North East Lincolnshire CCG

Attachment 05

Report to:	NEL CCG Partnership Board
Presented by:	Geoffrey Barnes/ Councillor Peter Wheatley
Date of Meeting:	September 11th 2014
Subject:	Public Health Annual Report 2013/14
Status:	☒ OPEN ☐ CLOSED
Agenda Section:	☒ STRATEGY ☐ COMMISSIONING ☐ OPERATIONAL ISSUES

OBJECT OF REPORT

It is a statutory requirement that all top tier local authorities produce an independent report from their designated chief officer for public health on the health of the local population. This fulfils this requirement for 2013-14 which was the first year that North East Lincolnshire Council has been responsible for the delivery of local public health responsibilities since the transition of public health in April 2013. It is considered good practice that the Public Health Annual Report should also be jointly published by the local Clinical Commissioning Group(s).

STRATEGY

This is the Annual Report of the Director of Public Health for North East Lincolnshire. The report is divided into five chapters with an introduction and conclusion.

The introduction highlights the positive opportunities that the return of public health to local government is creating. Chapter 1 summarises the key intelligence about the health and wellbeing of the population of North East Lincolnshire. Chapter 2 summarises progress to date on building the new public health and wellbeing system in North East Lincolnshire. Chapter 3 gives a number of high quality examples of how we are doing things differently since becoming part of the council. Chapter 4 describes an innovative piece of health economics work that we carried out with colleagues in the Clinical Commissioning Group. Chapter 5 recognises that the protection of health remains a major focus for local public health activity in North East Lincolnshire Council, which we do in partnership with colleagues in Public Health England, and highlights some of the major issues that we had to deal with during 2013/14. The concluding section identifies three broad recommendations for maintaining and strengthening the delivery of public health responsibilities in North East Lincolnshire.

The report was formally agreed by North East Lincolnshire Council at a meeting of its Cabinet on August 6th 2014.

IMPLICATIONS **None**

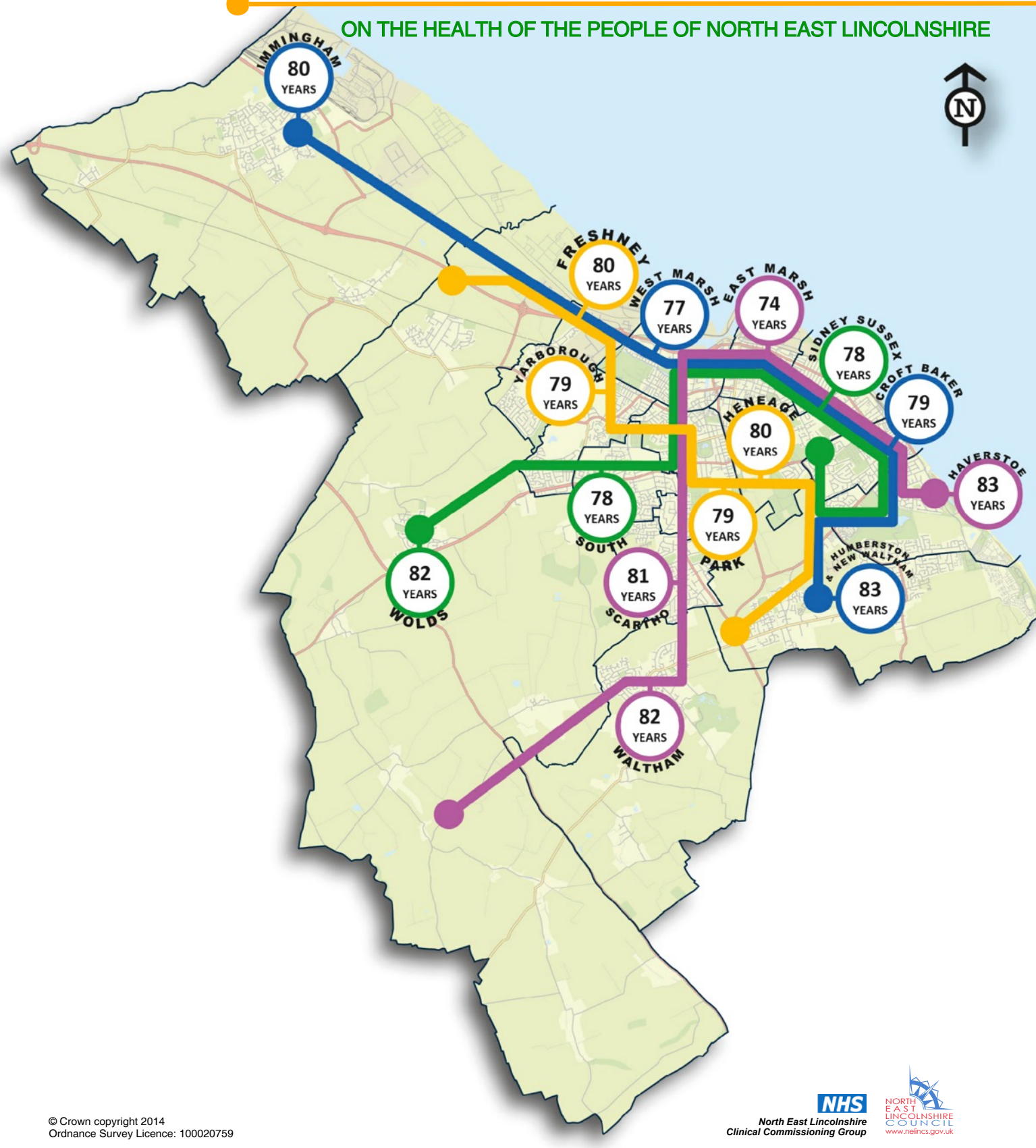
RECOMMENDATIONS (R) AND ACTIONS (A) FOR AGREEMENT

	Agreed?
It is recommended that the report is formally agreed by North East Lincolnshire Clinical Commissioning Group and the CCG agree that it can be jointly published with them and displayed on the CCG's website.	

		Yes/No	**Comments**
	Does the document take account of and meet the requirements of the following:		
i)	Mental Capacity Act	Y	
ii)	CCG Equality Impact Assessment	Y	
iii)	Human Rights Act 1998	Y	
iv)	Health and Safety at Work Act 1974	Y	
v)	Freedom of Information Act 2000 / Data Protection Act 1998	Y	
iv)	Does the report have regard of the principles and values of the NHS Constitution? www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_113613	Y	

Public Health Annual Report 2013-14

ON THE HEALTH OF THE PEOPLE OF NORTH EAST LINCOLNSHIRE



NHS
North East Lincolnshire
Clinical Commissioning Group

NORTH EAST LINCOLNSHIRE COUNCIL
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ACKNOWLEDGEMENTS

Many thanks to the following people for their assistance in producing this report:

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Diana Hodsdon

Isobel Duckworth

Glyn Thompson

Shola Bolaji

Trevor Parkin

Lauren Jackson

Dr Nicholas Aigbogun

David Hardy

Neil Clarke

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INTRODUCTION

This Public Health Annual report is the first that has been produced since the transfer of public health responsibilities from the NHS to local government in April 2013. It provides a summary of the momentous challenges that have been faced in delivering this transition and starting the process of creating a new model of public health and wellbeing in North East Lincolnshire Council, whilst continuing to deliver the traditional public health responsibilities of healthcare public health and health protection in collaboration with our Clinical Commissioning Group and Public Health England.

The opportunities that returning public health to local government could bring were a significant part of my last annual report but they are worth repeating again. Whilst health services have an important role to play in preventing poor health and managing illness, the greatest impacts on our long term health and wellbeing are our nurturing in the womb and in early life, the quality of education we receive, whether we are able to obtain decent employment, whether we have enough money to afford good housing and nutrition, the quality of our local environment, whether we are able to move around our neighbourhoods and communities in safety and security, preferably by walking or cycling, and whether we can remain active and independent in older life. Clearly these are all things that councils can and should be influencing and therefore if we can ensure that public health responsibilities are delivered effectively in the council and resources are allocated in the right place there is enormous potential to bring about improvements in health and wellbeing for our population, especially in those areas where unemployment, bad housing, poor environments, dangerous roads and high crime rates have ensured that very little improvement in health status has occurred in recent years.

The ‘bus route’ image shown on the front cover of this report and illustrated again in slightly more detail in figure 1 shows the challenge that lies ahead. We have extremely wide variation in life expectancy across North East Lincolnshire. People in East Marsh have a life expectancy at birth of just 74 years. If you journey a few miles up the road to Haverstoe and Humberston & New Waltham, life expectancy increases to 83 years. The variation is even greater if we consider only men.

Therefore public health in North East Lincolnshire council needs to be about working to improve employment opportunities, improving the quality of education, campaigning for 20mph speed limits in residential areas, improving the quality of our public open space and working with police to tackle crime. That’s not to say that we turn away from traditional areas of focus such as addressing unhealthy lifestyles and tackling high rates of smoking. Those remain high priorities but all the evidence suggests that to be successful here we must also address the wider determinants of health and ensure that communities wherever possible are given the ability and responsibility to lead their own health improvement initiatives.

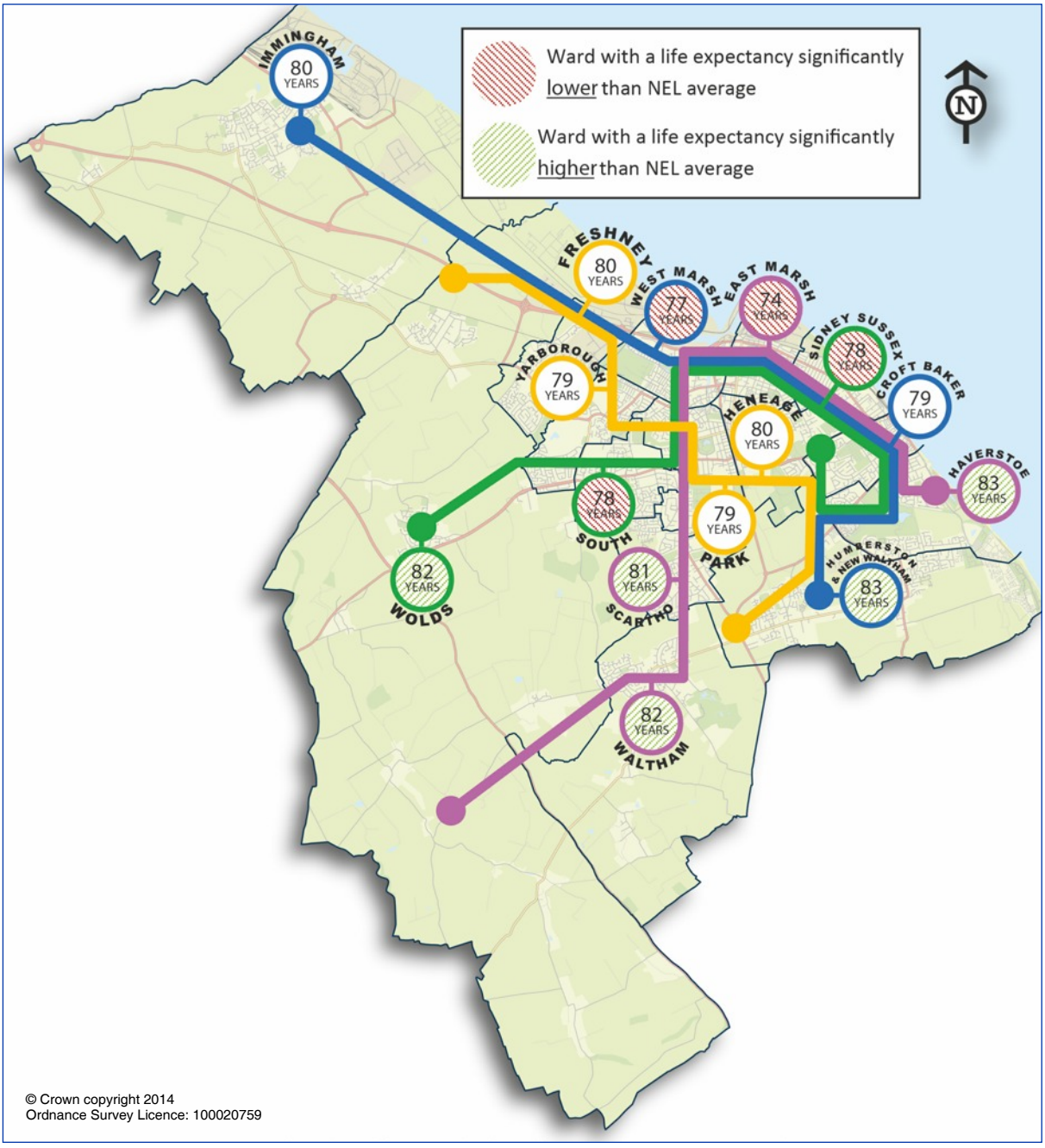
Acting Director of Public Health
Geoffrey Barnes

This public health annual report begins with the current picture on health and wellbeing in North East Lincolnshire extracted from the most recent Joint Strategic Needs Assessment (JSNA). Chapter 2 summarises progress to date on building the new public health and wellbeing system in North East Lincolnshire. Chapter 3 gives a number of high quality examples of how we are doing things differently since becoming part of the council. Chapter 4 describes an innovative piece of health economics work that we carried out to support our NHS colleagues in the Clinical Commissioning Group (CCG). Chapter 5 recognises that the protection of health remains a major focus for local public health activity in North East Lincolnshire Council, which we do in partnership with colleagues in Public Health England (PHE), and highlights some of the major issues that we had to deal with during 2013/14. We can be justifiably proud of our performance on health protection over many years as we have avoided many of the outbreaks of infectious diseases such as measles which have blighted other parts of the country. This has only been achieved by having good systems in place and by establishing strong relationships with services across the council and in primary care, hospitals, social enterprises and schools.

