# LEICESTERSHIRE

# JOINT STRATEGIC NEEDS ASSESSMENT

## March 2012

# Key Findings and Recommendations

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## 1. DEMOGRAPHY

Demographic information is key to understanding need and subsequent service planning and the commissioning of services. Accurate and up to date figures on the size of population and their characteristics across a variety of variables enables commissioners to quantify the levels of need for different groups. Projections and estimates allow us to predict the future need and plan services accordingly.

### 1.1 Key Findings

- The 2011 Economic Assessment notes that the main demographic trends are:
    - People living longer;
    - Increasing numbers of smaller households, many of them older people;
    - More cohabiting couples having families later;
    - More older 'empty nesters' left in family housing; and
    - More 'non nuclear' family households and different living arrangements.
- The total population of the county for 2011 is 655,500 and is projected to rise to 678,200 by 2016 and 729,900 by 2026;
- This represents an increase from 2011 of 3.5 percent to 2016 and by 11.4 percent to 2026;
- Between 2011 and 2016, age bands experiencing the greatest percentage decline are 40-44 (17 percent) and 60-64 year olds (10 percent). In comparison, the largest increases are in the 90+ (33 percent), 70-74 (22 percent) and 30-34 and 65-69 (both 19 percent);
- Between 2011 and 2026, the greatest percentage decrease is experienced in the 45-49 age band (20 percent) while the greatest increase is experienced in the 90+ (125 percent), 75-79 (64 percent), 85-89 (62 percent) and 80-84 (60 percent) age bands;
- There is a general upward trend in the overall number of young people between 2008 and 2026;
- There are 14,400 young people, 42,000 people of 'working age' and 4,200 older people from BME groups within the county. BME groups as a whole tend to be younger and less older than the White group. Over a fifth (22 percent) of the White ethnic group are 65 and over;
- The White ethnic group accounts for 90.6 percent of the overall population. The Asian or Asian British ethnic group makes up 5.8 percent. Within the districts, Oadby and Wigston has the highest proportion of Asian or Asian British and Black ethnic groups, making up 14 and 1.9 percent of the borough's population respectively;
- The 2001 Census continues to represent the most up to date data on religion;
- National data suggests that 94 percent of the population of the country class themselves as heterosexual. Applied to the county, this would equate to 616,170 heterosexual people, with 12,455 people classed as gay, lesbian, bisexual or other;

- Net internal migration (specifically domestic migration) accounts for the majority of projected population change over the next five and fifteen years;
- 68.2 percent of the population live in areas classed as 'urban' (settlements with a population over 10,000 people);
- According to the ONS Output Area Classification, the highest proportion of Leicestershire's population live within areas classed as 'Prospering Older Families' (14.1 percent), followed by 'Prospering semis' (13.3 percent) and 'Prospering Younger Families' (11.7 percent). These areas are characterised by proportions of rented accommodation, terraced housing and flats far below the national average and proportions of households with more than one car and detached housing far above the national average.

### 1.2 Recommendations

- Demographic information is key in supporting commissioning arrangements. It is essential that the most up to date information is analysed and interpreted and fed into service provision work in order to ensure that services are best placed to meet the needs of local populations;
- The release of 2011 Census data in mid-2012 will provide services with up to date demographic data for the sub region in order to shape commissioning. This will need to be analysed and interpreted in order to support commissioning areas.
- The Research and Insight Team are exploring working with Pop Group at the Local Government Association in order to develop new and effective ways to measure population locally at a small area level.

## 2. DEPRIVATION AND THE ECONOMY

Deprivation and economic data provide useful contextual information which helps to underpin health and wellbeing needs. Often the roots of health and wellbeing problems lie in socioeconomic factors around lifestyle and geography. The Leicester and Leicestershire Economic Assessment notes that:

*"Health is often considered both a consequence of worklessness and barrier to re-entering employment. Once on Incapacity Benefit claimants are less likely to return to work creating a cycle of poor health physically or mentally. The most common reason for claiming incapacity benefit is due to having a condition of 'mental and behavioral' disorders."* Leicester and Leicestershire Economic Assessment (2011)

Likewise, economic factors are shaped by the behaviour of the people living in any given area and this in turn, helps to shape economic and health inequalities. The links between people and places should be of paramount importance for commissioners in terms of understanding whether people create places or vice versa and how these impact upon life chances.

### 2.1 Key Findings

- There is a strong link between deprivation and health and wellbeing;
- All local authorities within Leicestershire have moved up the national rankings between 2007 and 2010, suggesting that they became more deprived overall;
- Overall, North West Leicestershire remains the most deprived district in the county while Harborough remains the lowest;
- Higher ranking (more deprived) neighbourhoods tend to be located within the urban areas of Loughborough, Coalville, Hinckley and South Wigston. Loughborough Bell Foundry LSOA is the most deprived neighbourhood in the county for the overall Index of Multiple Deprivation;
- Higher ranking tend to be located in Loughborough, Coalville and South Wigston, with lower ranking areas located in the rural parts of Melton and Harborough districts. Loughborough Bell Foundry is the most deprived LSOA in Leicestershire for Health Deprivation and Disability;
- Leicestershire Priority Neighbourhoods remain a focus for targeted interventions across a range of issues, experiencing multiple deprivation across a range of domains;
- Specific interventions are required for engaging rural communities and providing relevant information and advice to those vulnerable to economic changes;
- Being out of work and claiming benefits has obvious impacts on health and wellbeing status both in terms of the effect on income but also the purpose and social aspects associated with employment;
- Across all benefits data, rates for Leicestershire are lower than those for the East Midlands and England;
- The number of people on out of work benefits has fallen slightly since 2009;
- The 2011 Economic Assessment notes that "Current welfare reform is likely to tighten eligibility to all out-of-work benefit groups";

- Areas of lowest household income are clustered around parts of Loughborough, Coalville, Melton and South Wigston. Areas of highest income are located in more rural areas of the county such as east Charnwood and west Melton and parts of Harborough.

### 2.2 Recommendations

- Economic and deprivation information is key in supporting commissioning arrangements. It is essential that the most up to date information is analysed and interpreted and fed into service provision work in order to ensure that services are best placed to meet the needs of local populations.

# 3. HOUSING

The aim of this chapter is to identify how housing issues can influence health outcomes, and to identify the priority areas in relation to housing and health on a countywide and district by district basis. Housing is an important issue in terms of health and wellbeing, with good quality accommodation a necessity for a good quality of life. Housing is identified as a key driver for happiness and issues around happiness and wellbeing are addressed in the corresponding chapter of this report. The issue of addressing housing needs and how this can directly impact on health and wellbeing is well established and recognised as one of the major components in successfully improving the quality of life for residents.

Furthermore, Schmuecker (2011) notes that "the overall volume of housing demand is influenced by demographic and behavioural factors, such as migration, increased life expectancy, a greater propensity for people to live alone, and young adults delaying forming their own household." Information on the demographic trends in Leicestershire that help to inform and shape housing policy are included in the Demography chapter of this report and should sit side by side with information on housing.

## 3.1 Key Findings

- Housing issues are closely linked to demographic trends such as migration, increased life expectancy, a greater propensity for people to live alone, and young adults delaying forming their own household;
- Housing issues need to be viewed sub regionally in order to take into account the effect of Leicester City within the housing market. This would be in line with the Strategic Housing Market Assessment and the 2011 Economic Assessment;
- There is a considerable variation in property types and tenures across the Leicester and Leicestershire Housing Market Area (HMA), but these tend not to correlate to demography or actual need;
- The HMA has housing at a range of prices that are sufficiently high to contribute to economic buoyancy, and relatively affordable compared to household income. However, variations within this generalised pattern reveal significant shortage of affordable dwellings across the HMA both in rural and in urban areas to meet need;
- Affordability issues such as high property prices and lack of suitable housing in rural areas affect the pattern of provision. For example, middle and lower income households who are unable to access housing in expensive and sparsely populated rural areas tend to live in lower cost housing in more urban areas;
- Leicester City is a magnet for younger, newer and less well-off households with a flow of families from the City to the suburbs and smaller towns. There is evidence that the Asian population are moving towards more affluent households within the community such as Oadby, Thurmaston and Thurnby;
- Quality of place, the existing stock and accessibility are likely to influence relative demand in different towns or neighbourhoods within the housing market area;
- Many young would-be buyers no longer have sufficient savings to buy homes and this is having a substantial affect on the overall market;

- Households headed by someone 65 and over are set to increase by 51,000 by 2033. There will be an additional 39,000 single person households projected in the county whilst the number of couple households is projected to grow by 31,000;
- The size of a deposit needed has increased dramatically over the past few years, which has priced many people out of homeownership. The average ratio of 1:6 in Leicester and Leicestershire implies that for almost any median income household in Leicestershire, the average house is unaffordable;
- There is extensive housing need due to problems of affordability caused by high property prices and housing costs, as in most parts of the UK. The total extent of need for additional affordable units above current supply levels is estimated at some 2,700 a year;
- For older people, unmet support needs are highest for those in the private sector;
- There is a need for more extra care provision for older people, including those with mental health needs;
- There is a need for more provision for people with learning disabilities and people with mental health needs, in addition to more floating support services;
- There is a lack of move-on accommodation and tenancy support across all vulnerable people client groups (including older people/ people with mental health needs/ people with learning disabilities/ and people with physical and/or sensory disabilities);
- The 2010 SHMA update notes that the introduction of Choice Based Lettings (CBL) and its new systems to utilise applications, bidding and lettings data more effectively could be used to understand housing need and turnover;
- Housing need is high in most rural areas due to the pressures of outward migrations by wealthier households pushing up prices in villages. Models suggests the aspiration for some 250 additional affordable homes per year are currently needed in the rural areas.

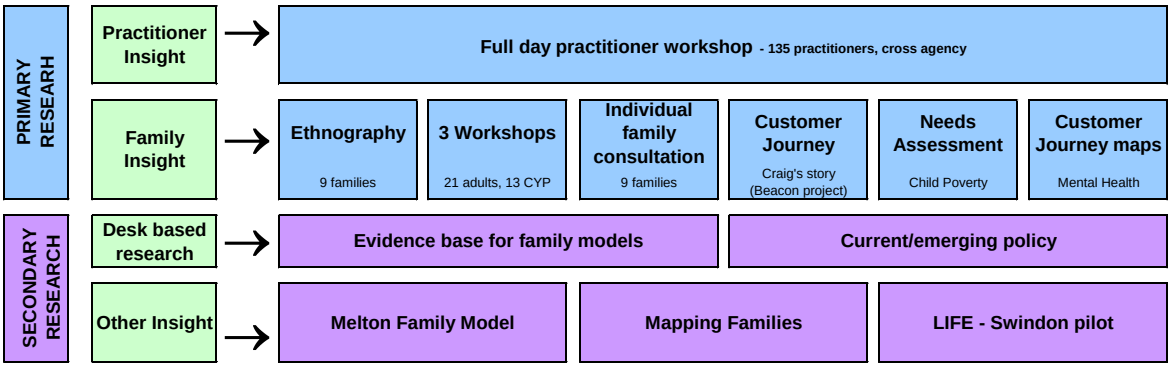
### 3.2 Recommendations

- Housing information is key in supporting commissioning arrangements. It is essential that the most up to date information is analysed and interpreted and fed into service provision work in order to ensure that services are best placed to meet the needs of local populations.

