Summary Report of the Leicester City Prevention and Health Inequalities Workshop – 5th August 2024

Introduction

In June 2024 the Director of Public Health for Leicester City Council established the Leicester City Prevention and Health Inequalities Steering Group. Composed of senior officers from Leicester City Council (Public Health and Social Care), the Leicester, Leicestershire and Rutland Integrated Care Board (LLR ICB), the University Hospitals of Leicester NHS Trust (UHL), and Leicestershire Partnership NHS Trust (LPT), this is a strategic group established to provide direction and alignment on prevention priorities to address health inequalities in the City. It reports to both the Leicester Joint Integrated Care Board (JICB) and Leicester City Health and Wellbeing Board.

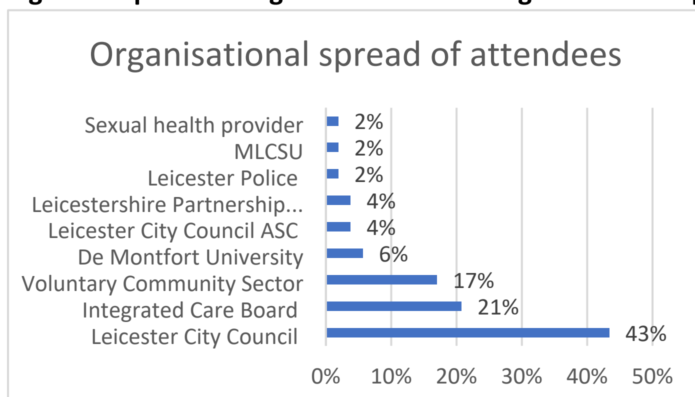
The primary purpose of the group is to:

- Ensure joined up working across the City Council, ICB and other organisations in relation to prevention (other groups include UHL, LPT and the VCSE sector)
- Ensure an approach to prevention that reduces health inequalities, ensuring existing resources are used where they are most needed to address preventable health inequalities
- Take a proportionate universal approach to the allocation of prevention resources across the system with a scale and intensity sufficient to tackle the inequalities faced by Leicester communities
- Use intelligence and evidence to identify a small number of prevention priorities where inequalities are greatest, the burden of disease and pressure on services is the highest, and prevention interventions have the greatest potential impact. A small number (4-6) areas will be chosen each year, for in depth review and focussed action
- Ensure that preventative activity is aligned with the Leicester Health, Care and Wellbeing Strategy and place led plans
- Identify opportunities to promote prevention throughout partner organisations, boards, and Collaboratives.

To develop this work, the Steering Group organised a half day workshop for key stakeholders held on August 5th 2024. (See Appendix 1 for Programme).

53 stakeholders attended the workshop from across Leicester, covering the ICB, Leicester City Council, voluntary and community sector, LLR ICB, LPT, Leicester Police, provider trusts and De Montfort University.

Figure 1: Spread of organisations attending the workshop



The workshop programme

Presentations were provided (See Appendix 2) outlining the social care prevention work – 'Leading Better Lives; drivers of health inequalities in the city; access to and outcomes of prevention interventions in Leicester, and what works to address these health inequalities.

This intelligence and evidence had been analysed by Public Health who had drawn up a list of 13 potential primary and secondary prevention programmes that the attendees were asked to discuss and then choose their top 3 or 4 priorities from (Appendix 3).

The 13 were chosen following a review health inequalities data and evidence (as presented in the workshop) and by reviewing what works to prevent these inequalities. Discussion were also undertaken with relevant topic leads within the Division of Public Health to understand the current provision of prevention interventions and identify gaps and poor / inequitable coverage.

Priorities identified

There was a range of priorities chosen by the different groups on the day, following discussion and feedback.

Breast cancer screening was most supported with 3 groups choosing it as a priority. 6 prevention items were then supported equally, with 2 groups choosing them as a priority. This includes a new priority not on the list presented, increasing uptake of childhood vaccines.

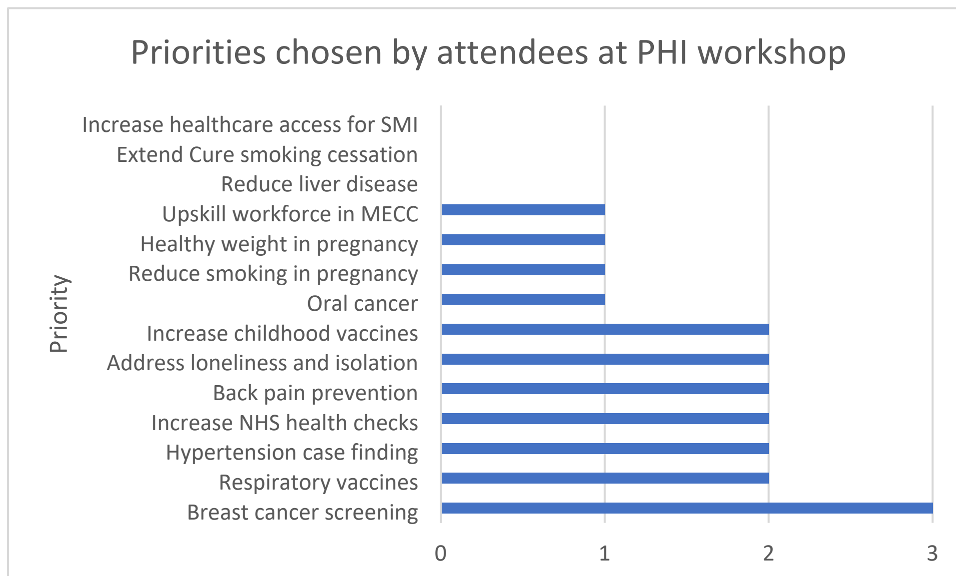
The most supported prevention items include:

- Breast cancer screening
- Increase uptake of childhood vaccines
- Address loneliness and isolation
- Back pain prevention
- Increase NHS health checks
- Hypertension case finding
- Increase uptake of respiratory vaccines

Whilst priorities were chosen, some groups felt:

- Anything that fits into the 'Plus 5' categories of the Core 20 plus 5 model is fine.
- Wider determinants are still the most important aspect of addressing health inequalities.
- Any of the options would result in a similar outcome, it is more about new and collaborative ways of working than anything else.

Figure 2: Prevention priorities chosen by groups at PHI workshop



Delivery approaches

Some priorities were given with advice on delivery; for example hypertension case finding was recommended to be merged with targeted increase of health check uptake.

