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Introduction

This is my second Annual Report as Director of Public Health for Lincolnshire. As I have previously said, it is not my intention that this Annual Report will give you a comprehensive account of the state of health of the people of Lincolnshire, rather that over the course of several Public Health Annual Reports we will build up a more comprehensive view of health and well-being in Lincolnshire. As well as this I would refer you to the Joint Strategic Needs Assessment which complements this report with the data that people may be looking for.

Over the past year there have been some very significant improvements in the performance of most of the programmes of work that contribute to improving the health of the population, for example, screening programmes have better uptake levels and more people are stopping smoking. We still have much progress to be made on changing the outcomes we are after including levels of obesity, reduced health inequalities and reduced numbers of teenage pregnancies.

The first chapter of this report looks at one of these outcomes, health inequalities, and describes some of the work underway to harness the whole system to do just this.

Last year chapter two considered the broad topic of the health of offenders. This was a preliminary view as we were currently working on a comprehensive health needs assessment on the health of prisoners in Lincolnshire. This has now been completed and published. A summary of the findings is given here to widen the audience for the results.

Chapter three identifies successful work to increase levels of screening for a wide range of cancers and some non-cancer conditions. We have to be careful in any screening programme to ensure that we do not widen inequalities in health because those with better health may be more likely to accept the invitations. In Lincolnshire we are working hard to raise awareness of the importance of these screening programmes.

Chapter four looks at sexual health and is an early summary of a Sexual Health Needs Assessment which is underway at present.

I am grateful to senior colleagues within the Public Health Directorate for writing the individual chapters and to those who have reviewed and proof-read the report.

I hope you enjoy reading this report and find something in it which will enable you take some action to improve the public’s health.

Dr Tony Hill
Joint Director of Public Health
NHS Lincolnshire and Lincolnshire County Council
Towards a New Health Inequality Framework.

Introduction & Background

Health inequalities and the underlying conditions of communities that drive them are proving deeply intractable despite overall improvements in health status, measured by increasing life expectancy.

The Joint Strategic Needs Assessment for Lincolnshire describes this phenomenon very clearly across nearly all of its indicators: the average health status in the population is getting better whilst the gap between the least and most healthy is increasing year on year.

Babies born in different wards in the City of Lincoln, for example Park and Minster wards, can expect life expectancies that differ by as much as eight years and within their lives can expect to have very different experiences of illness and disability.

These features on progress in improving the health of our populations are not limited to Lincolnshire - almost every community in the country is struggling to find the most effective mechanisms to address inequalities. Probably the most insightful report into our failure in recent times is that by Sir Michael Marmot ‘Fair Society, Healthy Lives’ published in 2010.

This report argues strongly and clearly for a programme of work designed to address the social determinants of good health that are most influential in holding down the improvement in health of some communities and individuals. The report does not, however, argue that we discontinue the interventions that are already in place to support best access to healthcare and improvements in individual lifestyles across all communities.

These interventions do need to be accessible to everyone though. This means taking a proactive approach to designing in access for specific groups and lowering the other social barriers that get in the way of people using them effectively.

The chapter seeks to cover two key issues in this agenda of addressing health inequalities:

1. To identify the things we have already started to do to address the first issue of designing out barriers to accessing existing health improvement interventions for disadvantaged groups.

2. To put forward new thoughts about how social drivers of health may be considered when assessing the needs of populations and planning to address the inequalities they experience.

The Shape of Health Inequalities in Lincolnshire

Much is known and understood about the distribution of health and health inequalities in the county, and whilst this distribution changes from time to time significant quantum of change generally only occur when a significant event happens.

Most recent events of this nature have centred on the rapid influx, and changing nature, of migrant populations from parts of the European Union where people have poorer health than the UK average. However, we have experienced longer term trends around health inequalities driven by migration of UK population out of areas with historically poor health into parts of Lincolnshire. For example, the inward migrants from parts of our previously heavily industrialised neighbouring regions into rural and coastal East Lindsey ‘imported’ a range of inequality in long term conditions that is not easily remedied.

Our knowledge of inequalities extends across all three domains where it might be reasonable to measure them, plan to address them and track our progress in doing so:
The sum of all of these measures, and our ultimate measurement of success or failure in addressing health inequalities, is the comparative mortality and premature death rates between populations.

The ultimate measures used for tracking effect and outcome of our interventions are therefore short term in nature and are performance managed in time frames that encourage focus on quick wins. This has a perverse effect on the prioritisation of policies and interventions with longer term payback. This can be seen in the weighting of our work programmes towards healthcare and lifestyle interventions at the cost of social condition interventions.

In a resource limited environment, investment is naturally more attractive to public services where the return, seen here as a year on year reduction in premature mortality, is achieved quickly and in a predictable fashion. A consequence of this is a significantly lower investment rate (of staff resources in securing partnership delivery as well as cash) in the services and interventions that are longer term deliverers of improvement like those in the underlying conditions domain.

Given the closely interconnected nature of the three domains it is not surprising that inequality and inequity distribution across communities models significant overlaying of problems in vulnerable communities.

This is most evident in communities that are defined by geography, as many of the measures of effective healthcare delivery and lifestyle are attributed to geographical measures. However, needs assessment of communities of interest generate a very similar pattern of lack of service access and underlying barriers to good health. Without routine monitoring and investment in inequalities domains, even in communities of interest, there is significantly less investment in understanding and acting upon longer term underlying conditions than there are for the other two domains.

This is certainly not to say that no progress on addressing inequalities is being made in the county.
Effective Healthcare

Access to a range of healthcare services is always important to securing good health whether these are the more secondary prevention-focused services in primary healthcare or acute, tertiary prevention in interventions.

Significant progress has been made in recent years in improving access of a number of disadvantaged communities to good healthcare. Most notable have been the Health Support Service for Offenders and Homeless People and the dramatic improvements in access to health and wellbeing interventions by people in substance misuse treatment.

Primary Care access is now offered on site to offenders being supervised in the community and those accessing emergency and ongoing support services as a result of homelessness. The rate of diagnosis and treatment of both chronic conditions and acute illness and injury has increased by over 100% since the inception of these services.

Another key focus area has been around addressing the significant inequalities arising from inequity in access to cancer screening programmes by some parts of the community. For example, work has recently commenced utilising the Early Presentation of Cancer (EPOC) community development workers and volunteers to increase the uptake of the breast screening programme across the more vulnerable populations in the Lincoln, Skegness, Gainsborough and Mablethorpe districts. These workers provide additional information for women through literature and discussing of specific queries with individual women. This is bringing positive and encouraging results. The Lincolnshire breast screening unit has been reporting an increase in women attending for screening in the targeted population. This successful work will expand next year to ensure more women are fully informed and aware of the benefits of breast screening. Other work that has taken place around health inequalities and other screening programmes is highlighted in the screening chapter of this report (chapter 3).

Lifestyle and Disease Management

A range of services in primary care grouped under the heading of the Primary Care Quality and Outcomes Framework (QOF) are in place to reduce the impact of chronic disease on health. These are services that seek to identify disease early, in many cases before people have symptoms, and make sure the best preventative healthcare is in place and controlling risk factors. Significant progress has been made in exploring and addressing the hidden inequities within certain parts of the QOF. Whilst it is perfectly reasonable for practices to have to limit their individual efforts to secure participation in preventative healthcare within QOF schemes, it was clear that the very people who were ‘voided’ from these schemes were those with the most barriers to access and the most likely to experience health inequality.

Practices and Clinical Commissioning Groups are now doing additional work with partners to identify how these people can be brought into the extremely beneficial schemes already accessed by everyone else.

Additionally, specific lessons learned from this exploration of exclusion criteria from QOF schemes has led to measures to avoid this happening being built into the NHS Health Check Programme.
Some significant progress is being made with planning authorities and partnerships in the County to develop health impact and health improvement opportunities into planning considerations. An example is in the pioneering work with Central Lincolnshire’s Joint Planning Unit. The team is working not just to embed public health principles now into the core central planning policies across three districts, but to proactively work with developers of new, substantial building developments in the County to understand, recognise, and mitigate any possible negative health or inequity issues. This will be done through a new requirement for developers to conduct a health needs assessment where indicated to truly highlight local issues and improve health through the planning process.

This work is just the start however, a regional conference in 2012, focussing on health and planning will further develop this area, and links are now being made with varied local interests, such as transport planning and nature parks in the County to further embed and improve health through the planning ‘levers’ available to us.

An Approach to a New Inequalities Framework for Lincolnshire

The Joint Strategic Needs Assessment and all of its source materials are a rich mixture of information for understanding the state of health of a population and the key drivers and barriers for good health that exist within it.

A selection of measures should be identified to answer the questions we want to answer about the population in question at the outset rather than letting what is known lead the enquiry.

In order to ensure an enquiry does not fall into a tried and tested pattern of measures, a framework which requires consideration of all three domains would be useful.

The framework would need to give the structure to ensure all possible issues were considered whilst being flexible enough to allow irrelevant material to be rejected at the outset.

In essence, a framework could be viewed as a series of light filters on a camera or a potato sorter in a food production plant where the appropriate filters could be added or subtracted by the operator.