## 4. TROUBLED FAMILIES

Community Budgets is a government initiative and Leicestershire is one of 16 original pilot areas inputting significantly into government policy. An important strategic objective of Community Budgets is to test the principles of improving outcomes – at a reduced cost of providing public sector services through collaboration.

In Leicestershire, the Community Budgets programme has taken an evidence based approach to informing 'need' which has included a wide range of research and insight techniques and methodologies. The diagram below provides an overview of the insight phase.




**Troubled Families Insight**

A summary of the insight and the individual reports can be found at:

http://www.leicestershiretogether.org/index/partnerships/community_budgets-3/fwcn/insightphase.htm

### 4.1 Key Findings

- In Leicestershire, the Community Budgets programme has identified 1,300 families as 'Troubled' (defined by those who have 5 of 22 defined 'risks' or characteristics)
- A further 2,000 families are at risk of becoming a 'Troubled Family'.
- These families have multiple and complex issues including offending (48%), parental substance misuse (61%), worklessness, lack of/low parental educational attainment (68%), including school attendance issues, teenage pregnancy, caring responsibilities and a range of problematic health and social issues such as low income (including debt and poverty), poor housing, domestic violence, mental health difficulties, disabilities, life limiting health conditions as well as poor parenting skills, difficulties maintaining relationships and a lack of resilience.
- All of these issues relate to individual and families health and wellbeing.

### 4.2 Recommendations

- A key recommendation emerging from the Community Budgets work with Troubled Families is to ensure that providers work together to improve outcomes for the most troubled families, to develop a model of early intervention, whole family working and joint commissioning.

# SECTION 2: POPULATION HEALTH NEEDS

## 5. HEALTH INEQUALITIES

Health inequalities are a key cross cutting theme that will be evident in every area of health and social care that has been considered within the JSNA. It is therefore important in reading the JSNA to remain aware of inequalities in health.

Health in Leicestershire as in the rest of the UK is improving. However over the last 10 years health inequalities between different social classes and groups have widened. Health inequalities are unjust differences in health outcomes or measures between different individuals or groups. They can be defined as 'systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically' (Starfield 2001) [1].

As well as geographical and economic inequality, inequalities exist within specific population groups as a result of social exclusion. Leicestershire has a number of population groups that are often on the margins of society and particularly at risk of poor health. These groups frequently experience difficulty in gaining access to health care. Examples include black and minority ethnic people; disabled people; people with mental health problems; gay, lesbian and bisexual people; transgender people; prisoners/offenders; gypsies and travellers; the homeless; asylum seekers and refugees.. Additional risk factors for these groups can include poor support systems, isolation, alcohol and substance misuse and unemployment.

Rural deprivation and rural health inequalities are also important issues for Leicestershire. On average people in rural communities enjoy better health and wellbeing than their urban counterparts, However many rural areas are characterised by high levels of inequality within them. The concept of the 'rural idyll' - an idealised stereotype of country life ignores the real difficulties faced in many rural communities, such as poverty, lack of services, poor public transport and traumatic social or economic changes at a local level.

### 4.1. Key Findings

Life expectancy - health inequalities as measured by life expectancy:

- On the whole Leicestershire is an affluent and healthy county. Both men and women are likely to live longer on average in Leicestershire than in the rest of England. Despite this, inequalities do exist. Leicestershire has geographical pockets of relative deprivation. Leicestershire has a variation in life expectancy between boroughs and across nationally identified super output areas. The difference in life expectancy between the most and least deprived individuals in Leicestershire County and Rutland is 5.9 years for males and 4.7 years for females (2005-09) [2].
- The causes of premature mortality that exist in deprived and socially excluded populations in Leicestershire are:
- Circulatory disease and cancers remain the main causes of premature death in Leicestershire. This is in line with national trends with disproportionately higher rates seen in certain geographical areas and amongst certain population groups
- For some conditions such as malignant melanoma, people in Leicestershire have higher rates of disease than England generally

- Poor nutrition (including breast feeding), emotional and mental health and smoking all contribute to the mortality gap
- There are higher rates of low birth weight babies and infant mortality in areas of deprivation and high risk groups. The main drivers of infant mortality have been identified as smoking in pregnancy, sudden unexplained death in infancy, maternal obesity and teenage pregnancy [3].

### 5.1 Recommendations

Commissioners across health and social care have a broad responsibility to tackle social determinants of health. They also need to ensure that services are commissioned equitably and additionally that commissioning decisions comply with the 2010 Equality Act [4].

In essence, commissioners will need to ensure that equity sits alongside quality as a key standard and indicators of equity are developed and monitored for all services commissioned.

The key actions identified in the health inequalities strategy for Leicestershire are:

1. Supporting families, mothers and children - to ensure the best possible start in life and break the inter-generational cycle of health
2. Engaging communities and individuals - to ensure relevance, responsiveness and sustainability
3. Preventing illness and providing effective care for:
    a. Smoking cessation and tobacco control
    b. Substance misuse including alcohol
    c. Sexual health
    d. Obesity / healthy weight
    e. Cardiovascular disease and diabetes
    f. Cancer
    g. Childhood immunisation
4. Addressing the underlying (wider) determinants of health including income/poverty, housing, education and employment through:
    a. First contact services
    b. Debt management / financial sustainability
    c. Employment
    d. Housing
    e. Transport

The Director of Public Health Annual report in 2010 focussed on Health Inequalities[5] and the Annual Report in 2011[6] focussed on children's health. It should be ensured that the more detailed recommendations identified in these reports should be implemented.

## 6. CHILDREN AND YOUNG PEOPLE

The Director of Public Health Annual Report (DPH) 2011 [7], focused on the health of children. This is a key resource on children's health and is the basis for this Children's JSNA chapter refresh. Information at a District level will also be available. There will be a separate needs analysis for children and young people's needs that are not covered in this JSNA chapter.

The DPH Annual report and this JSNA chapter is based, where possible, on evidence based practice and policy. Key national reports and policy relevant to this area include: the "Our Health and Wellbeing Today" [8], "Healthy Lives, Healthy People" [9]. The Healthy Child Programme, the Marmot review, the Graham Allen review, the Munro review, Dame Clare Ticknell review and Rt Hon Frank Field review. All emphasis the importance of early years, early help and intervention, and prevention to provide a good start to life and support to those in greatest need.

The Marmot Review[10] review's ultimate aims in relation to supporting mothers, families and children are to:

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

### 6.1 Key Findings

- The health of children in Leicestershire is generally similar to or better than the England average. Infant and child mortality rates are similar to the average. The prevalence of breastfeeding is higher than the England average in all districts except Hinckley and Bosworth (42.3%) and North West Leicestershire (42.5%).
- Children in Leicestershire have lower than average levels of obesity. One in seven (14.8%) of children in Year 6 are classified as obese, this is lower than the England average in all districts with the exception of Rutland, Melton, and Oadby and Wigston. However, less than half (47%) of children participate in more than three hours of sport a week.
- Hospital admission rates for alcohol specific stays are lower than the England average and are in line with the England average for substance misuse. Hospital admission rates for injury are lower than the England average. The percentage of children who say they use drugs and who say they have been drunk recently is similar to the England average.
- The numbers of children with disability, including hearing disability, complex health needs, those with autism spectrum disorder and those with behavioural emotional and social difficulties have all increased. Special Education Needs (SEN) placements has increased, and joint funded placements with health, because of children and young people’s psychiatric needs, have also increased.
- Child road casualty and accident figures have reduced significantly from 2000 to 2010.

- Reported bullying has continued to decrease steadily. However, cyberbullying and internet safety is an issue for children and young people.
- The number of Children in Care has increased, although this is lower than the Local Authority Statistical Neighbours comparators. The 10-15 years olds continue to be the largest group in care.
- The number of care leavers in education, employment and training has significantly decreased - almost half of the 2011/2012 cohort has presenting health needs such as mental health issues and depression, pregnancy, significant learning difficulties.

### 6.2 Recommendations

The following recommendations are aimed at improving the health outcomes for children and young people and are based on information in this JSNA Chapter and also on the DPH report 2011 focusing on children's health.

**Early Help -** National reviews (such as the Marmot, Graham Allen, Munro, Dame Clare Ticknell and Rt Hon Frank Field) emphasise that early years, early help, intervention and prevention provide a good start to life and help to prevent problems arising later, which could then cost more to address. This key policy message suggests strategic commissioners consider how **early years support can be resourced** and embedded in planning for the health and well-being of the population to yield greatest benefits for individuals and the population as a whole.

**Improve services and support for children and young people with complex needs and SEN** by:

- Developing local specialist provision for children with SEN to avoid expensive out county placements, particularly in the areas of Autism and Behaviour, Emotional and Social Difficulties.
- Ensuring that wrap around support is available to families who might otherwise seek residential placements for their children
- Consider the best way of delivering an integrated audiology service across health and education for children in Leicestershire via multi agency review process

**Starting well, through early help and prevention** - develop strong universal public health and early education together with targeted interventions for disadvantaged families and children at risk of poor health outcomes. To include:

- Increasing number of Health Visitors to deliver the healthy child programme.
- Working with schools and academies to address bullying and support the delivery of key public health programmes.
- Ensuring that the right services are in place to support pregnant mothers to make healthy choices regarding smoking (increasing Smoking in Pregnancy Services); healthy eating, physical activity and substance misuse and alcohol, and they have access to high quality antenatal support.
- Supporting, and continuing to deliver, integrated programmes for childhood immunisation, pregnant mothers and breastfeeding provision (mainly through Children's Centre provision).

**Developing well** – continue public health initiatives to improve the health and wellbeing of school age children and their transition into healthy adulthood. To include:

- Continuing partnership working through the Healthy Child Programme, making full use of the Children's Centres and Leicestershire Healthy Schools Programme.
- Reducing childhood obesity by:
    - Early identification of children who are over weight or obese.
    - Promoting 'positive food and physical activity culture' so that eating a healthy balanced diet and participating in physical activity becomes a 'social norm' in schools.
    - Routine promotion of physical activity, including unstructured play at home, in school, in childcare settings and in the community.
    - Ensuring children's living environment encourages and facilitates this.
- Continuing to improve the identification, treatment and prevention of mental health problems in children and young people by improving the access to mental health services for children and young people, including those with Attention Deficit Hyperactivity Disorder (ADHD), Autism, self harm, behaviour and vulnerable children such as Children in Care/Care Leavers, offenders or those at risk of offending, homeless, or have a physical illness.
- Improving transition from child to adult services.

**Addressing risk taking behaviour in teenagers** – develop and deliver on health programmes aimed at supporting young people (including vulnerable young people) to make informed healthy choices regarding smoking, physical activity, healthy eating, sexual health and substance misuse, including alcohol to reduce risk taking behaviours that impact on health and transition into adulthood.

## 7. STAYING HEALTHY

The population of England is healthier than it has ever been. However, the number of people with longstanding illnesses looks set to rise and many of the diseases that people in England now suffer from are linked to lifestyle. The numbers of people smoking, taking illicit drugs and drinking harmful levels of alcohol have all declined in recent years, but there remains a large population who seriously harm their health through lifestyle choices [11].