Other advice around delivery included:

- Any approaches to prevention needs to be culturally sensitive.
- VCS are best placed to deliver some of this, but with adequate funding. Relationship needs to be bi-directional and asks should be made in a co-ordinated way so as not to overwhelm.
- Consider health and digital literacy in prevention – e.g. make responses to health invites as easy as possible – digital, phone, text.
- Reallocate existing resources.
- Engage the community including the Community Wellbeing Champions Network
- Create multiple points of entry to prevention interventions.
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Principles

Many groups fed back that certain principles should be followed in the delivery of this work, as principles can help us operationalise our priorities.

1. **Approach to prioritisation**

- clear and significant inequalities in the priority looked at.
- data available to understand/monitor/measure progress on the priority.
- priority requires a whole system approach.
- identify where we can achieve the most.

2. **Working together**

Improved system working by taking more of a joined-up approach to messaging, delivery of programmes, finance and possibly co-location of services. Do not offer new programmes in isolation.

3. **VCS engagement**

Take the community with you on any project by engaging properly with those who know the communities best.

4. **Efficacy of delivery**

Any recommendations or actions should be solution-focussed, rather than just scoping out the issues, as communities feel they already know what the problems are and have articulated these often.

5. **Resourcing**

Use resources within system already (buildings, spaces with communities, stalls for screening).

6. **Build on previous work**

It is important to always find out what has been done before and has worked- there are programmes which have been successful in the past but stopped due to funding constraints for example. It's important for the system not to lose this learning.

Workshop Evaluation

Participants were asked to complete an evaluation form (Appendix 4) at the close of the workshop.

27 were completed of 53 stakeholders in attendance

- 100% found the workshop useful
- 93% thought the aims were clear
- Only 1 person (4%) said the workshop did not meet their expectations, with 70% saying it did and 26% partially/unsure
- Respondents thought the discussions and data presentations worked well (figure 1)
- Suggestions for improvement were that the session was quite data heavy and the presentations needed a break. Discussions with different groups on the priorities would have been good, lots of good options made it difficult to choose, and a list of attendees for attendees would have enabled networking.
- 52% are clear on the priorities for the Prevention and Health Inequalities Steering group going forward.
- 52% will you do something different as a result of the workshop

Comments on the workshop included:

'Enlightening!'   'Great session - more please!'   'A good start.'   'Follow up on table conversations'.

Figure 3: Word cloud of what worked well

Next steps

This report will now be taken to the next meeting of the Leicester Prevention and Health Inequalities Steering Group who will decide on the 3-5 priorities to take forward. Once this is agreed the Steering Group will suggest leads for each of the task and finish group and develop some guidance (terms of reference, principles, timescales and governance) for the T&F groups to consider. The groups will report back to the Steering Group before each meeting (bi-monthly).

Rob Howard, Director of Public Health, Leicester City Council

Grace Brough, Acting Consultant in Public Health, Leicester City Council

30th August 2024.

Appendix 1: Programme

Prevention and health inequalities workshop 5th August 2024

Attenborough Hall, Leicester.

Suggested agenda

12pm- 4.30pm

Time	Task	Presenter
12pm-12:30pm (30 mins)	Lunch	All
12:30pm- 12:40pm (10 mins)	Welcome and introduction to the afternoon	Cllr Russell
12:40pm-12:50pm (10 mins)	Importance of tackling health inequalities through prevention	Rob Howard
12:50pm-13:10pm (20mins)	Inequalities of outcomes and risk factors regarding key conditions. What contributes to health inequalities and inequalities in life expectancy.	Helen Reeve
13:10pm-13:30pm (20 mins)	Inequalities of access/uptake/delivery of public health and NHS primary and secondary prevention interventions in the city. Are some groups and communities under-represented?	Janine Dellar
13:30-13:40pm (10 mins)	Feedback from the group – any surprises or anything not shown in the data?	Grace Brough
13:40pm-14:00pm (20 mins)	Which prevention interventions would make the biggest difference to mortality and morbidity? We can use the evidence base for each intervention to help inform this.	Grace Brough
14:00pm- 14:10pm (10 mins)	Present list of primary and secondary prevention items to tackle. Inequalities can be framed both in comparison to LLR and England.	Rob Howard

14:10pm- 14:30pm (20 mins)	**Tea/coffee**	**All**
14:30pm- 15:10pm (40 mins)	**Table activity- Each table go through 10-12 of these and whittle down what their top 4-5 are, identifying the interventions where we can make a difference.**	**Steering Gp Members to facilitate**
15:10pm- 15:30pm (20 mins)	**Feedback from groups**	**Grace Brough/Rob Howard**
15.30 – 16:00pm (30 mins)	**What would a task and finish group on your chosen areas look like and who would need to be involved?**	**Steering Gp Members to facilitate**
16:00pm – 16:20pm (20 mins)	**Feedback from groups**	**Grace Brough/Rob Howard**
16:20pm – 16.30 (10 mins)	**Summary**	**Rob Howard**

Appendix 2: Presentations

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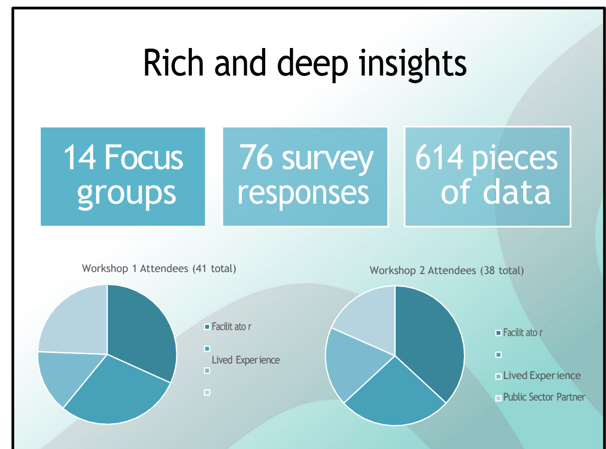

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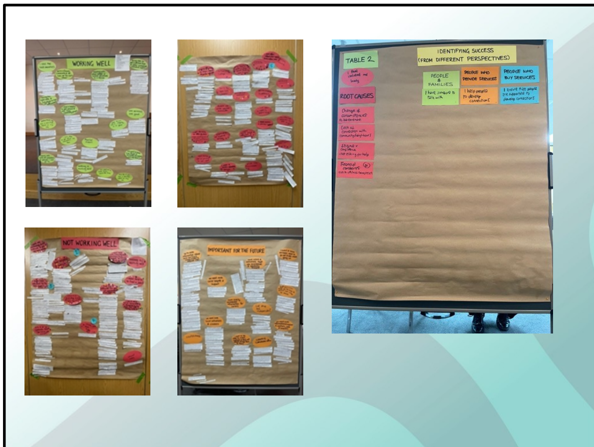

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Next steps: Priority themes and actions

Loneliness & Isolation	• 'Street Champions'
Struggling to access advice & support online	• Information and advice festival
Not knowing where to go for advice & support	• Multi-disciplinary meeting / drop-in held in community facilities
Not feeling listened to	• People based in community centres who know about community activities, information, advice & guidance and can link with the council.

