact of increasing demands on expenditure from ageing populations
- The increase in diseases associated with alcohol, obesity and smoking
- Higher levels of public expectation and choice
- The continued introduction of new technology and treatments

From 2011/12 we anticipate NHS resources will remain static. As a result, along with other public services, the NHS is planning for 'worst case' or 'zero growth' conditions and will need to become much more efficient and productive if we are to continue to deliver high quality preventive and treatment care. We are working to achieve this through our plans for Quality, Innovation, Productivity, and Prevention (QIPP). NHS LCR has led the LLR health economy in taking a leading edge collaborative approach to financial planning and helped to embed QIPP into consolidated local NHS plans

11.2 Ongoing impact of financial downturn

Economic recessions are likely to disproportionately impact on those who are already the poorest in society [67]. There is a real danger that the current financial downturn will widen health inequalities. This reinforces the pressing importance of collective actions to reduce health inequalities identified in this report.

11.3 NHS organisational changes

In July 2010 the government set out its new strategy for the NHS in 'Equity and Excellence: Liberating the NHS' [74]. This document outlined the government's plans to create a more responsive, patient-centred NHS, which achieves outcomes that are among the best in the world. There are fundamental changes proposed to the structure of the NHS: There will be a new, integrated public health service to protect and improve the nation's health and wellbeing and which will be located in the local authority. Meanwhile, PCTs will be abolished and GPs will become the principal commissioners of healthcare in England.

The details are still being worked through but it is expected that the new Public Health Service (PHS) will be a professional, unified and efficient service with a clear mission to achieve measurable improvements in public health outcomes; and provide effective protection from public health threats by:

- Protecting people from infectious disease and biological, chemical and radiological threats
- Helping people and families to be able to take care of their own health and wellbeing through clear and evidence-based advice and support

- Inspiring, challenging and commissioning partners from all sectors, at both national and local levels, to help people, families and communities to protect and improve their health and wellbeing, and by rewarding communities for improving outcomes at local level
- Upholding excellence in all public health practices, by commissioning, disseminating and using the best research and evaluation, and encouraging innovation.

The Department of Health are currently developing the Public Health White Paper which will set out a new approach to public health, this will be published in December 2010.

From 2013-2014, GPs will be responsible for commissioning most of health care services needed by patients locally. It is vitally important that funding for both primary care and community health services are distributed equitably across NHS LCR. GPs as commissioners will also need to recognise and acknowledge the role they can play in influencing the wider/social determinants of health. As we have shown earlier social determinants of health play a huge role in determining whether an individual will enjoy good health or not. Many of these factors have traditionally been felt to lie outside the direct responsibility of health services. However GPs can and should influence these factors where possible both in their clinical dealings with patients and through their role as commissioners of services.

12 SUMMARY

In this year's director of public health's annual report I decided to focus on the health inequalities challenges facing NHS LCR and partners and on how we can surmount these challenges in the next five years. I acknowledge the particular demands this will present at a time of rapid change in the local health and social care landscape and against a backdrop of the economic downturn and associated public sector cuts.

Although people in Leicestershire and Rutland continue to benefit from improvement in their overall health status, not everyone is able to share in these improvements. We know that significant health inequalities remain. The gap in premature mortality between the most and least deprived is widening and areas with high mortality rates also experience higher levels of illness including mental illness and poor health as a result of cardiovascular disease respiratory disease and cancer.

We also know that health inequalities continue as a symptom of underlying socio-economic inequalities and these inequalities are unacceptable. Many of the factors that underly health inequalities are deeply rooted in society and may take many years to change. Such factors have an influence from very early in life and persist not only into old age but into subsequent generations. Others factors are more amenable to change in the short term.

The causes of health inequalities are predominately social, economic, cultural and political and we must develop solutions that themselves are social, economic, cultural and political. Equally I acknowledge the importance of ensuring that the NHS and partners must work to guarantee that socially excluded people can access the quality health and social care they need.