The people of Leicestershire County and Rutland are living longer than they ever have before. A man in LCR can expect to live to 79.7 years and a woman to 83.4 years (2007-09) [12]. Despite the overall progress in life expectancy, one in three deaths occur before the age of 75 and one in six before the age of 65 years (LCR data, 2009).

Many deaths and illnesses could be avoided through healthier lifestyle choices. By focussing efforts on reducing smoking, obesity and substance misuse, it is possible to achieve health and other benefits in the short, medium and longer term. Action to improve health must find a balance between helping people to maintain healthy lifestyles and supporting people to change unhealthy behaviours.

### 7.1 Key Findings

While services are well established to help people to stop smoking or using illicit drugs or to reduce harmful levels of drinking, broader programmes of work to prevent tobacco use, obesity and problems associated alcohol or physical activity are in their infancy. Improving health for all and reducing inequalities between more and less advantaged social groups are long-term ambitions that can only be achieved through organised efforts of agencies, communities and families. Specific issues and gaps are as follows;

- The biggest unmet needs in LCR continue to relate to the most disadvantaged social groups, such as people with mental illness, offenders and routine and manual workers. In order to reduce inequalities, health improvement services should be targeted to priority groups and areas.
- Targeted services are effective for those who access them, but to achieve a step change in lifestyle behaviour at a population level, there is a also need to scale up and sustain current health improvement programmes for the long-term.
- Some of this scale can be achieved by using the potential of every frontline contact by health, social care and other professionals. Public health messages should be simple and consistent and approaches to lifestyle change should be based on whole families and address multiple factors.

## 7.2 Recommendations for commissioning

### 7.2.1. Smoking

- Maintain resources for stop smoking services and wider tobacco control to sustain momentum of current programme of tobacco harm-reduction.
- Implement the Tobacco-free Leicestershire and Rutland (TLR) Strategy and Action Plan locally in order to achieve comprehensive tobacco control. Key strands of the local programme include young people's services to preventing the uptake of smoking, enforcement activities to tackle underage and illicit sales and stop smoking services to help smokers to quit.
- Commission stop smoking and other services that work and are value for money by following relevant guidance (including NICE and Department of Health) and utilising tobacco control toolkits.

### 7.2.2. Obesity, physical activity and diet

- Current support for physical activity and diet and nutrition interventions should be maintained. Any potential additional investment should be focussed on broadening the provision of weight management interventions across LCR.
- Alternative funding and delivery models for obesity (such as Social Impact Bonds) should continue to be explored.
- Commissioners should refer to NICE guidance on obesity and physical activity when commissioning obesity interventions.

### 7.2.3. Substance misuse including alcohol

- The recently integrated, whole-system approach to tackling substance misuse across LCR needs to be properly evaluated. If this approach works and offers value for money, it should be sustained and extended in the long-term.
- Key elements of the community substance misuse treatment system need to be fully integrated to be effective and to ensure continuity of care. These elements include acute care, primary care, specialist services, pharmacies and social care. The same is true of the criminal justice treatment system.
- The focus on recovery from substance misuse and reintegration into society should be maintained throughout the system, as well as the rebalancing of investment to tackle alcohol and drug problems.
- The Community Budgets plan to reduce health harm, crime and disorder, negative impact on children and families and associated costs needs to be fully implemented and adequately resourced.

## 8. SEXUAL HEALTH

Sexual health is defined by the World Health Organisation as:-

> 'A state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled' [13].

Good sexual health is an important part of physical and mental health and wellbeing. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease.

NHS Leicestershire County and Rutland is responsible for ensuring sexual health services meet local population needs and to reduce health inequalities.

In 2011 Leicestershire County and Rutland undertook a detailed health needs assessment which has formed the basis of the summary presented here.

### 8.1 Key Findings

The key issues facing LCR with respect to sexual health are driven by the wide geographical area that the PCT covers. The landscape of rural areas with market towns surrounding the large urban centre covered by Leicester City PCT makes delivery of comprehensive and equitable sexual health services very difficult. This is further complicated by an incomplete knowledge of the sexual health needs across the patch to enable the PCT to design and develop services in the areas of greatest need.

- The population at greatest need of sexual health services are those aged 15-24, and in LCR there are around 93,400 people in this age group.
- In 2007-09 there were 1,139 conceptions to females aged 15 to 17 within Leicestershire County and 57 conceptions in Rutland. Leicestershire County has a rate of 31.6 conceptions per 1000 females aged 15-17 which is lower than the rate in England (40.2) or the East Midlands (39.2).
- 58% of teenage conceptions in Leicestershire ended in abortion, this is higher than the England average of 50% (2008).
- Emergency hormonal contraception (EHC) is provided at 94 pharmacies across LCR. However, access to EHC is not equitable across the PCT as not all localities have a pharmacy providing EHC.
- In 2009 there were 1,628 abortions to residents of Leicestershire County and Rutland. Abortion rates in LCR are significantly lower than the England average. In 2009, 70% of abortions for LCR women were carried out by 10 weeks gestation; this is lower than the national average of 74.4%.
- In 2009/10 17,318 people aged 15-24 were screened for chlamydia through the National Chlamydia Screening Programme, and a further 3,410 were screened for chlamydia through other routes. 4.1% of those screened were diagnosed with Chlamydia.

- The diagnosed prevalence of HIV in 2010 in Leicestershire County and Rutland is considered by the Health Protection Agency to be low (0.59 per 1000 population aged 15-59) and is lower than the East Midlands average (1.12 per 1000 population aged 15-59). However, the number of residents accessing HIV related care in LCR has increased by 70% between 2006 and 2010 [14].

### 8.2 Recommendations for commissioning

In 2010 Leicestershire had a visit from the Teenage Pregnancy National Support Team. It should be ensured that work is continued to meet the recommendations highlighted in this report.

The three big challenges in sexual health in Leicestershire are:

- Increasing access to contraceptive services for the whole population, with targeted work for young people. This is necessary in order to have a direct impact on teenage pregnancy rates.
- Maintaining community sexual health provision, including condoms and pregnancy testing. This is in the context of changes to youth services and Connexions.
- Personal, social, health and economic education (PSHE) and sex and relationship education (PSE) are changing in light of OFSTED guidance and the formation of academies.

# 9. LONG TERM CONDITIONS

Long-term conditions refers to a group of illnesses that, at present, cannot be cured but can be controlled by medication and other therapies. Once diagnosed with a long-term condition, a patient's life is forever altered. However, by supporting patients with a long-term condition to manage their condition and their risk factors, the NHS and social care can support the patient to attain better health outcomes and quality of life, slow disease progression and reduce disability.

This chapter of the JSNA reviews the following long term conditions in detail:

- Cardiovascular disease (which includes hypertension, coronary heart disease (CHD) and stroke)
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Complex long term neurological conditions

## 9.1 Key Findings

### 9.1.1. Hypertension

In LCR 17.2% of the adult population are recorded as having hypertension or around 1 adult in every 6. This is higher than the national prevalence rate of 16.6% and a 0.7% increase on the recorded prevalence in 2009. Between 2007 and 2009 there were 130 premature deaths (before the age of 75 years) from hypertensive disease[15], the majority of these will be due to stroke.

National models of disease prevalence estimate that the actual prevalence of hypertension in LCR is 29.9% of the adult population. This is equivalent to 171,272 people with hypertension and suggests that 75,040 adults are undiagnosed.

It is anticipated that the prevalence of hypertension nationally and locally will continue to increase slowly in the future. The estimated prevalence of hypertension is modelled to increase to 30.6% in 2015 (184,128 people) and 31.6% by 2020 (198,633 people). This is an overall increase of 16% in the number of people living with hypertension by 2020.

### 9.1.2. Coronary Heart Disease

In LCR 4.0% of the adult population or 1 adult in every 25 are recorded as having coronary heart disease (CHD). Between 2007 and 2009 there were 439 premature deaths from coronary heart disease (146 per year) (before the age of 75 years) [16].

National models of disease prevalence estimate that the actual prevalence of CHD in Leicestershire County and Rutland is 5.1% of the adult population. This is equivalent to 29,031 people with coronary heart disease and suggests that 6,460 adults are undiagnosed.

It is anticipated that the prevalence of coronary heart disease nationally and locally will continue to increase slowly in the future. The estimated prevalence of CHD in LCR is modelled to increase to 5.5% in 2015 (33,009 people) and 5.8% by 2020 (36,851 people). This is an overall increase of 27% in the number of people living with CHD by 2020.

### 9.1.3. Stroke

In LCR 2.0% of the adult population, or 1 adult in every 50, have been diagnosed with stroke. Between 2007 and 2009 there were 248 premature deaths from stroke (83 per year) (before the age of 75 years) [17].

National models of disease prevalence estimate that the actual prevalence of stroke in LCR is 2.3% of the adult population. This is equivalent to 13,409 people with stroke and suggests that 1,966 adults are undiagnosed.

It is anticipated that the prevalence of stroke nationally and locally will continue to increase slowly in the future. The estimated prevalence of stroke in LCR is modelled to increase to 2.6% in 2015 (15,579 people) and 2.8% by 2020 (17,313 people). This is an overall increase of 29% in the number of people living with stroke by 2020.

### 9.1.4. Diabetes

In LCR 5.3% of the adult population, or 1 adult in every 20 has been diagnosed with diabetes. This is similar to the national prevalence rate and a 0.5% increase on the recorded prevalence in 2009.

National models of disease prevalence estimate that the actual prevalence of diabetes in LCR is 7.0% of the adult population. This is equivalent to 39,609 people with diabetes and suggests that 9,737 adults in Leicestershire are undiagnosed.

It is anticipated that the prevalence of diabetes nationally and locally will continue to increase significantly in the future. The estimated prevalence of diabetes in LCR is modelled to increase to 7.7% in 2015 (45,558 people) and 8.3% by 2020 (51,195 people). This is an overall increase of 29% in the number of people living with diabetes by 2020.

### 9.1.5. Chronic Obstructive Pulmonary Disease

In LCR 1.8% of the adult population, or almost 2 adults in every 100, have been diagnosed with chronic obstructive pulmonary disease (COPD). This is similar to the national prevalence rate of 2.0% and a 0.2% increase on the recorded prevalence in 2009. Between 2007 and 2009 there were 660 deaths from bronchitis, emphysema and other chronic obstructive pulmonary disease in NHS LCR (230 per year) [18].

National models of disease prevalence estimate that the actual prevalence of chronic obstructive pulmonary disease in Leicestershire County and Rutland is 2.7% of the adult population (Table 2). This is equivalent to 15,504 people with chronic obstructive pulmonary disease and suggests that 5,531 adults, over a third of these individuals, are undiagnosed

It is anticipated that the prevalence of COPD nationally and locally will continue to increase slowly in the future. Whilst the estimated prevalence of COPD is modelled to remain the same at 2.7% in 2015, it is anticipated that this will equate 16,484 people, accounting for population growth. The estimated prevalence is 3.8% by 2020 (17,933 people). This is an overall increase of 16% in the number of people living with chronic obstructive pulmonary disease by 2020.