Steps towards an enquiry would look like:

<table>
<thead>
<tr>
<th>Steps</th>
<th>For Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select the Population</td>
<td>Those at risk of offending</td>
</tr>
<tr>
<td>Consider the measures</td>
<td>Death</td>
</tr>
<tr>
<td></td>
<td>Disease</td>
</tr>
<tr>
<td></td>
<td>Risk and Odds</td>
</tr>
<tr>
<td>Apply the appropriate filters</td>
<td>Effective Healthcare</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
</tr>
<tr>
<td></td>
<td>Substance Misuse</td>
</tr>
<tr>
<td></td>
<td>Lifestyle</td>
</tr>
<tr>
<td></td>
<td>Smoking</td>
</tr>
<tr>
<td></td>
<td>Alcohol</td>
</tr>
<tr>
<td></td>
<td>Underlying Conditions</td>
</tr>
<tr>
<td></td>
<td>Housing</td>
</tr>
<tr>
<td></td>
<td>Learning</td>
</tr>
<tr>
<td></td>
<td>Work</td>
</tr>
<tr>
<td></td>
<td>Household income</td>
</tr>
<tr>
<td>Process the Measure Values Through the Filters</td>
<td>Reject the irrelevant</td>
</tr>
<tr>
<td>Identify those requiring action</td>
<td></td>
</tr>
</tbody>
</table>
In several years of policy and strategy designed to reduce inequalities in health status we have failed to make a significant difference in closing the gap for communities with more barriers.

It could be argued that this is the case because we have paid too little attention in our work to the underlying conditions that influence health. If we are to seriously address this, then we need to introduce some form of systematic tool to require planners and deliverers of services to get into the habit of considering these factors.

A possible approach has been proposed in outline in this chapter, but there are many other ways of approaching this that have been designed by much more skilled modellers.

The recommendation holds however:

Lincolnshire should adopt a systemised model of planning needs assessment for its communities that ensures the due consideration of the underlying conditions that may be contributing to health inequalities.
Prison Health Needs Assessment

Introduction and Context of Prison Health Needs Assessments

Prisoners are not typical of the general population with regard to their health needs as they have a disproportionally higher prevalence of ill health compared to the general population. Primary Care Trusts (PCTs) have responsibility for commissioning health services for the prison population to the same quality as those commissioned for the general public in the community. One of the Prison Health Performance and Quality Indicators is in relation to Directors of Public Health in PCTs carrying out a Health Needs Assessment (HNA) for their local prison population. It is essential to carry out these HNAs given the complex health needs of the prison population and the opportunity that it brings to understand their needs and to be able to address these both in prison and beyond. It is well evidenced that improving offenders’ health and well being can have wide community benefits.

Background to the Health Needs Assessment

During 2011, the Directorate of Public Health carried out a HNA for the prison population at HMP North Sea Camp (NSC) and HMP Lincoln. It was also planned to carry out a needs assessment for HMP Morton Hall, however, at the start of the process, it was announced that the prison would be closing and it would become a male immigration detention centre.

Although led by a small team from Public Health, the needs assessment was planned and developed by a small working group which had representatives from prison healthcare (Lincolnshire Community Health Services at that time but provided by Lincolnshire Partnership Foundation Trust from April 2011) and the Patient and Public Involvement (PPI) team at NHS Lincolnshire. The timescale for carrying out the HNA was limited and therefore this reflects the scope of the HNA.

This chapter of the annual report provides a summary of the process of carrying out the HNA and some of the key findings and recommendations that were made. Furthermore, it provides some information on the work that has taken place to address these recommendations.

Lincolnshire Prisons

Prisons have different security categories which range from category A (prisoners who are highly dangerous) to category D (prisoners who can be reasonably trusted in open conditions). HMP Lincoln is a category B male prison located in Lincoln City. It has a certified normal accommodation for 436 and an operational capacity of 738 prisoners. The prison population was 602 for the purpose of this assessment.

HMP NSC is an adult, male category D prison (open) located in Freiston, a rural area near Boston. It has certified normal accommodation and an operational capacity of 318 prisoners. The prison population was 333 for the purpose of this assessment, reflecting an increase in capacity since the most recent visit by HM Inspector of Prisons (2009).

Aim and Objectives of the HNA

The HNA had the following aim and objectives:

Aim:

- To collect and interpret evidence pertaining to the health and well-being of prisoners in Lincolnshire, to better inform partnership working and the commissioning of prison healthcare services.

Objectives:

- To summarise the literature on national offender health issues and key policies driving change.
- To review local data on prisoner health status and utilisation of current services.
- To capture a flavour of the views of service users (i.e. prisoners), providers of healthcare and key stakeholders on the problems, successes and challenges in the provision of quality prison healthcare.
Methodology

Data for the HNA was selected from a limited number of areas of interest as agreed by the steering group. These are provided in Table 1.

Table 2.1: HNA Areas of Interest

<table>
<thead>
<tr>
<th>Area of Interest</th>
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</thead>
<tbody>
<tr>
<td>Demography and diversity of the prison population</td>
</tr>
<tr>
<td>General health and long term conditions</td>
</tr>
<tr>
<td>Mental health and wellbeing</td>
</tr>
<tr>
<td>Disabilities</td>
</tr>
<tr>
<td>Infectious disease and sexual health</td>
</tr>
<tr>
<td>Lifestyle risk factors</td>
</tr>
<tr>
<td>Determinants of health</td>
</tr>
<tr>
<td>Patient care experience</td>
</tr>
<tr>
<td>Additional health services</td>
</tr>
</tbody>
</table>

Three main sources of information were used in relation to these areas of interest. Firstly, a literature review was conducted to identify research literature and policy context in relation to offender health. Secondly, collection and analysis of quantitative evidence was gathered by extracting data from SystmOne (prison healthcare clinical system that has recently been introduced). The third source of data was the collection and analysis of qualitative evidence using targeted interviews to capture the service user and service provider perspectives. This also involved gaining information from stakeholders via a questionnaire.

Key Findings

This section of the chapter provides some key findings from the HNA. Further information can be found in the full report (see the end of this chapter for further information on where this can be obtained).

Demography and diversity of the prison population.

Some findings from the literature

Nationally, the prison population is largely young, overwhelming male, with about 60% of inmates under the age of 30 years (3). However, people aged 60% and over are the fastest growing age group in prisons.

Some local information

Data from both HMP Lincoln and HMP NSC confirms over-representation in the 20-40 years age range (see Figures 2.1 and 2.2). Lincoln data suggests a less diverse population (ten percent ethnic minorities versus almost 27% in prison nationally) compared to 23% at NSC. Missing data and coding issues made it difficult or impossible to properly assess the languages spoken and the levels of deprivation amongst the prison population.

Figure 2.1: Age distribution of prisoners in HMP Lincoln (Source: SystmOne Prisons, January 2011).

Figure 2.2: Age distribution of prisoners in HMP NSC (Source: SystmOne Prisons, January 2011).

General health and long-term conditions

Some findings from the literature

On entering the prison system, prisoners have complex health needs and on first reception all prisoners should be offered a general health assessment.

Table 2.2 provides some information from the research literature.

- Prisoners have health care needs which are a consequence of imprisonment (3).
- Prisoners are more likely to turn to primary care services because of restrictions on self care and informal care (3).
- Some older prisoners have a physical status of 10 years older than their contemporaries in the community (4).
- Half of all those sentenced to custody are not registered with a GP prior to being sent to prison (4).
Some local information
Prevalence of certain medical conditions was determined to allow comparison against a typical Lincolnshire general practice, particularly in relation to the burden of long-term conditions, for example, asthma, cancer, diabetes, stroke, epilepsy. Data was also collected on primary prevention of cardiovascular disease and numbers receiving palliative care for terminal illness.

In both HMP Lincoln and HMP NSC (with the exception of epilepsy) the prevalence of general health conditions amongst the prison population appears low, relative to the Lincolnshire community (see Figures 2.3 and 2.4).

Figures 2.3: Prevalence of general health conditions in HMP Lincoln (Source: SystmOne Prisons, January 2011).

Figures 2.4: Prevalence of general health conditions in HMP North Sea Camp. (Source: SystmOne Prisons, January 2011).

At both HMP Lincoln and HMP NSC, prison service users reported both compliments and concerns about services. At Lincoln prison, service provider views did not highlight any strong concerns about healthcare provision. At NSC, the environment for dispensing medication was raised by both prisoners and staff.
Mental health and well-being

Some findings from the literature

It has been shown that mental illness can contribute to re-offending and is associated with social exclusion. Nearly three quarters of male sentenced prisoners have two or more mental health disorders and a fifth have four disorders. Seventy-five percent of all prisoners have a dual diagnosis, i.e. mental health problems combined with alcohol and drug misuse[6].

Some local information

Data was extracted from SystmOne on a range of mental health conditions. There was concern that this may not completely reflect the prevalence of mental health conditions amongst the prison population. However, from the data obtained, depression and anxiety had the highest prevalence in both HMP Lincoln and HMP NSC (see Figures 2.5 and 2.6).

Figure 2.5: Data on mental health condition prevalence in HMP Lincoln (Source: SystmOne Prisons, January 2011).

Figure 2.6: Data on mental health condition prevalence in HMP North Sea Camp (Source: SystmOne Prisons, January 2011).

At Lincoln prison service users provided positive comments on mental healthcare services. Service providers expressed concern about non emergency waiting times (Lincoln) and the lack of integration between general health and mental health clinical records (NSC).

Disabilities

Some findings from the literature

The Disability and the Equality Act 2010 aims to protect disabled people and prevent disability discrimination. It is estimated that up to 30% of the prison population have a learning disability. However, people with learning disorders are relatively unrecognised within the criminal justice system, therefore affecting their ability to cope and access support.

Some local information

Data was extracted from SystmOne on prisoners with learning, physical, visual and hearing disability. This data showed very low levels of disability amongst the prison population. At both HMP Lincoln and HMP NSC, less than one percent of the prison population had a recorded disability, with the exception of HMP Lincoln where just over one percent had a learning disability.

Although no data about utilisation of services by people with disabilities was available, provision is made for people with disabilities, for example, physical adaptations to the environment, appropriate literature, etc.

At Lincoln prison service users expressed concern about accommodation/reasonable modifications for persons with physical disability. Service providers reported that they are able to meet the needs of prisoners with disabilities, for example, the accommodation that is provided. A range of key stakeholder views was not available. However, from the limited response it was mentioned that it would be useful to have greater expert advice in relation to meeting the needs of prisoners with disabilities (Lincoln).