There are currently many local initiatives to deliver reductions in health inequalities within Leicestershire and Rutland. It is important to recognise that tackling health inequalities is everyone's business and the role of multi–agency partnership action is vital. A visit from the Regional Support Team for Tackling Health Inequalities (RST HI) to NHS LCR and partners in July 2010 endorsed this view in recommending that across the PCT and within wider partnerships *'there needs to be recognition that …* ***health inequalities are everyone's business'***

Therefore, activity must be co-ordinated across traditional boundaries, and we must continue to work in partnership with front-line health and local authority staff, voluntary, community and business sectors, as well as service users. A 'one size doesn't fit all' approach will not work. National standards will need to be used to support a mix of local services to meet a diversity of local need.

In my role as joint director of public health for NHS Leicestershire county and Rutland, Leicestershire County Council and Rutland County Council, I recognise that the role of local government in tackling health inequalities remains pivotal. Local government understands the wider needs of its citizens (beyond healthcare) and provides leadership and the structures within which citizens can make their voices heard. Local government is also responsible for many of the services that will address the wider influences on health inequalities including housing, environment, schools, crime and disorder, and regeneration.

NHS LCR already works closely with partner organisations through the Leicestershire Together Partnership. In tackling health inequalities, the totality of the local NHS (primary care, community services and secondary care) will need to continue to work through partnerships using the Local Strategic Partnerships at both district and county levels and directly with local voluntary sector/third sector and private organisations. This focus must not be lost in the radical NHS re-organisation that lies ahead.

This annual report borrows heavily from the Leicestershire Together Health Inequalities Strategy and Action Plan [2]. The strategy and plan provide a broad framework to facilitate change across the partnership by identifying the priorities, delivery mechanisms and actions that are needed to reduce health inequalities in LCR over the next five years.

The recommendations in this report and in the Leicestershire Together Health Inequalities Strategy and Action Plan present a major challenge in the prevailing financial environment and in the organisational turbulence that lies ahead both in health and social care. Nevertheless we need to be aspirational. We must set ourselves targets hat stretch us if we are to achieve the reduction in health inequalities that we strive for and that are should be the right of the people of Leicestershire and Rutland.

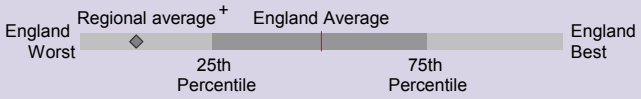
Dr Peter Marks
Joint Director of Public Health Leicestershire and Rutland

Health summary for Leicestershire

31

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated



+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	7542	1.2	19.9	89.2		0.0
	2 Children in poverty	12900	10.9	22.4	66.5		6.0
	3 Statutory homelessness	327	1.35	2.48	9.37		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	3888	52.6	50.9	32.1		76.1
	5 Violent crime	8566	13.4	16.4	36.6		4.8
	6 Carbon emissions	4770	7.4	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	863	13.0	14.6	33.5		3.8
	8 Breast feeding initiation	4872	72.6	72.5	39.7		92.7
	9 Physically active children	40186	46.7	49.6	24.6		79.1
	10 Obese children	526	8.9	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.1	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	391	32.0	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	20.6	22.2	35.2		10.2
	14 Binge drinking adults	n/a	18.5	20.1	33.2		4.6
	15 Healthy eating adults	n/a	30.4	28.7	18.3		48.1
	16 Physically active adults	n/a	12.9	11.2	5.4		16.6
	17 Obese adults	n/a	24.6	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	78	12.0	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	6562	16.4	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	10420	1330	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	26782	4.15	4.30	6.72		2.69
	23 New cases of tuberculosis	52	8	15	110		0
	24 Hip fracture in over-65s	597	433.6	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	240	13.6	15.6	26.3		2.3
	26 Life expectancy - male	n/a	79.3	77.9	73.6		84.3
	27 Life expectancy - female	n/a	82.8	82.0	78.8		88.9
	28 Infant deaths	33	4.82	4.84	8.67		1.08
	29 Deaths from smoking	838	166.5	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	451	61.2	74.8	125.0		40.1
	31 Early deaths: cancer	727	100.3	114.0	164.3		70.5
	32 Road injuries and deaths	274	42.7	51.3	167.0		14.6

ndicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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Health summary for Rutland