### 9.1.6. Long term neurological conditions (LTNC)

In LCR in 2010/11 there were 3,700 people in LCR recorded with epilepsy, this is a prevalence of 0.7% of population, significantly lower than the England average of 0.8%

## 9.2 Recommendations for commissioning

### 9.2.1. Cardiovascular disease

- Commissioning for prevention, early detection and treatment of CVD is a priority. The NHS Health Check programme is an attempt at this nationally. The Health Check Programme aims to help prevent heart disease, stroke, diabetes and kidney disease. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk[19].
- Appropriate treatment in primary care is important, and the effectiveness of primary care treatment needs to be maximised e.g. by auditing services.

### 9.2.2. Diabetes

- As it is estimated that the number of people living with diabetes across Leicestershire County and Rutland will increase by around 29% by 2020[20], services must be commissioned to accommodate this increase in demand.
- NICE guidelines suggest that structured education is an integral part of diabetes care and that structured education should be offered to every person and/or their carer at and around the time of diagnosis, with annual reinforcement and review[21]. Therefore it is imperative that sufficient and appropriate patient education is commissioned across LCR to meet the need of diabetes patients.

### 9.2.3. Chronic obstructive pulmonary disease

- Clinical Commissioning Groups are looking to prioritise COPD in terms of ensuring the following services are adequately commissioned:
    - Spirometry testing in primary care
    - Appropriate prescribing in primary care
    - Pulmonary rehabilitation services

### 9.2.4. Complex long term neurological conditions

- Services for long term neurological conditions should be commissioned in line with Department of Health National Service Framework for long-term conditions[22].

## 10. CANCER

About one person in three in England develops cancer sometime in their life and more than one in four die from cancer, making it the second most common cause of death after circulatory diseases.

Cancer is the most common reason for people in our population to die prematurely[23], with two fifths of all premature deaths due to cancer (40%). Reducing premature deaths from cancer will increase life expectancy and help to reduce health inequalities.

Although cancer services have improved for everyone, the progress made in achieving better cancer outcomes has been uneven. We know that inequalities between different groups of people persist: in incidence, access to services and treatment, patient experience and outcomes.

### 10.1 Key Findings

- In 2009 in Leicestershire County and Rutland there were 1,700 deaths from cancer[23]
- 800 of these deaths occurred prematurely, i.e. before the person reached 75 years of age. This is over 42% of all premature deaths.
- In March 2011 in Leicestershire County and Rutland there were almost 10,600 people on GP disease registers with a diagnosis of cancer[24]. This is a population prevalence rate of 1.7% of the population. This is significantly higher than the England average (1.6%).
- Between 2006 and 2008 over 9,900 people in LCR were newly diagnosed with cancer (incidence), over 3,300 people per year[25]. This gives an incidence rate of 361 per 100,000 European Standard Population - a rate that is significantly lower than the England average (374 per 100,000).
- Between 1993-95 and 2007-09 under 75 mortality rates from cancer have fallen in LCR from a rate of 132 per 100,000 to 99 per 100,000[23].
- Mortality rates from cancer for all ages and for people aged under 75 years are significantly lower in Leicestershire County and Rutland than the England average (2007-09 data)[23].
- Cancer survival rates for lung, breast and colorectal cancers at one and five years are not significantly different to the England averages.

### 10.2 Recommendations for commissioning

Commissioners should consolidate collaborative working with the local Cancer Network as the Network plays a pivotal role in supporting commissioning of cancer care locally and also works directly with local providers on the delivery of quality cancer services

Commissioners need to consider five key areas if they are to reduce the rate at which people die from cancer and to help those sections of population with most need improve fastest:

**Intelligence:** Commissioners need the detail to be able understand which cancers are killing local people disproportionately, how well people with cancer are being treated and whether the local situation is different from that in similar areas.

Therefore commissioners need to explicitly stipulate their data requirements from providers e.g. local hospital trusts, cancer intelligence agencies and incorporate these requirements into contractual arrangements. This should include quantitative and qualitative data. Data should be timely and should contain information on type, stage, survival and demographics and cover equality issues in order to inform activity to tackle inequalities and to measure progress.

**Prevention:** Commissioners need to:

- target preventive measure as almost half of all cancers are preventable through developing positive lifestyle choices and
- increase awareness of and uptake of National Cancer Screening Programmes
- target secondary prevention e.g. lifestyle changes to can reduce the risk of recurrence for cancer survivors, the impact of side effects of treatment and the burden of cancer survivors on the NHS and the benefits system.

**Early diagnosis:** Commissioners should work with patients and primary care providers particularly to improve early awareness and diagnosis of cancer and to:

- raise awareness of several cancer warning signs and risk factors, especially in more deprived and in certain ethnic groups in the UK, to facilitate improvements in early presentation and cancer prevention behaviours
- address barriers to seeking help, such as fear and lack of confidence to discuss symptoms with GPs
- ensure that primary care is responsive when patients present with signs and symptoms suggestive of possible cancer
- increase awareness of and uptake of National Cancer Screening Programmes

**Better Treatment:** Commissioners will want to ensure that patients have timely access to high quality, clinically effective and cost effective treatments and care for all cancers, at every stage of the cancer journey, including delivery of waiting time standards, expansion in capacity and the effectiveness of radiotherapy services through to end of life (including End of Life Care-see 'End of Life' JSNA chapter). Commissioners should also aim to improve broader outcomes and experiences for people living with and beyond cancer.

**Health Inequalities:** Commissioners must ensure that cancer services from prevention through to end of life are delivered equitably and commissioning plans target existing inequalities in the outcomes and experience of cancer patients which can occur at every stage of the patient pathway, including in awareness, incidence, access to treatment and care, patient experience, survival and mortality.

## 11. MENTAL HEALTH

The World Health Organisation defines mental health as:

> "A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"[26]

Mental health is not necessarily dependent on mental health status, people with mental health problems can have good wellbeing, while others without a diagnosed mental health problem may find it difficult to cope. However, fewer people are likely to develop mental health problems in populations with high levels of mental wellbeing. There are many factors which can contribute to a person's state of mental health. Of particular concern is the continuing economic crisis in the UK.

The prevalence of mental health problems in England is significant; at least one in four people will experience a mental health problem at some point in their life and at any one time, one in six adults have a mental health problem. [27]

Mental health problems are much more common in people with physical illness. People with diabetes, hypertension and coronary artery disease have double the rate of depression compared with the general population. They are also at risk of developing vascular dementia. Those with chronic obstructive pulmonary disease, cerebro-vascular disease and other chronic conditions have triple the rate of depression. People with two or more chronic physical conditions are seven times more likely to have mental health problems. Suffering from physical and mental health problems can delay recovery from both conditions[28]. Furthermore, those with mental disorders consume 42% of all tobacco consumed in England[29] illustrating an interesting link between mental health and health behaviour.

### 11.1 Key Findings

- In relation to expected trends, the greatest concern is the estimated increase in mental health prevalence in the older population (almost 2,000 more people suffering from depression/ severe depression aged 65 or over by 2015.
- Debt is also known to be strongly associated with higher rates of mental health problems and employment rates are also low for those suffering with mental health problems.
- It has been reported nationally that half of lifetime mental health problems have already developed by the age of fourteen.
- Through detailed examination of people accessing Leicestershire County Council services, where primary category of need is 'mental health', 23.3% of those accessing services in 2010/11 lived in priority neighbourhoods. The expected proportion of mental health service users living in these areas would be 10%, illustrating the high prevalence of people accessing mental health services in the priority neighbourhoods of Leicestershire.
- • In terms of gender, 61% of people accessing Adult Social Care Mental Health Services are female (general population 18+ = 51%). This supports the results of various studies which have found a higher prevalence of most mental health conditions in females.

- Depression is the most common mental health problem in older people and is associated with social isolation, long-term physical health problems, caring roles, and living in residential care.
- In figures from 2010/2011 for people accessing Drug and Alcohol Services (D&A), Improving Access to Psychological Therapies (IAPT) and Crisis Resolution (CR), just 3% of those referred were aged 65 or over. There is evidence that depression and anxiety in older people are not necessarily recognised in the same way as they would be for the adult population. It has also been suggested that staff tend to focus on the primary diagnosis or reason for admission to a service, rather than taking an holistic view of someone's needs and circumstances.

### 11.2 Recommendations

- Early intervention and prevention initiatives are central to reducing the cost of mental ill-health. Estimates suggest that between 25% and 50% of mental health problems in adults could be averted with timely and effective interventions in childhood and adolescence. Such initiatives will have a greater impact if targeted in areas of deprivation.
- The wider determinants of mental health, such as appropriate access to training, employment and housing, need to be addressed in more detail as they are likely to have a positive impact on people with mental health conditions.
- Current economic instability is likely to increase the demand for mental health services and could potentially lead to an increase in suicide rates.
- Access to relevant services to people aged 65 and over appears to be a local issue and this should be explored further. Although for some services the trends may be explained by referral pathways or the specific focus of a service, further exploration into apparent age discrimination in accessing mental health services is a particular priority.
- Increasing awareness of mental health issues, in both the public and professional arena, may help address the apparent under-representation of older people accessing mental health services and increase overall the number of people addressing mental health issues at an earlier stage.
- A more holistic and person centred approach to an older persons needs will increase the potential for older people suffering from co-morbidity to access appropriate interventions.
- The cause/ effect relationship between poor physical health and mental health needs to be better understood and addressed (particularly in the older population) in order to maximise the potential for positive outcomes.
- Further data gathering and analysis is required regarding the effectiveness of services and interventions provided locally, in order to better inform the future commissioning of services.

## 12. LEARNING DISABILITIES

A learning disability affects the way a person understands information and how they communicate; this means they face challenges with social functioning and adaptability; they can have difficulty in understanding new or complex information, learning new skills, and coping independently. Approximately 1.5 million people in the UK have a learning disability.

A learning disability can be mild, moderate or severe and is a lifelong condition, usually with early onset. Some people with a mild learning disability can talk easily and look after themselves, but can take longer than usual to learn new skills. Others may not be able to verbally communicate at all and may have more than one disability. Individuals with learning disabilities can face unique challenges that are often pervasive throughout their lives. The causes for learning disabilities are not well understood, although some causes of neurological impairments include heredity, problems during pregnancy and birth, and accidents after birth.

Autism is a spectrum condition. In the National Autism strategy (2010) Autism is defined as '…a lifelong condition that affects how a person communicates with, and relates to, other people. It also affects how a person makes sense of the world around them'. While all people with autism share certain difficulties, their condition will affect them in different ways. Some people with autism are able to live independent lives but others may have accompanying learning disabilities and need a lifetime of support. Asperger syndrome is a form of autism. People with Asperger syndrome are often of average or above average intelligence. They have fewer problems with speech but may still have difficulties with understanding and processing language. Asperger syndrome is mostly a 'hidden disability'.

### 12.1 Key Findings

- Projections estimate that the number of people locally with moderate to severe Learning Disabilities will rise from 2,546 in 2011 to 2,875 in 2030, an increase of 13%. The majority of this growth will occur in people aged 65 or over. However other estimates predict a rise of up to 24%.
- The prevalence of Autism Spectrum Disorders was found to be 1.0% of the adult population in England. The rate among men (1.8%) was higher than among women (0.2%).
- There may be an increasing need for services for older people with learning disabilities and older carers of people with learning disabilities.
- Although in previous studies the prevalence of learning disabilities in South Asian communities has been found to be higher (as reported in the previous JSNA), more recent evidence regarding learning disability prevalence and ethnicity is not consistent.
- Across Leicestershire there are currently 187 jointly funded packages (69 with a diagnosis of Autism) of people needing continuing health care at a total yearly cost of almost £10 million with an average yearly package cost of around £72,000.
- It is well recognised that prevalence of various conditions, including hearing and sight impairments, physical disabilities and common mental health conditions such as depression are higher in people with learning disabilities.

