NORTH EAST LINCOLNSHIRE COUNCIL
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North East Lincolnshire NHS
Care Trust Plus

PUBLIC HEALTH ANNUAL REPORT 2011/12

ON THE HEALTH OF THE PEOPLE OF NORTH EAST LINCOLNSHIRE

Cover photograph courtesy of Michael Huntley

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INTRODUCTION

Public Health in England is about to begin an exciting new era. Almost 40 years after the responsibility for public health was shifted from local government to the NHS, local government will once again regain this responsibility in April 2013. This will provide a range of new opportunities and challenges. Our greatest challenge will be to ensure that health improvement is at the heart of strategic planning in North East Lincolnshire and that there is a commitment across the Local Authority and all partner organisations to make improved health and wellbeing in its broadest sense a top goal for our area. We will need to work closely with elected members and with the new Health and Wellbeing Board to deliver an effective Health and Wellbeing Strategy that will bring about sustained improvement in health and a reduction in health inequalities. This will involve much more than a traditional approach to health improvement, it will require action right across the social and economic system in North East Lincolnshire.

One of the reasons behind the return of Public Health to Local Government is the perception that in many of the more deprived parts of the country health has not improved as much as was anticipated and therefore health inequalities have remained stark. Public health work at one primary care trust has provided some insight as to why this might be.

A few years ago the Director of Public Health for Sandwell in the West Midlands, John Middleton, was perplexed by his area's failure to improve health as fast as the rest of the country and was subject to regular criticism under the last government's performance regime for failing to improve life expectancy fast enough or reduce health inequalities in line with national rates, despite the big increase in investment in local health services. He therefore decided to investigate the reasons for this. What he discovered not only explains some of our difficulties in improving health in North East Lincolnshire today but also highlights the vital importance of addressing youth unemployment which is once again alarmingly high.

He found that men aged between 45 and 65 years in the Sandwell area were dying well before their time because they had been made unemployed during the recessions of the 1980s. I make no apologies for quoting directly from Dr Middleton's recent article in the Health Service Journal because the message is so important[1]:

"Most of them had left school at 16, secure in the expectation of a lifetime's job in manufacturing. When the jobs in manufacturing went, the chances of something else in IT, finance or new technology did not exist. Most of that generation did not work again except for casual, dirty, dangerous, wearisome and unrewarding work. They lived out much of their lives smoking and drinking in pubs, eating cheap, processed foods high in fat, being inactive, but being also stripped of opportunity, respect and hope, living for the dole cheque, afflicted by coronary heart disease or lung cancer at an early age. And now a new and even bigger generation are looking forward to lives of hopelessness, bereft of dignity, meaning and value. We should project a decrease in life expectancy again in 2030, if we cannot give meaningful existence to our new generation of young people who are keen and hungry for work.

Economic deprivation in one generation will have an impact on their health for many years, and ultimately result in their untimely deaths. It should be compelling enough evidence to put our potentially lost one million young people back to work now for their own good, for the good of our community safety and for our nation. If we don't, we might simply heap a burden of ill health and early death upon them and society in 30 years' time. Surely this makes it all the more urgent that we get people back to work."

Inspiring words which need to be heeded in North East Lincolnshire and many other places where unemployment is once again blighting a whole generation.

This year's annual report has a slightly different style to previous publications and is divided into three sections. The first section provides a special report identifying the strong links between drug and alcohol misuse, poor health and crime. It also describes some of the effective strategies and services which our Drug and Alcohol Action Team have introduced to tackle these issues in a joined up way. Section 2 provides a brief summary of a health equity profile of respiratory disease in North East Lincolnshire. The full version of this report is available on the NE Lincs Informed website (link below). Section 3 describes a number of important health improvement initiatives which have been introduced in response to issues identified in last year's public health annual report. I describe some important strategic work being led by our Tobacco Control Coordinator and Smoking Cessation Service to combat smoking in our communities, a new peer support service to promote and support breastfeeding, a promising new community development project to promote awareness of cancer symptoms, and a joint initiative between our health promotion service and a Grimsby school to encourage healthier diets in our children and young people. Finally I will provide some concluding comments and identify three overarching recommendations for Public Health in North East Lincolnshire going forward.

You may notice that this year's annual report does not include an epidemiological overview. This is because this information is now being produced as part of the Joint Strategic Needs Assessment (JSNA) and is readily accessible all year round via the NE Lincs Informed website **(www.nelincsdata.net/ias).**

REFERENCES:

1. MIddleton J (2012) Unemployment is bad for your health - now and in the future. Health Service Journal.

CONTENTS

ACKNOWLEDGEMENTS

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

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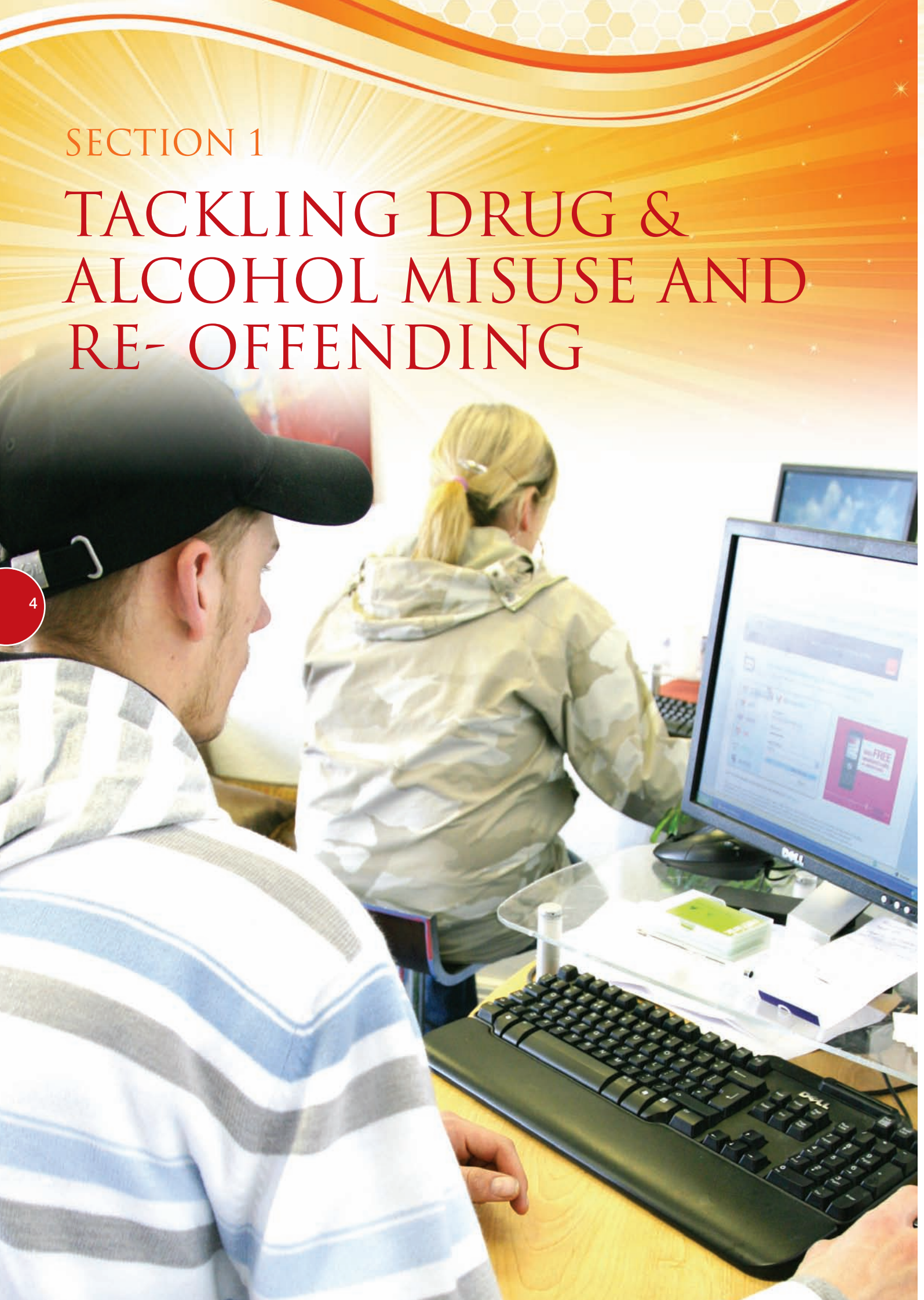
SECTION 1