An epidemiological overview of North East Lincolnshire is produced as part of the local Joint Strategic Needs Assessment and is readily accessible via the North East Lincolnshire Informed website (www.nelincsdata.net/ias) along with other local health needs assessments.

Geoffrey Barnes
Acting Director of Public Health
May 2014

Figure 1: Life Expectancy Ward Map for North East Lincolnshire



CHAPTER 1

HEALTH AND WELLBEING IN NORTH EAST LINCOLNSHIRE TODAY

Background

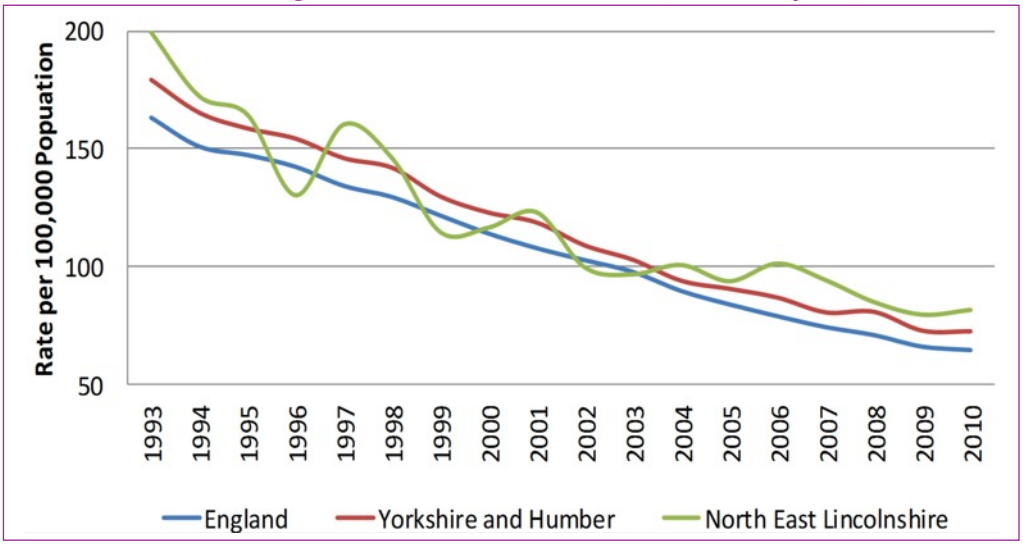
The Joint Strategic Needs Assessment is an assessment of current and future health and social care needs. North East Lincolnshire Council and the Clinical Commissioning Group have a joint duty to prepare the JSNA and resulting Joint Health and Wellbeing Strategy (JHWS) through the Health and Wellbeing Board.

The most recent JSNA produced evidence of overall improvement in the health of our population but little evidence of improvement in the areas of North East Lincolnshire where health is poorest and where social and economic challenges are greatest. The health inequality gap between the most affluent areas and the poorest areas therefore remains as wide as ever and closing this gap is the main priority for the Health and Wellbeing Board.

The Good News

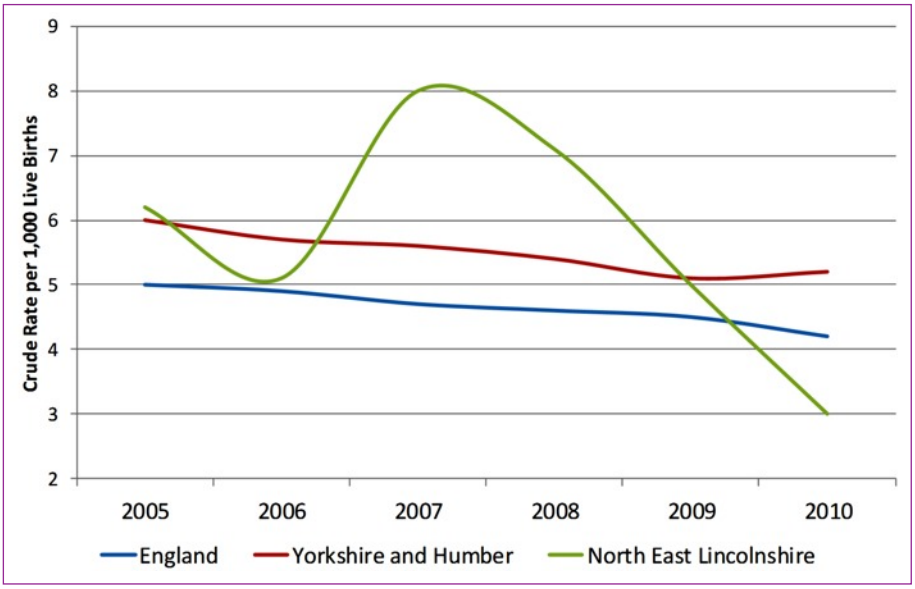
During the last 20 years there has been a steady increase in life expectancy. This has been especially the case for men where life expectancy in England has increased from around 73.5 in the early 1990s to just over 78 today, an increase of over 4 years. Within North East Lincolnshire the equivalent growth has been just under 4 years, from 72.7 to 76.5 years. The main reason for this big increase in life expectancy has been a dramatic decline in early mortality (under 75 years) from circulatory disease (e.g. heart attacks and strokes). Figure 2 shows that early deaths from circulatory disease in North East Lincolnshire have fallen from around 200 per 100,000 population in 1993 to just over 80 in 2010. This has been due to better therapies in primary care, e.g. the development of statins, and healthier lifestyles, especially the decline in smoking. However in those parts of North East Lincolnshire where smoking rates remain high, the rates of circulatory disease are still very high. For instance early deaths from circulatory disease are almost four times as high in East Marsh as they are in Humberston & New Waltham.

Figure 2: Directly age standardised mortality rates from circulatory diseases for England, Yorkshire and Humber region and North East Lincolnshire, Under 75 years, 1993-2010



Another positive finding from the recent JSNA was the big fall in infant mortality in the area during the last few years. As recently as 2007 North East Lincolnshire had one of the highest infant mortality rates in the country and sustained investments were made by the NHS and the Local Authority to address this. New guidance was introduced in the hospital to manage sick babies, whilst there have been initiatives to target smoking in pregnancy and low rates of breastfeeding. Figure 3 shows that since 2007 the infant mortality rate has fallen from 8 per thousand births, well above the national average, to just 3 per 1000 in 2010, which is well below the national and regional average. This is a great achievement in an area which includes pockets of severe socio-economic deprivation.

Figure 3: Crude infant mortality rates for infant deaths aged under 1 year, for England, Yorkshire and Humber region and North East Lincolnshire, 2005-2010



The Challenges

Closing the gap: building healthy communities and reducing inequalities

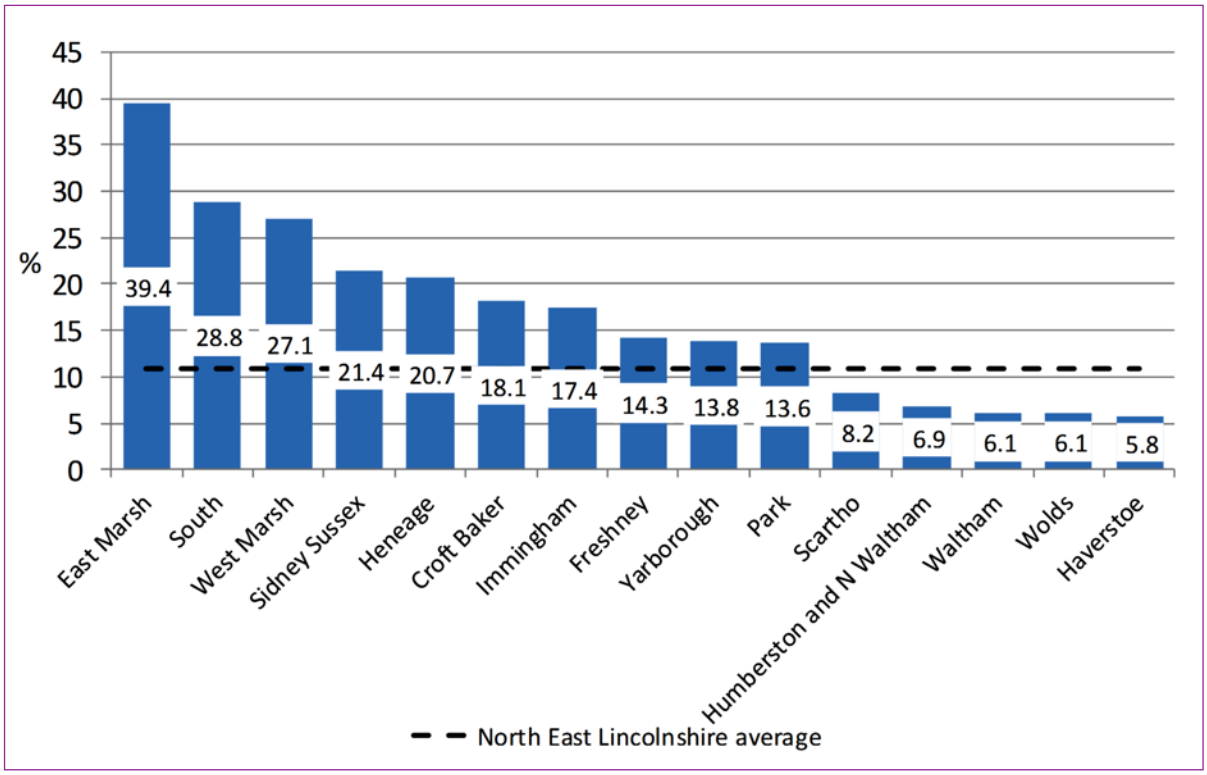
Whilst there is much good news regarding progress in North East Lincolnshire, there remains stark geographic and socio-economic health inequalities across North East Lincolnshire. Public health is concerned with the health of the population and the wider determinants of health, such as employment, housing, education, transport, and deprivation. These determinants can have a major influence on health and health inequalities, and to build healthy communities by tackling these factors, requires a strategic partnership approach if long-term change is to be realised. It is also important to tackle the often mistaken belief that health and ill-health is the sole responsibility of the health sector, because it is often other sectors that are better positioned and able to influence the wider determinants.

Unemployment is a major determinant of health. Employment reduces the potential for poverty, can have a positive effect on mental health, and can boost self-esteem. It is important to note that to realise these benefits, employment needs to be sustainable, with fair levels of pay, a regard for health and safety, and opportunities for progression, whilst also enabling a fair work/ life balance, otherwise employment that does not have these conditions could itself contribute to poor health e.g. work related stress.