- Only 1 in 10 people with a learning disability are in employment. Research shows that 65% of people with a learning disability want to work, and that they make highly valued employees when given the right support.

### 12.2 Recommendations

- A further, more details analysis of people with learning disabilities is planned for 2012, due to the projected increase in the number of people who will need social care support in the coming years. As part of this, more specific analysis regarding projected service demand and level of need is required, including the number of people with profound and multiple learning disabilities, and the number of out of county placements.
- People with learning disabilities who have complex care needs place a significant demand on services. Capturing robust information regarding the number coming through the transitions stage will help to ensure better planning once reaching adult services.
- Future Health promotion work needs to be targeted towards people with learning disabilities and their carers.
- There needs to be a significant increase in the number of people with learning disabilities receiving personal budgets.
- Increased diagnosis is highly likely to impact on demand for specialist services for autism in the future. Detailed monitoring of numbers diagnosed locally is recommended, in order to ensure availability of appropriate services, particularly at transition stage.
- More effective work between children and adult services will improve the life chances of people with learning disabilities including accessing volunteering, training and employment, and in turn promoting independence.
- Developments in information and advice provision need to address the current barriers to accessing the right information for people with learning disabilities and their carers.
- Work against the Valuing Employment Now action plan needs to be closely monitored, and work is needed to examine reasons for the fall in numbers in employment and volunteering.
- The current review of day services needs to ensure access to employment, training and volunteering are carefully considered for all persons with learning disabilities who are eligible to access community opportunities.

## 13. PHYSICAL AND SENSORY DISABILITIES

In its broadest context, a definition of disability used in order to combat discrimination is set out in the Equality Act 2010. This defines a person as disabled if he or she has a physical or mental impairment resulting in substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities.

Since 5th April 2011, all public authorities have a statutory duty in respect of equality. This means that they must have due regard to the need to eliminate unlawful discrimination, harassment and victimisation relating to all equality issues, including disability. Significant barriers prevent many disabled people from enjoying the same opportunities in life as non-disabled people. For example, disabled people are more likely to live in income poverty, to be without work and to be dependent on the welfare state. Disabled people identify a lack of choice and control over their lives as a key driver of these disadvantages. This is now being addressed through the personalisation agenda, providing more choice and control to those receiving services. In addition, the Government is developing an overarching Disability Strategy to coordinate work towards disability equality.

A physical disability is any impairment which limits the physical function of one or more limbs or motor ability. Other physical disabilities include impairments which limit other facets of daily living, such as respiratory disorders and epilepsy. The following chapter provides information about these disabilities including a focus on older people.

### 13.1 Key Findings

- The estimated prevalence of people with physical disabilities has not changed and minimal growth is expected in the Leicestershire population within the 18 – 64 year age category.
- The estimated prevalence of people with visual and hearing impairments up to 2030 is set to increase significantly, largely reflecting the anticipated growth in the older people's population. Accordingly, and as illustrated below, the number of people with a serious visual impairment is expected to rise by 3% up to 2030 for those aged 18-64 years, but for those with a moderate or severe visual impairment it is expected to increase by 27% up to 2030 for those aged 65-74 years (by 46% for those aged 75 and over). Projections also indicate that the number of people with a registrable eye condition is set to rise by 46% up to 2030.
- Similar trends are apparent from projected figures for the prevalence of people with moderate or severe and profound hearing impairment. The total number of people with a moderate or severe hearing impairment (across all age groups) is expected to rise by 36% up to 2030, whilst the number of people with a profound hearing impairment is expected to rise by 43% up to 2030.
- Even though a high proportion of customers in the 18-64 age group have physical disabilities, just 7% of the Adult Social Care budget is spent specifically on physical disability. This is due to the types of services provided for this group. The most common community based service for people with physical disabilities is equipment and adaptations (47%) followed by direct payments (24%).

- The challenges faced by disabled people are well documented. Compared with non-disabled people, disabled people are more likely to live in poverty, less likely to have educational qualifications and more likely to be economically inactive.
- Research has shown that the number of people claiming DLA in Leicestershire is consistently rising
- Future estimations of numbers accessing benefits will be subject to the outcomes of the Welfare Reform Bill, currently at committee stage.
- When considering recipients of services aged 65 years or more, there are 10,266 within the physical disability category, accounting for 83% of the total number of people accessing services in this age bracket.

### 13.2 Recommendations

- Outcomes in relation to Welfare Reform for customers of Adults and Communities will need to be monitored closely at a local level.
- Potential employment/ training/ voluntary opportunities for people with physical disabilities must be routinely considered when assessing need, due to the positive outcomes associated with employment.
- Further exploration of the effectiveness and provision of assistive technology, equipment and adaptations would be advantageous. In particular, this should focus on the potential benefits for clients and their carers as well as the impact they may have on the commissioning of services (for instance, reducing costs of care packages).

## 14. HEALTH AND WELLBEING OF OLDER PEOPLE

England is an ageing society. The projected growth in the older person's population nationally is evident in Leicestershire and the changing age structure of the local population will have a major impact on the development of services. As the population changes, service provision will need to reflect future needs and demands of Leicestershire people.

The term 'older people' can cover a number of different age groups and individuals with a wide range of needs; 'Older People' are not a uniform group. The range of needs that older people may have can been seen as three distinct groups:

- Entering Old Age – people who have completed their career in paid employment and/or child rearing. This is a socially-constructed definition of old age, which, according to different interpretations, includes people as young as 50, or from the official retirement ages of women and men.
- Transitional Phase - This group of older people are in transition between healthy, active life and frailty. This transition often occurs in the seventh or eighth decades but can occur at any stage of older age.
- Frail Older People - These people are vulnerable as a result of health problems such as stroke or dementia, social care needs or a combination of both. Frailty is often experienced only in late old age, so services for older people should be designed with their needs in mind

### 14.1 Key Findings

- The projected growth in the older person's population nationally is evident in Leicestershire and the changing age structure of the local population will have a major impact on the development of services. As the population changes, service provision will need to reflect future needs and demands of Leicestershire people.
- People aged 65 and over are more likely to experience a range of conditions, have ongoing disability, mental health problems and require specific care.
- Those aged 90 or over in Leicestershire are set to increase by 75 percent to 16,600 by 2033.
- A total of 16,560 people (3% of the total population aged 18 and over) received a service provided or commissioned by Adult Social Care at Leicestershire County Council during 2010/11. Seventy five percent of customers were aged 65 and over which equates to 10.5% of the total population in this age group. Eighty three percent of customers in this age group were within the category of physical disability, frailty and sensory impairment and of these customers; over a third of those accessing services were aged 85 years or over.
- This high prevalence of older people accessing services is reflected in the investment in Adult Social Care services, for which the largest proportion is spent on older people (41% in 2011/ 2012).
- 14% of older people are more likely to live in the top 10% most deprived areas in Leicestershire.
- The likelihood of having a fall which requires being admitted to hospital significantly increases when aged 75 years or over (this equates to 4% of all people in this age category). Due to the rapid increase in the number of people

expected in this age category in the coming years, falls are of serious concern to both health and social care in terms of resource and cost implications.

- People aged 85 years and over in hospital have a length of stay 6 times that of someone younger than 85 years old.
- People with learning disabilities are living longer. This is predicted to result in an increase by 54% (176) in the number of people aged 65 and over with moderate or severe learning disabilities from 323 in 2010 to 499 in 2030. In 2010/11, 131 people with learning disabilities were aged 65 and over and were known to be in receipt of Adult Social Care services, half of which were in residential care.
- From 2010 to 2030, the proportion of people aged 65 years and over providing unpaid care is projected to stay at about 11% of all people aged 65 years and over the number increasing in proportion to the increased number population in this age group.

### 14.2 Recommendations

- Social care and health services need to prepare for the demographic effects described in the Demographic Chapter as groups of older people enter the following phases as described in the Department of Health's National Service Framework for Older People (2001): [30]
    - for those Entering Old Age – promote and extend healthy active life, and to compress morbidity (the period of life before death spent in frailty and dependency).
    - for those in Transitional Phase – identify emerging problems ahead of crisis, and ensure effective responses which will prevent crisis and reduce long term dependency.
    - for Frail Older People – anticipate and respond to problems recognising the complex interaction of physical, mental and social care factors, which can compromise independence and quality of life.
- The groups that need particular focus are frail older people, people living with dementia, and carers, and the themes common to all of them are:
    1. early identification and effective assessment of both health and social care needs for frail older people, people with dementia and their carers, from a multi-agency perspective
    2. integrated pathways and community based services to support older people and their carers so that they are able to stay in their home for as long as is possible. This includes the provision of respite services for carers and crisis prevention.

## 15. DEMENTIA

Dementia is a term used to describe various different brain disorders where a loss of brain function is progressive and eventually severe. The most common form of dementia is Alzheimer's disease followed by vascular dementia. Symptoms include loss of memory, mood changes, and problems with communication and reasoning.

All types of dementia are progressive. This means that the structure and chemistry of the brain becomes increasingly damaged over time. The person's ability to remember, understand, communicate and reason gradually declines. The pace of progression depends on the individual and what type of dementia they have. The way people experience dementia depends on many factors, including physical make-up, emotional resilience and the support available to them. Dementia is a terminal illness but people may live with dementia 7–12 years after their diagnosis. Nationally one in four females and one in five males over the age of 85 have dementia.

Due to the significant increase in the older population expected to be seen in Leicestershire in the coming years, the potential increase in dementia prevalence is of considerable concern. As part of the planning for this, a joint strategy for dementia across Leicester, Leicestershire and Rutland was developed in 2011.

Direct costs of dementia to the NHS and Social Care are estimated at £8.2bn per annum. The Department of Health has confirmed local health and social care communities will be held to account, and are expected to publish plans detailing how they will work together to deliver high quality care for people living with dementia.

### 15.1 Key Findings

- As age increases, the likelihood of dementia markedly increases. The prevalence of dementia for people with learning disabilities is higher than the general population.
- It is currently estimated (2011) that there are 8,296 people living in Leicestershire with dementia. The number of people suffering from dementia (aged 65 and over) is expected to almost double by 2030.
- The proportion of people living with dementia in care homes has been shown to rise with age.
- Older people are more likely to experience delayed discharge from hospitals. Where delayed discharge is a problem, around half of those affected are people with dementia.
- The current estimated cost of dementia is potentially £207million per year if all were accessing appropriate services. The World Alzheimer’s report (2007) states that costs far exceeds the societal costs of cancer, heart disease or stroke and almost equals the cost of all three if lost productivity is included.
- Consultation highlights the importance of providing clear information and advice, both pre- and post diagnosis, a coherent joint health and social care pathway for people with dementia, support services for carers including crisis support, and appropriate and responsive treatment for other health issues.
- There is the potential for assistive technology to address some of the tipping factors particularly around positive risk management and establishing actual level of risk.