More Quick

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Life expectancy and health inequalities

Leicester City Council

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Key headlines

- Deprivation is a **major driver** of inequality in life expectancy
- **Deprived citizens experience more illness**
- **Illness and death occur earlier amongst deprived**
- **Certain conditions affect the deprived more**
- **Life expectancy gap across Leicester City show clear links with deprivation**
- **Leicester is more affected by inequality in health and life expectancy than the national average**

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Factors affecting life expectancy

Life expectancy is affected by many factors including

- Behavioural risks such as smoking and poor diet
- Wider socio-economic determinants of deprivation; income, education, housing and employment
- Access to and use of health care
- Geography
- Population characteristics such as ethnicity, disability

These factors can impact on an individual's physical and mental conditions resulting in experience of not being 'in good health'

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Deprivation is a major contributor to lower life expectancy

Findings from the Health foundation Report:

- People in the 10% most deprived areas can expect to develop a major illness 10 years earlier than people in the least deprived areas.They are 3 times more likely to die before the age of 70 years
- The projected number of working-age people with major illness is predicted to grow with 80% of illness in the 50% most deprived areas
- COPD is the condition with the highest relative inequality. Chronic pain, type 2 diabetes and anxiety and depression will increase at a faster rate in the most

Source: Health Foundation report: Health inequalities in 2040: current and projected patterns of illness and deprivation in England

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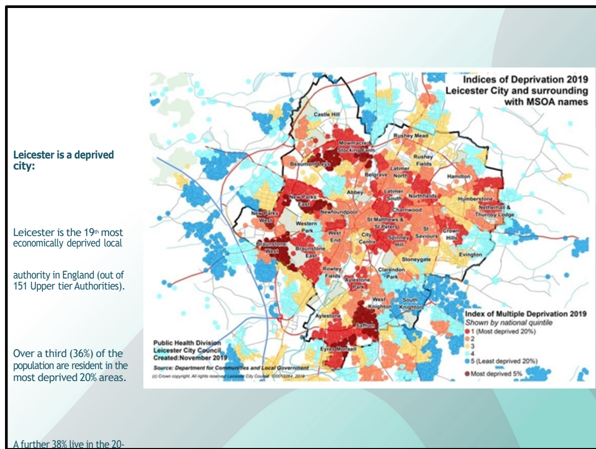

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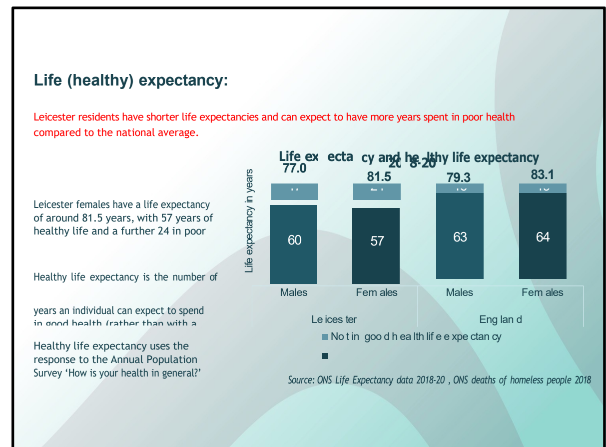

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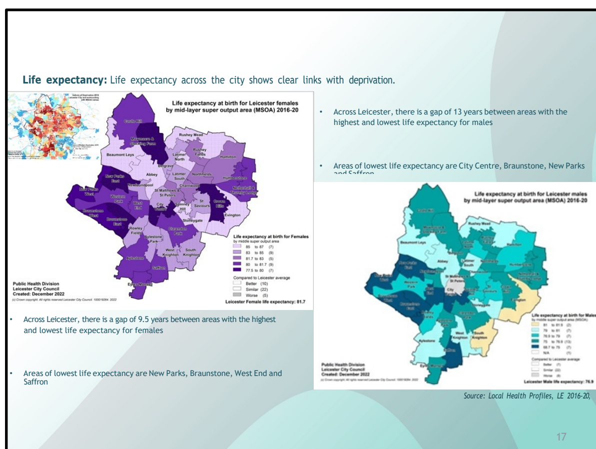

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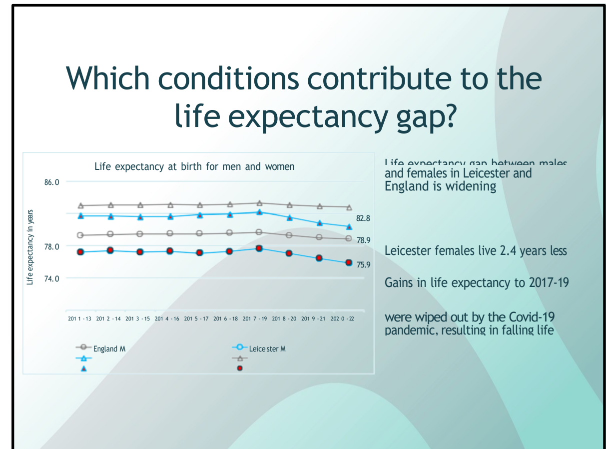

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Key headlines

- Life expectancy gap driven by 3 main conditions, cancer, circulatory and respiratory (~60% of the gap)
- Men- Cancer (25%), circulatory (19%), respiratory (15%)
- Women – Circulatory (25%), cancer (20%), respiratory (15%)
- 60-79 year olds experience life expectancy gap the most
- Drivers of these conditions include health behaviours (e.g. smoking) and access to prevention interventions (e.g. screening/ hypertension management)

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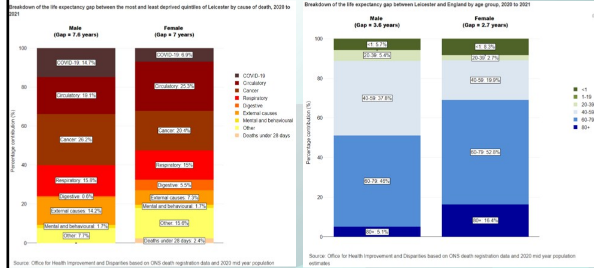
Life expectancy gap

makes to the overall **life expectancy gap between the least and most deprived areas in Leicester** in 2020-21

the overall life expectancy gap between the least and most deprived areas in Leicester compared with England in 2020-21



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Driver diagram - to guide prioritisation of action

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How much of this is preventable?