Unemployment underpins poverty and poor health and Figure 4 shows out of work benefit claimants in 2012 by electoral ward, which highlights that several North East Lincolnshire electoral wards have a high percentage of people claiming these benefits. An analysis of unemployment figures over a number of years reveals that unemployment has become a long-term problem for some of the electoral wards in North East Lincolnshire.

Fuel poverty is a growing challenge and can have a considerable impact on health and quality of life. Cold housing has a disproportionate effect on the health of certain population groups particularly older people living on their own. There has been a substantial increase in fuel poverty over recent years given the large rises in fuel bills, and fuel poverty is projected to increase further as energy bills continue to rise. Although rates of fuel poverty are inevitably higher in our poorer wards, we still find that almost one in five households in the Wolds ward are deemed to be living in fuel poverty. This partly relates to a higher incidence of older people living in more affluent wards, often residing in large houses which can be difficult to heat.

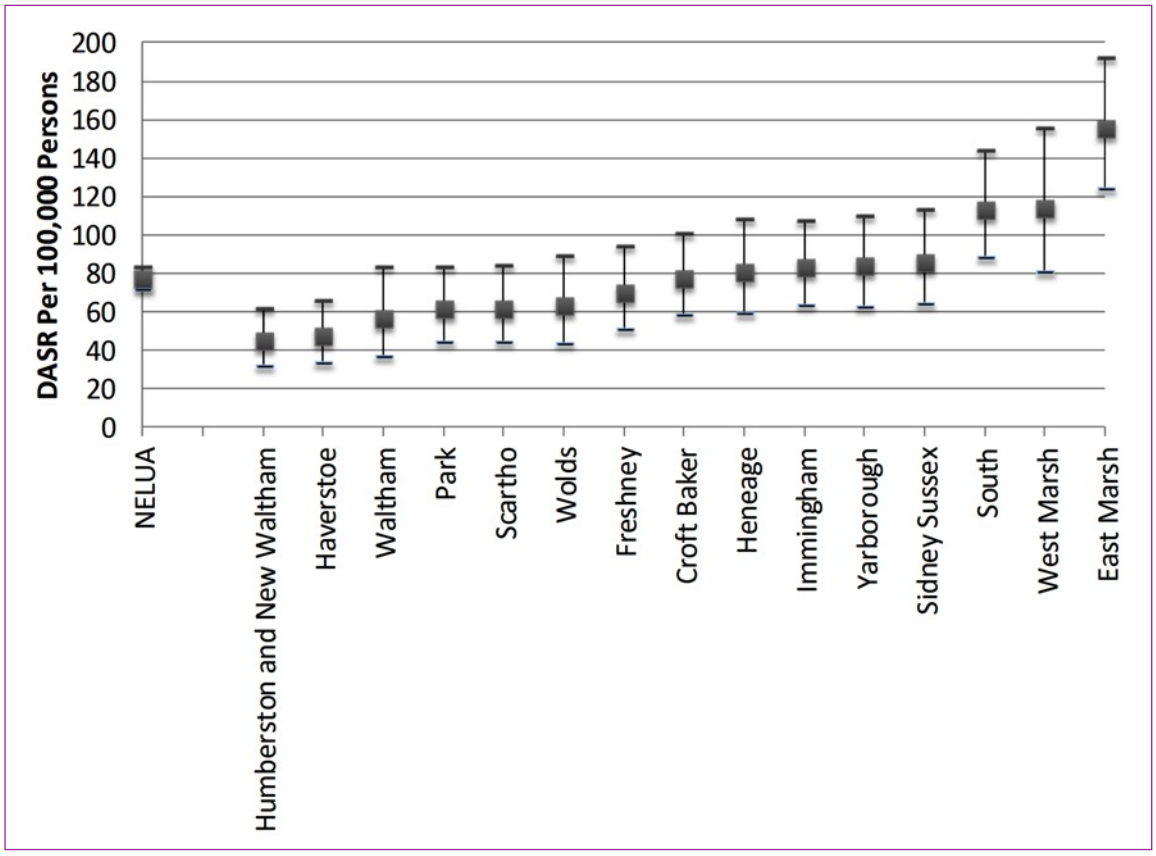
Figure 4: Working age benefit claimants in North East Lincolnshire, by electoral ward: February 2012



Cardiovascular diseases (CVD) includes diseases of the heart and circulation e.g. coronary heart disease and stroke. Figure 5 shows the CVD mortality rate for persons aged under 75 years by electoral ward. There is almost a four-fold difference in the rate of early deaths from CVD between the worst and best wards.

The East Marsh, West Marsh, South, Sidney Sussex, and Heneage electoral wards repeatedly have the worst health outcomes as shown by indicators throughout the JSNA. These are the most deprived wards in North East Lincolnshire which confirms that deprivation is a determinant of health and that these populations are experiencing higher levels of ill-health and premature mortality.

Figure 5: Directly age standardised mortality rates from cardiovascular diseases for North East Lincolnshire and electoral wards, Under 75 years, 2007-11



Changing behaviour and lifestyle

Individual lifestyle and behaviour choices have a major impact on health. There are so many choices that we make which can affect our health e.g. the amount of physical activity we do, whether our diet is balanced and healthy, whether we smoke, how much alcohol we consume, and whether we take illegal drugs.

Smoking is known to be the principal avoidable cause of premature deaths in the UK. More cancer and other deaths can be attributed to smoking than any other risk factor. Smoking is a major cause of chronic obstructive lung disease (COPD), coronary heart disease (CHD), stroke, and vascular disease. Reducing prevalence is therefore a key priority in improving the health of the population.

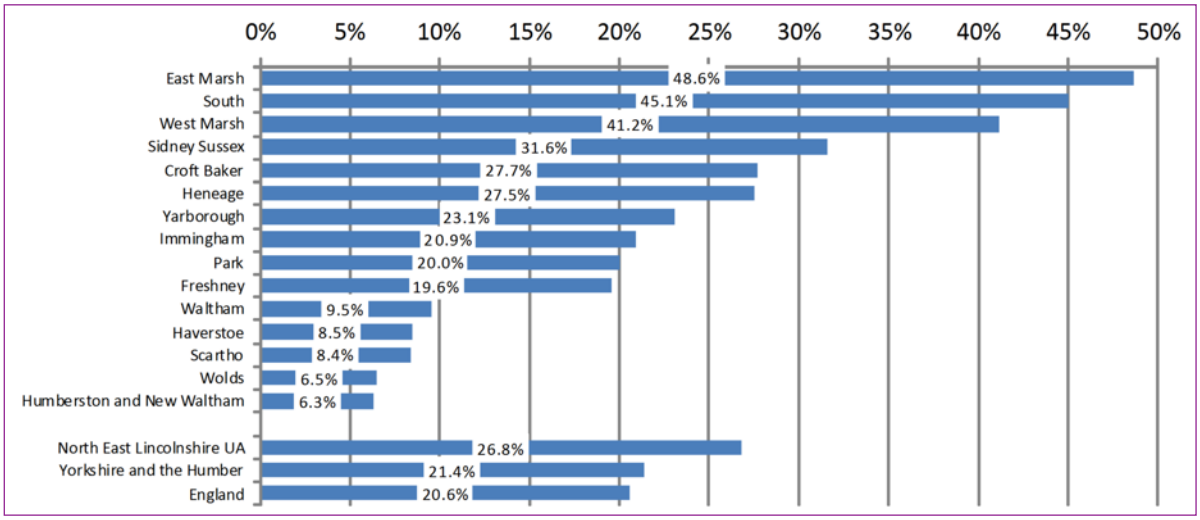
North East Lincolnshire has one of the highest rates of smoking prevalence in England. 25.8% of residents in our area smoke compared with 19.5% for England. The good news is that smoking rates do appear to be falling as our prevalence rate was over 30% just two years ago. Our recent adolescent lifestyle survey also showed a dramatic reduction in the number of teenagers taking up the habit.

Children and young people

A number of improvements have been seen in North East Lincolnshire, however there continues to be issues of low breastfeeding uptake, obesity in reception year children, and high rates of under-18 conceptions. Many of these are particularly pronounced in the most deprived electoral wards.

Underlying poverty has a major impact on health and wellbeing and Figure 6 shows the proportion of children aged under-16 years living in poverty (August 2010) in North East Lincolnshire by electoral ward. As can be seen in Figure 6, some wards in North East Lincolnshire have particularly high rates of child poverty.

Figure 6: Percentage of children living in poverty in England, Yorkshire and Humber region, North East Lincolnshire and electoral wards, 2010



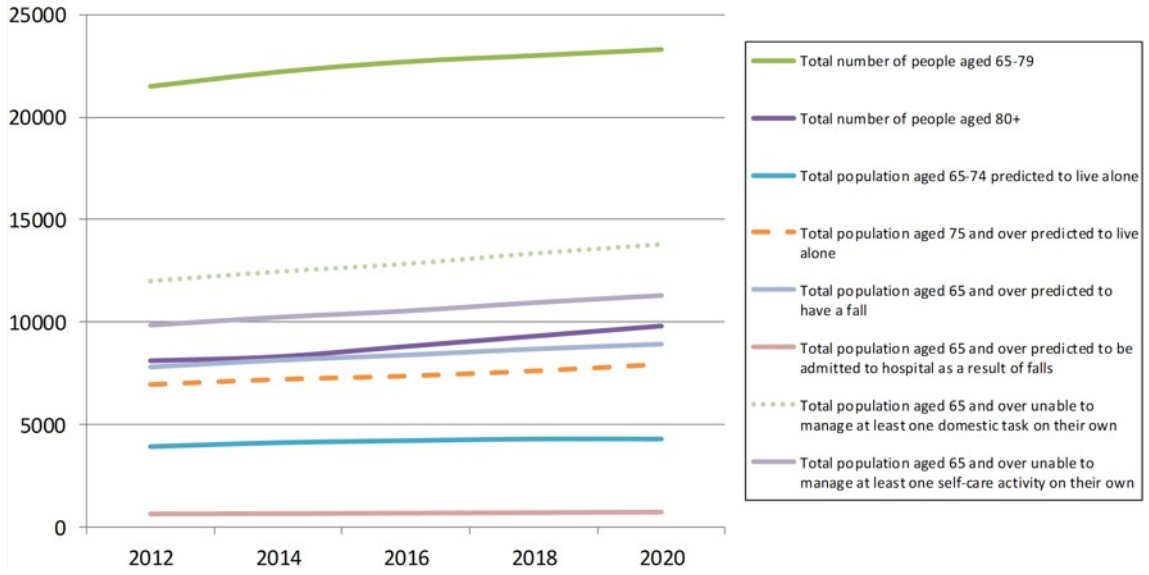
Wellbeing of older people

The JSNA included population projection estimates which showed that considerable population increases are projected in the 65+ age groups. North East Lincolnshire already has a higher proportion of its population aged 65+ years than the national average. Figure 7 shows the projected rise in the numbers of people aged 65 to 79, and over 80 years, in North East Lincolnshire from 2012 to 2020.

Older people can become socially isolated leading to a greater risk of poor mental health and injury. Figure 7 shows the projected rise in the numbers of older people in North East Lincolnshire predicted to live alone, be admitted to hospital due to a fall, and be unable to manage at least one domestic/ self-care task on their own, from 2012 to 2020.

These demographic trends will have a considerable impact on health and social care service demands, and strategies for North East Lincolnshire need to take this into account along with other factors of an aging population, such as housing and transport.

Figure 7: North East Lincolnshire population estimates for older people predicted to live alone, be admitted to hospital due to a fall, be unable to manage domestic tasks or self-care activity on their own, 2012 to 2020



CHAPTER 2

PUBLIC HEALTH IN NORTH EAST LINCOLNSHIRE COUNCIL

A NEW ERA BEGINS

The transfer of public health responsibilities to local authorities provides new opportunities for addressing the wider determinants of health. By the wider determinants of health we mean ensuring that people have access to decent jobs, homes and schools, ensuring that the local environment that people live in is pleasant and encourages walking and cycling, that people can move around their area in safety and comfort and that people live in safe communities where crime and anti-social behaviour is minimised. Studies show that when this can be achieved people's mental health and wellbeing is substantially enhanced resulting in less illness and better health.