TACKLING DRUG & ALCOHOL MISUSE AND RE- OFFENDING



The cost to society of illegal drug use and alcohol misuse runs into billions, required to treat the health, crime and social problems generated. In North East Lincolnshire the levels of such use, health inequalities and overall crime levels are significantly worse than England averages. Those problems impact upon the workload and budgets of all local agencies contributing to chronic ill health, high hospital admissions, crime, family breakdown, poor educational attainment, unemployment, teenage pregnancies and much more besides.

Locally we have linked efforts to tackle drug and alcohol misuse with those to stop criminals re-offending as in a large proportion of cases we are dealing with the same people. Most local crime is committed by a few local offenders, so it makes sense to target the few and try to prevent them continuing their 'lives of crime'. But what has this got to do with Public Health? Every crime has a victim and for many crimes the public health link is obvious – violent crime being the obvious. But being a victim of any crime can engender a number of negative emotions and reactions - fear, anxiety, mistrust, anger - which can in many cases manifest as physical or mental ill health. Then consider that most crime occurs in our worst areas of deprivation where lifes' problems are already magnified and it's easy to see that high levels of crime in an area are bad for a community's 'health'.

Providing effective drug and alcohol treatment and reducing re-offending by partners working together to provide 'pathways' back to 'recovery' and positive citizenship supports good public health.

What does the local problem look like?

Drugs

1388 individuals were estimated to use heroin and/or crack cocaine in North East Lincolnshire during 2009/10, representing a 10% drop from the previous year. 93% of that total are heroin users and we have a higher rate of heroin and crack cocaine users than regionally and nationally. The number of individuals using other drugs is not known but during 2010/11 1068 individuals were in treatment in North East Lincolnshire and 964 of those (90%) used heroin or crack cocaine as their main drug but most used other drugs like cannabis, benzodiazepines and amphetamines and often alcohol as well.

Drug treatment in North East Lincolnshire for our predominant heroin problem usually involves long term structured engagement with services, involving expert medical intervention, prescribing of a legal replacement such as methadone, supported with psycho-social interventions (counselling and 'pathway' support). About a third of the total in treatment are women and the bulk are aged between 25 – 65 years, with an increasingly ageing population. The use of heroin amongst the young seems to be declining, following national trends.

Analysis of those in both drug (and alcohol) treatment reveals that the majority live in our most deprived areas and currently 40% of those in treatment have entered via the Criminal Justice System as an offender. This high relationship between offending and drug treatment means that large numbers are not initially 'volunteers' and places extra demands on local treatment services. It requires close working relationships with the police, probation and prisons, to ensure drug using offenders are identified, enter treatment in the community, continue it in prison, and are picked up by community services again upon release. An average of 135 people are drug tested for heroin and/or crack cocaine in police custody upon arrest each month, with about 40 testing positive. These are compulsorily required to attend the offender based Drug Intervention Programme (DIP).

In short we have a high number of offenders using highly addictive and dangerous Class A drugs that need to be engaged in effective treatment if we are to reduce the health, social and crime problems that they generate.

Alcohol

In 2006 the Public Health team completed a research study into harm caused by alcohol misuse in North East Lincolnshire. This study came to the conclusion that North East Lincolnshire has an ingrained culture of 'hard drinking'. It revealed that there are about 25,500 people in North East Lincolnshire who regularly drink beyond sensible limits, with 15,000 being regular binge drinkers and about 5,000 of the total being dependant on alcohol. Surveys show our school pupils are statistically more likely to have tried alcohol and been drunk more often than the England average - and girls are more likely to get really drunk than boys. This local need led us to develop a local Alcohol Strategy, known as Reasonable Measures in 2007.

Just as with drugs not all problem drinkers will go on to commit crime and disorder and be repeat offenders but the link between alcohol and crime is clear. North East Lincolnshire has the second worst rate of alcohol related crime and alcohol related violent crime in the Yorkshire and Humber region. In response we set up our own Alcohol Intervention Programme (AIP) in 2008 to specifically tackle alcohol based offending in a similar way to DIP for drugs. This activity has given us greater information about how alcohol fuels crime. We have found that about 40% of all arrests are linked to alcohol use, with about 150 offenders each month being referred to our AIP. Drink and violence, especially domestic violence are particularly prevalent.

Research shows that most people who are slipping into excessive or binge drinking respond well to a simple questionnaire (screening) and then Information and Brief Advice (IBA) about the potential problems they are likely to face if they continue. The screening is scored and shows individuals what common effects their drinking habits induce. The scoring shows that sensible drinking is 'Low Risk' but beyond that 'Increased' or 'Higher' Risk occurs and beyond that possible 'Dependence'. However the good news is that most people reflect upon IBA, or slightly longer and detailed Extended IBA, and amend their drinking habits positively. Where the screening score indicates dependence, specialist treatment is advisable. The following chart shows how we have increased this activity since we launched Reasonable Measures in 2007.

Table 1.1 Increases in alcohol treatment productivity

	2008/09	2009/10	2010/11
Number screened	4850	6595	7633
Number of Information & Brief Advice (IBA)	361	812	1916
Extended IBA	85	427	699
Specialist Treatment	347	366	445

One of the most obvious effects of alcohol misuse is the national rise in alcohol related hospital admissions, costing the NHS £2.7 billion per year and North East Lincolnshire £5.4 million in 2009/10. The interventions described above are known as 'High Impact' – they reduce such admissions and save money.

What does treatment deliver?

