ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2016

RUTLAND

OVERVIEW OF HEALTH IN RUTLAND & THE ROLE OF WORKPLACE HEALTH IN IMPROVING HEALTH

FOREWORD

Welcome to my annual report for 2016. In my last annual report I set out the case for the role of communities in improving health and well being. As can be seen in 'update on recommendations', there has been a renewed focus on community level work through the co-creation of the new integrated community prevention and wellness service.

Last year I also highlighted the findings of the Joint Strategic Needs Assessment 2015. Presenting the findings of the JSNA was well received by people and partners and reminded me that the annual report can be a useful way of sharing information on the health of the people of Rutland.

This year, I have split the report between a further information update and a focus on a topic important to health. In the first part of the report I have reviewed the Health Profile for Rutland. These are the nationally produced snapshots of health across the country and set what I believe to be the priorities for action for the forthcoming year.

For this year's topic I have looked at the importance of work and health, covering the health of the working age population and the importance of workplace health. I have also revisited the progress being made on 'the wider determinants of health' from my report of 2014, highlighting how this work will underpin economic development and improved population health.

As always, I hope you find this interesting, informative and a spur to further progress in improving the health of Rutland. I would like to thank Gabi Price, Michele Monamy, Stephanie Webb, Liz Orton and Rob Howard for their contributions to this report and the public health department for their continued hard work.

Mike Sandys

Director of Public Health

CONTENTS

Foreword **2**

1. **Introduction** **6**
2. **Recommendations** **7**
3. **Overview of the Health Profile 2016** **9**
4. **The Role of Workplace Health in Improving Health** **14**

4.1 The Health and Well Being of Working Age Adults **14**

4.2 Workplace Health **21**

4.3 Improving the Economy and Improving Health by Tackling the Wider Determinants of Health **23**

5. **Feedback from Recommendations for 2015** **30**

References **31**

List of Tables

1. Health Profile comparator performance

List of Figures

1. The determinants of health

2. Number of working days lost due to sickness absence, 1993 to 2013, and the top reasons for sickness absences in 2013

3. Employment and unemployment (January to December 2015) – Rutland, East Midlands and Great Britain

4. Economic inactivity (January to December 2015) – Rutland, East Midlands and Great Britain

5. Gap in the employment rate between those with a learning disability and the overall employment rate

6. Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate

7. Percentage of working hours lost to sickness by age group – 1993 (blue) and 2013 (orange)

8. Working-age client group – main benefit claimants (November 2015)

1. INTRODUCTION

Each year the Director of Public Health publishes an independent report on the health and wellbeing of the local population. This report is a statutory duty and intended to inform local strategies, policy and practice across a range of organisations and interests. The purpose of the report is to highlight opportunities to improve the health and wellbeing of people in Rutland.

Evidence suggests that good health should improve an individual's chances of finding and staying in work and of enjoying the consequent financial and social advantages. Furthermore work has an inherently beneficial impact on an individual's state of health (1). The review *'Is work good for your health and well-being?'* concluded that work was generally good for both physical and mental health and well-being. It showed that work should be 'good work' which is healthy, safe and offer the individual some influence over how work is done and a sense of self-worth. Overall, the beneficial effects of work were shown to outweigh the risks and to be much greater than the harmful effects of long-term worklessness or prolonged sickness absence (2). Illness is incompatible with being at work and that an individual should be at work only if 100% fit. This thinking underpins much of the current approach to the treatment of people of working age with health conditions or disabilities.

Personal characteristics, such as age, sex and ethnicity, are highly significant for health but cannot be influenced by public health. Consequently they sit at the core of the 1991 Dahlgren and Whitehead, wider determinants of health model (Figure 1). The basis of the model is the concept that some of the factors that influence health are fixed and others can be influenced. Individual lifestyle factors are behaviours such as smoking, alcohol and other drug misuse, poor diet or lack of physical activity. Lifestyle factors have a significant impact on an individual's health. Social and community networks are our family, friends and the wider social circles around us. Social and community networks are a protective factor in terms of health. Evidence tells us that important factors for life satisfaction are being happy at work and participating in social relationships (3). Living and working conditions include access to education, training and employment, health, welfare services, housing,

public transport and amenities. It also includes facilities like running water and sanitation, and having access to essential goods like food, clothing and fuel. General socio-economic, cultural and environmental conditions include social, cultural, economic and environmental factors that impact on health and wellbeing such as wages, disposable income and availability of work.