The Council is committed to ensuring that public health is 'everyone's business' so it is moving away from having a separate public health directorate and is instead devolving responsibilities for public health outcomes across the authority.

Getting Our Strategic Delivery Right: Public Health Outcomes Review

Following the transition of public health responsibilities in April 2013, North East Lincolnshire Council received a grant from the Department of Health of £9.7 million to support these new responsibilities.

One of the first things that we did following the transfer was to look at the effectiveness and efficiency of all the new public health responsibilities which had been transferred. A Public Health Outcomes review was established under the former Director of Public Health to ensure that services were based on the best evidence of efficiency and effectiveness. The aim was to assist us in identifying where we need to make investments to improve health and to identify services which were not delivering outcomes or were over funded relative to other services and needed to be cut back or stopped.

The review looked at 26 programmes which the council were now responsible for delivering or commissioning. Some of these were combined to ensure that the process was more manageable which left us with 16 separate reviews to carry out. A programme lead was assigned to each public health review and the responsible lead was tasked with submitting a short report describing the programme/service, identifying costs where they were known and what the service was achieving in terms of outcomes. These reports were then submitted to the panels for review.

The outcomes panel consisted of a mix of senior officers and councillors from North East Lincolnshire Council and a range of internal or external experts who were invited to participate relevant to their area of expertise, e.g. the Humberside Police and Crime Commissioner participated in the drugs and alcohol panel. During the panel stage, service leads were questioned about the delivery of the programme/service and asked to identify challenges against a series of criteria. They were also asked to provide evidence of the effectiveness of the relevant programme.

The panel assessed the overall effectiveness of the programme and quantified strengths and weaknesses in particular areas. Each public health programme area was then scored by the panel against the following set of criteria:

- Achieving effectiveness and efficiency
- Achieving Value for Money and improving resource use
- Achieving stated programme aims
- Demonstrating capacity to improve
- Demonstrating effective partnership working

A summary report was produced by each programme lead which identified achievements in terms of outcomes, whether services were meeting the needs of the communities of NEL and what needs to be considered during integration of public health into the council. Finally the service leads were invited for a comprehensive feedback session. A full report of the outcomes review process is available from the office of the Director of Public Health and a summary of the findings and actions leading from the review are presented in box 1 and 2.

The process identified a great deal of impressive work done with limited resources and an obvious desire of all programme leaders and their partners to work better together in order to improve outcomes and avoid duplication. High scoring areas included immunisations, tobacco control and drugs and alcohol, although in the latter case there was concern about the proportion of the overall public health grant that was spent on this relative to other areas.

Areas of weakness where scores were relatively low which required investment or a better use of existing resources included mental health, workplace health, physical activity and healthy weight. Overall almost all participants in the process reported that they had found it to be a great learning opportunity and it had given them a much needed "pause" for reflection and taking stock.

The outcomes review process assisted in the development of the health and wellbeing strategy and the development of a new model for public health delivery in the council.

Box 1: Public Health Outcomes Review Summary Findings

Issues identified by the review process were:

- **Duplication** of effort/roles with some agendas needing joining up to increase impact.
- **Commissioning accountabilities** post NHS reforms appear to be complex, with responsibilities lying with different organisations e.g. councils, CCGs, NHS England, Public Health England. The panel recommended that joined up commissioning and a strong steer from the health and wellbeing board would be essential to overcome this fragmentation.
- Some of the programmes could **utilise the resources of communities, the third sector and primary care** more effectively than they do at present, in order to get their message across.
- A number of **health improvement delivery gaps** were highlighted particularly within the school setting.
- There is an **imbalance between primary prevention and early detection/treatment services**, with the emphasis being on the latter which needs addressing.
- More **targeting on working within communities suffering deprivation in a much more holistic way**, again working with partners for health, such as local GPs and the voluntary and community sectors.
- An identified requirement for the adoption of **health inequality related outcomes and** targets within contracts.
- Working in **silos** in some areas, suggesting partnerships in some areas needed development and growing.
- A concern to ensure that **mandatory services requirements are met as set out in LAC[1].**
- There is a need to look at resources across 3 domains of public health and re-think current resource allocation.

Box 2: Public Health Outcomes Review Actions

Actions leading from this review include:

- **Restructuring public health functions across the council to improve delivery and integration:** The review demonstrated fragmentation of delivery. This weakness appears to be a result of a lack of a strategic or compelling vision for public health across the council. There is a need to bring the 3 domains of public health together to form a small integrated health and wellness "hub" in order to better improve quality and improve outcomes.
- **Embedding public health across service areas:** The location of public health within the council setting provides a valuable opportunity to make health and wellbeing everyone's business, and to tackle the wider determinants of health.
- **Refocus on prevention:** It was noted in some programme areas there was a need to refocus work upstream to mitigate harm and strengthen communities of interest. This was particularly noted in relation to drugs and alcohol and school nurses. School nursing had drifted towards more time being spent on safeguarding away from prevention.
- **Reviewing services that scored disappointingly:** There is a clear need to address issues in partnership working or duplication of effort in some areas where scores were low. These areas include health weight, mental health and workplace health.
- **Improving governance and monitoring of programmes of work:** Using the public health outcomes framework and other indicators to develop robust governance arrangements for all public health programmes to ensure that there are clear priorities for action and outcome measures to which enable progress to be tracked.
- **Innovating more:** by investing in the capacity of individuals and communities to support themselves to facilitate the achievement of sustainable behaviour change and make better use of resources.

[1] Department of Health (2013) *Local Authority Circular (LAC 2013) Ring Fenced Public Health Grant.* London. Department of Health

Health and Wellbeing Board

A critical element of the new health system in North East Lincolnshire is the Health and Wellbeing Board which was established in April 2013. The Board is chaired by the council's portfolio holder for health and wellbeing and includes membership from senior officers and members of the council as well as senior officers from the CCG, the voluntary sector, Healthwatch and NHS England. The Board has already agreed a new strategy for improving health and wellbeing by redirecting efforts and resources towards the prevention of poor health and targeting areas in North East Lincolnshire where health has not been improving.

Health and Wellbeing Strategy

A new Health and Wellbeing Strategy was agreed by the Board in December 2013. The strategy aims to build a new upstream model of public health which is focused on addressing the wider determinants of health by shifting resources away from expensive services that treat health problems which have developed in a small proportion of the population in favour of primary preventative and early intervention services and initiatives which will help to ensure that problems do not develop in the first place. This approach will bring benefits across the health and wellbeing system by ensuring that treatment costs in the long term will be substantially reduced. For instance if we can turn around the upward trend in overweight and obesity in our children and adults we will ultimately reduce the numbers of people who develop diabetes. Diabetes brings enormous costs to the health and social care system due to expensive treatment costs which can extend over several decades and the likelihood that it eventually leads to some disability and further health problems.

In addition the strategy is going to build links into communities, especially in the most deprived parts of the borough to ensure that public health and health improvement becomes less about professionals telling communities and individuals how they should live and much more about communities leading the strategy for themselves and able to access funding to enable them to do that. Five priorities for the strategy have been identified and these are being developed into an implementation plan. The five priorities are as follows:

- Securing the future for children and young people
- Keeping people well so they can have healthier lives with an immediate focus on improving positive mental health and wellbeing
- Creating healthy and sustainable communities
- Improving access to high quality, integrated and equitable services
- Maintaining and enhancing independence of vulnerable groups with an immediate focus on those areas where interventions can support those experiencing income shortfall

The successful delivery of the strategy and implementation plan will help to turn around the wide health inequalities in the Borough and improve the health and wellbeing of everyone in North East Lincolnshire.

CHAPTER 3

DOING THINGS DIFFERENTLY

This section highlights a range of initiatives which showcase how North East Lincolnshire are doing things differently since public health responsibilities transferred to the council. There is no longer have a large public health directorate delivering on a wide range of public health services. Instead a very small and lean team who work with colleagues across the council, the CCG, the voluntary and community sectors and national organisations to support evidence based public health and wellbeing services.

This section also discusses the new vision of our colleagues in the improved health team who have refocused the work of their lifestyle services to reflect more closely the new health and wellbeing strategy. A range of initiatives to tackle unhealthy weight, which are being coordinated by children's services colleagues, and have involved developing strong links with leisure service providers, social enterprises and community groups are also presented - a new approach to tackling substance misuse which has been supported by the police and again involves reaching into non-traditional areas of public health practice is also discussed. Next to be presented is the innovative work of the tobacco control and public protection team in changing attitudes towards tobacco in areas of North East Lincolnshire where there is unacceptably high levels of smoking and associated health problems and in fighting back against the spread of cheap, illicit and sometimes contaminated illegal tobacco. Finally work by colleagues in the voluntary sector which is focused on mobilising all communities across North East Lincolnshire to become more active in their local communities and thereby enhancing community capacity and wellbeing is presented.

Lifestyle and Behavioural Change Services - A Vision For The Future

Recent years have seen a reduction in the prevalence of preventable ill health across North East Lincolnshire, however the health inequality gap that exists between the higher and lower socio/economic gradient remains a concern. The behaviour of individuals, communities and populations is one of the major determinants of their health outcomes and healthy lifestyle and behaviour choices are central to helping prevent illness and early death. Locally the greater proportion of preventable ill health and associated health inequalities is found in - East Marsh, West Marsh, Sidney Sussex and South, those wards with the highest rates of socio-economic deprivation. Over the years these wards have been the centre of measures to redress this position, however most of this input has been concentrated on addressing community deficits and problems. Whilst specialist lifestyle and behaviour change service initiatives have had considerable success in targeting key groups and communities, there is a need for these services to become more strategic and locality based. The Local Government Association report "A glass half full" suggests there is a need to move to an asset based intervention model to impact upon health inequalities "assessing and building on the strengths of individuals and the assets of a community opens the door to new ways of thinking about and improving health and of responding to ill-health"[2].

Looking to the future

Whilst maintaining the overall trend of local health improvement there is an obvious need to accelerate such improvements in those communities at greatest risk of preventable ill health and health inequalities. To meet this challenge in 2013/14, the council's lifestyle and behaviour change services were remodelled to modify the way practitioners engage with individuals and the way services are delivered, driven by a strategic lead. Work has included the harmonisation of the Stop Smoking Services, Health Check programme and Health Trainer Services functions. Developing a unified strategy that will focus on key communities and population groups to help encourage them to make healthy choices and foster change where their behaviour is harming their health and the development of a "Client Service Hub" which will offer a central point of access to clients wanting to make direct contact with services. Operating on a "One for all" principle the Hub will provide for:

- Information and advice
- Matching and access to specialist clinic and community based programmes
- Individual assessment
- Virtual support (web based, texting, telephone etc.)
- Relapse prevention schemes.

Healthy Weight Services

Minimising weight gain during pregnancy a community based approach

The Maternal and Early Years Healthy Lifestyle Service (MEYHLS) supports women with a BMI of ≥30 with dietary and lifestyle advice as part of a planned care behaviour change programme, to minimise weight gain using US guidelines (5-9kg), reducing obesity associated outcomes during pregnancy and childbirth. Women are referred (with a BMI ≥30) to the service following their pregnancy booking by their midwife. Women are invited into their local Children's Centre to be part of the programme which is made up of eight 1:1 contacts pre and post birth. Early observations of weight gain after the second appointment (18-22 weeks) indicate that over half of the women have maintained their weight gain in line with recommendations.

[2] Improvement and Development Agency (2009) *A Glass half-full: how an asset approach can improve community health and wellbeing.* London. Local Government Association

Building activity into our lives through walking and cycling

Move More Through Active Travel is a new programme which encompasses a number of schemes designed to encourage participation in physical activity with schools, colleges, workplaces and within the community. Such as promoting Active Travel as an easy way to achieve the recommended active minutes as suggested by the chief medical officer. Healthy Travel Officers work with schools on a variety of different initiatives and capture the impact on health, academic achievement, road safety and environmental issues. Schools which have a higher prevalence of overweight children or concerns related to road safety are particularly targeted by the programme.