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Key headlines

- A lot of deaths from conditions driving inequality in life expectancy are from causes considered preventable
- Leicester has more deaths from preventable causes than the England average
- In under 75's-
  - 41% of CVD deaths are preventable
  - 45% of cancer deaths are preventable
  - 53% of respiratory deaths are preventable
  - 90% of liver disease deaths are preventable

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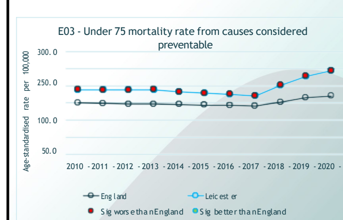
Mortality from causes considered preventable:

Preventable mortality includes causes of deaths that



Preventable causes include

- **Infectious diseases**: including Tetanus: Covid-19:
- **Respiratory diseases**- pneumoconiosis assoc. with TB:
- **Cancers** of lip, oral cavity and pharynx, Liver Trachea and Lung, Mesothelioma, Skin, Bladder, Cervix:
  Endocr
  aneurysm, Hypertension
- **Cardiovascular:** Ischaemic heart diseases, Cerebrovascular diseases, Atherosclerosis
- **Respiratory**: Influenza and pneumonia, COPD, Lung disease from external agents, Other respiratory diseases
- **Congenital malformations**: Anencephaly, Spina bifida, Fetal alcohol syndrome
- **Accidents:**Transport accidents, Accidents/exposure to external forces
- **Liver disease:** Hepatitis, Fibrosis and cirrhosis of

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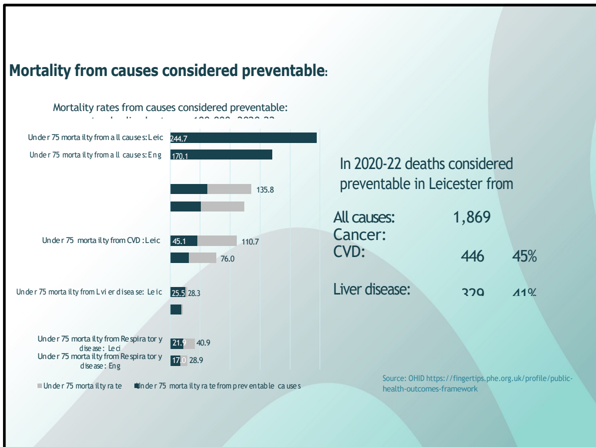

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Key headlines

- Diabetes, heart disease (IHD), lung cancer, COPD, chronic kidney disease, back pain, alcohol and drugs are all conditions that make a large contribution to disability adjusted life years in Leicester **AND** are largely, if not wholly, attributable to risk factors
- The top 5 risk factors for DALY's are- Tobacco, high BMI, dietary risks, high blood pressure, high fasting plasma glucose

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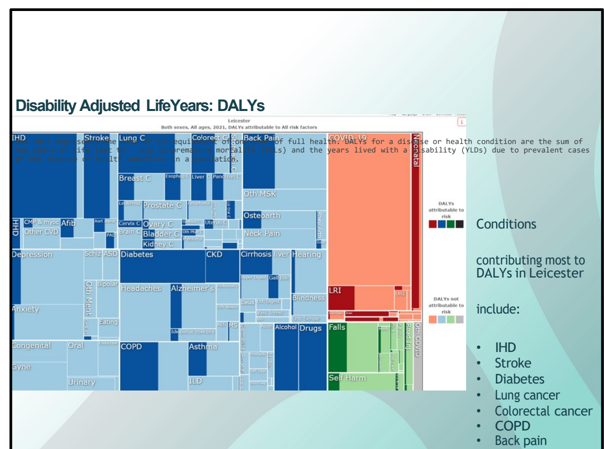

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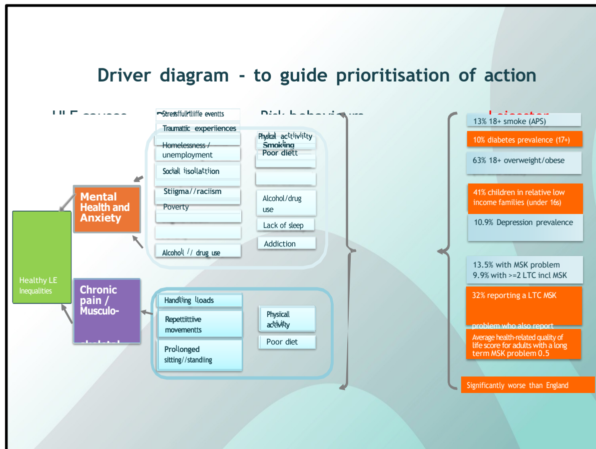

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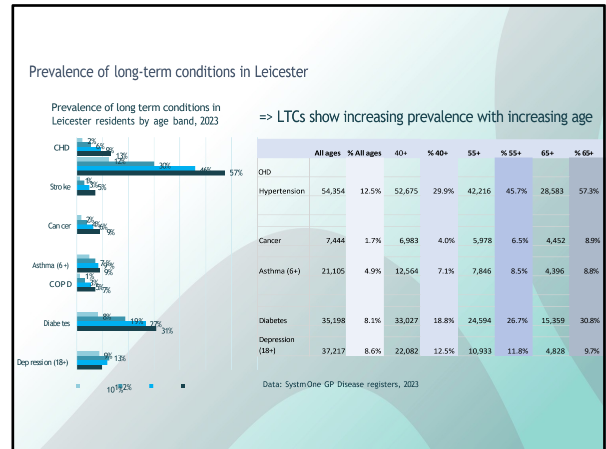

	All ages	% All ages	40+	% 40+	55+	% 55+	65+	% 65+
CHD								
Hypertension	54,354	12.5%	52,675	29.9%	42,216	45.7%	28,583	57.3%
Cancer	7,444	1.7%	6,983	4.0%	5,978	6.5%	4,452	8.9%
Asthma (6+)	21,105	4.9%	12,564	7.1%	7,846	8.5%	4,396	8.8%
Diabetes	35,198	8.1%	33,027	18.8%	24,594	26.7%	15,359	30.8%
Depression (18+)	37,217	8.6%	22,082	12.5%	10,933	11.8%	4,828	9.7%

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Lifestyle factors

Indicator	Period	Leicester	England
Overweight (including obesity) prevalence in adults (18+ years)	2022/23	62.8%	64.0%
Physically inactive adults (19+ yrs)	2022/23	27.8%	22.6%
Smoking prevalence in adults (18+)	2022	13.1%	12.7%
Adults meeting the '5-a-day' fruit and veg consumption recommendat	2022/23	21.4%	31.0%
% Reporting a long-term MSK problem	2023	13.5%	28.4%
Estimated diabetes diagnosis rate	2018	83.0%	78.0%

Healthy lifestyle can be increased through

- Improving poor lifestyle habits before onset of long term conditions
- Interventions
  - Healthy lifestyle advice for individuals with high risk of long-term conditions (identified through health checks and screening programmes)

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NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

Inequalities in access to NHS prevention services

Inequalities of access/uptake/delivery of public health and NHS primary and secondary preven city. Are some groups and communities under-represented?