Infectious disease and sexual health

Some findings from the literature

Primary prevention is an important public health principle and immunisation against infectious diseases is a good preventative practice. Prisoners may have missed out on routine childhood immunisations and other required vaccines. Therefore, periods of imprisonment may serve as health promoting opportunity (1). The rate of Hepatitis B and C and HIV among the prison population in the UK is significantly higher than similar populations in the community[5].
**Some local information**

Data was collected on the prevalence of infectious diseases known to have a higher prevalence or particular importance in prison populations. All the information was obtained from SystmOne as access could not be obtained from the genitourinary medicine (GUM) service and therefore this possibly represents underreporting of sexually transmitted infections data. Figures 2.7 and 2.8 show the prevalence of certain conditions.

Service providers raised the important role of the prison induction in providing information on harm minimisation/prevention. A range of key stakeholder views was not available. However, from the limited response it was mentioned that it would be useful to have greater expert advice in relation to infectious diseases and sexual health (Lincoln).

### Lifestyle

**Some findings from the literature**

Many premature deaths and illnesses could be avoided by improving lifestyles, for example, stopping smoking, improving diet and increasing physical activity.

Table 2.3 provides some findings from the literature in relation to the lifestyle of prisoners.

**Table 2.3: Some of the evidence from the literature search.**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Lincoln</th>
<th>NSC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>7.0%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>4.0%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>3.0%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>2.5%</td>
<td>3.0%</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>2.0%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Genital Herpes</td>
<td>1.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Genital Warts</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

30% of young adult prisoners report having an alcohol problem when they enter prison.

80% of prisoners smoke.

40% of prisoners participate in exercise.

Drug use amongst prisoners is reported to be high.

**Some local information**

Data was extracted from SystmOne on the lifestyle risk factors of smoking and alcohol abuse. No data was available on prisoner diet or levels of physical activity. Information on substance use was extracted from the Integrated Drug Treatment System (IDTS). The data showed that:

- Two percent of Lincoln and 3.5% of NSC prisoners were misusing alcohol.
- Twenty-four percent of Lincoln and 47% of NSC prisoners were smokers.
- Only five percent of the prisoners at Lincoln prison had a recorded Body Mass Index (BMI). Thirty percent of prisoners at NSC had a recorded BMI. Twenty percent of the prison population were overweight/obese.

- During a six month period approximately a fifth of new receptions at Lincoln prison require treatment for their substance misuse, this compared with no prisoners at NSC.

At Lincoln and NSC, service users provided positive comments on the opportunities that they have for engaging in some lifestyles behaviours, e.g. physical activity. Service providers recognised the benefits of the IDTS service. A range of key stakeholder views was not available. However, from the limited response it was mentioned that it would be useful to have greater expert advice in relation to lifestyle risk factors (Lincoln).
Determinants of health

Some findings from the literature
Material circumstance, social environment, psychological factors, behavioural and biological factors are all important influences on people’s health (6).

Table 2.4 provides some findings from the literature in relation to the determinants of health of prisoners.

Table 2.4: Some of the evidence from the literature search.

<table>
<thead>
<tr>
<th>Determinants of Health</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prisoners are from lower socio economic groups and have poor levels of education. The unemployed and undereducated are over represented (3).</td>
<td>Nearly half of prisoners have no qualifications (4).</td>
</tr>
<tr>
<td>Prior to entering prison, 15% of prisoners are homeless (4).</td>
<td>The risk of someone becoming an offender starts early in life (2).</td>
</tr>
</tbody>
</table>

Some local information
Data was sought on indices of deprivation and several of the wider determinants of prisoner health (education, housing and employment). However, due to re-coding of postal codes and lack of access to P-NOMIS data, information on these areas could not be gained.

At both Lincoln and NSC prisons, service providers reported the benefits of prisoners engaging in work and educational programmes.

Conclusions

Prisoners are not typical of the general population with regard to their health needs. This HNA has obtained a range of national information on the health of prisoners, which shows the significant health inequalities that exist amongst the prison population. The local data that has been gathered as part of this assessment provides some information on the health of the Lincolnshire prison population. However, some of this data does not indicate the level of ill health and unhealthy lifestyle behaviours that would be expected given the findings in the literature.

A wide range of recommendations have been made as a result of carrying out the Prison HNA. Some of these recommendations are being addressed by public health staff working jointly with people responsible for delivering prison healthcare through the Prison Health Board and the Prison Health Planning Meeting. For example, trying to improve data to enable a greater understanding of the health status of the prison population to enable resources to be effectively targeted. Taking forward these recommendations will enable future prison HNAs to be developed.

Recommendations

- We need to improve the quality of the data for enabling a greater understanding of the demography and the health status of the prison population.
- The prison healthcare provider to maintain disease registers and to manage the prisoners on these registers to the same clinical outcomes as those of the Quality and Outcome Framework in primary care.
- We must ensure that an assessment tool is used to identify prisoners with a learning disability and an evidenced based care plan is used for people identified with a disability. Ensure that the prison population has access to a range of lifestyle services, e.g. physical activity and that access to these is recorded on the clinical systems.

References
Introduction

Population screening programmes have a key role to play in the early detection of disease. However, screening is not suitable for every condition and national screening programmes are only established on the recommendation of the UK National Screening Committee (NSC) after consideration of very strict criteria. This section of the annual report presents information about the national screening programmes offered to residents across Lincolnshire including Antenatal & Newborn, Diabetic Retinopathy, Cervical, Breast and Bowel cancer screening programmes. Figures 3.1 and 3.2 show the timeline of these programmes in more detail.

Screening for a disease involves applying a test to the population at risk in an attempt to detect those at increased risk of developing disease. Screening is not diagnostic, and people who receive a positive result of a screening test are offered further evaluation or diagnostic evaluations.

For screening to be successful, programmes need to achieve high standards in relation to coverage and processes. Quality assurance systems offer guidance on how standards can best be monitored and what data need to be collected to provide evidence of good practice. This is translated into specific targets and indicators of performance for each of the programmes, and for Lincolnshire this can be found in each of the programmes.

Significant achievements during 2010

In order to help address inequalities and increase uptake of screening, printed posters translated in several languages have been published and distributed across Lincolnshire.

Cancer champions and their volunteers are now acting and promoting early detection (including screening) around Lincoln, Skegness and Mablethorpe.

In cervical screening, we have been able to attain and maintain the two week turn around target of 98%. This is the percentage of women receiving their test results within 14 days of the test being taken. Lincolnshire stands at 99.6% compared to the national average of 96.2% and the East Midlands average of 93.3%.

The breast screening unit in Lincolnshire introduced digital mammography screening in May 2011 and it has been able to implement the start of a successful age extension to its screening programme, to be offered to all women aged 47 -73 years of age (previously only offered to women in the age range 50-70). Performance has been maintained to a very high standard compared to national and East Midlands.
**Antenatal & Newborn Screening Programmes**

There are six Antenatal and Newborn Screening Programmes available in Lincolnshire:

**Infectious Disease in Pregnancy**
- This type of screening is offered to every pregnant woman to assess the risk of them having Hepatitis B, HIV, Syphilis or being susceptible to Rubella. Identifying women at greater risk of any of these conditions prevents the transmission of infections from mother to child and safeguards the wellbeing of any woman who tests positive.

**Sickle Cell and Thalassaemia Screening**
- These inherited conditions affect red blood cells and hampers the body’s ability to transfer oxygen around the body. This initially involves a questionnaire to determine whether a pregnant woman, her partner or their family’s history identifies an increased risk of their unborn child having this type of inherited condition. If the risk is assessed as being higher, a blood test will confirm this. This is the first screening programme to link screening during pregnancy and screening of the child after birth.

**Foetal Anomaly Screening**
- All pregnant women, regardless of age are given the opportunity to access screening which identifies the likelihood of their child having Down’s syndrome or other inherited conditions. This type of screening involves ultrasound scanning and a simple blood test.

**Newborn Blood Spot Screening**
- This ‘heel prick’ screen is carried out when the baby is just over one week old. It checks for five key inherited conditions including cystic fibrosis and sickle cell disease. Most babies will not have any of these conditions, however, for the small number of babies who do, early treatment can improve their health, prevent severe disability or even death.

**Newborn Infant Physical Examination**
- All newborn babies are given a full examination before they are 72 hours old and again between six and eight weeks of age. This involves an all round physical examination with specific notice paid to the eyes, heart, hips and the testes of boys. Any problems can be quickly identified and referred on for specialist treatment.

**Newborn Hearing Screening Programme**
- One or two babies in every 1000 are born with a hearing loss in one or both ears. Most of these babies are born to families who have no history of hearing problems. Therefore, the importance of screening all babies within their first two weeks of life to identify any hearing loss at an early age is clear.

These six screening programmes individually play an important role in improving the health outcomes of mothers and babies in Lincolnshire by directly treating an infection, offering vaccination e.g. rubella or hepatitis B, or identifying other health problems quickly to allow early treatment. There are around 6,500 babies delivered in Lincolnshire each year with many more women booking for antenatal care, unfortunately, in some cases these pregnancies do not continue to term. In addition, there are over 1500 babies moving into the County every year either just after birth at a maternity hospital in a neighbouring county or moving here from abroad and other parts of the UK. After a baby is born we offer the ‘heel prick’ test up to one year old, therefore, these additional babies make a considerable difference to the workload of the Newborn Screening programme.

The large numbers involved with each of these screening processes coupled with the constant movement of women and infants in and out of the county make the quality assurance of each of these programmes incredibly important, yet difficult to achieve. To accomplish this, the Lincolnshire Joint Antenatal and Newborn Screening Board (LJANSB) has been established over the last 18 months. Its aim is to bring together expertise from each area of screening to complete a work programme which ensures standards set by the National Screening Centre are met, referral pathways and failsafe procedures are developed, audit and GAP analysis for each of the programmes are completed annually and key performance indicators (KPIs) are collected every three months.