There are a number of community awareness events, held as part of an annual programme, raising the profile of walking and cycling across North East Lincolnshire, which include:

- **The Wolds Walking Festival** - 334 participants
- **Walk Dr event** - 59 adults took a walk health check
- **Walk to Work Week** - 29 adults participated in organised walks
- **Bike Week** - 8 NELC 'Improved Health' colleagues
- **Skyride, Breeze and Social Cycling** (in partnership with British Cycling and North Lincolnshire Council) - 187 participants

The programme also trains volunteers involved in walking and cycling activities and is developing links with local clubs to ensure opportunities to encourage active lives are maximised.

A partnership approach to increasing physical activity opportunities for young people

As part of a *Moving More* focus around childhood obesity the *Junior Gym* facility was developed in partnership with key agencies. The main aim of the programme is to increase the levels of physical activity in Young People (8-15 years) facilitating universal and targeted programmes for those who would benefit from lifestyle support, including a referral programme *5ive Active* (at Cleethorpes Leisure Centre), for young people at risk of obesity.

Since its inception in October 2013, 5,370 young people attended Junior Gym which includes inductions, mainstream visits, school and club use and 5ive active. The programme evidences impact on children's weight, engages with local schools to increase leisure usage, meets demand for gym access for children and young people under the age of 15 and is currently achieving almost 75% of its gym membership target.

The 5ive Active referral programme assesses lifestyle and behaviour change pre and post the programme, participants who have completed the programme have been successful in achieving positive behaviour changes with regard to motivation, happiness and stated that post programme they would continue to live a healthy lifestyle. A total of 63 attendances have been made as part of the programme.

Changing Social Norms around Tobacco

We know that the majority of people who smoke first start in their teens and are much more likely to take up smoking if their family and friends smoke or they feel that it is "normal" to smoke in their community. People are influenced by what they think the majority of others are doing so if we believe that most people in our community smoke, we are more likely to smoke ourselves. However, we tend to overestimate unhealthy behaviour and assume that far more people smoke, drink alcohol regularly or take little exercise, than what is actually true.

A project started in 2012 to challenge some of these misconceptions and feedback the information to the community in an effort to influence attitudes and perception of the social norm around smoking. The local community were involved in the design, development and data collection, 700 questionnaires were distributed throughout the East and West Marsh wards.

There was a significant difference between what they thought was the situation in their community and what was actually happening; for example:

- Residents thought that 7 out of 10 adults in East and West March smoke whereas we found that only 4 out of 10 actually do.
- Residents thought that less than 2 out of 10 households did not allow smoking in their home whereas 6 out of 10 homes are kept smoke free.

A campaign theme was developed via focus groups, which used pictures of the head of an Emu and the phrase *"He knew, she knew Emu"*. Initially, pictures of Emus were handed out to direct people to a Facebook page but gave no indication of what the campaign was about. This stimulated a lot of curiosity with 7,136 people visiting the site. Individual findings from the questionnaires were then displayed on lamp posts, message boards, in community buildings and through letter boxes.

After the campaign had run for two months, a further set of questionnaires were completed to identify if any changes in perceptions from the first survey had occurred. It was evident that there had been some slight increases in the number of residents who now keep their homes and cars smokefree and believe that other areas that children use, such as playgrounds, should also be kept smokefree.

Bringing about changes in attitudes and behaviour is a slow, gradual process and the work is to be continued over the next 3 years to build on what has been achieved to date.

Trading Standards, Public Health and Illicit tobacco

In 2012/13 tobacco smuggling cost the Government approximately £3.2 billion in lost revenue. Smuggled tobacco provides a cheap and unregulated supply which undermines the Government's policy of using tax to maintain the high price of tobacco and help reduce smoking. Illicit tobacco products have a variation of nicotine and tar content and have been found to contain inferior ingredients, including high levels of contaminants which increase the health risk. Widespread availability in the poorer wards of NEL makes it easier for young people to take up smoking, encourages people to smoke more often and be less likely to quit. Smuggling also damages law abiding businesses and funds other forms of organised crime.

In NELC, Tobacco Control Trading Standards Officers are responsible for enforcing strict regulatory controls on the sale and supply of tobacco products with 3 major outcomes to improve the health and wellbeing of the community:

- **Preventing children from starting and maintaining a smoking habit** - through enforcement against underage sales and illicit tobacco
- **Supporting smoking cessation** - through enforcement of Smoke Free laws in commercial premises and CIT control.
- **Reducing the attractiveness of tobacco** - through enforcement of advertising and health warning rules.
- **Ensuring level playing field for businesses** - tackling illegal tobacco sold through fag houses and retailers

Trading standards also monitors compliance at business premises such as newsagents, supermarkets and pubs and clubs. Monitoring potential breaches such as; Sales to under 18's and appropriate signage, display of tobacco products, and sales of tobacco direct to consumers from vending machines (prohibited from October 2011).

Preventing Substance Misuse

Following a successful three year funding bid from the office of Police and Crime Commissioner (formerly Humberside Police Authority) by the Specialist Health Promotion Service a new substance misuse programme has been put in place. The aim of which is to assist in reducing alcohol related crime and disorder in tackling local substance misuse issues via three distinct work streams:

1) **The recruitment of a specialist substance use prevention post - to increase capacity**
   A serving PCSO in Humberside Police, was the successful candidate for the substance misuse prevention post, tackling the joint health and crime priorities of substance misuse and closely aligned to the on-going work of the local authority's Drug and Alcohol Action Team.

2) **To develop an education and prevention strategy in schools**
   A lesson activity pack to support teachers in delivering substance use preventative education has been developed with the assistance of NEST, the local substance use treatment agency for young people. Additionally, a strategy has been devised for schools encompassing all aspects of substance misuse, including policy, dealing with incidents, staff training, utilising outside agencies and referral pathways for students who have developed substance misuse problems.

3) **To provide an alternative activity in an area identified as having a significant issue in young people's substance misuse.**
   A partnership project with the Young People's Support Service has been running at the new Parkour facility in the Duke of York Gardens, in the West Marsh area of Grimsby. To provide support and advice around substance misuse issues, in the same location as diversionary activities, as part of a focus of targeting "at risk" groups.

The key outcomes for this project include; Reducing the number of young people using drugs and alcohol and delay the age of first use for those that do, increasing the provision of education on substance misuse within schools, identifying areas/groups with specific additional needs and responding to them, supporting parents/those involved in caring for young people to build their knowledge and skills in substance misuse prevention and partnership working to raise awareness of specific issues.

Voluntary Action North East Lincolnshire: Reaching Communities funded project: ENFUSE

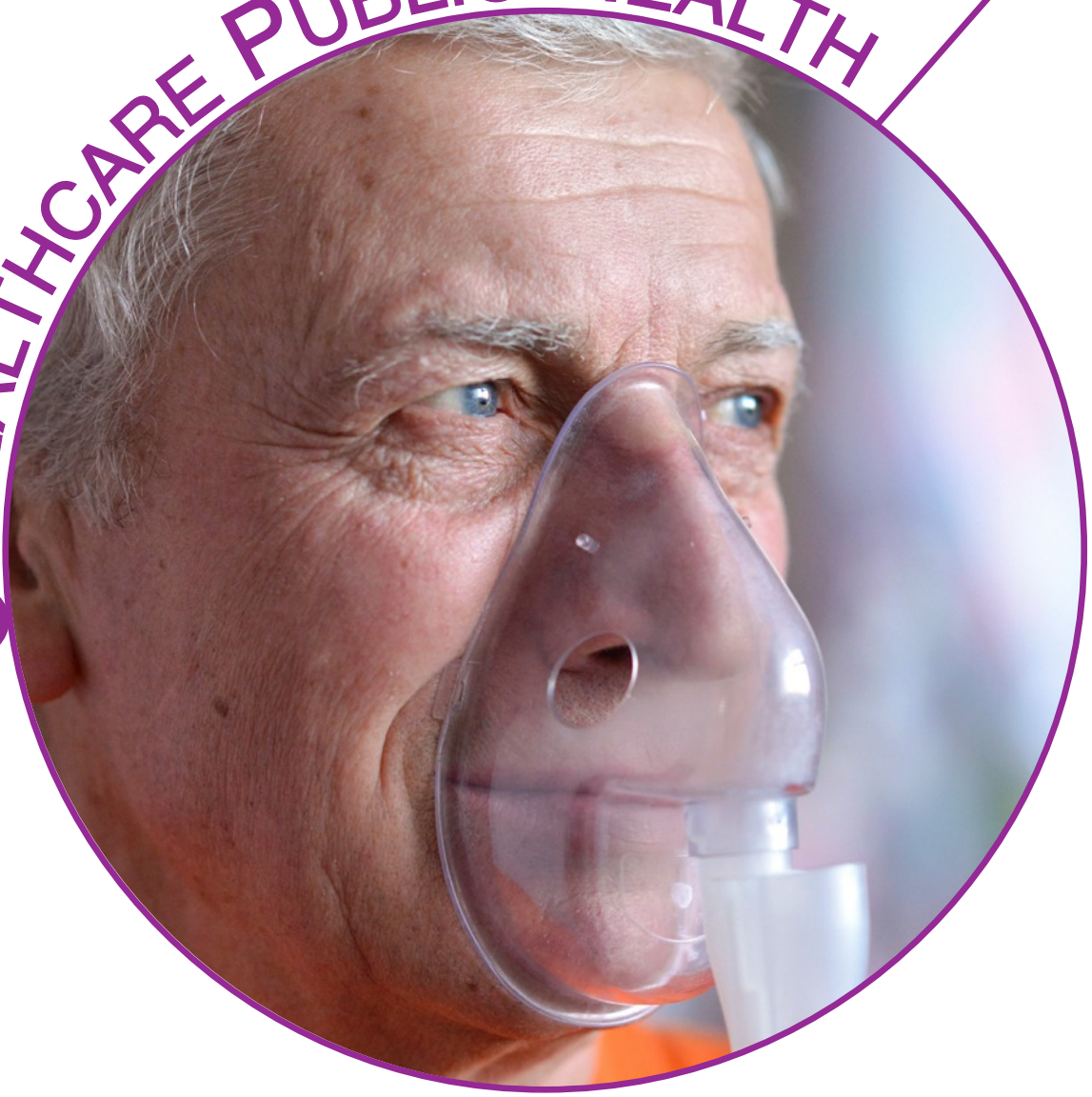
"Helping Young People to Help Communities Help Themselves"

The aim of our ENFUSE programme is to mobilise all communities across North East Lincolnshire to become stronger and more involved with local life, by developing more active and involved citizens, better able to work together to tackle their collective issues. This will be achieved by developing a coordinated team of young, community, based and managed, development workers to support, guide and work alongside community members. Helping local people in the community address their own problems by enabling them to mobilise their community peers to become more involved. Many community members are currently not involved as shown by low levels of volunteering, lack of actively involved communities, low voter turnout, low income and high dependency on public sector services and benefits. Feedback received from a community development network demonstrated a need for communities to be managing their own community development rather than being dependent on others to provide it, hence helping communities to help themselves.

In its first year the young people will benefit from the knowledge and expertise gained via the thematic community workers, leaving a further 3 years to embed the young people in communities across North East Lincolnshire. As previous experience has shown it takes up to 2 years to set up and establish such programmes before impact can really begin to effect change. We want to ensure the programme harnesses and maximises the energy of the young people in order to change their attitudes towards volunteering in and engaging with their community. Apprentices on this programme will benefit as both individuals and as members of the communities they live in by learning skills in community games, health improvement, digital technology, victim support, probation (youth & adult), coastal communities and tourism, recycling, minority communities and restorative practices.