00FP

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

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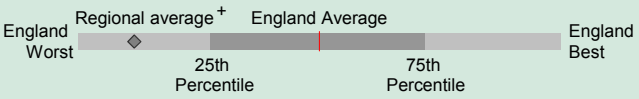

+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Children in poverty	475	6.6	22.4	66.5		6.0
	3 Statutory homelessness	22	1.47	2.48	9.37		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	276	58.2	50.9	32.1		76.1
	5 Violent crime	326	8.5	16.4	36.6		4.8
	6 Carbon emissions	467	12.2	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	45	13.0	14.6	33.5		3.8
	8 Breast feeding initiation	253	72.6	72.5	39.7		92.7
	9 Physically active children	1707	38.1	49.6	24.6		79.1
	10 Obese children	22	7.2	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	0.7	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	19	15.2	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	16.2	22.2	35.2		10.2
	14 Binge drinking adults	n/a	18.8	20.1	33.2		4.6
	15 Healthy eating adults	n/a	30.9	28.7	18.3		48.1
	16 Physically active adults	n/a	15.5	11.2	5.4		16.6
	17 Obese adults	n/a	20.2	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	9	21.5	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	232	10.2	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	539	1130	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	1382	3.53	4.30	6.72		2.69
	23 New cases of tuberculosis	n/a	n/a	15	110		0
	24 Hip fracture in over-65s	47	462.0	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	12	11.9	15.6	26.3		2.3
	26 Life expectancy - male	n/a	80.1	77.9	73.6		84.3
	27 Life expectancy - female	n/a	84.5	82.0	78.8		88.9
	28 Infant deaths	1	3.62	4.84	8.67		1.08
	29 Deaths from smoking	43	125.7	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	20	40.1	74.8	125.0		40.1
	31 Early deaths: cancer	37	83.2	114.0	164.3		70.5
	32 Road injuries and deaths	26	68.6	51.3	167.0		14.6

ndicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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Health summary for Blaby

31UB

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

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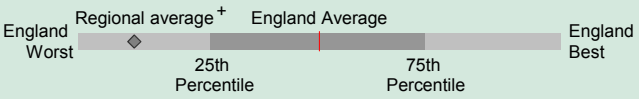

+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Children in poverty	1376	7.8	22.4	66.5		6.0
	3 Statutory homelessness	n/a	n/a	2.48	9.37		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	191	49.4	50.9	32.1		76.1
	5 Violent crime	850	9.1	16.4	36.6		4.8
	6 Carbon emissions	551	5.9	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	131	13.0	14.6	33.5		3.8
	8 Breast feeding initiation	741	72.6	72.5	39.7		92.7
	9 Physically active children	4171	45.0	49.6	24.6		79.1
	10 Obese children	98	9.7	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.0	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	54	31.1	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	20.5	22.2	35.2		10.2
	14 Binge drinking adults	n/a	15.9	20.1	33.2		4.6
	15 Healthy eating adults	n/a	27.8	28.7	18.3		48.1
	16 Physically active adults	n/a	12.5	11.2	5.4		16.6
	17 Obese adults	n/a	25.1	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	12	12.3	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	802	14.1	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1630	1450	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	3890	4.16	4.30	6.72		2.69
	23 New cases of tuberculosis	10	11	15	110		0
	24 Hip fracture in over-65s	72	350.6	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	45	19.6	15.6	26.3		2.3
	26 Life expectancy - male	n/a	79.9	77.9	73.6		84.3
	27 Life expectancy - female	n/a	83.5	82.0	78.8		88.9
	28 Infant deaths	6	5.73	4.84	8.67		1.08
	29 Deaths from smoking	113	157.7	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	60	55.1	74.8	125.0		40.1
	31 Early deaths: cancer	110	103.1	114.0	164.3		70.5
	32 Road injuries and deaths	30	31.9	51.3	167.0		14.6

ndicator Notes

I % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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Health summary for Charnwood