Over the past year we have successfully developed improved failsafe processes for the Sickle Cell and Thalassaemia programme, completed a GAP analysis of the Infectious Disease in Pregnancy programme, improved the clinical pathway and audited the outcomes for the Newborn Bloodspot Screening programme. The Newborn Hearing programme has also successfully completed a quality assurance inspection this year. Future developments for 2012/13 include:

- Continuing to develop and improve the data collection for each of the six programmes’ KPIs; this in turn will act as a vehicle to improve the efficiency of each area.

The Newborn and Infant Physical Examination programme will undergo a complete overhaul in 2013. Lincolnshire is taking part in a national pilot to develop the best possible way of running, recording and sharing the results of this complicated programme.
The majority of the Foetal Anomaly Screening programme’s standards have been met in Lincolnshire. However, the optimal time needed to perform an ultrasound scan has recently been increased, unfortunately there is no capacity within Lincolnshire hospitals to increase these individual time slots at the moment. The Maternity Unit and the LJANSB are working together to ensure the additional resources needed to do this will be in place early in 2012.

The Newborn Bloodspot Programme would benefit from a dedicated coordinator, at the moment the antenatal screening coordinators manage this as well as the prenatal screening, the LJANSB is developing ways to facilitate this.

**Public Health Implications** - The Public Health implications of not screening for the six antenatal and newborn screening programmes are wide-ranging. The most basic Public Health outcome lies around screening for infectious disease this helps protect the mother, infant and future pregnancies by identifying, treating or vaccinating affected patients. Picking up anomalies and inherited health problems in babies while they are still in the womb allows parents to have all the information they need to prepare for the birth or make more difficult decisions dependant on the severity of the condition. Knowing about any physical problems in advance also allows professionals to plan appropriate care in advance.

The most well-known screening programme is the Newborn Blood Spot or ‘Heel Prick Test’. This simple test picks up several inherited conditions and allows early diagnosis, treatment and can improve the affected baby’s health outcomes. Screening for physical problems in newborn babies allows early diagnosis and treatment which improves the child’s overall development and ultimately health and social outcomes. Hearing, eyes, heart, hips and testes are all screened for any problems and referred for further testing and treatment.

In summary: Undetected infection, inherited conditions and physical problems which have appeared without previous warning can cause extreme distress for the parents. Early Public Health detection protects, prepares and allows for early diagnosis and treatment which improves the overall developmental, health and social outcomes for the child.

**Diabetic Retinopathy Screening Programme**

**What is Diabetic Retinopathy Screening?** - Diabetes can affect the small blood vessels in the part of your eye called the retina, this is called diabetic retinopathy. If this happens it can affect your sight. Diabetic Retinopathy is the most common cause of blindness in the working age population. The aim of the screening programme is to reduce the risk of sight loss amongst people with diabetes, through prompt identification and effective treatment. Systematic screening involves digital photography of the back of the eye, changes are photographed, recorded and treatment started where necessary. All people with diabetes (aged 12 years or over) are offered screening once a year.

**How have we performed?** - In Lincolnshire approximately 80% of eligible patients attend for a screen. However we know that the 20% who do not attend are at risk from developing further complications. The reasons for people not attending are varied and complicated. Some people do not recognise the risk, or are even aware of the risk, if they do not receive or are unable to process the appropriate information. To achieve an improvement in this, work is needed with different agencies and involving staff who work specialise in diabetes, eye departments, General Practitioners, Practice Nurses, opticians and the general public through organisations, such as Diabetes UK.

**Figure 3.3 Lincolnshire’s Performance on Diabetic Retinopathy Screening**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2007/08</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic patients</td>
<td>32171</td>
<td>33894</td>
<td>35839</td>
<td>38445</td>
</tr>
<tr>
<td>Patients excluded</td>
<td>3782</td>
<td>3632</td>
<td>2758</td>
<td>3625</td>
</tr>
<tr>
<td>Patients to be screened</td>
<td>28389</td>
<td>30262</td>
<td>33081</td>
<td>34820</td>
</tr>
<tr>
<td>Offered screening</td>
<td>27495</td>
<td>24575</td>
<td>11542</td>
<td>34199</td>
</tr>
<tr>
<td>Receiving screening</td>
<td>24069</td>
<td>19642</td>
<td>10319</td>
<td>25840</td>
</tr>
<tr>
<td>Offered screening (%)</td>
<td>94.5%</td>
<td>82.4%</td>
<td>36.3%</td>
<td>99.0%</td>
</tr>
<tr>
<td>Uptake (%)</td>
<td>87.5%</td>
<td>79.9%</td>
<td>89.4%</td>
<td>75.6%</td>
</tr>
<tr>
<td>Excluded (%)</td>
<td>11.8%</td>
<td>10.7%</td>
<td>7.7%</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

*Source of data: United Lincolnshire Hospitals NHS Trust – DRS service*
The national recommendations for diabetic retinopathy screening require that all eligible diabetics are invited within a 12 month period. Figure 3.3 shows Lincolnshire’s performance for data available in 2011.

The NHS Diabetic Retinopathy Screening Programme Quality Assurance Standards (April 2011) has an objective to maximise the number of invited persons receiving the test. It has a minimum standard of at least 70% and an achievable standard of at least 80%. The target for Lincolnshire during 2011/12 is 78%. During 2010/11 the uptake in Lincolnshire was 75.6%.

In 2009/10 the offered screening percentage is low due to a postponement of the screening programme to allow quality improvement works to take place. 2010/11 shows a vast improvement following the implementation of these quality measures with a screening percentage offered of 99%.

NHS Diabetic Retinopathy Screening programme Inequalities work 2010/2011 - During 2011, work has taken place with the Diabetic Retinopathy Screening programme to try to reduce the number of eligible patients who do not attend their appointment. This has included reviewing ways of working, such as altering administrative processes and appointment booking systems, raising awareness through press articles and looking at ways to increase uptake in the more vulnerable populations. Further work is planned for 2012 to include improving uptake rates.

Public Health Implications (1)

- The prevalence of diabetes continues to grow. The increase is due to lifestyle factors, the increasing ageing population and improved identification.

- Diabetic retinopathy is leading cause of blindness in the working age population.

- The screening programme has the potential to reduce the annual incidence of blindness in England by at least a third.

- There is a significant relationship between screening attendance and visual outcome. People with diabetes are more likely to have severe levels of retinopathy or suffer sight loss if they do not attend screening.

Cervical Cancer Screening Programme

What is Cervical Cancer screening? - Cervical screening detects early changes within the cells which could lead to cancer in a woman’s cervix. A sample of cells is taken from the cervix for analysis. Early detection and treatment can prevent most cancers developing.

How does the NHS Cervical Cancer Screening Programme work? - The programme aims to reduce the number of women who develop invasive cervical cancer (incidence) and the number of women who die from it (mortality). It does this by regularly screening all women at risk so that conditions which might otherwise develop into invasive cancer can be identified and treated. All women between the ages of 25 and 64 are eligible for a free cervical screening test every three to five years. In the light of evidence published in 2003(2) the NHS Cervical Screening Programme offers screening at different intervals depending on age. This means that women are provided with a more targeted and effective screening programme. The screening intervals are:

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Frequency of screening</th>
</tr>
</thead>
<tbody>
<tr>
<td>24.5</td>
<td>First invitation</td>
</tr>
<tr>
<td>25 - 49</td>
<td>3 yearly</td>
</tr>
<tr>
<td>50 - 64</td>
<td>5 yearly</td>
</tr>
<tr>
<td>65+</td>
<td>Only screen those who have not been screened since age 50 or have had recent abnormal tests</td>
</tr>
</tbody>
</table>

References

(1) Annual Report. English National Screening Programme for Diabetic Retinopathy. UK National Screening Committee. 2011

(2) P Sasieni, J Adams and J Cuzick, Benefits of cervical screening at different ages: evidence from the UK audit of screening histories, British Journal of Cancer, July 2003
How have we performed? - The effectiveness of the programme can be judged by the percentage of eligible women who have been screened in the last five years. If overall coverage of 80% can be achieved (the amount of women invited who attend for a screen), the evidence suggests that a reduction in death rates of around 95 per cent is possible in the long term.

Public Health Implication - If the Lincolnshire programme is to be more effective it needs to hit the 80% target.

Cervical Cancer Screening Coverage

The following table compares NHS Lincolnshire performance as of March 2011 against national and regional comparators.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Eligible Screened  3.5yr Coverage</th>
<th>Eligible Screened  5.5yr Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>9,370,157</td>
<td>7,376,643</td>
</tr>
<tr>
<td>East Midlands</td>
<td>784,506</td>
<td>687,456</td>
</tr>
<tr>
<td>Derby City</td>
<td>51,784</td>
<td>42,861</td>
</tr>
<tr>
<td>Derbyshire County</td>
<td>112,434</td>
<td>90,420</td>
</tr>
<tr>
<td>Leicester City</td>
<td>62,208</td>
<td>54,972</td>
</tr>
<tr>
<td>Leicestershire County &amp; Rutland</td>
<td>106,297</td>
<td>85,676</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>113,654</td>
<td>90,819</td>
</tr>
<tr>
<td>Milton Keynes</td>
<td>49,192</td>
<td>36,122</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>121,829</td>
<td>90,819</td>
</tr>
<tr>
<td>Nottingham City</td>
<td>55,113</td>
<td>40,157</td>
</tr>
<tr>
<td>Nottinghamshire County</td>
<td>109,995</td>
<td>88,453</td>
</tr>
</tbody>
</table>

Cervical Screening Coverage: Mar-11

Source: Open Exeter

Breast Cancer Screening Programme

What is breast cancer screening? - Breast screening is a method of detecting breast cancer at a very early stage. The first step involves an x-ray of each breast - a mammogram - which is taken while carefully compressing the breast. The mammogram can detect small changes in breast tissue which may indicate cancers which are too small to be felt either by the woman herself or by a doctor.