A proud partner in the: Leicester, Leicestershire and Rutland Health and Wellbeing Partnership

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Cancer

- One of the biggest actions the NHS can take to improve cancer survival is to diagnose cancer earlier
- Patients diagnosed early, at stages 1 and 2, have the best chance of curative treatment and long-term survival
  - **75% of cases diagnosed at stage 1 or 2 by 2028**
- Actions to improve diagnosis at stage 1 or 2 include:
  - greater awareness of symptoms of cancer
  - lower the threshold for referral by GPs
  - accelerate access to diagnosis and treatment
  - maximise the number of cancers that we identify through screening

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Indicator	Period	Leicester Recent Trend	Leicester Count	Leicester Value	Region Value	England Value	England Worst	England Range	England Best
Cancer screening coverage: breast cancer (New data)	2023	↓	17,796	52.0%	68.5%*	66.2%*	34.3%		78.9%
Cancer screening coverage: bowel cancer (New data)	2023	↑	27,731	58.6%	73.5%*	72.0%*	53.3%		79.5%
Cancer screening coverage: cervical cancer (aged 25 to 49 years old) (New data)	2023	↓	43,600	54.3%	68.3%*	65.8%*	42.4%		75.9%
Cancer screening coverage: cervical cancer (aged 50 to 64 years old) (New data)	2023	↓	20,508	69.0%	76.2%*	74.4%*	55.1%		[illegible]7.7%

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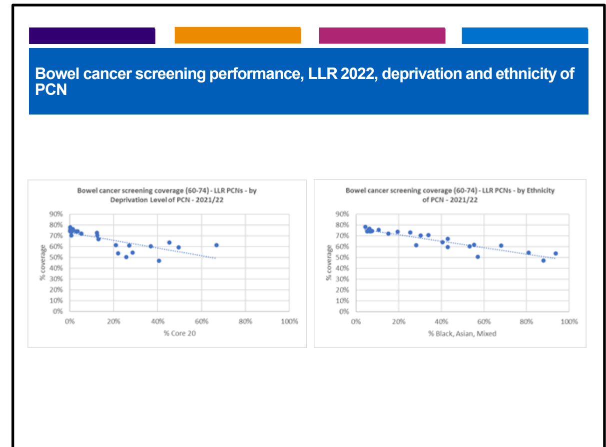

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CVD Prevention

- High blood pressure is the largest single known risk factor for cardiovascular disease and related disability.
- High blood pressure increases the risk of:
  - heart failure
  - coronary artery disease
  - stroke

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Years lived with disability for CVD, Leicester City, GBD 2021

CVD - Years Lived with Disability
Leicester City

- In **Leicester in 2021, GBD estimated that 1480 years of life lived with disability were attributable to CVD**
- The top 3 risk factors associated with these YLDs were
  - High systolic blood pressure
  - High LDL cholesterol

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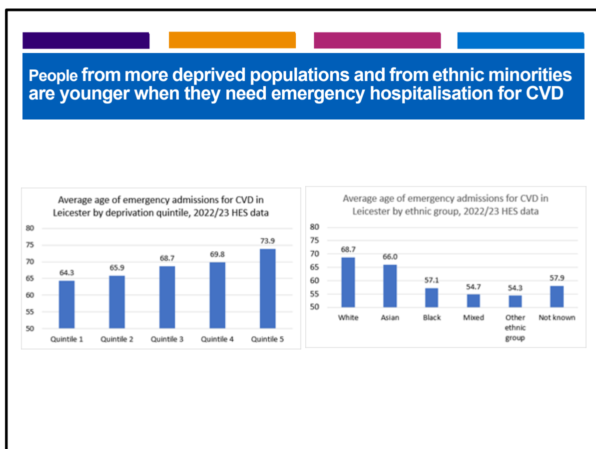

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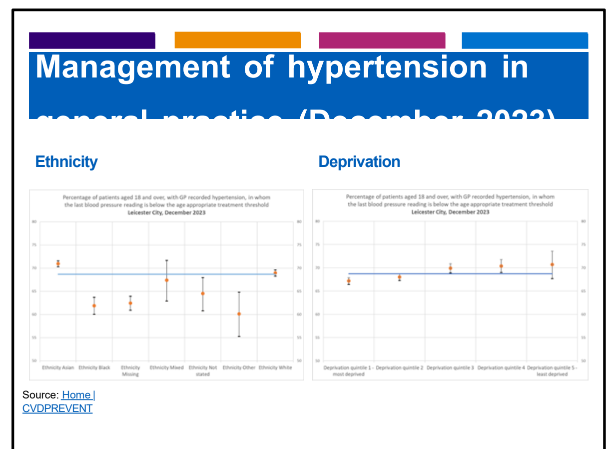

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Respiratory disease – Core 20 Plus 5

- Increase uptake of COVID, flu and pneumonia vaccines
- To reduce infective exacerbations of COPD and emergency hospital admissions due to those exacerbations

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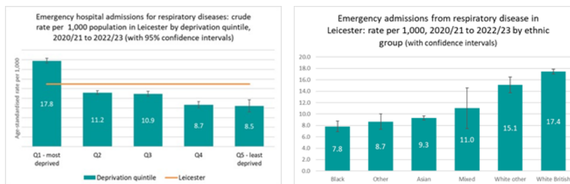
Respiratory Disease



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Improving Physical Health for People with Serious Mental Illness (SMI)

- People with SMI die up to twenty years younger than the average population
- Preventable cardiovascular disease (CVD) is the major cause of death, along with endocrine disease and respiratory failure.
- Evidence also suggests that people with SMI receive a lesser standard of health promotion and physical health care
- Despite national awareness and guidelines early mortality rates have not improved