The Public Health Department's Drug and Alcohol Action Team (DAAT) carry out an annual assessment of what local treatment services need to deliver in order to tackle our local problems and meet national requirements. The aim is to develop a system, where different services work together to provide a variety of treatments for different people's needs; some will stay in one service but others will move between them as their needs change. Three services are only for offenders, several are based in GP surgeries whilst others provide more specialist care. The system allows direct access with little, or often no waiting time. Carer support is available for those affected by another person's drug or alcohol misuse. The system also delivers a needle exchange scheme so that injecting drug users do not spread blood borne viruses and this is complemented by a proactive hepatitis screening and inoculation programme.

So what do we expect drug and alcohol services to deliver for the local population? The discussion so far suggests less crime, fewer repeat offenders and improved health for those involved and the remainder of this section is devoted to explaining how the route to those expectations has changed since the Government's 2010 Drug Strategy.

Recovery

The main policy shift has been to demand a more ambitious outcome from drug treatment – 'recovery' – more people than ever before off drugs for good and fully re-engaged with the community. Prior to this the overall aim of drug treatment was seen as one of harm reduction, mainly directed at the deadly heroin epidemic and aimed at reducing drug related deaths, the spread of blood borne viruses such as hepatitis, HIV and AIDS and the crime associated with stealing to 'fund a drug habit'.

The new recovery agenda initially demanded a culture shift amongst treatment providers, individual practitioners, clinicians and the service users themselves. They all know that drug (and alcohol) addiction are long term chronic relapsing conditions people give up only to start again, just as with smoking, meaning long term 'cures' are difficult. However that shift has occurred in North East Lincolnshire and now service users are far more optimistic about their long term aspirations and see their peers abandoning illegal drugs, completing treatment and leaving 'drug free' and sustaining it.

The North East Lincolnshire treatment system, as we have seen is faced with particular challenges and our rates of 'recovery' at 12.5% in 2011/12 – measured by the proportion of people leaving the treatment system drug free and not returning within 6 months remain below the national average of 14.8% in 2009/10. However our successes continue to increase. 60 individuals left drug free in 2008/09, increasing to 106 last year and 136 in 2011/12.

For anyone to achieve lasting recovery from drug or alcohol misuse, access to decent housing, education, training, employment and wider support services are vital alongside treatment. Locally we have seen huge strides forward in this respect with well integrated working between drug, alcohol and offender services.

Reducing Re-offending

During 2009, partners in North East Lincolnshire identified gaps in the local approach to reducing re-offending amongst substance misusers. The main issue of concern was that it was only tackling those with long offending histories and subject to probation supervision. It was not flexible enough to identify and tackle offenders currently causing most harm in local neighbourhoods. In late 2009, North East Lincolnshire adopted an Integrated Offender Management (IOM) approach, under the banner of 'Better Together', bringing criminal justice services into partnership with the Local Authority, substance misuse treatment services, health, education and employment agencies to work with a wider group of offenders to tackle not only their offending but also its causes. These so called 'pathways' out of crime match those needed to support drug and alcohol services in helping towards recovery.

Accommodation: Surveys of North East Lincolnshire offenders in prisons in November 2011, showed that 35% identified lack of suitable and settled accommodation as being a causal factor in their offending and 32% believed they would be transient or have no fixed address on prison release. The new partnership approach has included North East Lincolnshire Council's Strategic Housing and Supporting People departments as well as Private and Registered Social Landlords, the YMCA and Salvation Army Hostels. Pre-release planning and a resilient infrastructure of housing provision and support have resulted in no individual needing to be roofless in our communities.

Substance Misuse: Of 607 offenders in the community and under Probation Service supervision during November 2011, 46% identified alcohol as being a causal factor in their crimes, with 28% similarly identifying drugs. In respect of 257 offenders in prison, these factors increased to 55% and 48% respectively. To address the link between drug and alcohol misuse and crime, substance misuse treatment services are embedded within the IOM framework, retaining individuals in service until they are both crime and drug free.

Physical, Emotional and Mental Health: Significant numbers of offenders report current needs in their physical, emotional and mental health with many linking their offending behaviour to those needs. The IOM framework ensures that all offenders receive health screening and are supported to access health services. The district benefits from Open Door, a community based Health and Social Care day centre that specialises in support for the vulnerable and hardest to reach in our communities.

Finance, Benefit and Debt: 26% of offenders serving community sentences identify lack of ability to manage finance as a cause of their offending. This increases to 46% of all offenders in custody and 76% of those serving short-term sentences. A number of agencies exist locally to provide information and guidance for benefit and debt and, working together as a financial inclusion forum, they are developing more visible and robust pathways for the offenders in IOM and within substance misuse services.

Young Offenders, Children and Families: The Youth Offending Service (YOS) has been an integral element of IOM since 2009, applying the same methods as applied to adult offenders. Year on year the YOS have achieved a significant reduction in re-offending by young persons and a reduction in first time entrants to the criminal justice system.

Women Offenders: The Baroness Corston Report recommends women's specific services to resolve issues for women involved in the criminal justice system. The Report recognises the improvements made in prisons for women offenders but also the poorer outcomes for women once released into the community. Women suffer problems accessing the 'pathways' far more than men. Humberside Probation Trust in partnership with Women's Aid and local Children and Family centres has developed a range of resettlement and recovery interventions specifically for women offenders.

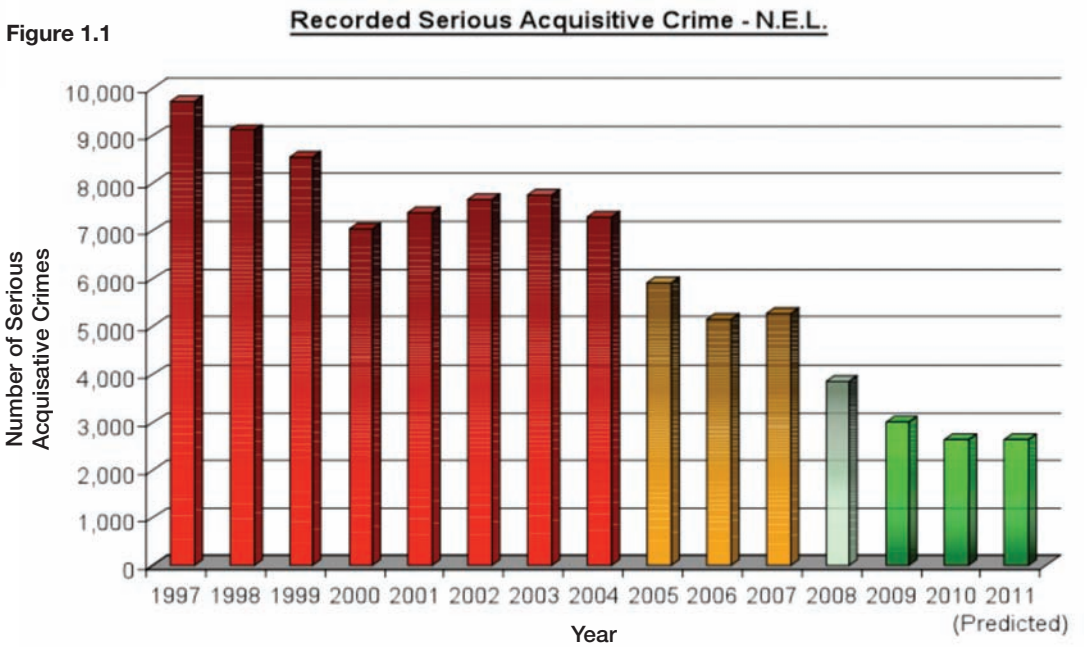
Education, Training and Employment: North East Lincolnshire is challenged by a significantly higher rate of the working age population being not in work or receiving benefit. Jobs in North East Lincolnshire are in the main, low skilled with low rates of pay; many being part-time or shift work. 50% of offenders in the community are unemployed with 75% of those in custody being unemployed at time of conviction. 32% of all offenders link their lack of education, training and employment to offending.