What does the NHS Breast cancer Screening Programme do? - The NHS Breast Screening Programme provides free breast screening every three years for all women aged 50 and over. Because the programme is a rolling one which invites women from GP practices in turn, not every woman receives an invitation as soon as she is 50. But she will receive her first invitation before her 53rd birthday. Once women reach the upper age limit for routine invitations for breast screening, they are encouraged to make their own appointment.

Local Achievements - In 2011, Lincolnshire has successfully commenced a nationally recommended extension of the age range of women invited for breast screening to those aged 47 to 73. The full roll out of the age extension (which has to be done in a phased manner) is expected to be completed by 2017.

How have we performed? - The national targets for breast screening require that all eligible women are invited within a 36 month period and that at least 80% attend for screening. The table below shows Lincolnshire’s performance for data available in 2011.

NHS Cervical Cancer Screening programme Inequalities work 10/11 - The Boston area has historically shown the lowest uptake in cervical cancer screening. The practices in this area have this year taken measures to target Eastern European women. Letters were translated and posters were put up in practices. Public health is actively working in Boston with practice managers to develop improved ways of encouraging women to access the service. The Early Presentation of Cancer (EPOC) programme is supporting the cervical screening programme by using volunteers to encourage the uptake of the programme in areas where health inequalities exist and to target the younger cohort of women.
The proportion of women aged 50 to 70 tested within the last three years is shown in the table below. Uptake rates relate to the proportion of women screened within six months of invite, where the invite was issued within the 12 months to the end of the period reported.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Eligible</th>
<th>Invited</th>
<th>Screened &lt;36mths</th>
<th>Uptake %</th>
<th>36mth Coverage %</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>6,408,439</td>
<td>2,278,241</td>
<td>4,632,602</td>
<td>74.5%</td>
<td>72.3%</td>
</tr>
<tr>
<td>East Midlands</td>
<td>576,766</td>
<td>195,337</td>
<td>442,839</td>
<td>79.6%</td>
<td>76.8%</td>
</tr>
<tr>
<td>Derby City</td>
<td>32,363</td>
<td>10,740</td>
<td>29,190</td>
<td>74.4%</td>
<td>70.7%</td>
</tr>
<tr>
<td>Leicester City</td>
<td>27,842</td>
<td>9,034</td>
<td>20,747</td>
<td>73.7%</td>
<td>74.5%</td>
</tr>
<tr>
<td>Leicestershire County &amp; Rutland</td>
<td>27,946</td>
<td>4,685</td>
<td>19,098</td>
<td>69.9%</td>
<td>68.3%</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>94,912</td>
<td>30,958</td>
<td>24,821</td>
<td>71.9%</td>
<td>70.7%</td>
</tr>
<tr>
<td>Milton Keynes</td>
<td>87,330</td>
<td>37,170</td>
<td>70,229</td>
<td>83.0%</td>
<td>80.4%</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>102,882</td>
<td>38,060</td>
<td>78,401</td>
<td>78.4%</td>
<td>77.8%</td>
</tr>
<tr>
<td>Nottingham City</td>
<td>84,028</td>
<td>26,485</td>
<td>64,021</td>
<td>79.5%</td>
<td>76.2%</td>
</tr>
<tr>
<td>Nottinghamshire County</td>
<td>86,804</td>
<td>32,123</td>
<td>67,476</td>
<td>81.1%</td>
<td>77.7%</td>
</tr>
</tbody>
</table>

Data source: Open Exeter

77.2% of Lincolnshire registered women have been screened for breast cancer within the last three years. This compares to 76.8% within the East Midlands and 72.5% nationally.

**Public Health Implication** - If the Lincolnshire programme is to be more effective, it needs to hit the 80% target.

Extension of NHS breast cancer screening programme to women aged 47 to 49 and 71 to 73.

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Aged 47-49</th>
<th>Aged 71-73</th>
<th>Aged 47-49 &amp; 71-73</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligible</td>
<td>Invited &lt;36mths</td>
<td>Screened &lt;36mths</td>
<td>Uptake %</td>
</tr>
<tr>
<td>England</td>
<td>1,209,007</td>
<td>7.2%</td>
<td>116,942</td>
</tr>
<tr>
<td>East Midlands</td>
<td>110,718</td>
<td>6.0%</td>
<td>71,334</td>
</tr>
<tr>
<td>Derby City</td>
<td>7,287</td>
<td>6.0%</td>
<td>6,763</td>
</tr>
<tr>
<td>Derbyshire County</td>
<td>21,048</td>
<td>9.1%</td>
<td>19,095</td>
</tr>
<tr>
<td>Leicester City</td>
<td>6,567</td>
<td>0.4%</td>
<td>3,134</td>
</tr>
<tr>
<td>Leicestershire County &amp; Rutland</td>
<td>15,408</td>
<td>1.7%</td>
<td>8,885</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>16,895</td>
<td>1.3%</td>
<td>11,472</td>
</tr>
<tr>
<td>Milton Keynes</td>
<td>5,630</td>
<td>2.0%</td>
<td>2,132</td>
</tr>
<tr>
<td>Northamptonshire</td>
<td>13,788</td>
<td>14.2%</td>
<td>7,662</td>
</tr>
<tr>
<td>Nottingham City</td>
<td>5,870</td>
<td>11.7%</td>
<td>2,883</td>
</tr>
<tr>
<td>Nottinghamshire County</td>
<td>15,433</td>
<td>3.7%</td>
<td>9,315</td>
</tr>
</tbody>
</table>

Data source: Open Exeter

The data shows that 1.3% of Lincolnshire women aged 47 to 49 and 21.5% of those aged 71 to 73 have been invited for screening within the last 36 months.

**NHS Breast Cancer Screening programme Inequalities work 10/1** - Work has recently commenced utilising the Early Presentation of Cancer (EPOC) community development workers and volunteers to liaise with the Lincoln Breast Unit in order to increase uptake across the more vulnerable populations. These workers provide additional information for women through literature or discussing specific queries with individual women. This resulted in the breast screening unit reporting an increase in women attending for screening in the targeted population. This successful work will expand next year to ensure more women are fully informed and aware of the benefits of breast screening.

**Bowel Cancer Screening Programme**

**What is Bowel Cancer screening?** - About one in 20 people in the UK will develop bowel cancer during their lifetime. It is the third most common cancer in the UK, and the second leading cause of cancer deaths, with over 16,000 people dying from it each year.(3) Bowel cancer screening aims to detect bowel cancer at an early stage (in people with no symptoms), when treatment is more likely to be effective. Bowel cancer screening can also detect polyps. These are not cancers, but may develop into cancers over time. They can easily be removed, reducing the risk of bowel cancer developing.

Regular bowel cancer screening has been shown to reduce the risk of dying from bowel cancer by 16 per cent(4). The NHS Bowel Cancer Screening Programme offers screening every two years to all men and women aged 60 to 69. People over 70 can request a screening kit by calling the free-phone helpline 0800 707 6060. Preparations are being made in Lincolnshire to enable a national age extension to the programme which will mean invites are sent to those aged 60 to 75.

**How does the NHS Bowel Cancer Screening Programme work?** - All eligible parties will receive a test through the post with instructions for participation. The test is returned via Freepost to the regional Hub at Nottingham who will process the results. Where a positive result is suspected the individual will be invited to attend a local clinic run by the screening centre (provided by United Lincolnshire Hospitals NHS Trust). At this appointment a Specialist Screening Practitioner will discuss the results with the individual and the options for further investigation. If cancer is confirmed on further investigation then the individual will be referred for appropriate treatment.
How have we performed? - We aim to screen at least 60% of men and women who are eligible. However, like other screening programmes this needs to be continually improved. This can be achieved by working with all organisations involved in the identification and treatment of bowel cancer and recognising the importance of involving the general public.

People screened within six months after invite, stands at 61%, the national average is 57.4%. People screened within 30 months of invite, stands at 38.7%, the national average is 50.8%.

Public Health Implication - In order for the programme to be more effective, the “screened within 30 months” cohort needs to be greater.

NHS Bowel Cancer Screening programme inequalities work 2010/2011

Work has started in preparation for next year when we will begin to target populations with a low uptake. The Early Presentation of Cancer will, in the future, also be working with the screening unit in an attempt to target populations.

New Abdominal Aortic Aneurysm Screening Programme

In 2008, the Department of Health announced a population based screening programme for abdominal aortic aneurysms (AAAs) and the decision to introduce it as a screening programme in England was supported by the UK National Screening Committee. The AAA screening programme is now being rolled out across the UK in several phases.

Lincolnshire is part of phase four and will be rolled out by March 2013

What is an Abdominal Aortic Aneurysm (AAA)? - An AAA is a widening of the main artery in the body as it passes through the abdomen. The walls of the artery weaken, causing it to balloon out. It is more common in older men, smokers, people with high blood pressure and people with other cardiovascular diseases. By the age of 65, about 1 in every 25 men will have an AAA and about a third of these aneurysms will rupture if not treated. The challenge is to reduce mortality from an aneurysm by diagnosing and treating the condition before a rupture occurs. Research shows that screening men aged 65 will reduce the death rate from a ruptured aneurysm by around 50%. A simple ultrasound scan of the abdomen is the easiest way to check whether a man has an AAA. The AAA screening programme will offer an ultrasound scan to all men during the year they turn 65.