31UC

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

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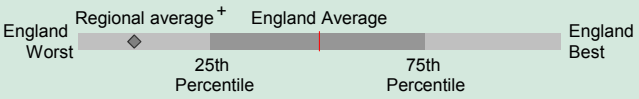


+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	4464	2.8	19.9	89.2		0.0
	2 Children in poverty	3808	13.4	22.4	66.5		6.0
	3 Statutory homelessness	105	1.57	2.48	9.37		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	972	48.3	50.9	32.1		76.1
	5 Violent crime	2835	17.2	16.4	36.6		4.8
	6 Carbon emissions	1175	7.1	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	220	13.0	14.6	33.5		3.8
	8 Breast feeding initiation	1244	72.6	72.5	39.7		92.7
	9 Physically active children	9407	43.8	49.6	24.6		79.1
	10 Obese children	113	9.4	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.2	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	82	26.7	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	19.9	22.2	35.2		10.2
	14 Binge drinking adults	n/a	19.1	20.1	33.2		4.6
	15 Healthy eating adults	n/a	30.4	28.7	18.3		48.1
	16 Physically active adults	n/a	13.2	11.2	5.4		16.6
	17 Obese adults	n/a	24.5	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	15	9.9	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	1862	17.1	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	2643	1390	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	7043	4.21	4.30	6.72		2.69
	23 New cases of tuberculosis	18	11	15	110		0
	24 Hip fracture in over-65s	142	440.8	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	55	12.9	15.6	26.3		2.3
	26 Life expectancy - male	n/a	79.0	77.9	73.6		84.3
	27 Life expectancy - female	n/a	82.8	82.0	78.8		88.9
	28 Infant deaths	10	5.85	4.84	8.67		1.08
	29 Deaths from smoking	200	169.9	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	111	64.7	74.8	125.0		40.1
	31 Early deaths: cancer	171	100.2	114.0	164.3		70.5
	32 Road injuries and deaths	51	31.1	51.3	167.0		14.6

ndicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

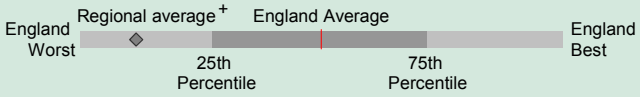
More indicator information is available in The Indicator Guide: www.healthprofiles.info For information on your area contact your regional PHO: www.apho.org.uk

Health summary for Harborough

31UD

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated



+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Children in poverty	1173	7.3	22.4	66.5		6.0
	3 Statutory homelessness	13	0.39	2.48	9.37		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	650	61.7	50.9	32.1		76.1
	5 Violent crime	699	8.5	16.4	36.6		4.8
	6 Carbon emissions	595	7.2	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	103	13.0	14.6	33.5		3.8
	8 Breast feeding initiation	584	72.6	72.5	39.7		92.7
	9 Physically active children	5774	49.1	49.6	24.6		79.1
	10 Obese children	61	7.6	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.0	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	35	21.8	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	18.0	22.2	35.2		10.2
	14 Binge drinking adults	n/a	18.8	20.1	33.2		4.6
	15 Healthy eating adults	n/a	33.8	28.7	18.3		48.1
	16 Physically active adults	n/a	12.5	11.2	5.4		16.6
	17 Obese adults	n/a	22.1	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	12	12.7	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	625	12.7	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1141	1100	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	2935	3.54	4.30	6.72		2.69
	23 New cases of tuberculosis	5	6	15	110		0
	24 Hip fracture in over-65s	70	380.6	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	7	3.0	15.6	26.3		2.3
	26 Life expectancy - male	n/a	80.1	77.9	73.6		84.3
	27 Life expectancy - female	n/a	83.7	82.0	78.8		88.9
	28 Infant deaths	3	3.50	4.84	8.67		1.08
	29 Deaths from smoking	95	140.6	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	49	49.0	74.8	125.0		40.1
	31 Early deaths: cancer	93	96.0	114.0	164.3		70.5
	32 Road injuries and deaths	50	60.8	51.3	167.0		14.6

Indicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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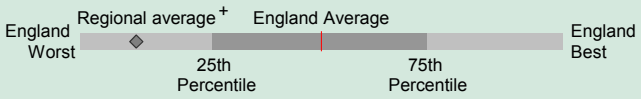
Health summary for Hinckley and Bosworth

31UE

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated



+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Children in poverty	1981	10.5	22.4	66.5		6.0
	3 Statutory homelessness	73	1.61	2.48	9.37		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	797	52.8	50.9	32.1		76.1
	5 Violent crime	1322	12.7	16.4	36.6		4.8
	6 Carbon emissions	689	6.6	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	138	13.0	14.6	33.5		3.8
	8 Breast feeding initiation	779	72.6	72.5	39.7		92.7
	9 Physically active children	7699	51.3	49.6	24.6		79.1
	10 Obese children	89	9.4	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.2	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	77	40.1	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	22.0	22.2	35.2		10.2
	14 Binge drinking adults	n/a	19.4	20.1	33.2		4.6
	15 Healthy eating adults	n/a	30.6	28.7	18.3		48.1
	16 Physically active adults	n/a	13.1	11.2	5.4		16.6
	17 Obese adults	n/a	26.0	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	15	14.4	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	1168	18.0	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1650	1260	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	4433	4.21	4.30	6.72		2.69
	23 New cases of tuberculosis	4	4	15	110		0
	24 Hip fracture in over-65s	90	399.3	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	41	13.9	15.6	26.3		2.3
	26 Life expectancy - male	n/a	79.6	77.9	73.6		84.3
	27 Life expectancy - female	n/a	82.9	82.0	78.8		88.9
	28 Infant deaths	5	4.63	4.84	8.67		1.08
	29 Deaths from smoking	144	170.4	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	72	57.5	74.8	125.0		40.1
	31 Early deaths: cancer	119	95.6	114.0	164.3		70.5
	32 Road injuries and deaths	42	40.5	51.3	167.0		14.6

ndicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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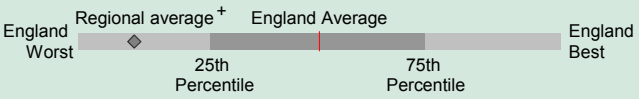
Health summary for Melton

31UG

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated



+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Children in poverty	961	10.4	22.4	66.5		6.0
	3 Statutory homelessness	61	2.85	2.48	9.37		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	272	54.4	50.9	32.1		76.1
	5 Violent crime	661	13.4	16.4	36.6		4.8
	6 Carbon emissions	419	8.5	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	67	13.0	14.6	33.5		3.8
	8 Breast feeding initiation	378	72.6	72.5	39.7		92.7
	9 Physically active children	3476	56.9	49.6	24.6		79.1
	10 Obese children	40	8.8	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	0.9	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	30	33.3	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	21.5	22.2	35.2		10.2
	14 Binge drinking adults	n/a	16.9	20.1	33.2		4.6
	15 Healthy eating adults	n/a	32.8	28.7	18.3		48.1
	16 Physically active adults	n/a	13.4	11.2	5.4		16.6
	17 Obese adults	n/a	24.1	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	6	11.9	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	365	12.2	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	615	985	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	1995	4.05	4.30	6.72		2.69
	23 New cases of tuberculosis	3	5	15	110		0
	24 Hip fracture in over-65s	41	356.3	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	36	25.4	15.6	26.3		2.3
	26 Life expectancy - male	n/a	79.2	77.9	73.6		84.3
	27 Life expectancy - female	n/a	82.5	82.0	78.8		88.9
	28 Infant deaths	2	3.87	4.84	8.67		1.08
	29 Deaths from smoking	69	168.3	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	33	56.4	74.8	125.0		40.1
	31 Early deaths: cancer	62	106.4	114.0	164.3		70.5
	32 Road injuries and deaths	32	64.4	51.3	167.0		14.6

ndicator Notes

I % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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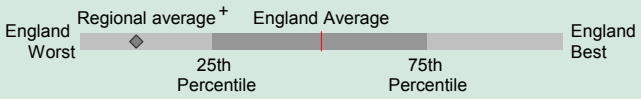
Health summary for North West Leicestershire