In January 2011, a consortium of 16 partner agencies led by the Care Trust Plus and Shoreline Housing Partnership, launched EMPOWER, an Employability Mentoring Programme framed to overcome the barriers to employment faced by offenders/ex-offenders. This programme provides interventions to meet individual needs. By November 2011, the programme had supported 243 referred clients. The support provided by programme peer group mentors and volunteers has provided a range of services from accommodation, confidence and emotional health to access to transport options. Additionally, the programme has helped the client group to access training and qualifications and also volunteering activity. On 1st December 2011, the programme had helped 42 individuals to enter sustainable employment and a further 39 to progress to being work ready and being supported to gain employment.

Individuals engaged within the EMPOWER programme also improved their situation around housing, health, substance misuse and finance. Following EMPOWER engagement, there is a significant reduction in offending and in most cases a total cessation of crime.

The following graph provided by Humberside Police shows how acquisitive crime levels (burglary, car crime and robbery) have fallen since 1997. The drop in 2005 followed the first full year of the Drug Intervention Programme (DIP) for offenders. The drop in 2007/08 coincided with the introduction of a similar scheme for alcohol offenders (AIP) and the last three year's performance reflects the impact of IOM to which DIP and AIP are integral. The reductions in these types of crime that are particularly suited to an IOM approach represents over 6,000 fewer victims in 2011 compared to 14 years ago. Continued efforts to get more individuals to give up drugs, moderate their drinking and reduce offending will contribute to improving local Public Health.

Figure 1.1



The on-going integration of partnership working to tackle drugs, alcohol and reoffending appears to be delivering tangible positive results in relation to improving health and reducing crime and disorder. Further extending that integration into support services such as housing, training and employment opportunities remains the current and on-going challenge. The current climate of financial austerity looks set to continue for a number of years and how to further integrate this type of work with other related 'interventions' may present future opportunities.

Recommendations

1. As the responsibility for delivering reductions in substance misuse shifts from Community Safety Partnerships to Public Health within Local Authorities and Health and Well Being Boards, the existing and successful links to reducing reoffending must be recognised and maintained.
2. The work to screen individuals for alcohol misuse and then deliver Information and Brief Advice with referral to specialist treatment for those that need it could be extended and better coordinated, further helping to improve health and save money. The emerging Clinical Commissioning Group should consider rolling out screening and IBA across the whole of the health community and providing additional capacity for community specialist treatment to help dependent drinkers.

SECTION 2

RESPIRATORY DISEASE EQUITY PROFILE FOR NORTH EAST LINCOLNSHIRE

The British Thoracic Society state in their latest report[1] on the burden of lung disease that respiratory disease now kills one in five people in the UK and accounts for more deaths each year (117,456 in 2004) than ischaemic heart disease (IHD – 106,081 in 2004), and as such is the second biggest cause of mortality. This difference is exacerbated across social classes as social inequality is associated with a higher proportion of deaths in respiratory disease than any other disease area (44% compared to 28% of deaths for ischaemic heart disease).

Respiratory cancers are some of the biggest respiratory killers (30% of all respiratory deaths), followed by pneumonia (29% of all respiratory deaths). Chronic obstructive lung disease, mainly chronic obstructive pulmonary disease (COPD), is the third biggest cause of respiratory death, accounting for more than one fifth (23%) of all respiratory deaths[1].

Respiratory disease is the second most common illness responsible for emergency admission to hospital and cases of COPD take up more than one million (1,099,440) hospital bed days a year in England (2004). Respiratory disease costs the UK £6.6 billion in 2004 – £3.0 billion in NHS care costs, £1.9 billion in mortality costs and £1.7 billion in morbidity costs. In 2002/03, 25 million sick days were taken due to respiratory diseases, not including self-certified sick days[1].

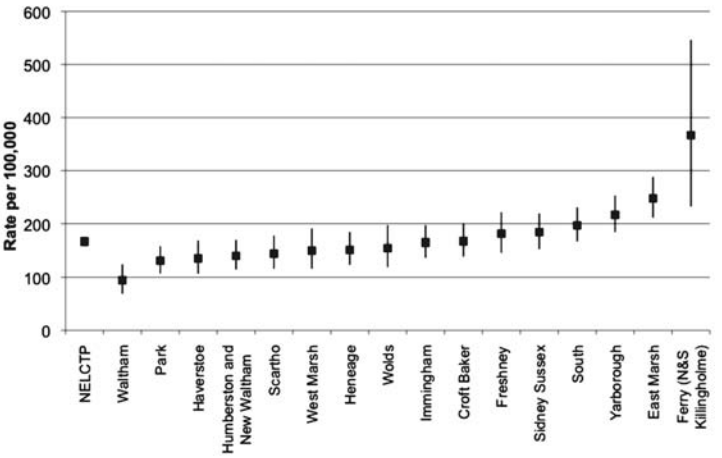
Influenza and Pneumonia

Influenza vaccination in the population aged 65 and over has been declining locally since 2005/06, down to 70.8% in 2009/10. This is well below the WHO target of 75%.

In 2009/10, 89.4% of children were immunised with pneumococcal vaccine locally by their second birthday. This is higher than the national but lower than the regional average and below the local target of 92%. 69.3% of the population aged 65 and over have been vaccinated with Pneumococcal Polysaccharide Vaccine.

Hospital admission rates for pneumonia in East Marsh, Yarborough and Ferry ward were all significantly higher than the area average, as was Fiveways Neighbourhood.