Public Health Implications:-

• Less than one percent of women have an AAA
• AAA causes two percent of deaths in men aged over 65
• AAA is largely preventable
• The risk of developing an AAA is reduced by not smoking, a healthy lifestyle and having blood pressure and cholesterol checked
• Screening men aged 65 can reduce the death rate from a ruptured AAA by 50%

Recommendations and Actions for 2012:

• The Lincolnshire Joint Antenatal and Newborn Screening Board should stress test each programme through regular audit and GAP analysis and report the results within the Screening Annual Report in 2012.
• The commissioners, public health teams and providers work together to improve the quality of data in order to understand the demography of people who do not attend (DNA) for screening and target specific evidence based programmes to reduce DNA rates
• The commissioners, public health teams and providers work together to increase uptake in areas identified with the lowest coverage and to play a pivotal role in the introduction of the high risk service in breast screening and age extension in the bowel screening programme.
• The commissioners, public health teams and providers work together to introduce and roll out this screening programme across Lincolnshire by March 2013.
Sexual Health

Introduction

Our sexual health affects our physical and psychological wellbeing and is central to some of the most important and lasting relationships in our lives. The World Health Organisation (2011) defines sexual health as a “state of physical, mental and social well-being in relation to sexuality. It 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.”

The wider aim of working towards good sexual health for all includes reducing unintended teenage pregnancies, prevention of HIV and other Sexually Transmitted Infections (STIs), the promotion of positive satisfying relationships and the provision of excellent Sex and Relationships Education (SRE).

Lincolnshire faces tough challenges within the sexual health agenda; the rates of newly diagnosed STIs nationally rose 3% between 2008 and 2009, continuing the trend of the past decade. Lincolnshire is the 4th largest county in England, many of its communities live in areas of significant levels of socio-economic deprivation; it is a largely rural county, stretching across 2,350 square miles, without motorways but, with a coastal strip and some large towns. Therefore, it is important to ensure there are services in a range of settings across the county to manage the diverse geography and populations.

This added problem of geographical isolation makes accessing preventive services difficult. Sexual health screening, health promotion and education remain to be of key importance to STI and HIV prevention through improving public awareness and encouraging safer sexual behaviour.

To ensure we are providing the right services in the right place, at appropriate times to offer the optimal facilities for our communities, we conducted a Health Needs Assessment (HNA) in 2011. This process includes examining both the met and unmet needs of the community by examining local data and questioning service users and providers in order to identify gaps in provision or areas where the needs of the community could be improved.

Key Findings

Education and access to good quality information - It is extremely important that good quality information is available to everyone, including young people in school settings. The Sexual Health Improvement Programme team in Lincolnshire have been putting together a directory of training available to a range of professionals and schools. The Healthy Schools Team is working with local schools and School Nursing Services to encourage good quality sex and relationships education. Health promotion colleagues work on a range of awareness raising activities supporting key messages such as condom use, the importance of chlamydia screening for 15-24 year olds and World Aids Day.

Now that the HNA is complete it is important that the Public Health Sexual Health Improvement Programme team continue to monitor and review availability of these information services, particularly in the light of recent financial and organisational restructuring, for example the reduction in the number of youth services available across Lincolnshire.

Sexually Transmitted Infections (STIs) - Affect all age groups, ethnicities and sexual orientations; however, Chart 4.1 below demonstrates that young people under the age of 25 in Lincolnshire continue to be disproportionately affected by the most commonly diagnosed infections at Genito-Urinary Medicine (GUM) clinics.

Chart 4.1

Data: Lincolnshire Community Health Services 2011
Poor access to sexual health services is a risk factor for the continuing rise in STIs. Young people are particularly vulnerable to experiencing poor sexual health and can face significant barriers to accessing sexual health services. Similarly those living in rural communities with little road or public transportation can find difficulty in accessing services. Lincolnshire has faced a complex challenge over the last few years to improve access to GUM services. This has been achieved by providing access to all new patients within 48 hours of their initial request for an appointment. Nevertheless, the public health importance of swift treatment is fundamental to preventing the spread of infection, particularly where there are no obvious symptoms.

There has been significant improvement in achieving early access to treatment and the network of services across Lincolnshire can now offer this service within the timescale. However, the continuing issue in some settings is that patients might not be seen as quickly because the venue is not convenient for them or in some cases they choose to attend later.

**HIV / AIDS** - Patterns of communicable disease have also been changing, with the UK exhibiting one of the highest rates of HIV infections in Europe (Beaglehole, 2009). The number of people living with HIV in the UK has reached an estimated 85,000; a quarter of these people are unaware of their infection and a disproportionate number of diagnoses remain high amongst men who have sex with men (MSM). Nationally there were 27,427 MSM (all ages) seen for HIV care in 2009 in the UK, more than double the number seen in 2000 (12,177). In Lincolnshire GUM services in 2011 a total of 5,465 people accessed testing or care for HIV (females - 2839 and males - 2626). Despite increasing numbers of MSM seen for HIV care across the UK, uptake of HIV testing was only 77% among STI clinic attendees in 2009, despite current guidelines which aim to normalise, challenge the stigma of, and increase HIV testing in all healthcare settings.

Despite the continuing impact of HIV and AIDS, it is becoming apparent that awareness of the condition is decreasing, particularly amongst young people. Nationally, men who have sex with men (MSM) remain the group who are at greatest risk of contracting HIV and other STIs. Locally there is a need to continue raising awareness of HIV transmission routes and risks of unprotected oral sex in all groups, including heterosexual communities where the rates are rising fastest.

According to Health Protection Agency data in the East Midlands region, new HIV diagnoses from 2001 onwards have increased significantly. This may be due to increased testing, increased infection rates or higher numbers of people coming into area with the virus. In terms of transmission, the regional tables identify that routes of probable exposure show higher numbers in the heterosexual categories than MSM, although these two are higher than injecting drug users, mother to infant and infected blood/tissue products.

Age categories identify that the highest age group over time for year of diagnosis is 30-34, closely followed by 25-29 and 35-39. This fits in with the national picture for prevalence in age groups too. In Lincolnshire, the sexual health clinics have relatively few new diagnosed cases of HIV compared to some other areas, but there is still work to be done to raise awareness about the condition and its transmission. There are however far more transfers in than out from other areas. The cost of annual medication alone can be in the region of £10,000, meaning that for a patient diagnosed in his/her mid 30’s the annual lifetime cost of medication can be over £350,000.
**Chlamydia** - The higher rates of infections in the under 24s are also mirrored in chlamydia infection. Chlamydia is the most commonly diagnosed sexually transmitted infection in England and Lincolnshire is no exception. Whilst it is most common amongst 15-24 year olds, anyone who is sexually active is at risk, no matter what their age. Even infants can be affected if born to an infected mother. Untreated infection can cause fertility problems in women and men, resulting not only in a huge financial burden to the NHS, but real heartache to couples wanting to start a family. NHS Lincolnshire provides an opportunistic screening programme called Lincolnshire Face Facts (Free access to chlamydia tests) targeting 15-24 year olds, with the aims of controlling chlamydia through early detection, preventing long term complications and reducing the spread of the infection. In 2010-2011 nearly 25,000 tests were carried out on people in this age group within the programme, representing 28.7% of the target population. Table 4.1 shows further information on these tests.

### Table 4.1

<table>
<thead>
<tr>
<th>Clinical Commissioning Group</th>
<th>Number of Tests</th>
<th>Number of Positive Tests</th>
<th>Positivity Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Lindsey</td>
<td>1763</td>
<td>85</td>
<td>4.80%</td>
</tr>
<tr>
<td>Lincolnshire West</td>
<td>10993</td>
<td>653</td>
<td>5.90%</td>
</tr>
<tr>
<td>Lincolnshire SW</td>
<td>4140</td>
<td>222</td>
<td>5.40%</td>
</tr>
<tr>
<td>Skegness &amp; Coast</td>
<td>1858</td>
<td>118</td>
<td>6.40%</td>
</tr>
<tr>
<td>South Holland</td>
<td>1183</td>
<td>61</td>
<td>5.40%</td>
</tr>
<tr>
<td>Welland</td>
<td>1157</td>
<td>66</td>
<td>5.70%</td>
</tr>
<tr>
<td>Boston</td>
<td>2231</td>
<td>102</td>
<td>4.60%</td>
</tr>
<tr>
<td>Lincolnshire</td>
<td>23325</td>
<td>1307</td>
<td>5.60%</td>
</tr>
</tbody>
</table>

Data: NHS Lincolnshire Informatics 2011

We can see from table 4.1 above that an average of 5.6% of those tested were positive, which is slightly higher than the national average of 5.2%. When we examine the data at a lower level we can see that Lincolnshire West, Skegness and Coast and the Welland areas are all demonstrating higher numbers of positive results for every test carried out.

Chlamydia screening is a useful vehicle to communicate sexual health messages to young people, but clearly there are risks of onward transmission for many other conditions which are as preventable. Diagnoses of STIs continue to rise locally, which could either indicate an increased prevalence of certain conditions or increased risk taking behaviour. Accessibility to community based services may also contribute to this. Locally, it appears that herpes and genital warts are some of the most common, but cases of syphilis and gonorrhoea also surface periodically. Prevalence across different groups of people has also been identified as a key area for health promotion. For example, it has been identified that those in the over 40 age groups, who perhaps have new sexual partners after the breakdown of a longer term relationship, are seen more commonly accessing services for diagnosis and care. Therefore, it is important that the sexual health programme continues to get messages across and provides services to meet the needs of the wider age groups in ways and places accessible to them.