- As illustrated, there are many and varying opportunities to improve services for people with dementia and their carers in Leicestershire, which need to be taken forward through delivery of the local strategy

### 15.2 Recommendations

- Ensure clear, consistent, integrated care pathways and effective joint commissioning.
- Awareness raising initiatives in order to increase diagnosis rates.
- An increased focus on preventative approaches will enable people with dementia and their carer(s) to maintain independence. These should include consistent and accurate information, advice and signposting to relevant support (such as respite and assistive technology).
- Current and future support provision for people with dementia need to consider the benefits of person centred service development.
- Targeted awareness raising programmes using appropriate communication methods are recommended for people with learning disabilities.
- Further research into treatment of patients with dementia in local hospitals will inform the development of appropriate care pathways which can minimise hospital admissions/ readmissions and reduce delayed discharges.
- Availability of residential care staff trained in person centered approaches for dementia may result in a reduction in challenging behaviour. Detailed monitoring of quality of care for people with dementia needs to be a key component of the new Quality Improvement team.
- Further work is needed to consider and address the difficulties and barriers that exist for people with dementia receiving a personal budget.
- Further market development is needed to ensure community based services are available for people with dementia and their relatives to purchase.
- The potential for assistive technology to support people with dementia needs to be explored as a priority in AT implementation.
- Improved local recording of people accessing services with dementia will provide the opportunity to further explore local impact, including service quality and efficiency.

## 16. END OF LIFE CARE

End of life care encompasses the holistic assessment and management of physical care, pain and other symptoms including the provision of; psychological, social, financial, spiritual and practical support for both the patient and their family/carers in their place of choice, during the last year of life[31] (DH 2008). It also includes care given after bereavement.

The Leicester, Leicestershire and Rutland (LLR) 'End of Life Care Strategy' states that the overall aim for LLR is: To enable people in LLR at End of Life to die in their preferred place of care. More than 50 percent of people express a wish to die at home although currently only about 20 percent are actually supported to do this.

All patients who have been diagnosed with an advanced, progressive, incurable illness (e.g. advanced cancer, heart failure, COPD, stroke, diabetes, chronic neurological conditions, dementia) should have access to high quality end of life care which offering dignity, choice and support to achieve their preferred priorities for care in the last year of life.

### 16.1 Key Findings

There are an average of 5839 deaths per year in NHS Leicestershire County and Rutland (LCR), two thirds of these are in those aged over 75.

- Around three quarters of all deaths result from end stage disease and are therefore 'predictable'. For every 2000 patients (average GP list size) there are 17-19 'predictable' deaths per year
- Of the 17-19 predictable deaths per 2,000 patients per year, 5 deaths result from cancer, 6 from organ failure - heart failure, COPD etc and about 7-8 deaths from frailty/dementia/multiple co-morbidities.
- In 2009/10 in LCR there were 742 people on palliative care registers, which equates to around 8% of the annual number of deaths. This compares to the LCR aim to identify 35% of patients for inclusion on palliative care registers.

National studies show us that:

- Over half of people would prefer to die at home and only 11% would prefer to die in hospital. In LCR in 2010, 52% of deaths took place in hospital and only 23% at home.
- In adults those aged 75-84 were most likely to die in hospital, with a greater proportion of those aged 85+ dying in nursing and residential homes.
- Those living in the most deprived quintile nationally were significantly more likely to die in hospital as were those in Mosaic group M – 'Elderly people reliant on state support'.

### 16.2 Recommendations

- Focus on proactive identification of patients across all diagnoses with end of life care needs, allowing timely access to advance care planning.
- Specialist palliative care services to shift their focus to causes of deaths with more complex end of life trajectories
- Continued commitment to provide quality services which enable patients to be cared for and supported within their place of choice.

- Support the continued development of a single point of access service, to improve the co-ordination of end of life services.
- Contract for a pathway or package of care that encourages providers to work together to deliver a more streamlined service.
- Commission for outcomes rather than activity-focusing contracts on outcome measures (rather than structures or processes). This can facilitate collaborative work between providers.
- Traditional measures such as morbidity and mortality do not apply in the same way in the context of end-of-life care. It is the qualitative experience of care, particularly whether the care provided has met the patient's needs and preferences, that is more applicable (Addicott 2010) [32]
- All clinical commissioning groups should involve a dedicated end-of-life care lead as recommended by the National Council for Palliative Care (Sam et al 2011) [33].

## 17. CARERS

A carer is defined locally as someone who looks after a person they care about, without payment, as a result of long term illness, disability, mental health problems or old age and because the person is not able to care for themselves. The cared for person could be the carers parent, son, daughter, wife, husband, partner, brother, sister, friend or neighbour.

A young carer is someone in a caring role under the age of 18 and some of the issues for young carers vary from those who are older carers. Many young carers are disadvantaged in terms of their educational, personal and social development as a result of their caring role.

Carers provide a significant amount of care that would otherwise be the responsibility of health and social care services. With the growth of the older people's population, and the accompanying resource pressure on Health and Social Care services, supporting carers is becoming increasingly fundamental to the health and social care agenda.

Carers play a major role in terms of providing community based support and the demands of the caring responsibility can be considerable. The impact on carers lives varies depending on the amount of caring time provided, the age of the carer and of course the individual needs of the cared for person.

### 17.1 Key Findings

- 10.4% of the total population are estimated to be carers, equating locally to 68,172 people in 2011.
- Claimants of carers allowance has risen consistently in the last 4 years, to 4,400 in February 2011.
- The number of community care assessments completed in 2010/11 compared to the previous year was a reduction of 1,146.
- There is a paucity of local data in relation to the prevalence in Leicestershire of young carers, but nationally it has been found that the average age of a young carer is 12, more than half of young carers live in one-parent families and almost a third care for someone with mental health problems.
- Carers will have an ever-increasing role to play due to the continuing pressure of the economic situation, increasing survival rate of people with complex needs, and the ageing population on health and social care services.
- Carers have been found to play a crucial role in long term reablement effectiveness.
- Around half of all carers may be excluded from paid employment.
- The number of people aged 64 and over providing unpaid care is expected to rise by 13% by 2015
- 2,418 (21.6%) of Leicestershire's' carers over 65 have poor health.
- Telecare may have the potential to transform lives of carers and cared for people, better, by promoting independence, enhancing quality of life and enabling carers to access paid employment.

- A local ‘employees who are carers’ survey was carried out in 2011 highlighting carers issues such as poor health; lack of information and advice; caring responsibilities and changing aspirations.
- A local consultation with people living with dementia and their carers identified carer stress as a key trigger point that led to people requiring higher levels of care and support.

### 17.2 Recommendations

- Continuing investment in carer support is critical, including timely and accessible respite care.
- In the current climate, it is important to support carers with regard to maintaining employment/ accessing employment opportunities and ensuring benefits are maximised. This can be achieved through ensuring information and advice is easily accessible, and working with employers to ensure policies and flexible working arrangements (where possible) support carer needs.
- An improvement in the information, advice and support provided to carers in relation to managing personal budgets/direct payments is necessary. Information and advice overall needs to be effectively co-ordinated with partners to ensure accuracy and accessibility.
- Further promotion of the health and wellbeing of carers through regular health checks, particularly for older carers is required.
- Additional work is required to identify the barriers and address the issues associated with completing carers’ assessments.
- Further work is needed to promote the self assessment form/ process by all sectors including health, to increase the number of carers in receipt of Direct Payments.
- Barriers to identifying young carers are complex and require further examination. The paucity of local data is of particular concern and schools have a key role to play in the early identification of young carers. Particular attention also needs to be drawn to carers of people with mental health issues, due to the prevalence of young carers caring for this client group
- Further exploration of the effectiveness of assistive technology and its impact on carers (such as carer health and wellbeing) will be of significant value.
- The further development of the refreshed local strategy should consider how recommendations may be taken forward.

## 18. OFFENDER HEALTH

In this chapter, the term ‘offender’ refers to an individual who is convicted in a court of law as having committed a crime, violated a law or transgressed a code of conduct. There is a distinction made between community offenders and those accommodated in prison. The term ‘youth offender’ is used to refer to those under the age of 18 who offend in preference to ‘young offender’ as this may be confused with the prison Young Offender Institute estate that manages prisoners between the ages of 18 and 21.

Investment in prison health services continues to be driven by the health needs assessments, performance measured through the national Prison Health Performance and Quality Indicator process and other local processes, and issues raised by the HM Inspectorate of Prisons and the Care Quality Commission as part of local prison inspections.

Adults and young people in contact with the criminal justice system are more likely to be socially excluded and experience high levels of health inequalities. They are more likely to suffer from mental health problems and learning disabilities, and to have problems with drugs or alcohol. The link between offending, reoffending and wider factors, including health, is widely recognised.

There are three prisons in Leicestershire with a total of approximately 2298 prisoners. There were 3,763 offenders supervised in the community in 2010/11.

### 18.1 Key Findings

- High prevalence of mental health problems (up to 63%) in prisoners
- High levels of alcohol and substance misuse in prisoners
- Offenders meeting the criteria for Alcohol Treatment Requirements face challenges in accessing timely interventions
- Up to 75% of prisoners and 88% of juvenile offenders smoke
- Predicted high prevalence of learning disabilities, but no data at present
- Dental health is significantly worse in prisoners, and waiting times are extended
- There is a relatively low recorded uptake of Hepatitis B vaccination within prison Healthcare and within Integrated Drug Treatment Services, actual uptake may be higher
- Access to mental health assessments at court for youth offenders.
- Access for youth offenders to education.
- Access to appropriate accommodation for adult and youth offenders.
- High costs of escorts and bed watches
- Potential for greater use of SystemOne (clinical recording software) to identify hidden morbidity
- Mismatch between identification of mental health issues in court/criminal justice system and ability to link those issues/needs to services

- The **'Bradley Report' (2009)** and the document **'Improving Health, Supporting Justice'** present an opportunity to review and develop health services for individuals made subject to the Criminal Justice System.
- The commissioning landscape for offender health is rapidly changing with medical care of prisoners commissioned by the National Commissioning Board, but substance misuse services both within prisons and for offenders in the community will be commissioned separately through local arrangements

### 18.2 Recommendations

Investment in prison health services continues to be driven by the health needs assessments, performance measured through the national Prison Health Performance and Quality Indicator process and other local processes, and issues raised by the HM Inspectorate of Prisons and the Care Quality Commission as part of local prison inspections.

- Commissioning should be directed by national guidance and local needs assessment. Services should be tailored for equity of access and targeted for greatest impact
- Support the development of an integrated offender health pathway across all criminal justice agencies
- Develop:
    - Clear pathways and referral processes that enable offenders leaving custody to access community drug and alcohol services
    - An IT solution that promotes the Integrated Drug Treatment System through enhanced information sharing
    - Additional capacity to promote rapid access to alcohol treatment for those offenders made subject to the Alcohol Treatment Requirement
    - Services for prisoners who engage in hazardous drinking. 63% of male sentenced prisoners admit to hazardous drinking to an extent that carries a risk to physical and mental harm (Prison Reform Trust, 2004)
- Further strengthen delivery of the Improving Access to Psychological Therapies (IAPT) initiative within Leicestershire prisons. 40% of male sentenced prisoners have a neurotic disorder (Stewart, 2008)
- Offer the full range of NHS health checks and national screening programmes (England) to all offenders
- Commission adequate dental provision
- Escorts and bed watches: consider opportunities to reduce costs and improve clinical efficiency and experiences of patients and prison staff e.g. through use of telecare
- Develop a process for the implementation of the recommendations from:
    - the **Bradley Report**
    - the **Improving Health, Supporting Justice National Delivery Plan**
    - 'Actions Speak Louder' report
    - the **'Healthy Children, Safer Communities'**

## 19. ASSETS

In this chapter we set out a 'first go' at describing the assets of Leicestershire. This represents a new approach to describing the resilience and strengths of local people and how that can be protective against ill health in the local area.