Figure 2.1 Hospital admissions (primary diagnosis) pneumonia in North East Lincolnshire by electoral ward of residence, 2005-2009, all ages, rates per 100,000



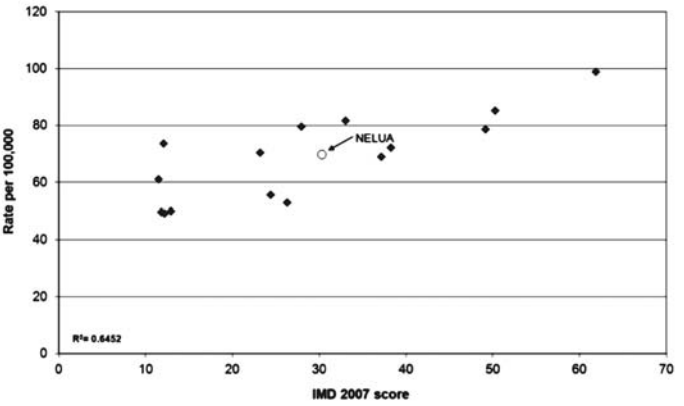
Asthma

10,338 patients were on asthma disease registers in North East Lincolnshire in 2008/09, equating to overall prevalence of 6.09%. Practice prevalence ranged from 4.17% at Stirling Street Medical Centre to 10.38% at Open Door.

Mortality rates from asthma are similar in North East Lincolnshire (1.92/100,000) to England (1.24/100,000) and Yorkshire and the Humber (1.46/100,000). Emergency hospital admissions for children under 16 due to asthma were significantly lower than the England and Yorkshire & Humber average with North East Lincolnshire ranking 12th lowest of 152 PCOs nationally. Admission rates have decreased year on year since 2005/06 to a 6 year low of 134.68/100,000 in 2008/09.

A strong positive correlation was found between deprivation and asthma admissions (r=0.803, p<0.01) with 65% of the variation in admissions explained by deprivation. The admission rate for those living in the most deprived quintile of North East Lincolnshire was significantly higher than the area average and for those living in the more affluent quintiles.

Figure 2.2 The relationship between electoral ward deprivation and asthma hospital admissions 2005/06-2009/10, rates per 100,000



Chronic Obstructive Pulmonary Disease (COPD)

COPD mortality rates declined in North East Lincolnshire in 2009 after increasing since 2005. Rates are now back to levels seen in 2006. North East Lincolnshire CTP ranks second highest in the Yorkshire & Humber region for COPD mortality with a rate which is significantly higher than England and Yorkshire and the Humber region.

For those living in the most deprived quintile, mortality rates were significantly higher than the area average and the more affluent areas. Mortality rates were significantly higher in West Marsh, South and East Marsh.

Hospital admissions from COPD were also strongly correlated with deprivation ($r=0.926$, $p<0.01$), with 86% of the variation in admissions explained by deprivation. The highest hospital admission rates were also in the most deprived wards of East Marsh and South and Fiveways ward. As with mortality from COPD, for those living in the most deprived quintile, admission rates were significantly higher than the area average and the more affluent areas.

North East Lincolnshire ranked 3rd highest of 152 PCTs for persons and highest for males for years of life lost due to mortality from bronchitis, emphysema and other COPD. A separate indicator for years of life lost due to bronchitis and emphysema reveals that most of this impact is a result of other COPD.

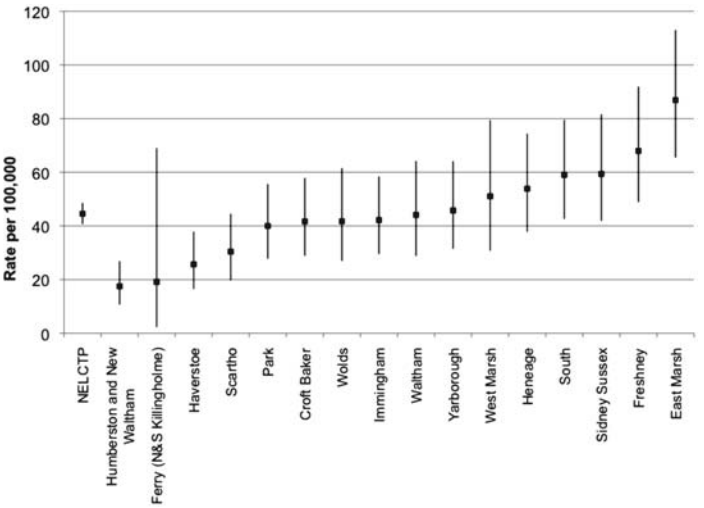
Lung Cancer

The lung cancer mortality rate in North East Lincolnshire declined over the period from 2001 to 2004 after which it increased. The North East Lincolnshire rate has remained below the regional rate but above the national rate for much of the decade since 1999, however, it increased in 2008 and again 2009 to be higher than both regional and national rates. North East Lincolnshire has a statistically significantly higher rate of mortality from lung cancer than the England average, and is in the mid-range in the Yorkshire & Humber PCTs.

The highest mortality rate occurred in East Marsh ward and the lowest in Humberston & New Waltham. Fiveways neighbourhood had a mortality rate significantly higher than the area average.

Mortality rates in the most deprived quintile of North East Lincolnshire were significantly higher than the area average and in the more affluent areas. For females, the mortality rate in the most deprived quintile was almost 2.2 times higher than in the more affluent areas (64.15/100,000 compared to 29.3/100,000).

Figure 2.3 Mortality from lung cancer in North East Lincolnshire by ward, 2005-2009, rates per 100,000



The highest rate of hospital admissions also occurred in Fiveways neighbourhood. As with deaths, admission rates for residents of the most deprived quintiles were higher than in the more affluent areas (significantly so for persons).

Recommendations

- due to a 5 year decreasing coverage of influenza vaccination coverage in the population aged 65 and over, work is undertaken to promote the importance of immunisation in this and other vulnerable groups of the population.
- asthma management and control are prioritised in patients living in deprived communities.
- urgent work is undertaken to address the high COPD mortality rate in North East Lincolnshire. Despite a reduction in the rate in 2009, for 2007-09 North East Lincolnshire ranked 16th highest of 152 PCOs nationally.
- work is particularly targeted in the most deprived wards – West Marsh, South and East Marsh wards were the areas with the highest mortality from COPD.

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1. British Thoracic Society (2006). The Burden of Lung Disease: 2nd Edition. (www.britthoracic.org.uk/)

SECTION 3.1
SMOKING

Although smoking prevalence is slowly reducing in North East Lincolnshire, we still have one of the highest smoking levels in England with about 35,000 adult smokers (27% of the population). This results in levels of lung cancer, other respiratory diseases, stroke and heart disease in our communities between 35-50% higher than the national average.

Too many young people, particularly girls, are still taking up smoking despite the known health risks that this poses and although the proportion of women who are smoking during pregnancy has reduced from over 30% to 23%-25% in 2011/12, North East Lincolnshire still has the highest rate in the Yorkshire and Humber region.

Details of 4 initiatives are provided below to illustrate what is currently taking place locally to tackle these issues.