**Teenage pregnancy** - Is closely interlinked with poverty and the evidence is clear that teenage parenthood often results in poor health, under-achievement and low earnings for both the mother and child. Children born to teenage mothers have 60% higher rates of infant mortality and are at increased risk of low birth weight which impacts on the child’s long term health. Teenage mothers are also three times more likely to experience poor emotional health and well-being, and are more likely to suffer from postnatal depression and experience poor mental health for up to three years after the birth.
Over the past decade there has been significant progress in reducing teenage pregnancy and improving outcomes for pregnant teens. England’s under-18 pregnancy rate is currently at its lowest level for over 20 years, but it is still unacceptably high at just over 38 per 1000 of the 15 to 17 years population. The teenage pregnancy rate has fallen by 13% nationally, 18.8% in the East Midlands and in Lincolnshire has reduced by 25.1% since the base year in 1998, to 37.5 per 1000. We can see from the data in Chart 4.2 that, although the average for Lincolnshire is in line with the national rate, there are areas within the county which demonstrate considerably higher rates. In particular Skegness and Coast is above the average Lincolnshire rate with Boston and Lincolnshire West both just under 37%.

The local Teenage Pregnancy team offer a range of services to support young teens, such as the Young Expectant Parent accreditation programme, which provides guidance and advice to expectant teenage parents as well as providing an opportunity to meet other young parents. Similarly they offer a range of workforce development training including Delay for Parents, which deals with delivering sex education messages and encouraging young people to delay sexual activity. There are also a range of self esteem initiatives which include Life Choices, Making Men and Go Girls.

**Access to contraception services**

Contraception in its many varied forms is available in numerous settings across Lincolnshire including Community Health Service Clinics, Pharmacies, GP practices, School Nursing Services, Outreach Workers, etc.

We already know that the highest numbers of STIs are found in the under 25s. Coupled with high rates of teenage conceptions this makes it essential in particularly, to improve access to good quality contraception services for this vulnerable group of young people. Many young people in Lincolnshire are bussed in and out from surrounding villages to large secondary schools. School nursing teams are therefore essential to provide onsite access to health information, advice and support, emergency contraception and condoms which may otherwise be harder to obtain in home towns and villages. Presently, the range offered in schools is varied and largely depends on the extent to which a school will support provision. The future challenge will be to ensure consistency of provision across all educational establishments.

Examination of community contraception clinic access data show that approximately 8,300 patients accessed community based contraception services in 2010/11. We know that 67% of these clients were aged 15 to 29 years, with 71% accessing these services in Lincolnshire South West and Lincolnshire West. Given that some of the worst sexual health outcomes in Lincolnshire are found in other Clinical Commissioning Group areas, future service redesign to provide equitable access for all is inevitable.

Examination of a snap shot sample of GP prescribing data revealed that the numbers of women accessing oral contraception is broadly similar across each of the CCG areas. This further strengthens the case for improving access to contraception services, as there does not appear to be sufficiently high uptake through GP services in areas of the county where access to community contraception clinics is poor.

Pharmacies also provide emergency contraception to people aged under 25 years. A comprehensive assessment of where these pharmacy sites are currently situated show they are spread unevenly across Lincolnshire and are not focused in the areas of greatest need. More deprived and harder to access areas must be targeted in future to ensure that the most vulnerable populations receive adequate services.

Service users in Lincolnshire were interviewed during 2011 to find out what they thought of the range of local services available. Several barriers to access were identified, these include:

- Lack of confidence in attending services
- Long waiting times and limited opening hours at clinics (attending a clinic in the lunch hour or on the way home from school may be difficult).
- Inability to make appointments at local clinics
- Condoms and over the counter EHC (emergency hormonal contraception) are expensive
- Sometimes limited availability of free condoms and EHC

**Support for Sexual Assault and Rape**

Nationally, sexual violence is recognised as having a devastating impact on victims, their families, friends and wider society. “Addressing these crimes and the harm they cause is a priority for the government and fits within the agendas on public health, reducing crime and the fear of crime, bringing offenders to justice, safeguarding adults, education and gender equality”1

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1. Data: SUS Hospital Statistics 2011

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**Chart 4.2**

[Chart showing hospital admissions for delivery or termination of pregnancy (16 at time of conception) by Clinical Commissioning Groups (CCGs)]

Data: SUS Hospital Statistics 2011
Between 2005 and 2011 Lincolnshire police reported adult rapes averaged 150 – 180 per annum. It was recognised that Lincolnshire did not have a service that adequately met all the needs of victims of these crimes and a project started in 2009 to open a Sexual Assault Referral Centre (SARC) to provide a holistic service to victims. The Lincolnshire SARC opened in April 2010 and is an excellent example of many different agencies working together to achieve a common goal. Not only police and health but agencies such as Victim Support and the Crown Prosecution Service were involved in ensuring it met the needs of the individuals for whom it was designed. Now male and female victims are able, from one service, to access 24 hour crisis workers, forensic testing and general health needs with direct referral to sexual health services, combined with the support of an independent sexual violence adviser who can also refer for counselling. In this way the health needs of individuals can be looked at holistically to ensure that support is available at this difficult time in their lives. Since opening, the SARC has seen over 200 critical incidents, the majority of whom are aged under 30 years, although those in higher age groups are also using the service. Increasingly people are also accessing it for telephone advice and signposting.

**Specific Vulnerable Groups** - learning disability, sex workers, young people, MSM, migrant workers, asylum seekers and refugees

We also need to know more about the sexual health and wellbeing of some of the more vulnerable groups in our community including sex workers, people with learning difficulties, migrant workers, asylum seekers and refugees. Sexual health matters for everyone, but we know that sexual health needs vary from one person to another and from one community to another, as well as evolving throughout life. There are significant social costs arising from the growth in sexual health need. The burden of sexual ill health is not equally distributed among the population but concentrated amongst the most vulnerable segments including gay men, young people, looked after children, black and ethnic minority groups, and people with learning disabilities.

Sexual ill health also disproportionately affects groups of people already experiencing high levels of social exclusion and health inequality. There is a strong link between social deprivation and poor sexual health, STIs, abortions and teenage conceptions. Nationally there is a lack of research and intelligence around the sexual health and well being of these vulnerable groups and this is mirrored locally with very little robust information. There is a real need to develop an understanding of the sexual health needs of these groups across Lincolnshire and where necessary to put in place services, advice and information to reduce sexual health inequalities in the future.

**Conclusion**

Positive Sexual Health is important to the majority of the population and it is our responsibility in Public Health to ensure sexual health & relationship education and information is freely available and easily accessed by all. Easy access to contraception and the timely diagnosis, treatment and appropriate support to those infected with STIs must be available in an equitable manner across the county of Lincolnshire. It is also our responsibility to conduct surveillance in order to monitor changes in, for example, infection rates or rises in teenage conceptions or changes within specific populations and address these quickly through service redesign.

**Key Recommendations:**

- The commissioners, public health teams and providers work together to maintain and sustain access to good quality contraceptive and sexual health services within 48 hours or less of first requesting the same.
- A link is developed from Chlamydia screening with the wider need to reduce sexually transmitted infections and unwanted pregnancy and promote safer sex messages.
- HIV testing is targeted at the 20-49 age groups and work towards reducing the number of undiagnosed individuals and increase HIV testing in the higher ‘at risk’ groups in the community, particularly in men who have sex with men, migrant communities, intravenous drug users, prison population and lower socio-economic groups.
- In partnership with key stakeholders, teenage pregnancy prevention and support for young parents is integrated into a wider range of locally decided plans and implemented effectively.
- Awareness is raised to identify particularly vulnerable groups, such as those with learning disabilities in relation to sexual assault and rape.
- The commissioners, public health teams and providers work together to ensure service redesign of sexual health to meet population needs.

**References**

(4) 1 A Gap or A Chasm – Home Office research study 293
Individual Funding Requests

Introduction

The annual budget of NHS Lincolnshire is around £1,200 million. This money has to meet all the reasonable health needs of around 740,000 people. It is a large amount of money but is not sufficient to meet all the demands for health care that we receive.

Since its foundation in 1948 the NHS has had to prioritise treatments, to decide which treatments to fund and which not to fund. For example, as a general principle, the NHS has never funded treatments which are primarily cosmetic in nature. Essentially, the NHS has followed utilitarian principles: to maximise the greatest good for the greatest number of people.

The large majority of treatment is funded through contracts with NHS or private hospitals, and other providers. Approval of funding for contracted treatment of any individual patient is not normally required in advance. For some treatments, hospitals and other providers are required to seek prior approval of funding before the treatment can proceed. There are two main categories of treatments where prior approval is required, and a decision whether to fund or not has to be made, based on the patient’s individual circumstances:

- Procedures which are cosmetic in nature or which we feel are normally a low priority for NHS funding. Such procedures include breast augmentation, breast reduction, tattoo removal, and in vitro fertilisation (IVF).

- Treatments which are rare or experimental. Such treatments also tend to be expensive. As an example, requests to fund new cancer drugs usually fall into this category.

There is extensive case law with regard to individual funding requests. There is no legal right to NHS funding of any treatment. We do, however, have a statutory duty to remain within budget. We are allowed to restrict funding for any procedure or treatment, at our discretion, provided that we follow a fair process to consider individual circumstances. In particular, we cannot operate a “blanket ban” on any treatment – we must in each case decide whether there are exceptional individual circumstances.

Since 1995, the NHS in Lincolnshire has operated a Low Priority Procedures List i.e. a list of procedures that are not normally funded but which we will fund if there are exceptional individual circumstances. We have reviewed, and widely consulted upon, the content of this list and the processes we use to consider requests, at frequent intervals since then.

Since 2009, all nine primary care trusts in the East Midlands covering the counties of Lincolnshire, Nottinghamshire, Derbyshire, Leicestershire, Northamptonshire and Rutland have followed the same processes to consider individual circumstance, and use the same eligibility criteria for cosmetic procedures. By collaborating with neighbouring primary care trusts, the postcode variation in what is funded or not funded is reduced.
Statement of principles

NHS Lincolnshire has adopted a formal set of commissioning principles that underpin decision making with respect to individual funding requests:

- NHS Lincolnshire requires clear evidence of clinical effectiveness (defined as the extent to which a particular intervention works) before NHS resources are invested in the treatment.
- NHS Lincolnshire requires clear evidence of cost effectiveness (value for money) before NHS resources are invested in the treatment.
- The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor.
- NHS Lincolnshire will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- NHS Lincolnshire will balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- NHS Lincolnshire will consider all relevant national standards and take into account all proper and authoritative guidance.
- Where a treatment is approved, NHS Lincolnshire will respect patient choice as to where a treatment is delivered.