31UH

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated



+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	3078	3.5	19.9	89.2		0.0
	2 Children in poverty	2388	13.7	22.4	66.5		6.0
	3 Statutory homelessness	47	1.29	2.48	9.37		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	468	50.4	50.9	32.1		76.1
	5 Violent crime	1450	16.0	16.4	36.6		4.8
	6 Carbon emissions	1055	11.7	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	134	13.0	14.6	33.5		3.8
	8 Breast feeding initiation	759	72.6	72.5	39.7		92.7
	9 Physically active children	5153	43.9	49.6	24.6		79.1
	10 Obese children	78	8.5	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.0	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	72	42.2	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	23.4	22.2	35.2		10.2
	14 Binge drinking adults	n/a	21.5	20.1	33.2		4.6
	15 Healthy eating adults	n/a	29.8	28.7	18.3		48.1
	16 Physically active adults	n/a	14.9	11.2	5.4		16.6
	17 Obese adults	n/a	24.9	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	12	12.6	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	1152	20.8	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1629	1480	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	3883	4.28	4.30	6.72		2.69
	23 New cases of tuberculosis	4	5	15	110		0
	24 Hip fracture in over-65s	115	596.3	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	30	11.0	15.6	26.3		2.3
	26 Life expectancy - male	n/a	77.9	77.9	73.6		84.3
	27 Life expectancy - female	n/a	81.9	82.0	78.8		88.9
	28 Infant deaths	5	4.82	4.84	8.67		1.08
	29 Deaths from smoking	136	191.7	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	87	83.8	74.8	125.0		40.1
	31 Early deaths: cancer	109	105.5	114.0	164.3		70.5
	32 Road injuries and deaths	60	66.4	51.3	167.0		14.6

ndicator Notes

1 % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

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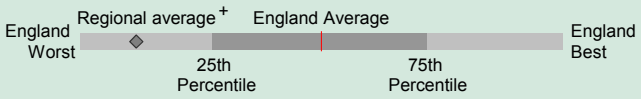
Health summary for Oadby and Wigston

31UJ

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the red line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated



+ In the South East Region this represents the Strategic Health Authority average

Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	0	0.0	19.9	89.2		0.0
	2 Children in poverty	1212	11.4	22.4	66.5		6.0
	3 Statutory homelessness			2.48	9.37		0.00
	4 GCSE achieved (5A*-C inc. Eng & Maths)	538	53.9	50.9	32.1		76.1
	5 Violent crime	749	13.2	16.4	36.6		4.8
	6 Carbon emissions	287	5.0	6.8	14.4		4.1
Children's and young people's health	7 Smoking in pregnancy	69	13.0	14.6	33.5		3.8
	8 Breast feeding initiation	387	72.6	72.5	39.7		92.7
	9 Physically active children	4506	41.9	49.6	24.6		79.1
	10 Obese children	47	8.5	9.6	14.7		4.7
	11 Tooth decay in children aged 5 years	n/a	1.2	1.1	2.5		0.2
	12 Teenage pregnancy (under 18)	41	32.5	40.9	74.8		14.9
Adults' health and lifestyle	13 Adults who smoke	n/a	18.7	22.2	35.2		10.2
	14 Binge drinking adults	n/a	15.6	20.1	33.2		4.6
	15 Healthy eating adults	n/a	28.7	28.7	18.3		48.1
	16 Physically active adults	n/a	8.6	11.2	5.4		16.6
	17 Obese adults	n/a	25.2	24.2	32.8		13.2
Disease and poor health	18 Incidence of malignant melanoma	6	10.4	12.6	27.3		3.7
	19 Incapacity benefits for mental illness	588	16.9	27.6	58.5		9.0
	20 Hospital stays for alcohol related harm	1112	1620	1580	2860		784
	21 Drug misuse						
	22 People diagnosed with diabetes	2603	4.55	4.30	6.72		2.69
	23 New cases of tuberculosis	9	15	15	110		0
	24 Hip fracture in over-65s	67	517.3	479.2	643.5		273.6
Life expectancy and causes of death	25 Excess winter deaths	26	15.3	15.6	26.3		2.3
	26 Life expectancy - male	n/a	79.9	77.9	73.6		84.3
	27 Life expectancy - female	n/a	82.5	82.0	78.8		88.9
	28 Infant deaths	2	3.14	4.84	8.67		1.08
	29 Deaths from smoking	81	160.7	206.8	360.3		118.7
	30 Early deaths: heart disease & stroke	38	56.7	74.8	125.0		40.1
	31 Early deaths: cancer	64	99.0	114.0	164.3		70.5
	32 Road injuries and deaths	9	15.3	51.3	167.0		14.6