1. Changing attitudes and behaviour towards smoking through a Community Social norms approach

Our behaviour is often influenced by what we perceive as 'normal' or 'typical' and often we do what we think the majority of others are doing. If people believe that the majority of their peers smoke, for example, they are more likely to smoke themselves. The problem with this is that our views about what we think the attitudes and behaviour of others are can be very different to what they are in reality. Social norms marketing can help to identify these differences which can then be used to inform a community what is actually happening which can turn in help to bring about positive changes in attitude and behaviours

North East Lincolnshire is taking part in a regional study to identify how effective a social norms approach can be to change smoking behaviour. 500 questionnaire responses have been obtained from residents in West Marsh which ask questions about what they do or think about smoking issues and what they think other people do in their community. Using this information, a health promotion campaign will be designed and implemented through 2012 and beyond to highlight the differences between these perceptions and gradually bring about a change whereby smoking will be seen as less desirable and less acceptable.

2. Reducing the numbers of women who smoke during pregnancy

There are many short and long term adverse health implications associated with smoking during pregnancy for both the mother and baby which include an increased risk of premature birth, miscarriage or low birth weight. The baby is also at increased risk of respiratory problems such as asthma and bronchitis and of having poorer intellectual development and behavioural problems.

Although between 23% and 25% of mothers in North East Lincolnshire smoke during pregnancy, there is considerable variation between different wards. In 2009/10, less than 2% of women smoked in pregnancy in Waltham and Haverstoe wards whereas the figure was over 30% in West Marsh, East Marsh and South wards.

In 2009 the Tobacco Control Alliance identified that funding was required to support the smoking in pregnancy strategy. This came in the way of 2 year grant funding from the Department of Health provided to areas with high smoking prevalence, in supporting work to reduce the health inequalities caused by smoking. The Tobacco Control Alliance granted the Health Trainers funding through 2011/12 with the express remit of supporting the North East Lincolnshire Specialist Stop Smoking Service to reduce smoking in pregnancy prevalence rates.

The Health Trainer Service in partnership with North East Lincolnshire's Specialist Stop Smoking Service has developed a programme of activities based in Children's Centres to work with women who are pregnant to support them to quit smoking during their pregnancy and work with women to quit prior to them becoming pregnant. An additional benefit is that women who have recently given birth and their partners have the ability to access one to one support by the health trainers to support and help them to quit. During 2011/12 the Specialist Stop Smoking Service in collaboration with the Health Trainers who are based within the Maternity Services at Diana Princess of Wales Hospital in Grimsby are supporting pregnant women and their partners to quit smoking.

During 2009/2010, 51 pregnant women set a quit date and this produced 22 actual quits. To date during 2011/2012, 85% women have set a quit date with 38 actual quits. We therefore project a greater than 40% increase in women setting a quit date and a minimum of a 50% increase of women actually quitting smoking during their pregnancy. This improvement highlights the positive affect this initiative is clearly having in identifying those women who want to quit smoking whilst they are pregnant but need additional support and help to do so.

A new post of Public Health Lead for maternity services is to be provided from Spring 2012, one of the roles of which will be to enhance the part that midwives play in encouraging pregnant women and their partners to quit smoking. The postholder will also undertake work to identify reasons why many pregnant women are still choosing to continue to smoke despite the health risks that this poses to their unborn child and themselves. The learning from this work will be used to develop additional training for midwives to enable them to address these issues with their clients.

The Tobacco Control Plan for England published by the Department of Health in March 2011 set a national target to reduce smoking in pregnancy to 11% by 2015. Although the percentage of pregnant women smoking in North East Lincolnshire is twice as high as this, it is believed that the additional measures introduced will help to continue the significant decline in smoking in pregnancy rates towards the national target.

3. Reducing the number of young people who take up smoking

Every year, in England around 200,000 children and young people start smoking regularly. Of these 67% start before the age of 18 and 84% by age 19. The younger the age of uptake of smoking, the greater the harm is likely to be because early uptake is associated with subsequent heavier smoking, higher levels of dependency, a lower chance of quitting, and higher mortality.

Locally the 2007 North East Lincolnshire adolescent lifestyle survey identified that 24% of girls and 15% of boys aged between 15 and 16 (year 11) smoked regularly. Smoking initiation amongst this age group is associated with a wide range of risk factors including: parental and sibling smoking, the ease of obtaining cigarettes, smoking by friends and peer group members, socio-economic status, exposure to tobacco marketing, and depictions of smoking in films, television and other media.

The North East Lincolnshire "Decide" programme for young people is actively supporting a range of preventative take up campaigns in schools and youth settings. In addition it provides advice, information and practical support for young smokers and those who support them in schools, colleges and other youth settings.

"Don't Smoke, Won't Smoke" a major preventative take up campaign was launched in 2010/11. A number of workshops have been delivered to teachers in educational establishments already with an anticipation that 23 establishments will be delivering the programme by the end of 2013. To date the Don't Smoke – Won't Smoke campaign has been delivered to over 1,800 year 5 and year 6 pupils. In addition, the Decide co-ordinator has worked closely with Voluntary Action North East Lincolnshire on a number of projects including an arts based project based on Laceby Youth Centre in co-operation with Artlandish community outreach.

4. Getting more people to successfully quit smoking

2,173 smokers signed up to quit with the North East Lincolnshire Stop Smoking Services in 2010/11 of which 1,314 went on to quit against a target of 1,100 successful 4 week quits. The overall success rate was 61% compared with the national average of 49%. Specialist services delivered 80% of quits and 20% were delivered by intermediate service providers, i.e. Health Trainers, practice based staff and specialist nurses.

Many smokers, particularly those who have been formally referred via health professional routes to the specialist stop smoking service have trepidation about signing up to stop smoking support. This is reflected in as many as 1 in 2 smokers referred to the specialist service failing to sign up to quit.

To counter this problem, "Walk In" advice and information sessions have been developed and are expanding. These sessions are offered by the specialist service from a number of North East Lincolnshire community and new build health facilities. They are designed to provide the opportunity for smokers to meet informally with a specialist practitioner and discuss their needs without any obligation. During the session practitioners help the smoker to normalise any issues that they may have, identify the options that are available to them and where appropriate work with the smoker to tailor a support programme that meets their needs. These sessions are proving to be an increasingly popular pathway to services amongst smokers and are being utilised by health professionals to sign smokers to the service rather than formally referring them. This approach has demonstrated a sign up to quit rate of 83% and a success rate of 66% . Outputs compare well with the services overall success rate of 60% and this initiative is realising cost and resource efficiencies whilst extending pathways to the service and adding value to the services overall performance.

Oasis Academy Wintringham scoops the first Smokefree Schools Award in North East Lincolnshire

SECTION 3.2

BREASTFEEDING PEER SUPPORT

My 2010 Annual Public Health Report highlighted the low rate of breastfeeding in North East Lincolnshire compared with the rest of the country which was a great concern because of the extensive range of benefits that breastfeeding brings to mother and baby. I am pleased to report that our breastfeeding initiation rates have improved in the last couple of years. However a lot of women who initiate breastfeeding in hospital stop breastfeeding once they return home or sometimes even earlier. A couple of years ago we carried out some research with mothers in North East Lincolnshire which highlighted that as well as access to professional support, pregnant women and breastfeeding mothers value information and support from other mothers with breastfeeding experience. Local mothers said that they would like the opportunity to have contact with a Breastfeeding Peer Supporter before and after they had their children, including on the maternity wards[1]. This approach is also recommended by the Department of Health[2] and NICE[3].