NHS Lincolnshire will ensure that decisions:

- Comply with relevant national policies or local policies and priorities that have been adopted by NHS Lincolnshire concerning specific conditions or treatments.
- Are based on the available evidence concerning the clinical and cost effectiveness of the proposed treatment, including any NICE publications.
- Are taken without undue delay. A pragmatic approach may need to be taken when dealing with urgent requests where a delay in reaching a decision to fund adversely affects the clinical outcome.

NHS Lincolnshire considers the lives of all patients to be of equal value and in making decisions about funding treatments will seek not to discriminate on the grounds of age, sex, sexuality, race, religion, lifestyle, occupation, family and caring responsibilities, social position, financial status, family status (including responsibility for dependents), intellectual/cognitive functioning or physical functioning save where a difference in the treatment options made available to patients is directly related to the patient’s clinical condition or is related to the anticipated clinical benefits for this individual to be derived from a proposed form of treatment.

Lincolnshire process to consider individual funding requests

We follow a detailed process to consider individual funding requests. This process has been designed to be lawful and to avoid unnecessary bureaucracy. In summary, the key stages in the process are:

- Referring clinician or provider requests funding
- The funding request is screened to ensure that funding is provided for those treatments that do not actually require prior approval
- Where appropriate, advice on the evidence of effectiveness of the procedure concerned is sought from a public health consultant
- Advice to the Individual Funding Requests (IFR) Panel is prepared by a public health consultant
Individual Funding Requests Panel considers the funding request. Membership of this panel consists of two GPs (one of whom is the chair), a public health representative (not the person who prepares the advice for the Panel), a manager, and a lay representative. The Panel consider information provided by the referring clinician, the public health consultant, and the patient.

Table 5.1 summarises the decisions made relating to individual funding requests received in the latter part of 2011. As can be seen, funding is approved for the majority of requests.

Table 5.1 Decisions made relating to individual funding requests received by NHS Lincolnshire between 1st April 2011 and 31st December 2011

<table>
<thead>
<tr>
<th>Total number of requests received</th>
<th>2406</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withdrawn</td>
<td>70</td>
</tr>
<tr>
<td>Pending (at 31.12.2011)</td>
<td>125</td>
</tr>
<tr>
<td>Funding approved</td>
<td>1299</td>
</tr>
<tr>
<td>Funding denied, or request redirected elsewhere</td>
<td>712</td>
</tr>
</tbody>
</table>

Of the 2406 individual funding requests made within this time period, 722 related to cosmetic treatments. Table 5.2 summarises the decisions made relating to requests to fund cosmetic treatments. Only a minority of requests relating to cosmetic treatments are funded.

Table 5.2 Decisions made relating to individual funding requests received by NHS Lincolnshire between 1st April 2011 and 31st December 2011, that relate to cosmetic treatments

<table>
<thead>
<tr>
<th>Total number of requests received</th>
<th>722</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withdrawn</td>
<td>63</td>
</tr>
<tr>
<td>Pending (at 31.12.2011)</td>
<td>60</td>
</tr>
<tr>
<td>Funding approved</td>
<td>286</td>
</tr>
<tr>
<td>Funding denied, or request redirected elsewhere</td>
<td>313</td>
</tr>
</tbody>
</table>

The following skills, that are a key part of our training, are most relevant to the roles we fulfil within individual funding requests:

- Appraisal of published evidence of effectiveness. Particularly for new or experimental treatments it can be quite difficult to locate and appraise published evidence of effectiveness. We can provide an impartial summary of the evidence of effectiveness for the proposed treatment.

- Comparing the value of one treatment with another. The underlying judgement in this process is to compare the additional cost of a treatment with the additional benefit from that treatment. In a health care system with a fixed budget it is inevitable that saying yes to the funding of treatment for one patient means saying no to the funding of treatment for another patient. This requires a full understanding of health economics.

- Ethics. Considering patient funding requests inevitably involves value judgements. Part of our advisory role is to ensure that judgements are fair and non-discriminatory.

- Communications. Patient funding decisions are controversial, and frequently result in publicity in the media, and sometimes result in litigation. It is essential to be able to explain the decisions that have been made to patients, clinicians and in the media.
**Case Study**

R (on the application of AC) and Berkshire West Primary Care Trust(1)

The appellant (AC) was born in 1951 as a man. In 1996 she was diagnosed with Gender Identity Disorder (GID). A male with GID has the psychological outlook and mindset of a woman but the body of a man.

In 1996 she began gender reassignment treatment primarily by way of hormone treatment. She has lived as a woman since then.

It was hoped by the appellant that the hormone treatment would, amongst other things, significantly increase the size of her breasts. This was not successful. Her actual breast development would normally be found in females 11-13 years old.

The appellant made an application to Berkshire West Primary Care Trust for funding to pay for breast augmentation surgery in May 2006. The appellant in her witness statement stated “for a male to female transsexual to have breasts is a very natural and moral request. It is also necessary to establish feminisation in my journey from a male to female. My life will be one of turmoil if this is denied. Not fully knowing what or who I am and neither will those around me in everyday life.”

The respondent (Berkshire West Primary Care Trust) stated “When the application for NHS funding was originally made there was no suggestion that there was a serious mental health or psychological element to the application or that the requested operation was an essential part of the gender transformation process for the appellant. The application for funding was substantially justified on the basis that it would enable the appellant to feel more feminine.”

The respondent (Berkshire West Primary Care Trust) stated “When the application for NHS funding was originally made there was no suggestion that there was a serious mental health or psychological element to the application or that the requested operation was an essential part of the gender transformation process for the appellant. The application for funding was substantially justified on the basis that it would enable the appellant to feel more feminine.”

The respondent, in exercising its statutory responsibilities has to make very difficult choices as to what procedures to fund and not to fund and the choice made in this case is not irrational. The Court is not appropriately placed to make either clinical or budgetary judgements about publicly funded healthcare: its role is in general limited to keeping decision-making within the law.

The appellant’s appeal was dismissed, and judgement found in favour of Berkshire West Primary Care Trust.

This judgement also specifically addressed the issue of “exceptionality”:

Exceptional circumstances may be considered where there is evidence of significant health impairment and there is also evidence of the intervention improving health status.

The decision maker should first decide whether there is evidence of significant health impairment and evidence of the intervention improving health status. If there is, then the decision maker is enjoined to ask whether there are exceptional circumstances. The use of the phrase “exceptional circumstances” tells the decision maker that the number of persons who will succeed under the proviso is expected to be a small minority.”

References

(1) 2011 EWCA Civ 247

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**The future for individual funding requests**

Primary care trusts will be abolished in April 2013, and the bulk of their responsibilities and budget handed to Clinical Commissioning Groups (CCG). The NHS budget will be essentially static over the next few years, whilst demand for healthcare will rise considerably, due to an ageing population and the development of new treatments. To remain within their budget it is likely that CCGs will retain, and probably expand, a list of procedures that are not normally funded, and which therefore will require a formal process to consider funding requests on a named patient basis.

Our training and expertise ensures that as public health specialists we can continue to advise NHS decision-makers how to maximise improvements in health from a given budget. Advice and support to their individual funding requests process will form part of the “core offer” from local authority public health directorates to the CCGs.
Conclusions and Recommendations

This year my recommendations are that:

1. Lincolnshire should adopt a systemised model of planning needs assessment for its communities that ensures the due consideration of the underlying conditions that may be contributing to health inequalities.

2. We need to improve the quality of the data for enabling a greater understanding of the demography and the health status of the prison population.

3. The prison healthcare provider to maintain disease registers and to manage the prisoners on these registers to the same clinical outcomes as those of the Quality and Outcome Framework in primary care.

4. We must ensure that an assessment tool is used to identify prisoners with a learning disability and an evidenced based care plan is used for people identified with a disability.

5. The Lincolnshire Joint Antenatal and Newborn Screening Board should stress test each programme through regular audit and GAP analysis and report the results within the Screening Annual Report in 2012.

6. The commissioners, public health teams and providers work together to improve the quality of data in order to understand the demography of people who do not attend (DNA) for screening and target specific evidence based programmes to reduce DNA rates.

7. The commissioners, public health teams and providers work together to increase uptake in areas identified with the lowest coverage and to play a pivotal role in the introduction of the high risk service in breast screening and age extension in the bowel screening programme.

8. The commissioners, public health teams and providers work together to introduce and roll out this screening programme across Lincolnshire by March 2013.

9. The commissioners, public health teams and providers work together to maintain and sustain access to good quality contraceptive and sexual health services within 48 hours or less of first requesting the same.

10. A link is developed from Chlamydia screening with the wider need to reduce sexually transmitted infections and unwanted pregnancy and promote safer sex messages.

11. HIV testing is targeted at the 20-49 age groups and work towards reducing the number of undiagnosed individuals and increase HIV testing in the higher ‘at risk’ groups in the community, particularly in men who have sex with men, migrant communities, intravenous drug users, prison population and lower socio-economic groups.

12. In partnership with key stakeholders, teenage pregnancy prevention and support for young parents is integrated into a wider range of locally decided plans and implemented effectively.

13. Awareness is raised to identify particularly vulnerable groups, such as those with learning disabilities in relation to sexual assault and rape.

14. The commissioners, public health teams and providers work together to ensure service redesign of sexual health services to meet population needs.