CHAPTER 4

HEALTHCARE PUBLIC HEALTH



USING PBMA TO REDESIGN THE LOCAL CARE PATHWAYS FOR THE MANAGEMENT OF COPD AND ASTHMA

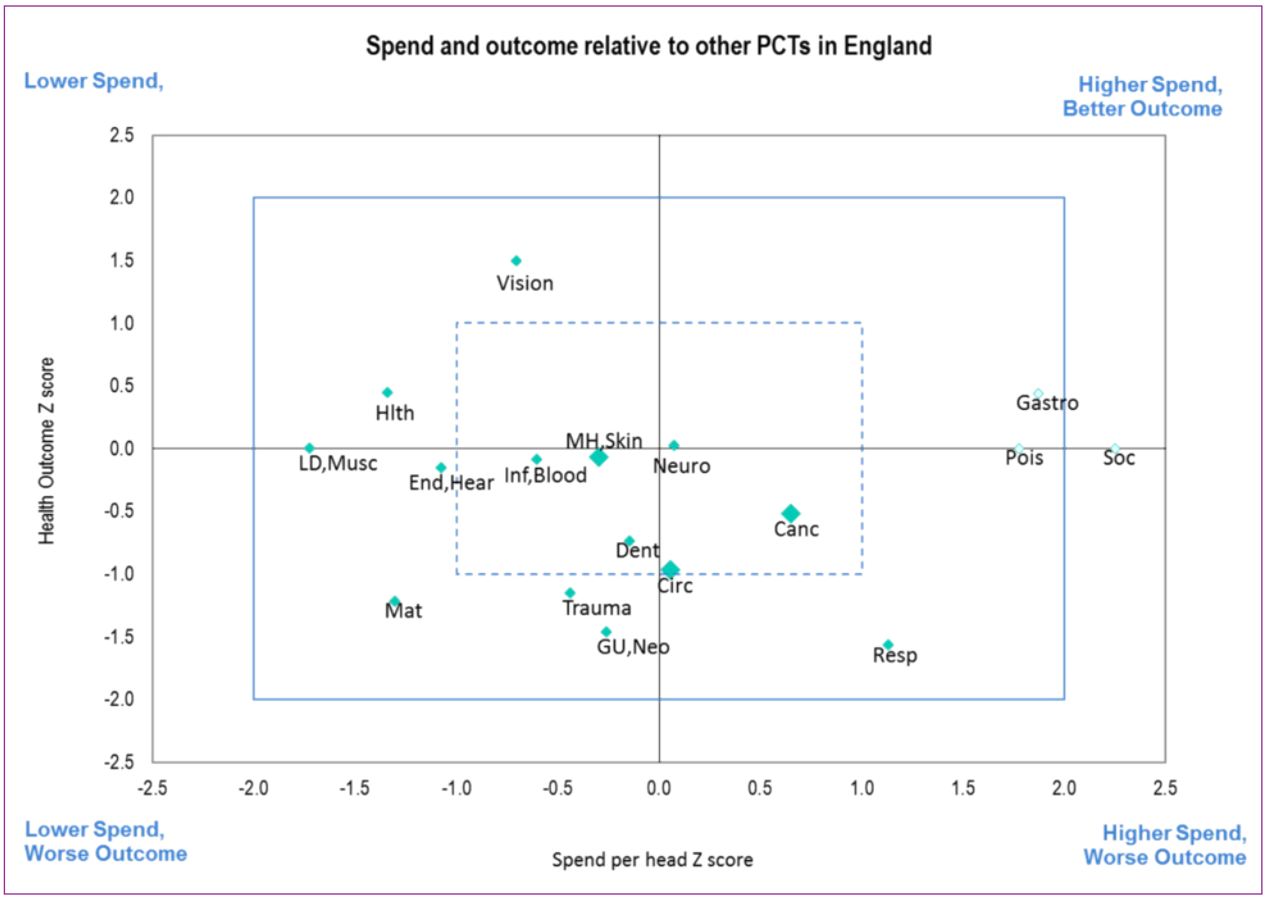
Primary Care organisations have a responsibility to ensure that services take into account population needs and are commissioned in the most cost-effective way to deliver improved outcomes. The current economic climate puts the NHS under increasing pressure to deliver high quality care for all, reduce costs and increase efficiencies. Programme Budgeting and Marginal Analysis (PBMA) is an excellent tool for ensuring that outcomes should not be sacrificed during times of economic shortage. This section provides a brief summary of a piece of work led by our health economic development manager which used PBMA to redesign local care pathways for the management of Chronic Obstructive Pulmonary Disease (COPD) and asthma.

Spend and Outcomes Tool

The Spend and Outcomes tool, which links health outcomes and expenditure, showed that respiratory spend for North East Lincolnshire in 2008, 2009 and 2010 was in the 'high spend and worse outcome' quadrant (Figure 8) compared with other PCTs in England.Yet despite this, respiratory outcomes for asthma in North East Lincolnshire in 2010 were the worst in England.

To investigate this further, the Care Trust Plus Board agreed to explore the use of an economic approach known PBMA to examine the entire disease pathway of respiratory disease. A PBMA group was established which included a Public Health Consultant, a Health Economist and a Development Manager with some external support provided by a commercial consultancy.

Figure 8: Spend and Outcome Relative to other PCTs in England - 2009/10



◆ Outcome indicators available

◇ No outcome indicators readily available

- A programme lying outside the bold blue box in Figure 8 above indicates that the data is significantly different from the England average.
- If a program lies to the left or right of the box it is significantly different on spend.
- If a program lies outside the top or bottom of the box it is significantly different on outcome.

Programme Budgeting and Marginal Analysis

PBMA is a systematic framework for option identification and appraisal for either investment or disinvestment. It is also a framework for health improvement, commissioning and accountability and is ideal for bringing clinicians, managers and the public to work together in this process[3].

PBMA addresses priorities from the perspective of resources,asking the following questions:

1. What resources are available in total?
2. In what ways are these resources currently spent?
3. What are the main candidates for more resources and what would be their effectiveness?
4. Are there any areas of care within the programme which could be provided to the same level of effectiveness but with less resources to fund candidates in priority 3?
5. Are there areas of care which despite being effective, should have less resources because a proposal from priority 3 is more effective (per £ spent)?

Aim

The aim of the PBMA project was to improve the quality of the COPD and asthma services, improve patient experience and outcomes with a focus on shifting more resources upstream by ensuring that scarce resources are used effectively and efficiently. This PBMA project is an integral part of the macro disinvestment work and acted as a pilot for future candidates with a learning aim of how to "industrialise" the process.

Method

The pre-existing respiratory disease stakeholder group was used as an advisory group to advise on the COPD project. The group consists of a consultant respiratory physician, general practitioners (GPs), COPD Lead, CTP Medical Director, primary and secondary care respiratory specialist nurses, prescribing adviser, CTP finance manager, complex case managers, nurse practitioners, pulmonary rehabilitation lead and a member of the public. The PBMA group were also members of the advisory group. A total of 12 meetings were held with the stakeholders over a period of 2 years i.e. 2010 to 2012 and an action plan produced at the end of the project.

Firstly, interviews were conducted with key people providing COPD and asthma care in order to understand the current COPD and Asthma care pathways, main cost drivers, areas of bottleneck, and their vision for improved pathways/ improvements in service provision. A programme budget was constructed and populated with costs and activity where information was available. Findings from these, together with a summary of NICE COPD cost-effectiveness medications were presented to the stakeholders. The cost effectiveness evidence helped structure the discussion with the health professionals in the group so that all proposals for disinvestment / investment had an evidence base requirement. A summary of this is shown in Table 1.

Table 1: Summary of COPD Cost - Effectiveness Interventions

INTERVENTION	IMPACT
Smoking cessation: Minimum counselling	£1,394 / QALY
Smoking cessation: Intensive counselling + 12 weeks nicotinereplacement	£4,264 / QALY
Smoking cessation: Intensive counselling + 9 weeks bupropion	£2,952 / QALY
Smoking cessation: Telephone counselling	£1,230 / QALY
Short acting beta agonists	Cost saving £361/patient
Long acting bronchodilators (LABA)	£16,961 / QALY
LABA and corticosteroid combination therapy	£26,710 / QALY
Patient education and self management programme	Cost saving £1,310 per patient
Long term continuous oxygen therapy: - 3 years - 5 years	 - £15,871 / QALY - £10,749 / QALY
Long term nocturnal oxygen therapy: - 3 years - 5 years	 - £318,619 / QALY - £204,237 / QALY
Pulmonary rehabilitation	£17,000 / QALY
Influenza vaccination	£6,174 / QALY
Pneumococcal vaccination	£14,715 / QALY to £39,240 / QALY
Lung volume reduction surgery - 3 years - 5 years	 - £123,500 / QALY - £91,000 / QALY
Lung transplantation	£164,913 / QALY
Non-invasive ventilation	Cost saving 645 per patient
Antibiotics for acute exacerbation	Cost £90 to £112 per exacerbation
Inhaler vs. nebuliser	Inhaler saved £4,538 per month in hospital spend

The quality-adjusted life year or QALY is a measure of disease burden, which takes into account both the quality and the quantity of life lived. It is used in assessing the value for money of a clinical intervention (e.g. an operation). The QALY is based on the number of years of life that would be added by the intervention. Each year in perfect health is assigned the value of 1.0 down to a value of 0.0 for being dead. If the extra years would not be lived in full health, for example if the patient would lose a limb, or be blind or have to use a wheelchair, then the extra life-years are given a value between 0 and 1 to account for this.

[3] Brambleby & Fordham R. (2003) Implementing PBMA. *Evidence Based Medicine.* **4** (3)

Options for change

The group discussed how changes could be made to COPD and Asthma services and examined the costs and benefits of such changes. Investment and disinvestment options were then identified by the group and are shown in Table 2.

Table 2: Proposed Investment and Disinvestment Options

INVESTMENT	DISINVESTMENT
Review current local Smoking cessation programme with a view to investing in areas which worked well	Restrict use of mucolytics for use in exacerbations. Find out which mucolytic medication is cheapest in North East Lincolnshire and incentivise usage
Patient education: • Telephone-based; • Group education; • Peer networks. Learn more about current programme(s)	Oxygen therapy: • Inappropriate oxygen access • Tighten service so that only those patients for whom continuous oxygen therapy is appropriate receive the service. • Reduce use of nocturnal oxygen therapy.
• Self-management plans • Investigate patient self-prescribing	Local Prescribing protocols for Inhaled corticosteroids
Non-invasive ventilation	Continuous review of surgical interventions with a view to disinvesting in this area
Engage in Acute Medical Unit redesign	
Vaccinations: Pneumococcal and Influenza	
End of life care planning	

Disinvestment ('Hit List')

Three agreed priority areas were identified by the stakeholder group for disinvestment as it was felt that there were opportunities to make efficiency savings in these areas. Only two of these were worked up into full business cases (Home oxygen service and Medicines management (prescribing)). Members from the group produced the business cases using the revised CTP business case template, which reflects the agreed criteria that address both disinvestments / investments.

Home Oxygen Service

The oxygen service was identified as one of the main cost drivers from the interviews undertaken earlier. The group agreed that disinvestment in this project will not result in any additional substantial savings as substantial savings have already been made as a result of the review of the service. It emerged that only 51% of home oxygen patients were actually COPD patients - equating to only 28% of the total home oxygen costs. However, a decision was taken by the group that only the acute hospital oxygen service would be able to place patients on oxygen. All GPs would have to refer patients to the oxygen service for assessment rather than place them on oxygen themselves.

Medicines Management (Prescribing)

Inappropriate prescribing was also recognised as one of the problems faced in the area from the interviews undertaken earlier. Inhaler prescribing was identified as an area with a potential for significant cost savings. As prescribing data did not provide detailed information as to the reasons why particular inhalers were being prescribed, the stakeholders decided that an audit should be undertaken by General Practices (GP) within North East Lincolnshire to investigate this further.

The audit had a positive impact on the care provided to COPD and Asthma patients. It has led to the following improvements:

- Introduction of appropriate treatment for patients linked to their clinical condition
- Release of resources. Patients are being reviewed as opposed to strategically switching inhalers, therefore the change in prescribing is more gradual and new patients are treated in line with agreed guidelines. Work is still on-going within practices to review prescribing of Seretide 250 Evohalers
- Fostair being recommended within the guideline. It is now becoming a mainstream treatment for asthma within the community
- Reviewing and updating of the locality care pathway for COPD in line with NICE guidelines
- Production of new asthma guidelines in an evidence based way. The costs of the different inhalers were added onto the asthma guidelines for awareness
- Training sessions have been provided for practices by the respiratory nurse specialist and the respiratory physician. Early recognition and management of risk factors in primary care, patient education and immunisation to prevent ill-health were included in order to improve health.

Emergency Admissions

There was some discussion as to what was the exact percentage of patients being admitted where an exacerbation of their respiratory condition was a key factor. The group acknowledged that the CTP had undertaken significant work on emergency admissions and agreed that this area should not be considered for further disinvestment and therefore not worked up into a full business case.