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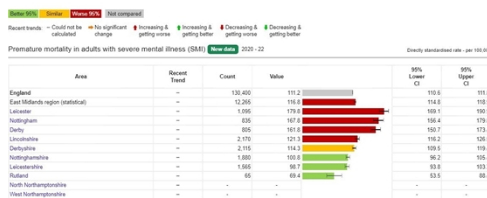
Premature mortality in adults with SMI


Better 95% | Similar | Worse 95% | Not compared

Recent trends: – Could not be calculated; No significant change; Increasing & getting worse; Increasing & getting better; Decreasing & getting worse; Decreasing & getting better

Premature mortality in adults with severe mental illness (SMI) New data 2020 - 22 — Directly standardised rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	130,400	111.2	110.6	111.8
East Midlands region (statistical)	–	12,265	116.8	114.8	118.9
Leicester	–	1,095	179.8	169.1	190.9
Nottingham	–	835	167.8	156.4	179.8
Derby	–	805	161.8	150.7	173.4
Lincolnshire	–	2,170	121.3	116.2	126.5
Derbyshire	–	2,115	114.3	109.5	119.4
Nottinghamshire	–	1,880	100.8	96.2	105.4
Leicestershire	–	1,565	98.7	93.8	103.7
Rutland	–	65	69.4	53.5	88.4
North Northamptonshire	–	-	-	-	-
West Northamptonshire	–	-	-	-	-

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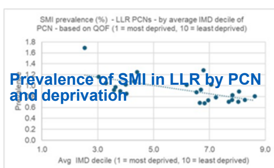
Prevalence and number with SMI in LLR – by PCN – by deprivation



Prevalence of SMI in LLR by PCN and deprivation

	Q3 23/24 by sub ICB			
	LC	ELR	WL	LLR
All checks	3,117	1,308	1,800	**6,225**
SMI register	4,708	2,939	3,590	**11,237**
% All checks	**66.2%**	**44.5%**	**50.1%**	**55.4%**

Physical health checks for patients with SMI – Q3 2023/24

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Childhood immunisations

- The World Health Organization (WHO) says:
  - The 2 public health interventions that have had the greatest impact on the world's health are clean water and vaccines
- Immunisation is a way of protecting against serious infectious diseases
- Once we have been immunised, our bodies are better able to fight those diseases if we come into contact with them

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Vaccination Uptake for 2022/23 (Q1-3), by Age, Local Authority and Vaccination

Age Group	Vaccination	County & R'land	City	LLR Total
12 Months	12m DTaP/IPV/Hib - primary %	96.3%	92.3%	94.8%
	12m PCV1 - 1 dose %	97.4%	95.0%	96.5%
	12m Rota - primary%	94.9%	86.7%	91.7%
	12m MenB - primary %	96.1%	91.7%	94.4%
	All 12 Months	96.2%	91.4%	94.3%
24 Months	24m DTaP/IPV/Hib - primary %	96.4%	93.0%	95.0%
	24m PCV booster%	94.9%	87.9%	92.0%
	24m Hib/MenC - booster%	95.1%	88.8%	92.6%
	24m MMR - 1st dose %	95.0%	89.2%	92.7%
	24m MenB - Booster%	94.4%	86.5%	91.2%
	All 24 Months	95.2%	89.1%	92.7%
5 Years	5y DTaP/IPV/Hib - primary%	97.1%	93.5%	95.7%
	5y MMR 1st dose %	97.3%	93.7%	95.8%
	5y MMR 2nd dose %	93.2%	80.0%	88.0%
	5y DTaPIPV - booster %	91.2%	77.1%	85.6%
	5y Hib/MenC - booster%	94.3%	87.1%	91.5%
	All 5 Years	94.6%	86.3%	91.3%
All Vaccinations		95.2%	88.6%	92.6%

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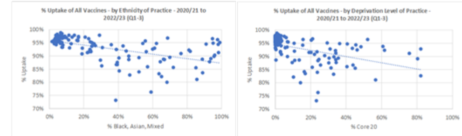
Uptake by ethnicity and deprivation in LLR

LLR Vaccination Uptake for 2020/21 to 2022/23 (Q1-3), by Practice Population Characteristics



Ethnicity Quintile	% Uptake
1 - Highest % Ethnic Minority	90.0%
2	88.7%

Core 20 Quintile	% Uptake
1 - Highest % Core 20	89.4%
2	89.8%

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Summary

- Range of NHS prevention activities
- Examples included directly impact on the gap in life expectancy and healthy life expectancy
- Inequalities in access and outcomes across all case studies by deprivation and ethnicity
- Prevention programmes need to meet the needs of different populations and communities to target and reduce inequity

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NHS
Leicester, Leicestershire and Rutland
Integrated Care Board

Thank you for listening

A proud partner in the Leicester, Leicestershire and Rutland Health and Wellbeing Partnership

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Which prevention interventions would make the biggest difference to mortality and morbidity?

Grace Brough

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Review of drivers of health inequalities

Mortality

- Cardiovascular diseases
- Respiratory diseases
- Cancers

In under 75's-

41% of CVD deaths are preventable

Morbidity

- Diabetes
- Heart disease
- Lung cancer
- COPD
- Chronic kidney disease
- Back pain

- Alcohol and drugs

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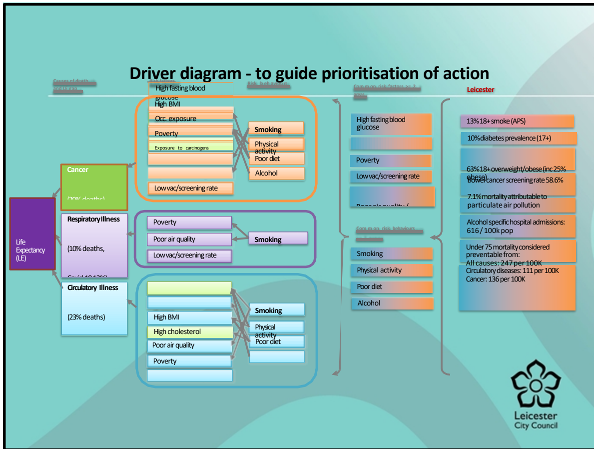

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Drivers of inequalities in life expectancy- what works

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Cardiovascular diseases

Behaviour change prevention includes-

- Healthy diet
- Healthy weight

Healthcare prevention includes -

ABC approach

- **Atrial fibrillation-** increase detection and management
- **Blood pressure** – Identify and manage hypertension
- **Cholesterol**- increase numbers having a CVD risk assessment (NHS Health Check), lifestyle advice and