ndicator Notes

I % of people in this area living in 20% most deprived areas of England 2007 2 % of children living in families receiving means-tested benefits 2007 3 Crude rate per 1,000 households 2008/09 4 % at Key Stage 4 2008/09 5 Recorded violence against the person crimes crude rate per 1,000 population 2008/09 6 Total end user CO_2 emissions per capita (tonnes CO_2 per resident) 2007 7 % of mothers smoking in pregnancy where status is known 2008/09 8 % of mothers initiating breast feeding where status is known 2008/09 9 % of year 1-13 pupils who spend at least 3 hours per week on high quality PE and school sport 2008/09 10 % of school children in reception year 2008/09 11 Weighted mean number of teeth per 5 yr old child sampled that were actively decayed, missing or filled 2007/08 12 Under-18 conception rate per 1,000 females aged 15-17 (crude rate) 2006-2008 (provisional) 13 % adults, modelled estimate using Health Survey for England 2006-2008 14 % adults, modelled estimate using Health Survey for England 2007-2008 15 % adults, modelled estimate using Health Survey for England 2006-2008 16 % aged 16+ 2008/09 17 % adults, modelled estimate using Health Survey for England 2006-2008 18 Directly age standardised rate per 100,000 population under 75 2004-2006 19 Crude rate per 1,000 working age population 2008 20 Directly age and sex standardised rate per 100,000 population 2008/09 (rounded) 21 New Problematic Drug User estimates were not available in time for inclusion 22 % of people on GP registers with a recorded diagnosis of diabetes 2008/09 23 Crude rate per 100,000 population 2006-2008 24 Directly age-standardised rate per 100,000 population for emergency admission 2008/09 25 Ratio of excess winter deaths (observed winter deaths minus expected deaths based on non-winter deaths) to average non-winter deaths 1.08.05- 31.07.08 26 At birth, 2006-2008 27 At birth, 2006-2008 28 Rate per 1,000 live births 2006-2008 29 Per 100,000 population age 35+, directly age standardised rate 2006-2008 30 Directly age standardised rate per 100,000 population under 75, 2006-2008 31 Directly age standardised rate per 100,000 population under 75, 2006-2008 32 Rate per 100,000 population 2006-2008

More indicator information is available in The Indicator Guide: www.healthprofiles.info For information on your area contact your regional PHO: www.apho.org.uk