We therefore decided that we needed to invest in breastfeeding peer support and with the help of some new funding from North East Lincolnshire Council we have been able to greatly improve the quality of the breastfeeding peer support service and provide personal development for mothers who come forward to become volunteer peer supporters.

Breastfeeding Peer Support at RAJ Medical Centre

A Breastfeeding Peer Support Co-ordinator was appointed at the end of 2010 to support the development of the Voluntary Peer Support network. With the support of the new coordinator the Peer Support service evolved substantially during 2011, women (and families) now have the opportunity to have contact with a peer supporter before and after they have had their baby. This can take place in a range of places and can be done in a variety of ways.

Breastfeeding Peer Supporters are all mothers who are or who have successfully breastfed their baby. In North East Lincolnshire Peer supporters are local volunteers who come from a wide range of backgrounds. They all bring their own experience, knowledge and enthusiasm to provide positive breastfeeding role models to other mothers and their families. Once recruited the peer supporters undergo security checks and complete further training so that they can offer women information and practical support in a variety of settings.

Comment from Peer supporter, Victoria Midgeley (Jan 2012):

"Having struggled for five days to breastfeed my first baby in hospital I came home and attended a breastfeeding support group. I found like-minded people who really helped me with tips on breastfeeding and with this support I cracked it! Whilst I was at the group I saw other mothers breastfeeding and this inspired me. If it hadn't been for this support from peer supporters I definitely would have given up a couple of weeks in. It is thanks to this support that I successfully breastfed my 3 children. I am now a practicing peer supporter and other mums tell me they wouldn't be breastfeeding if they hadn't come along to the group. It is hard to measure mum to mum support and often the things that can make a difference can't be measured… ".

Peer Support Before Birth

In North East Lincolnshire, Antenatal Breastfeeding Workshops are available to pregnant women, their partners and/ or significant others across hospital and community venues such as children's centres. They provide information to families about breastfeeding before the birth of their baby. The sessions are run by the Maternity Services Breastfeeding lead and supported by the Peer Support Co-ordinator and Volunteer Peer Supporters. This also gives parents "to be" the opportunity to speak to other parents and mothers with knowledge and experience of parenthood and breastfeeding. The workshops are well attended by pregnant women and have received positive feedback.

Peer Support on the Ward

We now have a number of Volunteer Peer Supporters who visit the Maternity and Neonatal wards at Diana Princess of Wales Hospital. Peer supporters work alongside staff teams including Midwives, Midwifery support, Neonatal staff and Doctors. They are able to spend dedicated time with breastfeeding mothers and provide practical support and information to help mothers establish and continue breastfeeding.

Peer Support in the Community

Peer supporters have made links with Primary Care with regular Peer Support update meetings and volunteer recruitment and breastfeeding awareness events at RAJ Medical Centre supported by the GP clinical lead for Women and Children's Health, Dr Marcia Pathak.

Peer Supporters also work in North East Lincolnshire Council's Children's Centres providing breastfeeding support within local communities.

A number of Health Trainers have been trained to provide breastfeeding peer support in the community and these staff can address a range of issues and refer onto the broader Health Trainer service to provide health promotion and support services as required.

The service has also forged links with community groups including local branches of the National Childbirth Trust (NCT). The NCT have contributed towards the provision of peer support and has published articles to raise awareness about Breastfeeding and peer support in North East Lincolnshire.

Ladies in pink: Peer Support, Scartho Children's Centre, Breastfeeding drop in Group

Peer Support Telephone Line

The Breastfeeding Peer Support Co-ordinator and Peer Support Volunteers offer an information and support telephone line. This provides information and postnatal support to mothers to help them continue breastfeeding once they have left hospital or following home delivery. Where possible, the peer supporters aim to telephone newly Breastfeeding mothers within 48 hours of their transfer home. In addition, breastfeeding mothers can ring the line directly. If required, they will also signpost and inform families where to access additional local and national support.

Future developments

The Peer Support Service improved substantially during 2011. Due to the voluntary nature of the service, the network relies on continual recruitment, and training of volunteers. The volunteers have been enthusiastic about offering their free time to promote and support breastfeeding. However volunteers inevitably have a limited amount of hours to contribute freely and may inevitably want to return to work and/ or study. It can therefore be a challenge to maintain a structured and equitable service. On the other hand, the experience of being a peer support volunteer has enabled some people to enhance their personal development, access further education and/ or return to work.

We are looking to further develop the peer support network in 2012 by securing funding where possible for dedicated and remunerated time to support the voluntary service. There is an identified need to develop capacity within the peer support role to extend the number of women reached by the service and also extend the venues for delivery of antenatal workshops. With the recent recruitment and training of a male Breastfeeding link volunteer we also hope to increase work done around Breastfeeding awareness amongst men and the wider community.

REFERENCES:

1. Jex N, Morris T, Simpson R, Woodhead L (2010), Breastfeeding Continuation: Quality Assurance Project. Public Health Directorate, North East Lincolnshire CTP

2. Commissioning Local Breastfeeding Support Services (2009), Department of Health, pp37-38.

3. National Institute for Health and Clinical Excellence (2008), A peer support programme for women who breastfeed, Commissioning Guide, NICE

SECTION 3.3
CANCER CHAMPIONS

In last year's annual report I highlighted the worrying finding of our cancer equity audit that although North East Lincolnshire has a lower rate of cancer than the Yorkshire and Humber region and England the death rate was actually higher. One possible factor behind this is that people in North East Lincolnshire do not act on their symptoms early enough making the cancer difficult to treat by the time of diagnosis. There is no doubt that the work done by the Cancer Collaborative over the past few years has successfully raised awareness of cancer in the general population. One very successful initiative for instance has involved Health Trainers proactively following up on people who fail to attend routine screening appointments, particularly women who default cervical smears and mammograms.

However even with increased knowledge about the signs and symptoms of cancer in the population there still appeared to be a "gap". This was that whilst many people have the information about the signs and symptoms of cancer, they were often not seeing their GP early enough. Anecdotally North East Lincolnshire has a history of individuals being reluctant to act on the advice given by health professionals and remain highly influenced by family, friends and communities.

Therefore we decided that we would have to take advantage of this by developing health 'champions' out of influential members of the public who have a strong interface with communities and were in a position to respond to and offer useful advice to comments and concerns about cancer. We thought that they would be more successful in encouraging individuals to see their GP early and/ or attend screening appointments. In this way we could bridge the gap between the Collaborative and Primary Care and the Health Trainer initiative.

The Cancer Champion initiative started in July 2011 as a joint venture between the Cancer Collaborative (part of Care Plus Group, a social business which provides adult health and social care services to people across North East Lincolnshire) and Public Health/CTP. Since September there have been five cohorts of Cancer Champions trained.