Public Health England | Health Matters

What health professionals can do to improve cardiovascular disease management

1. FIND THEM — make system audits routine and detect those at risk

2. TREAT THEM — treat in line with NICE guidelines

3. MANAGE THEM — many with unmanaged co-morbidities present an 'early wins' cohort; eg. start or switch from low-intensity to high-intensity statins

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NHS Health Checks Activity Data (2023/24)- Leicester

NHS Health Checks	Leicester
Invites	
Total Eligible Population (TEP)	92,394
Number of invites sent	21,835
Percentage invited of TEP	23.6%
Number of NHS Health Checks completed	12,220
Percentage uptake (of those invited)	56.0%
Number of people classified as high risk (Q-Risk >10%)	1,438
Percentage of high risk patients (of those completing a health check)	11.8%

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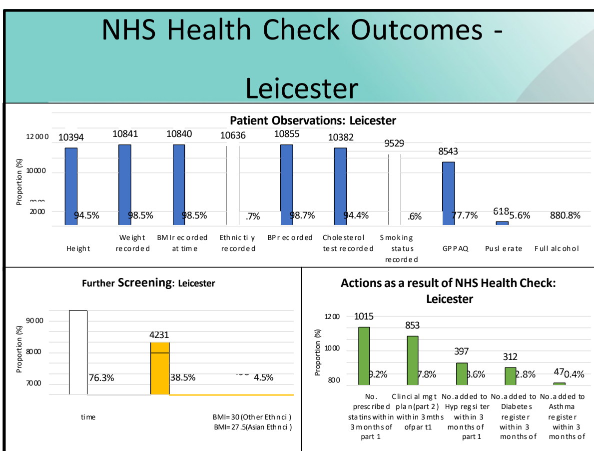
NHS Health Check Outcomes - Leicester



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Respiratory diseases

Respiratory disease covers common conditions such as **asthma** and chronic obstructive pulmonary disease (**COPD**), **lung cancer**, infections such as **pneumonia** and **flu**, and less common diseases such as interstitial lung disease and mesothelioma.

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Respiratory diseases – vaccines

- PPV vaccine shows 41% effectiveness against invasive pneumococcal disease (IPD).
- PCV vaccine has reduced incidence of IPD by more than 50%

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Respiratory diseases – flu vaccines (2)

Flu Vaccination group (CYP)	% Uptake in Leicester GP Practices
All Aged 2 years	29.9
All Aged 3 years	28.7
All Aged 4 years	13.5
All Aged 6 years	13.2
All Aged 7 years	15.2
All Aged 8 years	13.6
All Aged 9 years	13.3
All Aged 10 years	13.4
All Aged 11 years	11.1
All Aged 13 years	9.5
All Aged 14 years	9.3
All Aged 15 years	8.8

- Up to 65% effective in children, 55% effective in adults

Flu Vaccination group	% Uptake in Leicester GP Practices
65 plus	66.6
65 plus (at-risk only)	71.3
Under 65 (all patients)	10.3
Under 65 (at-risk only)	33.3
Pregnant and NOT IN a clinical risk group	22.6
Pregnant and IN a clinical risk group	30
All Pregnant Women	23.4

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Respiratory diseases – smoking cessation

A combination of NRT and specialist smoking cessation services.

In the City, we have **CURE** – an inpatient hospital service focussed on smoking cessation and referral to the community.

Live Well – is our community smoking cessation

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Cancer- prevention

Behaviour change prevention

- Smoking cessation
- Healthy weight
- Reduce alcohol consumption

Healthcare prevention

- HPV vaccine
- Early detection and identification e.g. oral cancer awareness
- Screening – breast, bowel,

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Cancer – what works

Vaccines and immunisations

- Community based clinics have some positive results, but numbers have been small (engagement and promotion first does have an impact on vaccines delivered and enquiries too)
- GP text messages out to patients generally yields higher uptake
- School based mobile clinics (higher numbers when headteacher/school governors heavily promote and

Screening

- Open appointments (drop-in sessions) have some success
- Option to book/rearrange appointments online/via the NHS app rather than having to ring
- Robust call and re-call system
- No Fear Practices | Cervical screening | Screening Saves Lives – we don't

have this in Leicester, but I would like

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Cancer- local capacity for benefit

Better 95% Similar Worse 95% Not applicable

Recent trends: Could not be calculated; No significant change; Increasing & getting worse; Increasing & getting better; Decreasing & getting worse; Decreasing & getting better

Benchmark Value: Worst, 25th Percentile, 75th Percentile, Best

Indicator	Period	Leicester Recent Trend	Leicester Count	Leicester Value	Region Value	England Value	England Worst	England Range	England Best
Cancer screening coverage: breast cancer New data	2023	↓	17,796	52.0%	68.5%*	66.2%*	34.3%		78.9%
Cancer screening coverage: bowel cancer New data	2023	↑	27,731	58.6%	73.5%*	72.0%*	53.3%		79.5%
Cancer screening coverage: cervical cancer (aged 25 to 49 years old) New data	2023	↓	43,600	54.3%	68.3%*	65.8%*	42.4%		75.9%
Cancer screening coverage: cervical cancer (aged 50 to 64 years old) New data	2023	↓	20,508	69.0%	76.2%*	74.4%*	55.1%		87.7%

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Liver disease

Behavioural prevention

- Reduced alcohol intake
- Healthy weight

Healthcare prevention

- Liver function test/ fibroscanning for identification of liver damage
- Blood pressure managed

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Liver disease- interventions

Alcohol reduction

- Leicester City Alcohol Harm Reduction Strategy
- Alcohol treatment services

Identification of harm

- Fibroscanning pilot – 30% identified as having liver stiffness, 9% had cirrhosis or fibrosis and 30% of patients subsequently entered structured treatment for support from Turning Point.
- Opportunistic Liver Function

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Healthy weight

- Whole systems approach to obesity
- Tiered levels of weight management
- NICE recommends multi-component interventions for behaviour change
- Possible medical interventions for those at a certain BMI e.g. semaglutide
- MECC – brief advice and guidance

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Back pain

- Physical activity
- Education
- Working practices
- Pain management programmes, including physio, psychologist and occupational therapist

Pain management programmes

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MECC

- Making Every Contact Count (MECC) is a low-cost intervention, underpinned by the evidence-base for behaviour change approaches to prevention.
- The wider Leicester workforce, VCSE and health workforce have a vital role in prevention and health. To achieve this, the workforce benefit from upskilling.