Investment ('Wish List')

Three priority areas were also identified for investment in Table 2 and a business case was developed for each of them. Only two were accepted by the group (Tobacco control and non-invasive ventilation).

Tobacco Control

- Community Smokefree Social Norms Project

The tobacco control business case described how the social norms approach supported by local frontline stop smoking services will be used to tackle the high smoking prevalence in North East Lincolnshire.The business case complements the smoking cessation services available, by addressing the social norms around smoking and other significant lifestyle interventions.

Social norms is an environmental approach which focuses on the entire community in which people live.Itis a highly cost effective and evidence based way of reaching large numbers of people, correcting misperceptions of the prevalence of a problem behaviour (e.g. smoking), and promoting healthier behaviours instead, e.g. being smokefree.The project was strongly supported by the group but it was felt that to maximise its impact the work should specifically target those parts of North East Lincolnshire where smoking rates are high and diseases caused by smoking are similarly high.It was finally agreed that the regionally funded pilot programme would be undertaken in West Marsh in the first instance.Voluntary Action North East Lincolnshire (VANEL) agreed to help coordinate this programme at the community level in this area and recruit about 10 volunteers to gather information from the community.

Following the pilot an investment business case for prevention was presented to the CTP dragon's den for funding approval.The business case was approved and further funding has been secured for 4 years.This programme has now been extended into the East Marsh area.

Non Invasive Ventilation (NIV)

- Securing resources for patients identified for NIV

The aim of this proposal was to enhance the current arrangements for the provision of NIV. The business case clearly detailed the objectives and opportunities for patients where a benefit is demonstrated NIV provision will reduce the number of admissions and will improve the quality of life for patients. This is both resource-releasing as a consequence of reducing admissions and improving patient care. Considering the cost implementation, the group felt that enhancing the current arrangements would rapidly lead to resource benefits. However, for this to be successful, the advisory group agreed that NIV should only be utilised after an initial trial for those patients who demonstrated the benefit to them. There is the option were it is shown not to be helpful, for the ventilator to be switched to a different patient, therefore, maximising the utilisation of this resource. The business case showed that cost benefits will be amplified after year one. This needs to be considered in the context that the ventilator usually has a life span of 7 years.

The CTP approved the NIV business case and 12 non-invasive ventilators were purchased.

Pulmonary rehabilitation

- New programme with a focus on patient education

This business case was rejected on the basis that General Practitioners should be providing this as part of their core service to patients.

Conclusions

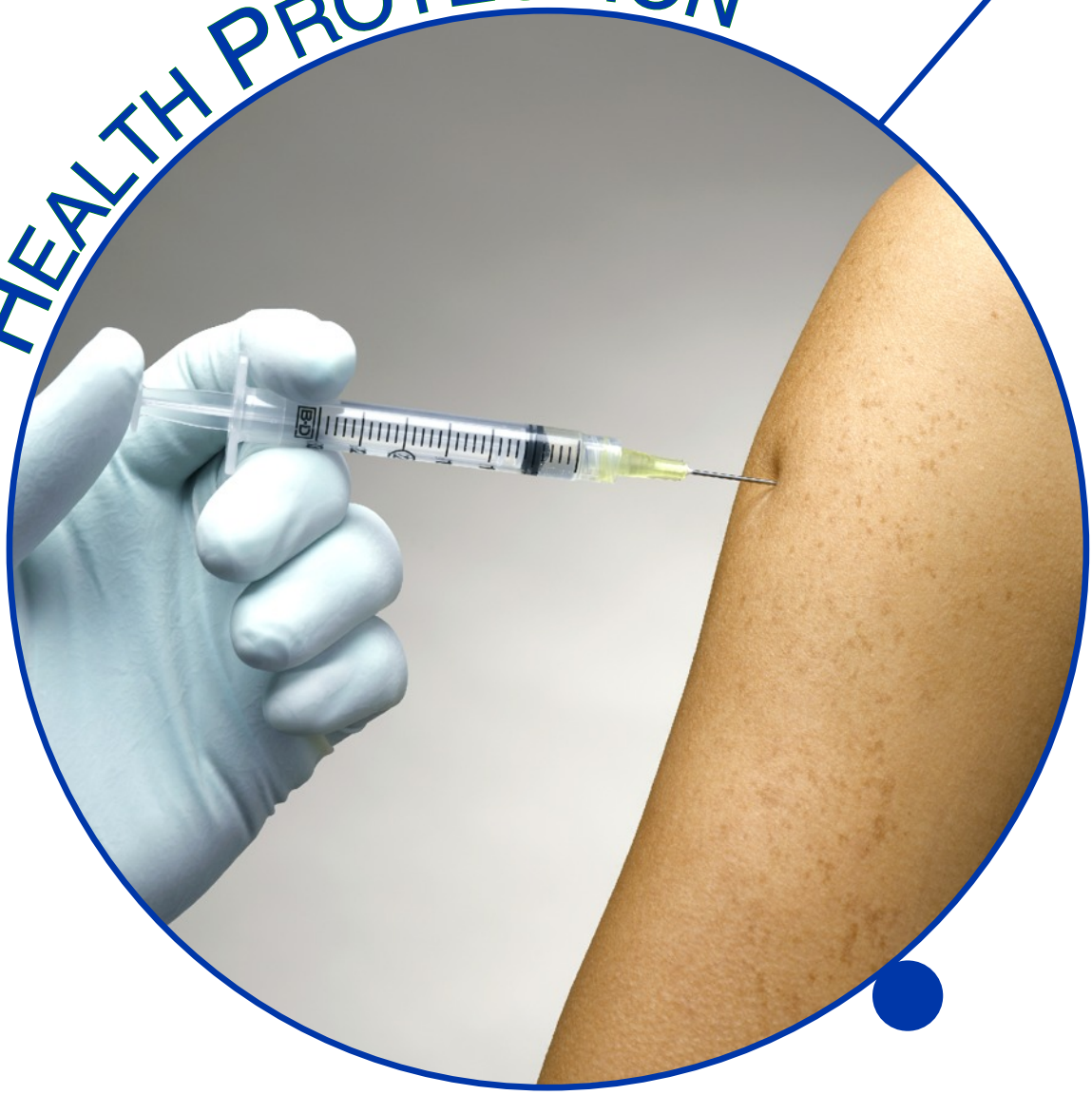
The PBMA project has been successful in bringing together professionals from different organisations and multiple disciplines to redesign the COPD and asthma service in a way that better integrates the divide between primary and secondary care in order to focus services much more around the needs of patients, rather than buildings.

Stakeholders were fully engaged, participated constructively in discussion and expressed their views openly. The PBMA work was successful in promoting prevention, improving health and shifting resources upstream. The multidisciplinary stakeholder group had one clearly defined goal and worked in a unified manner through several routes which has led to improved quality of care for COPD and asthma patients in North East Lincolnshire. The group realised the benefit of working together, pulling ideas together and unlocking more sustainable efficiencies and that savings can be made by tackling inefficiencies.

Although much of the work was carried out under the auspices of the former CTP, we have continued to support PBMA work in the Clinical Commissioning Group and we hope that this can continue to develop. PBMA has demonstrated that it is an effective way of reaching evidence based decisions which can ensure that decisions about investment and disinvestment are undertaken using a systematic decision making process which should ensure that service quality and efficiency is maintained and enhanced.

CHAPTER 5

HEALTH PROTECTION



On the 1st April 2013, as part of the Health and Social Care Act 2012, the Health Protection Agency which served North East Lincolnshire transferred into the new PHE. North East Lincolnshire is now covered by the North Yorkshire & Humber Health Protection Team. As part of the new arrangements the Health Protection Team have a responsibility to help local authorities and the NHS develop the public health system and it's specialist workforce. Below is a summary of the main surveillance information for notifiable diseases in North East Lincolnshire relating to communicable diseases, food poisoning and gastrointestinal infections, HIV/AIDs and immunisation.

Communicable Diseases

There were 42 positive laboratory reports for hepatitis C antibodies reported during 2012, 23 of which were PCR positive; 8 PCR negative. Most hepatitis C cases (locally and nationally) are associated with current or former injecting drug use; the virus being transmitted by sharing contaminated injecting equipment. There was one case of acute Hepatitis B and eight cases of chronic Hepatitis B notified.

Table 3 shows there were 3 laboratory confirmed cases of meningococcal infection (meningitis or septicaemia) during 2012. There was only 1 case of tuberculosis during the year, compared to 6 notifications in 2011.

Table 3: Notifiable Diseases, North East Lincolnshire, 2012

DISEASE	Notified	Laboratory Confirmed
Diphtheria	0	0
Dysentery	3	3
Leptospirosis	0	0
Malaria	1	0
Measles	11	0
Meningitis		
- Meningococcal	1	1
- Pneumococcal	3	3
- Haemophilusinfluenzae	0	0
- Viral	0	0
Meningococcal septicaemia	3	0
Mumps	10	0
Rubella	2	0
Scarlet Fever	33	1
Tuberculosis	1	1
Typhoid fever	0	0
Viral Hepatitis		
- Hepatitis A	0	0
- Hepatitis B: Acute	1	1
- Hepatitis B: Chronic/unknown	8	8
- Hepatitis C antibody positive	42	42
Whooping Cough	24	19

Source:
Public Health England - North Yorkshire & Humber Health Protection Team
Please note data is provisional

Food poisoning and Gastrointestinal Infections

The most common gastrointestinal organism was Campylobacter, with 136 cases, a decrease from 187 cases in 2011, as shown in Table 4. Less commonly identified gastrointestinal organisms included Salmonella (19 - compared to 14 in 2011) and Cryptosporidium (17). There were no reported cases of the potentially serious E.Coli 0157 infection (1 case was reported in 2011).

Table 4: Gastrointestinal organisms reported from laboratories, 2012

Gastrointestinal Organism	Reported Number
Campylobacter	136
SRSV/Norovirus	53
Salmonella	19
Cryptosporidiosis	17
Shigellasonnei	2
Shigellaboydii	1
E.coli 0157	0
Giardia Lamblia	0

HIV/AIDS

During 2011 (the most recent year for which data is available), a total of 47 people from North East Lincolnshire accessed treatment and care services for HIV/AIDS, a figure very similar to 2010 (when 48 people accessed services).

There were 30 males and 17 females, amongst which 31 were of white ethnicity, 8 were Black Africans, and 8 reported as “other”. There were 35 persons receiving triple or quadruple drug therapy, and 2 were receiving single drug therapy. Amongst the males, 16 acquired the infection through sex with other men and 12 became infected via heterosexual intercourse. Almost all females (16 out of 17) acquired the infection via heterosexual intercourse. There was 1 case contracted through injecting drug use and one case of mother to child transmission. In terms of socioeconomic status, 36 of the cases belonged to the two most deprived groups, while 9 belonged to the two least deprived groups.

Hepatitis C Look-back Exercise

During 2013 Public Health England Yorkshire and Humber co-ordinated a complex look-back exercise involving a hepatitis C infected healthcare worker who had previously worked in obstetrics and gynaecology in England between 1975 and 1983 with the early part of their career working at Grimsby Hospital (now Diana Princess of Wales). Like most people who are infected with hepatitis C, the healthcare worker had no symptoms and was unaware of the infection until after they retired. Healthcare workers also have a professional duty to get tested if they consider themselves at risk of contracting a blood borne virus and since 2007, all healthcare workers who are new to the NHS are tested for hepatitis C by their employing Trust, including anyone performing certain procedures (known as exposure prone procedures). Existing NHS healthcare workers performing EPPs for the first time are also tested for hepatitis C. Though there is only a small chance that a patient might acquire hepatitis C through surgical contact with an infected healthcare worker those patients identified as exposed or possibly exposed to hepatitis C were sent individual letters and asked to call a confidential helpline for more information.

North East Lincolnshire had the largest number of potential women exposed due to the time the healthcare worker was employed locally. PHE worked with public health and partners to keep them updated on what became a national look back activity and fortunately no additional cases were identified locally.

Immunisation

During 2013 improvements to the immunisation schedule have taken place throughout the lifespan. These include:

- Protection against Rotavirus (given to babies /children)
- Protection against shingles (older people)
- Expansion of the seasonal flu vaccination beyond those people over 65 years and at risk. It now includes 2 and 3 year old children and will be expanded to cover all children over the next few years.