An asset based approach describes the capacity, skills, knowledge, connections and potential of a community. It changes the way we look at our population, describing not the problems that need fixing and the gaps that need filling but celebrating what we already have within the local community. In an asset based approach, the glass is half-full rather than half empty.

This contrasts with the more familiar 'deficit' approach focuses on problems in a community such as deprivation and health-damaging behaviours.

"A health asset is any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life's stresses." Antony Morgan, Associate Director, National Institute for Health and Clinical Excellence (NICE) 2009

An asset can be any one of a number of things:

- The practical skills, capacity and knowledge of local residents
- The passions and interests of local residents that give them the energy for change
- The networks and connections – known as 'social capital' – in a community, including friendship and neighbourliness
- The effectiveness of local community and voluntary associations
- The resources of public, private and third sector organisations that are available to support a community
- The physical and economic resources of a place that enhance well-being.

### 19.1 Key Findings

- The concept of an asset based approach is new within the Joint Strategic Needs Assessment for Leicestershire and needs to be further developed in the future.
- Overall there are strong feelings of neighbourliness in Leicestershire. However, generally people in the 'rural' areas feel more positive about their neighbourhood and people from the 'deprived areas' feel less positive about it.

In a survey in 2009:

- 78% of people in Leicestershire have a sense of belonging within their local neighbourhood.
- 83% of people in Leicestershire feel that their neighbourhood is a friendly place.
- 60% of people thought that their neighbourhood was a place where people from different backgrounds got on well together.
- 31% of respondents believed that most people could be trusted, while 41% believed that many of the people in their neighbourhood could be trusted.
- 87% of people believed that it was likely or quite likely that they could get help from a neighbour if they needed it.
- 21% of people thought they could influence decisions in their local area on their own, and 64% of people believed that they could affect decisions as part of a group.
- Leicestershire is seen as being an area with good transport links.
- 78% of the population within Leicestershire identified themselves as having a religious faith.

### 19.2 Recommendations

This years JSNA represents a first go at measuring assets. We have drawn upon existing reports relating to the measurement of social capital, a key indicator in the assets based approach. Over time we will construct a much more comprehensive view of the assets that Leicestershire, and its population, draws upon. These should include a fuller description of physical assets and the extent of community and voluntary organisations in Leicestershire, and the use of techniques like participative appraisal to allow local residents to participate in the measurement of assets.

## 20. WELLBEING / HAPPINESS

There is a strong argument for gaining a better understanding of the happiness of a population. Jones (2006) states that the "mental and emotional well-being of citizens improves their performance and broadens the intellectual, physical and social resources of a nation." Generally speaking, being happy enables people to reach their potential and lead full and contented lives.

In the last few years, happiness and wellbeing have become increasingly important areas of public policy (OECD, 2011b), with increasing interest from central government. This is in part due to the gradual realisation that a purely economic growth-based approach to happiness and wellbeing - one that equates increases in GDP to increases in quality of life – has fundamental flaws and limited power to increase overall happiness (OECD, 2011b).

Layard (2005) notes that income has become a proxy for national happiness when we should rather explore what makes people happy. The data would suggest that increases in income - after a certain point - do not translate into increased happiness (Powdthavee, 2007, Wilkinson and Pickett, 2010) as – at the simplest level - individuals become used to the increase over time. Also, as GDP is a national measure, it assumes that everyone experiences each increase equally and also masks disparities in individual income.

The global financial crisis, recession and pressure on public finances has brought this notion into sharp focus and pushed the topic up the political agenda. In addition, government budgets cuts have meant that public services have had to re-examine their services and the benefits they bring, including the amount of social benefit, leading to an increased interest in techniques such as Social Return on Investment (SROI), which attempt to measure benefits beyond economics and into less tangible aspects such as increased quality of life.

Happiness and wellbeing are inexplicably linked to health, mental health as well as economic factors. This relationship is two-way, shaping and influencing each other. The work of the public sector as a whole is to reduce unhappiness through effective services and although many services do not make people happy in an explicit way, without them, residents would be more unhappy.

As a result, how public services influence levels of happiness and unhappiness through the services they offer is a key concern and worthy of further analysis in order to develop a full understanding of the issues.

### 20.1 Key Findings

- Evidence suggests that happiness and health are closely related, with more happy people experiencing better health outcomes.
- Happiness and wellbeing enable people to reach their potential and lead full and contented lives.
- Although unhappiness with general circumstances can aid motivation overall, happiness is seen as an inherently good state.
- In the last few years, happiness and wellbeing have become increasingly important areas of public policy (OECD, 2011b), with increasing interest from central government. This is mirrored by a general acceptance that using GDP as a measure of quality of life has significant limitations.

- Happiness and wellbeing are linked to a variety of other issues, such as mental health, health in general, employment and high-risk behaviour.
- There are a variety of drivers to happiness. The ONS work on measuring happiness has identified ten domains, including:
    - Our relationships
    - Health
    - Where we live
    - Personal finance
    - Education and skills
    - The economy
    - The natural environment
- Attempts to measure wellbeing are inherently difficult as the drivers to happiness ultimately rest with the individual. As a result, public services should arguably focus on reducing the causes of unhappiness, leaving individuals free to follow their own paths to happiness.
- There are close links between happiness and social capital, encompassing aspects such as trust, belonging and reciprocity.
- Analysis of the Joint Survey results suggests that in Leicestershire, life satisfaction is influenced by self reported health, age, gender, disability (when it affects employment) and participation. Surprisingly, there was no correlation between religion and life satisfaction, given that it is considered to be a driver of happiness.
- Nef's Five Ways to Wellbeing represents a framework for embedding happiness into the work of public services. The approach is being adopted by the Adults and Communities department at Leicestershire County Council.
- There is a strong economic case for promoting happiness in terms of reliance of services and efficiencies.

### 20.2 Recommendations

- Given the emphasis placed on measuring wellbeing by the Government and other organisations and individuals, as well as the acknowledgement that purely economic measures to not fully reflect quality of life, more should be done to understand happiness and its impact on health and wellbeing outcomes.
- The release of national measures on happiness will provide and interesting source of data. Depending on how this data is released, it should be explored fully in order to apply the learning to Leicestershire

# SECTION 3: SERVICE UTILISATION

## 21. PRIMARY CARE

Primary care, as the provision of essential health care, is the basis of our health care system. It provides both the initial and the majority of health care services for a person or population[34]. The principles of primary care are accessible, comprehensive, continuous, and coordinated personal care in the context of the family and community.

Primary health care should be available to all people without the barriers of geography, cost, language, or culture. In primary care, all types of problems, at all ages and for both genders, are considered, including care for acute self-limited problems or injuries, the care of chronic diseases such as diabetes, the provision of preventative care services such as immunisations and family planning, and health education[34].

Primary care consists of general practitioners (GPs), opticians, dentists, pharmacists and community health services.

### 21.1 Key Findings

#### 21.1.1. General practice

- The GP patient survey found that patients in LCR feel they are able to see a doctor fairly quickly and are satisfied with the opening hours. However, some patients do not find it easy to get through on the phone, and find it difficult to book ahead for an appointment. 43% of patients felt that care from out-of-hours services was not received quickly enough.
- Overall, patient satisfaction with their GP practice is high, with 9 out of 10 patients satisfied with the care they receive at the GP practice. However, 40% of patients do not feel they receive good care from the out-of-hours GP services.
- LCR scored a higher proportion of Quality and Outcomes Framework (QOF) points than the England average for the majority of clinical areas. However LCR scored slightly lower on Hypertension (98.8% compared to 99.1%), learning disabilities (98.8% compared to 99.2%) and atrial fibrillation (98.1% compared to 98.6%).
- LCR achieved a higher proportion of QOF points than the England average in all areas in the organisational domain and the additional services domain.
- Melton, Harborough and Rutland have large proportions of their population in the most deprived one-fifth of England in terms of access to services.

#### 21.1.2. Dentists

- In LCR 95% of those who have tried within the last 2 years to get an appointment with an NHS dentist have been successful. NHS dentists in LCR have seen half of the adult population, and over two-thirds of children, within the last two years. This is comparable to national averages.
- A significantly higher proportion of 5 year olds (37%)18 and 12 year olds (42%)19 have decayed, missing or filled teeth (d3mft > 0) than the national average (31% and 33% respectively).
- The 2008/9 the NHS Dental Epidemiology survey estimated that approximately 1708 12-year-olds require orthodontic treatment in LCR, only 40% of which are estimated to already be wearing an appliance.

### 21.1.3. Pharmacies

- Pharmacies in LCR dispensed 820,000 prescription items each month in Leicestershire and Rutland. On average, each pharmacy dispenses 6215 items per month, approximately 200 per day.
- Overall, pharmaceutical service provision is meeting most needs across the county. However, there is county-wide under-provision of Chlamydia screening and Smoking cessation counselling. Needle exchange services are under-provided in all localities except for Hinckley & Bosworth and Melton.
- The majority of residents of Leicestershire and Rutland live within five minutes driving time of a pharmacy. Harborough, Rutland and, in particular, Melton have a lower proportion of residents with quick access, some residents having to drive for more than ten minutes. A large proportion of the population live more than 30 minutes walking distance from their nearest pharmacy, particularly in Melton, Harborough and Rutland.

### 21.1.4. Opticians

- Optometrists in Leicestershire and Rutland performed just under 160,000 NHS Sight tests last year, 23,400 per 100,000 population. This is comparable to the national average.

## 21.2 Recommendations

It is essential that our population has access to primary care services that are:

- Timely
- Efficient
- Effective
- Equitable
- Patient-centered
- Safe

Primary care is a key component for delivering care closer to home. Particularly in a rural area such as Leicestershire it should be ensured that our population has local and equitable access to high quality primary care services.

Primary care services should be easily accessible. In the GP Patient Survey 35% of LCR patients did not find it easy to get through on the phone and 43% of patients felt that care from out-of-hours services was not received quickly enough.

Primary care services must be high quality and variation between services must reduced. Although practices in LCR consistently achieve well against QOF targets, QOF may not be the best measure of quality. In the future Clinical Commissioning Groups should look at other ways to measure quality which enables them to assess variation between services.

# 22. NHS HOSPITAL CARE

This section reviews the potential demand for NHS services in the future, alongside population health needs. This chapter has been developed in response to the 2009 JSNA and the key theme that was identified in the executive summary:

> Significant demographic changes in the local population will take place and there is a need to plan for our future large scale changes.

This chapter looks at the services that our population currently uses, benchmarks these against national and peer comparators and looks at the future need and demand for services.

Unlike other sections this section of the JSNA, this chapter does include reference to Leicester City. As our hospital care is largely provided by University Hospitals of Leicester (UHL) it is important that we look at the assessment of need in a way that supports commissioning across the population that is supported by UHL.