Appendix 2

2009	NHS LCR Counties PCT		Leicestershire, Northamptonshire & Rutland		East Midlands - PROVISIONAL 2009 figures	
Disease Notifications	Number	Rate per 100,000	Number	Rate per 100,000	Number	Rate per 100,000
Campylobacter	628	91.7	1584	95.1	4414	99.6
Cryptosporidium	90	13.1	188	11.3	473	10.7
E.Coli O157	18	2.6	28	1.7	73	1.6
Food Poisoning	26	3.8	57	3.4	Not comparable	
Gastroenteritis	1	0.1	4	0.2		
Giardia	84	12.3	129	7.7	261	5.9
Hepatitis A	2	0.3	9	0.5	16	0.4
Hepatitis B	26	3.8	115	6.9	270	6.1
Hepatitis C	57	8.3	149	9.0	320	7.2
Hepatitis E	0	0.0	3	0.2	48	1.1
Legionella	3	0.4	7	0.4	31	0.7
Listeria	1	0.1	6	0.4	15	0.3
Malaria	3	0.4	10	0.6	25	0.6
Measles	49	7.2	107	6.4	347	7.8
Meningococcal Disease	23	3.4	53	3.2	136	3.1
Mumps	352	51.4	809	48.6	1915	43.2
Norovirus	81	11.8	145	8.7		
Para-typhoid	1	0.1	6	0.4	14	0.3
Pertussis	50	7.3	57	3.4	122	2.8
Rotavirus	13	1.9	109	6.5		
Rubella	26	3.8	50	3.0	120	2.7
Salmonella	68	9.9	225	13.5	567	12.8
Scarlet Fever	35	5.1	109	6.5	258	5.8
Shigella	9	1.3	22	1.3	42	0.9
Tuberculosis	49	7.2	342	20.5	549	12.4
Typhoid	0	0.0	7	0.4	14	0.3

Rates calculated using ONS mid-2008 population estimates

This table contains both laboratory confirmed cases and notifications based on suspicion of disease. This data is taken from a combination of local and national systems. Please note this information is provisional and may be subject to change.

Glossary of Terms

A&E	Accident and Emergency
AIDS	Acquired immune deficiency syndrome
APHO	Association of Public Health Observatories
BME	Black and Minority Ethnic
BMI	Body Mass Index
CAMHS	Child and Adolescent Mental Health
CD	Council District
CHD	Coronary Heart Disease
CIS	COPD Improvement Scheme
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular Disease
DAAT	Drug And Alcohol Team
DESMOND	Diabetes Education and Self Management for Ongoing and Newly diagnosed Diabetes
DH	Department of Health
DPH	Director of Public Health
EM SHA	East Midlands Strategic Health Authority
GUM	Genito Urinary Medicine
HEA	Health Equity Audits
HIV	Human Immunodeficiency virus
HI NSTI	Health Inequalities National Support Team
HNA	Health Needs Assessment
HPA	Health Protection Agency
HPV	Human Papillomavirus
IAPT	Improving Access to Psychological Therapies
IMD	Indices of Multiple Deprivation
IT	Information Technology
IB/ESA	Incapacity Benefit/Employment and Support Allowance
JSNA	Joint Strategic Needs Assessment
LA	Local Authority
LAA	Local Area Agreement
LAD	Local Authority District
LCC	Leicestershire County Council
LD	Learning Disabilities

LES	Local Enhanced Service
LGB	Lesbian, Gay, Bisexual
LINks	Local Involvement Networks
LLR	Leicester, Leicestershire and Rutland
LRS	something to do with sport
LSP	Local Strategic Partnership
LPT3	Local Transport Plan
MDQ	Most Deprived Quintile
MH	Mental Health
MIND	Mental Health Charity in UK
MMR	Measles, Mumps and Rubella vaccination
MRSA	Methicillin-Resistant Staphylococcus Aureus
NHS	National Health Service
NHS LCR	National Health Service Leicestershire County and Rutland
NICE	National Institute for health and Clinical Excellence
PBC	Practice Based Commissioning
PCT	Primary Care Trust
PH	Public Health
PHS	Public Health Service
QIPP	Quality, Innovation, Productivity and Prevention
QOF	Quality and Outcomes Framework
RST HI	Regional Support Team for tackling Health Inequalities
SHA	Strategic Health Authority
SSS	Stop Smoking Services
STI	Sexually Transmitted Infections
TB	Tuberculosis
TIA	Transient Ischemic Attack (“mini stroke”)
TOP	Treatment Outcomes Profile
UA	Unitary Authority
UHL	University Hospitals of Leicester
UNICEF	Organisation that works with families, communities and governments in more than 190 countries worldwide to protect and promote the rights of all children.
WHO	World Health Organisation

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