Figure 9 shows quarterly uptake of diphtheria, tetanus, pertussis, polio and Haemophilus influenza B vaccines in North East Lincolnshire between 2010 and 2013. The rates have remained relatively stable, and are considerably better than rates in Yorkshire and the Humber and the whole of England.

Figure 9: Quarterly Uptake of diphtheria, tetanus, pertussis, polio and Haemophilus influenza B vaccines in North East Lincolnshire, 2010-13

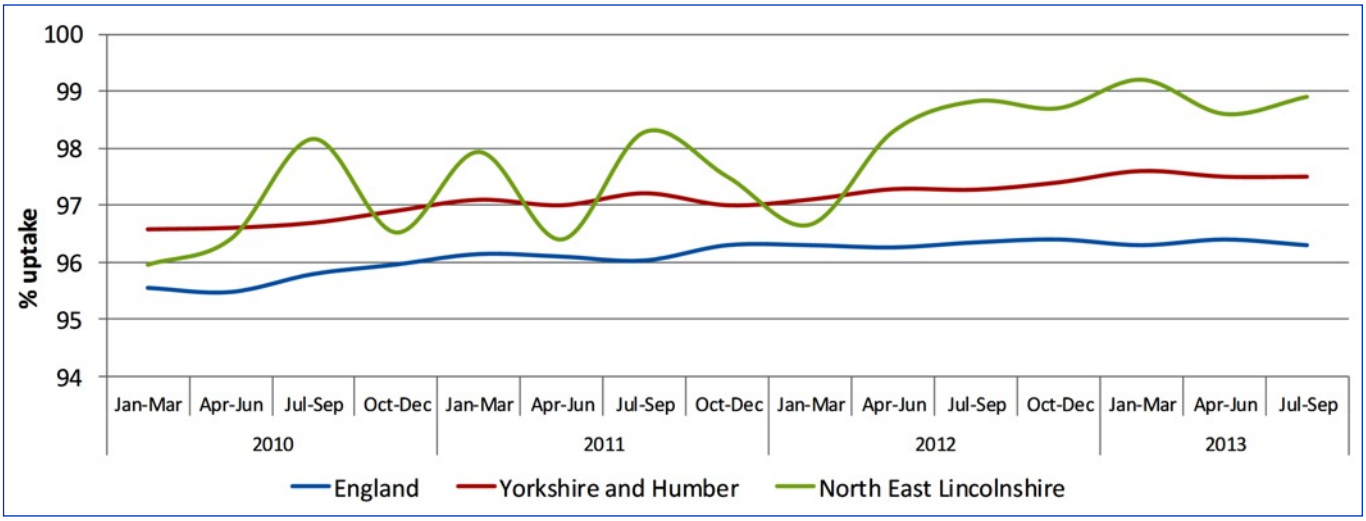
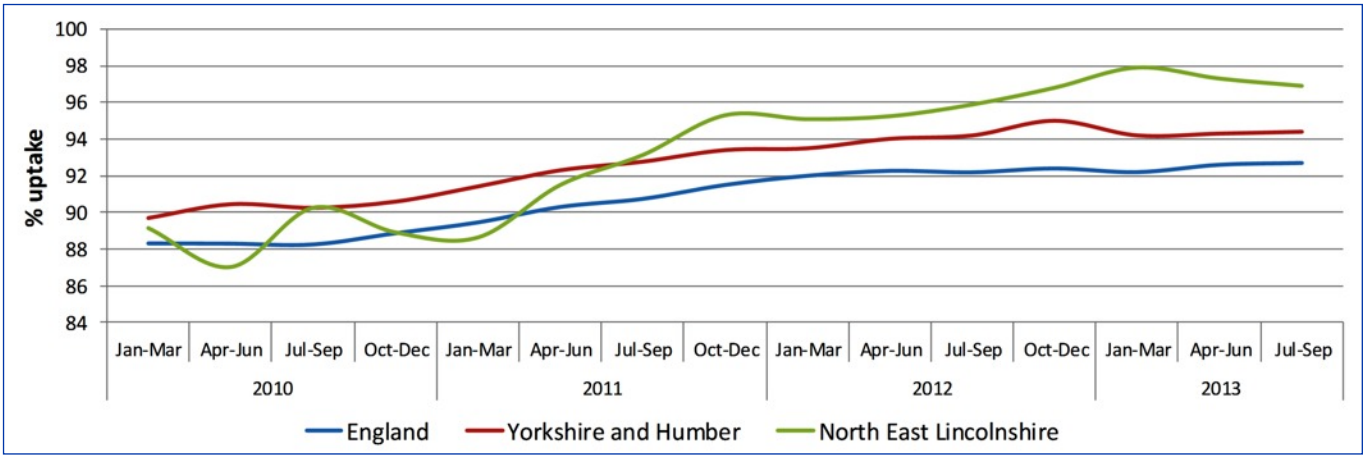


Figure 10 shows quarterly uptake of MMR (measles, mumps and rubella) vaccine in children under 2 years old in North East Lincolnshire for the past three years. From the first quarter of 2012 there has been a steady rise in uptake rates, reaching 99% uptake in the first quarter of 2013. This exceeds the uptake target of 95% in this age group, and is very encouraging. This rise may be linked to increased awareness and campaigns that have taken place as a result of recent outbreaks of measles in different parts of England and Wales. In contrast to most other parts of the country, in 2012 there were no confirmed cases of measles in North East Lincolnshire. The challenge will be to maintain recent improvements in uptake rates, and consolidate the gains from the last few years.

During 2013 when there were measles outbreaks in other parts of the country there was intensive partnership working to ensure that any child who had missed one or both doses of MMR for whatever reason where contacted and offered these to maintain high uptake levels.

Figure 10: MMR Uptake at 24 months, 2010-13



Concluding Remarks & Recommendations

I believe that ultimately the success of the transition of public health to local government will depend on how successful local authorities are at reducing a health inequalities gap which has remained stubbornly wide despite significant health gain in the wider population over the last four decades.

To achieve this will require a transformation of attitudes and methods of delivering our public health services and other services and functions which have a major impact on people's lives. Despite many challenges I think that we can be relatively satisfied with the progress that has been made in North East Lincolnshire during the first year that the public health responsibility has sat with the council. With the on-going harsh economic conditions it was never going to be easy to begin the transformation process but there has been a genuine shift in emphasis and a full commitment on behalf of members and officers across the council to ensure that enhancing health and wellbeing across North East Lincolnshire and reducing health inequalities is at the heart of the council's priorities.

Recommendation 1

The next stage will be to ensure that all our public health grant spending which currently equates to almost £10 million per annum is being spent in ways that are evidence based, effective and efficient. This process has begun with reviews of some of our highest spending areas but we will need to look at the entire spend and be prepared to make difficult decisions to ensure that investments can be made in those services and functions which are supported by evidence.

My first recommendation is therefore that public health carries out a detailed review of all spend within the public health grant to ensure that it is being spent efficiently and effectively and produces recommendations for how it can be spent better.

Recommendation 2

We must also continue to support the health sector, especially the CCG and the local hospital, to ensure that they are best placed to deliver health improvements to the population of North East Lincolnshire. The NHS faces its own major challenges in the years to come as it adapts to an ever ageing population at a time when the fiscal challenge is only likely to get harder.

My second recommendation is therefore that Public health capacity must be maintained so that the council is able to effectively deliver the core offer to the NHS which remains one of the five mandated functions for Local Authority Public Health services.

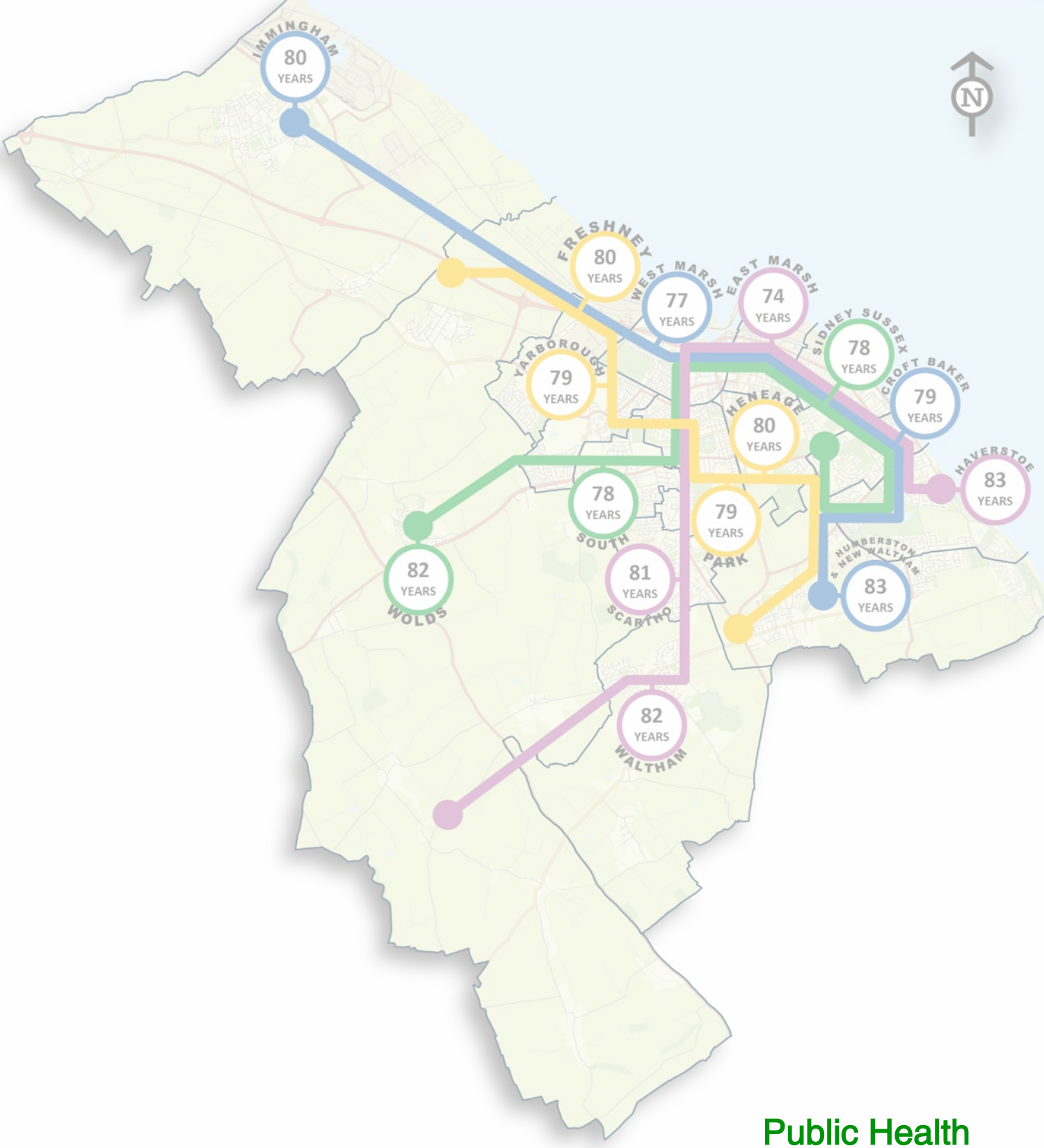
Recommendation 3

Whilst the council will be leading and developing the public health system in North East Lincolnshire, Public Health England has a substantial contribution to make to help us to achieve our outcomes. In the last few months I have held positive meetings with the PHE regional lead for health protection, their regional lead for drugs and alcohol, their Yorkshire and Humber lead for screening and immunisation and the national Chief Executive, Duncan Selbie. It was clear from all these meetings that PHE fully accept the principle that the era of national prescription for public health is over and health priorities, actions and spending should be determined locally. They will be supportive with regards to methods of delivery but challenging when it comes to assessing whether outcomes improve over time. That is as it should be.

My final recommendation is therefore that under the leadership of the DPH the council should develop close working relationships with Public Health England to ensure that the local public health system is strong and resilient and continues to produce good outcomes for health protection services.

"The public health transition is over and the transformation has begun."

Geoffrey Barnes
Acting Director of Public Health
May 2014



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