## 22.1 Key Findings

The main issues that have been identified within this section are:

- Across both Leicestershire County and Rutland and Leicester City PCTs the rates of hospitalisation are higher than the rates that you would expect for our populations when these are adjusted for key drivers of health needs
- This excess hospital utilisation is driven by high levels of emergency care
- It is anticipated that the aging and growing populations we are responsible for will drive the demand for NHS care up and the costs associated with this.

## 22.2 Recommendations

There is nothing intrinsically wrong with predicting the need for significantly greater levels of hospital care to deal with the needs of an aging population. The difficulty is that the level of resources made available to the NHS over the next 5-10 years is very unlikely to grow at a rate that will allow these predicted levels of hospital care to be funded without compromising other vital parts of the system such as community services, mental health and rehabilitation.

There are two broad courses of action that can help to address this issue:

1. To improve the efficiency of hospital services so that more patients can be treated appropriately within the existing resource.
2. Providing care in the most cost effective way. This may mean doing operations as day cases rather than as inpatients where appropriate, providing care in primary care rather than in secondary care (for example out patient treatment of many people with diabetes) or preventing the need for hospital care by intervening earlier in the community. For example, preventing the admission to hospital of an elderly person by providing better support and care in the community is a more cost effective approach as well as being much better for the person's wellbeing.

## 23. ADULT SOCIAL CARE – SERVICE USAGE, ASSESSMENT AND DEVELOPMENT IN SOCIAL CARE

In order to effectively examine the impact of current changes facing the Adults and Communities Department, service utilisation and development has been examined from an holistic perspective. This chapter therefore makes a detailed assessment of service usage, costs, customer safety (safeguarding), Personalisation, changing family structure, eligibility for services, self-funders and current and future developments. It also considers engagement and consultation exercises in relation to services and sets out recommendations for future service provision and development.

### 23.1 Key Findings

- A total of 16,560 people received a service provided/ commissioned by Adult Social Care in Leicestershire during 2010/11. A person is much more likely to be receiving services if over 65 years of age (11% of the population, compared with just 1% of the 18 -64 population).
- Ten percent of the population of Leicestershire live in locally identified priority neighbourhoods. However, the proportion of people accessing services from these areas is notably higher (23%).
- The majority of spend in Adult Social Care is on services; with £50 million spent on community care and £41 million on residential care. Increased investment has been made in both preventative services and in reablement.
- The largest proportion of spend in Adult Social Care services is in older people accounting for 41% of the set budget for 2011/ 2012.
- In 2010/11 a total of 927 referrals concerning the safeguarding of a vulnerable adult were received. Based on current performance the forecast for this year is 1,125 (21% increase).
- Locally, people aged 65 or over are much less likely to be receiving services through self directed support.
- The number of people over 65 expected to be living alone in Leicestershire is expected to rise by 63% (27,300) between 2011 and 2030.
- In the longer term pensions and housing equity held by many older people is likely to ensure ineligibility for social care support in the future. By 2030 25% of Leicestershire's population will be 65 or over, 77% of which will be home owners.
- Leicestershire county council has a Homecare Assessment and Reablement Team (HART) which was accessed by 3,278 people during 2010/11, 50% of whom were aged 85 or over.
- An integrated approach to community based reablement/ intermediate care incorporating both health and social care functions has the potential to offer significantly improved outcomes for patients after discharge from hospital, and in preventing hospital admission.
- Assistive Technology has been shown to be an affective way of sustaining people in their own homes as well as offering support to their carers, reducing and/or delaying admissions to hospital, residential or nursing care.

- There are currently 166 units of extra care housing across the County. The department is committed to considering all viable opportunities for developing this approach in the coming years.

### 23.2 Recommendations

- Market development will be a crucial activity over the coming 2-3 years as there is a need to ensure that local markets match demand. Accordingly, future JSNA reports need to support this process and good communication with providers and engagement with service users will be essential.
- A priority will be to increase quality and efficiency, and the embedding of engagement with customers in the development of local services (through the new engagement framework) will ensure a personalised and local approach.
- Reablement/enablement and assistive technology are expected to alleviate pressures on social care services in the longer term. Regular evaluation of the approaches employed, and impact/cost effectiveness are key.
- Extra care housing development needs to achieve cost savings without compromising on the quality of care received in residential care homes. It is recommended that detailed analysis is undertaken in relation to the existing schemes in the county, to ensure cost effectiveness of future models.
- Support for carers is a critical component in delaying/reducing an individual's need to access support and funding must be protected where possible.
- Further research specifically considering ethnic minority customers, the likely increase in numbers accessing services, and their experiences of services would be beneficial to service planning and development.
- People accessing services are more likely to feel isolated if living in a deprived neighbourhood and are more likely to be depressed if in the 45-54 age category - effective targeting of relevant interventions is required, particularly in relation to employment/volunteering opportunities.
- Activities for older people, particularly in residential care settings, have been highlighted as an issue from a customer perspective, in addition to staff retention.
- The development of information and advice for those who are unlikely to be eligible for social care support, targeted at those about to become 65 (potentially planning for retirement), may prevent/ delay the need for social care support in the future.
- Activities for older people, particularly in residential care settings, have been highlighted as an issue from a customer perspective, in addition to staff retention. These issues need to be considered when assessing the effectiveness of commissioned services.
- The development of information and advice for those who are unlikely to be eligible for social care support, targeted at those about to become 65 (potentially planning for retirement), may prevent/ delay the need for social care support in the future.

## REFERENCES


[1] Starfield B: Improving equity in health: A research agenda. International Journal of Health Services 2001

[2] Health Inequality Indicators for Primary Care Organisations: Slope Index of Inequality for Life Expectancy by Deprivation Deciles, 2001-05 to 2006-10: Sources: ONS death registration data and mid-year population estimates and Department for Communities and Local Government, Indices of Deprivation 2010: Analysis carried out by London Health Observatory and East Midlands Public Health Observatory on behalf of the Public Health Observatories of England. Published by APHO, 20 December 2011: http://www.apho.org.uk/RESOURCE/VIEW.ASPX?RID=110504

[3] Health inequalities intervention toolkit – infant mortality tool: Londo Health Observatory

[4] 2010 Equality Act: http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

[5] Director of Public Health Annual Report 2010: Health Inequalities: NHS Leicestershire County and Rutland, Rutland County Council. Leicestershire County Council: December 2010: http://www.lcr.nhs.uk/Library/DPHannualreportfinal.pdf

[6] Director of Public Health Annual Report 2011: Health through the life cycle: Report 1 – Children: NHS Leicestershire County and Rutland, Rutland County Council. Leicestershire County Council: December 2011: http://politics.leics.gov.uk/documents/s65310/Director%20PH%20Annual%20report%202011%20Final.pdf

[7] Director of Public Health's Annual Report 2011: Health Through the Life Cycle: Report 1: Children

[8] Our Health and Wellbeing Today, Department of Health, 30 November 2010, © Crown Copyright www.dh.gov.uk

[9] Healthy Lives, Healthy People: Our Strategy for Public Health in England, Department of Health, 30 November 2010, © Crown Copyright www.dh.gov.uk

[10] Marmot, M. (2009), Strategic Review of Health Inequalities in England post-2010 Marmot Review http://www.marmotreview.org/ Marmot, M. (2010) Fair Society, Health Lives. The Marmot Review: Executive Summary

[11] Our Health and Wellbeing Today; Department of Health; November 2010; © Crown Copyright

[12] The NHS Information Centre. Compendium of Population Health Indicators. https://indicators.ic.nhs.uk/webview/

[13] World Health Organization (2002) Defining Sexual Health: Report of a technical consultation on sexual health, 18-31January. Geneva, WHO

[14] Health Protection Agency (East Midlands). HIV in the East Midlands Annual Report 2010. December 2011.

[15] The NHS Information Centre for Health and Social Care (2011) Mortality from hypertensive disease (ICD10 I10 - I15) https://indicators.ic.nhs.uk/webview/ [accessed 23rd November 2011]

[16] The NHS Information Centre for Health and Social Care (2011) Mortality from coronary heart disease (ICD10 I20-I25) https://indicators.ic.nhs.uk/webview/ [accessed 23rd November 2011]

[17] The NHS Information Centre for Health and Social Care (2011) Mortality from stroke (ICD10 J40-J44) https://indicators.ic.nhs.uk/webview/ [accessed 23rd November 2011]

[18] The NHS Information Centre for Health and Social Care (2011) Mortality from bronchitis, emphysema and other COPD (ICD10 J40-J44) https://indicators.ic.nhs.uk/webview/

[19] NHS Healthchecks - http://www.healthcheck.nhs.uk/Default.aspx

[20] Association of Public Health Observatories (2010) APHO Diabetes Prevalence Model for England. Yorkshire and the Humber Public Health Observatory http://www.yhpho.org.uk/resource/view.aspx?RID=81090 [accessed 8th November 2011]

[21] National Institute for Clinical Excellence: Type 2 diabetes the management of Type 2 diabetes: May 2008. http://www.nice.org.uk/nicemedia/pdf/CG66NICEGuideline.pdf

[22] National Service Framework for Long Term Conditions: DH 2005 at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4105369.pdf

[23] The NHS Information Centre. Compendium of Population Health Indicators. https://indicators.ic.nhs.uk/webview/

[24] The NHS Information Centre. The Quality and Outcomes Framework 2010/11 data tables. http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework/the-quality-and-outcomes-framework-2010-11

[25] The NHS Information Centre. The Quality and Outcomes Framework 2010/11 data tables. http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework/the-quality-and-outcomes-framework-2010-11

[26] World Health Organization (2005). Promoting Mental Health: Concepts, Emerging evidence, Practice: A report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne. World Health Organization. Geneva.
[27] McManus s, Meltzer h, Brugha T et al. (2009) Adult Psychiatric Morbidity in England, 2007: Results of a household survey. leeds: nhs Information centre for health and social care.
[28] NICE (2009) Depression in Adults with a Chronic Physical Health Problem: Treatment and management. NICe Clinical Guideline 91, available at: www.nice.org.uk/CG91
[29] McManus S, Meltzer H and Campion J (2010) Cigarette Smoking and Mental Health in England: Data from the Adult Psychiatric Morbidity Survey 2007, available at: www.natcen.ac.uk/study/cigarette-smoking--mental-health
[30] Department of Health, 2001. *National Service Framework for Older People.* London: Department of Health, p. 3.
[31] End of Life Care Strategy – promoting high quality care for all adults at the end of life; Department of Health; © Crown copyright 2008; http://www.endoflifecareforadults.nhs.uk/assets/downloads/pubs_EoLC_Strategy_1.pdf
[32] Rachael Addicott, Rebecca Ashton, Delivering better care at end of life - The next steps Report from the Sir Roger Bannister Health Summit, Leeds Castle, 19–20 November 2009 - www.kingsfund.org.uk/document.rm?id=8552
[33] Sam E, Chapman S, Hayes A, Smith T (2011). *Commissioning End of Life Care. Act &Early* [online]. Available at: www.endoflifecareforadults.nhs.uk/assets/downloads/A__E_layouts_art_with_links.pdf (accessed on 29 July 2011).
[34] Answers.com. Dictionary; primary care http://www.answers.com/topic/primary-care