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Healthy conversation skills

- 'Enabling the **workforce** to **recognise the opportunity** they have in facilitating people to have a greater awareness of their health and wellbeing'

Alcohol consumption
Weight management
Physical inactivity
Diet
MEC
Education & Employment
Social Isolation
Mental Health
Housing

'Empowering **people** to seek out their **own solutions** to support their own health and wellbeing'

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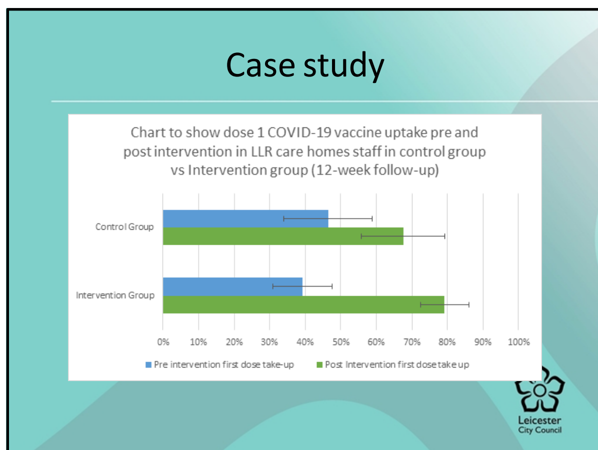

Data and outcomes to date

- E-learning – 1500+ across LLR
- MECC (lite) – approx. 400 trained in City
- City trainer network – 11 existing plus 12 completed in July 2024
- Approx 2 million website home page views

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Thank you

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List of primary and secondary prevention items to tackle

Cancer

1. Drive up breast cancer screening rates – using a data informed approach to target groups not attending e.g. those with Severe Mental Illness (SMI).
2. Oral cancer – strengthen focus on oral cancer and partnership delivery through the Oral Cancer Action Plan.

Respiratory

3. Increase uptake of flu vaccine in groups with low uptake e.g. pregnant women and under 65's at risk, and pneumococcal where uptake is low (24-month booster and over 65's).

Cardiovascular disease and chronic kidney disease

4. Extend hypertension case finding to target where gaps are e.g. Black communities who typically present in ED at younger ages for cardio events, those with SMI, or deprived areas.

5. Increase NHS Health Checks amongst communities most at risk, or where people are attending/ less, e.g. through tailoring the invitation process, encouraging GP engagement, novel delivery model. Increase Annual Health Checks for people with Learning

Disabilities.

CVD, respiratory, cancer, chronic kidney disease, diabetes

9. Undertake work to increase proportions of women who have a healthy weight in pregnancy – through healthy conversations with those preparing for pregnancy, and establishing and strengthening

support and advice mechanisms for pregnant women using NICE guidelines.

10. Upskill the workforce to use MECC approaches to have effective preventative conversations which result in referrals and signposting to manage risk factors for conditions contributing to health

inequalities. Target the workforce in touch with communities most

at risk of conditions driving inequalities E.g. social prescribers, pharmacists, practice nurses, specialist midwives.

Musculoskeletal

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Appendix 3: Prevention items

List of primary and secondary prevention items to tackle

Cancer

1. Drive up breast cancer screening rates – using a data informed approach to target groups not attending e.g. those with Severe Mental Illness (SMI).- 3 votes
2. Oral cancer – strengthen focus on oral cancer and partnership delivery through the Oral Cancer Action Plan. -

Respiratory

3. Increase uptake of flu vaccine in groups with low uptake e.g. pregnant women and under 65's at risk, and pneumococcal where uptake is low (24-month booster and over 65's).

Cardiovascular disease and chronic kidney disease

4. Extend hypertension case finding to target where gaps are e.g. Black communities who typically present in ED at younger ages for cardio events, those with SMI, or deprived areas.
5. Increase NHS Health Checks amongst communities most at risk, or where people are attending/ less, e.g. through tailoring the invitation process, encouraging GP engagement, novel delivery model. Increase Annual Health Checks for people with Learning Disabilities.

Liver disease

6. Targeted work to reduce alcohol harm – as 90% of liver disease are preventable. Work to identify Non-Alcoholic Fatty Liver Disease earlier – consider extending fibro scanning to areas most at risk.

CVD, respiratory and cancer

7. Targeted work to extend and improve the CURE offer. Cure is a programme identifying smokers in hospital, giving them nicotine replacement therapy and specialised support throughout their hospital stay and referring on to community support.
8. Targeted work to reduce smoking in pregnancy and smoking in the home with young babies.

CVD, respiratory, cancer, chronic kidney disease, diabetes

9. Undertake work to increase proportions of women who have a healthy weight in pregnancy – through healthy conversations with those preparing for pregnancy, and establishing and strengthening support and advice mechanisms for pregnant women using NICE guidelines.
10. Upskill the workforce to use MECC approaches to have effective preventative conversations which result in referrals and signposting to manage risk factors for conditions contributing to health inequalities. Target the workforce in touch with communities most at risk of conditions driving inequalities E.g. social prescribers, pharmacists, practice nurses, specialist midwives.

Musculoskeletal

11. Focus on back pain prevention and treatment as large driver of years lived with disability- explore current provision of pain management for treatment and ways of reaching those

who are vulnerable. Communicate messages on importance of physical activity and exercises in back pain- may be able to use the work well vanguard.

Mental health

12. Build on existing work on loneliness and isolation, to reduce situational loneliness, such as carers and recently bereaved through befriending or targeted activities, to prevent loneliness becoming chronic.
13. Work to link those with SMI with support to access healthcare, including GP registration, screening, and health checks; and access to healthy activities (e.g. through social prescribing).

Appendix 4: Evaluation Form

Prevention and Health Inequalities Workshop Evaluation

Please take a couple of minutes to let us know how you found the workshop, and how we can improve this in the future. Thank you.

* Required

* This form will record your name, please fill your name.

1. Please tell us your name - leave blank if you prefer your answers to be confidential

2. Please tell us the organisation you represent *

3. Did you find the workshop useful? *

- Yes
- No
- Not sure

4. Were the aims of the workshop clear? *

- Yes
- No
- Partially

5. Did the workshop meet your expectations? *

- Yes
- No
- Partially
- Not sure

6. If no, which expectations were not covered?

7. Please tell us what you thought worked well *

8. Please tell us how the workshop could have been better *

9. Are you clear on the priorities for the Prevention and Health Inequalities Steering group going forward?*

- Yes
- No
- Partially

10. Will you do anything different as a result of the workshop? *

- Yes
- No
- Not sure

11. If yes, what will you do differently?

12. Is there anything else you would like to tell us about the workshop and this work?

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