Cancer Champions are ordinary members of the community who are prepared to undertake some short training, following which their role is simply to raise awareness within their family, friends, neighbours and work colleagues, by word of mouth and distribution of information.

Importantly they are able to signpost people who they have contact with to the range of services available and assist in giving information which is beneficial to others, motivating people to seek early medical assistance. Anyone can become a Cancer Champion, many have a personal interest in cancer through a family member being affected, but most are just interested members of the community.

The training consists of two sessions. The first is delivered by Julie Grimmer from the Cancer Collaborative and is predominantly about the signs and symptoms of the most common cancers. The second session is delivered by Annie Darby the Specialist Projects Lead, with the focus being on how to respond opportunistically to those who have potential signs & symptoms of cancer but are reluctant to see their GP or attend screening.

In addition the "Champions" get a badge which may promote questions, from those they come into contact with, about cancer and a handbook of information, advice and contacts.

The first two cohorts of Cancer Champions met with the course leaders in February to feedback their experiences and help evaluate the success of the initiative. The feedback was overwhelmingly positive, with five good examples of good practice including one woman who raised awareness of Breast Cancer during her company's monthly meeting. Further Cancer Champion Training days are planned during 2012. The course leaders are also considering inviting potential Cancer Champions from locations where there are opportunities to reach people who might be more likely to engage in risky behaviours or groups of people who come into contact with many members of the public e.g. hairdressers, pubs, betting shops etc.

To support this they are currently bidding for monies to provide a small financial incentive to businesses who release their staff to undertake training.

Lung cancer calloaborative team out in Cleethorpes, raising awareness of lung cancer signs and symptoms

SECTION 3.4

COMMUNITY NUTRITION PROGRAMME & FOOD FOR FITNESS

Last year's Public Health Annual Report identified that reception year pupils had the highest rate of child obesity in the Yorkshire and Humber region as measured in the National Childhood Measurement Programme. I am pleased to report that the indications from the most recent measurement programme are that rates of childhood obesity appear to have peaked and may even be declining. In recent years we have introduced a wide range of new initiatives to increase activity and improve diets in our children, one of which is described here.

North East Lincolnshire Council's Specialist Health Promotion Service (SHPS) has a programme of work that aims to enable and encourage people to choose a healthier diet. Working with school settings is one of the mechanisms through which we aim to improve the diets of children, young people and families. 'Food for Fitness' develop a programme of support depending on the needs and priorities identified with the school and any other key partners. Taking a partnership approach is vital to make the most of the opportunities that we have to improve diet and nutrition: working together each partner adds value and strengthens the potential impact on our shared outcomes. This is illustrated by the following case study on the next page:

John Hickling, the Regional Advisor with the Royal Horticultural Society Campaign for School Gardening

Oasis Academy Wintringham 'Grow-it, Cook-it, Eat-it'

Janet Giles is the Manager of the Alternative Learning Provision (ALP) at Oasis Academy Wintringham (OAW). Over the past two years, Janet has been working on a vision to offer students opportunities to grow their own food, to learn how to cook with the produce and set up enterprise projects. This is part of the broad aim within the ALP to raise self-esteem and confidence, enabling students to take pride in what they achieve and receive the praise that they deserve. The SHPS identified an opportunity to work with the Royal Horticultural Society's Campaign for School Gardening to offer a programme of joint training days and one-to-one support for three local secondary schools, one of which was at OAW. Food for Fitness added the 'Cook-it, Eat-it' element to the training days, by running a practical cookery session so schools can take away ideas of how to use the produce growing in their gardens. The benefits of this work have already reached beyond the school gates, as some of the students have taken their skills, knowledge and enthusiasm away to set up vegetable gardens at home. Janet has the backing of the Senior Management Team to continue developing the school garden and other departments within the Academy are getting involved. There are also plans to continue with termly Twilight Training sessions which bring schools together to share ideas and support each other to continue with their Grow-it Cook-it Eat-it programmes.

Following on from this initial plan, Food for Fitness has now run a four week cookery course with staff and students at OAW. As well as the individual participants gaining new skills and confidence around cooking and healthier eating, by training school staff within the sessions, they gain the confidence, skills and knowledge necessary to run further healthy cookery courses with students and their families, using the Food for Fitness Cookery Course Toolkit. The impact of this work reaches wider still because Janet works closely with the Leisure Club based on the school site, opening up the opportunity for leisure club members to participate in growing and cooking activities to empower more people to choose a healthier lifestyle, which contributes to improving the health and wellbeing of people and communities in North East Lincolnshire.

CONCLUSIONS AND RECOMMENDATIONS

Significant investments have been made to improve health in North East Lincolnshire during the last few years and these are undoubtedly bearing fruit. In the last year we have seen an increased life expectancy, and rates of obesity and smoking in our young people which have remained stubbornly high now appear to be reducing. There are also clear signs that premature mortality associated with cardiovascular disease, which has long been responsible for the greatest number of deaths in people under 75, is falling as the benefits of prevention focused primary care are realised.

However it is clear that the greatest improvements in health are being made in those parts of North East Lincolnshire where health is already better and those parts of our community with the worst health are seeing only marginal improvements in key health indicators. This means that our health inequality gap is not narrowing and may indeed be increasing for some important health indicators. Undoubtedly the difficult economic situation, which has hit our more deprived communities hardest, makes health improvement an additional challenge. A renewed focus is therefore needed on reducing health inequality and this will require targeted action in those parts of North East Lincolnshire where health inequalities remain most stark. Therefore my three overarching recommendations from this annual report are as follows:

- The difference in life expectancy between the most affluent and the most deprived parts of North East Lincolnshire is currently around 11 years for men and 8 years for women. Reducing the health inequalities gap should be a central and overarching priority for the health and wellbeing board. Concerted action across the whole health and wellbeing system is needed if we are to make progress and narrow this gap. We must also address the economic problems that lie behind much of the health inequality that exists in our communities and we should seek to prevent problems in the future by doing whatever is necessary to give our young people employment opportunities today.
- Despite a slight fall in our smoking rate in recent years, around 27% of adults in North East Lincolnshire are still smoking and more than 40% of adults smoke in some of our more deprived areas. We also have one of the highest smoking in pregnancy rates in the country with around 24% of mothers smoking at the time of delivery. We must continue to invest in the tobacco control initiatives described in section 3.1 to ensure that rates are driven down.
- The cultural misuse of alcohol in North East Lincolnshire goes hand in hand with poor health, family breakdown, welfare dependence, crime and disorder and health inequalities. The Department of Health recommend the large scale use of screening for alcohol misuse, delivery of Information and Brief Advice and access to structured treatment as having 'High Impact' upon such a culture over time. We need to further increase the use of these interventions across the whole of our health community in order to deliver the 'sensible drinking' message. For the greatest impact these health based interventions need to be coordinated with action around policing, liquor licensing and health promotion already delivered through our local alcohol harm reduction strategy.

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