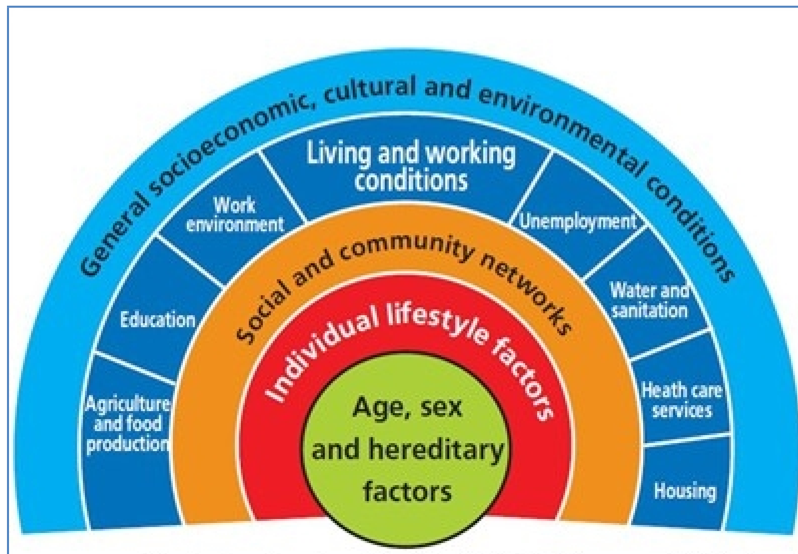

Figure 1 The wider determinants of health (4)

2. RECOMMENDATIONS

The recommendations have been developed along the three key roles for public health as defined by the World Health Organisation, which include public health as a leader; public health as a partner; and public health as an advocate. The recommendations are set out below:

A Leader – We will refresh our strategic work on overweight and obesity in adults in 2017

A Leader – Rutland Council has a key role to play in our work on the wider determinants of health. We will continue to provide specialist expertise on approaches to health impact assessment and health in all policies.

A Partner - As a partner to the NHS, we will work with University of Hospitals of Leicester Trust and Leicestershire Partnership Trust on joint approaches to

workforce health as part of the Leicester, Leicestershire and Rutland (LLR) response to the NHS 5 Year Forward View.

An Advocate – The Public Health Department will work with the public and private sector organisations to advocate the use of the Workplace Wellbeing Charter by employers, as part of the approach to workplace health.

3. OVERVIEW OF THE HEALTH PROFILE 2016

Public Health England publishes health profiles for all local authorities in England on an annual basis.

Health Profiles provide useful, accessible summaries of the health of local populations, and help identify inequalities because they allow local authority populations to be compared with the average for England, and also allow comparisons between and within regions. The profiles assist in the planning and prioritisation of services. The indicators included in Health Profiles were chosen because they measure an important aspect of the health of the population and can be communicated easily to a wide audience.

Rutland - Health in summary

The health of people in Rutland is generally better than the England average. Rutland is one of the 20% least deprived counties/unitary authorities in England. However, about 7% (400) children live in low income families.

Health inequalities

Life expectancy for both men and women is higher than the England average.

Child health

In Year 6, 13.3% (41) children are classified as obese, better than the average for England. Levels of teenage pregnancy, GCSE attainment and breastfeeding initiation are better than the England average.

Adult health

The rate of alcohol-related harm hospital stays is 609 per 100,000 population, this represents 237 stays per year. The rate of self-harm hospital stays is 204.1 per 100,000 population. This represents 67 stays per year. 48 people died of smoking related deaths in Rutland in the last year. Estimated levels of adult smoking and physical activity are better than the England average.

Rates of hip fractures, sexually transmitted infections and TB are better than average. Likewise rates of violent crime, long term unemployment, early deaths from cardiovascular diseases and early deaths from cancer are better than average.

The rate of people killed and seriously injured on roads in worse than average.

The table below shows how people's health in Rutland compares to the rest of England.

Table 1 – Rutland Health Profile 2016

Domain	Indicator	Rutland UA
Our Communities	1 Deprivation score (IMD 2015)	No significance can be calculated or data not available
	2 Children in low income families (under 16s)	Significantly better
	3 Statutory homelessness	No significance can be calculated or data not available
	4 GCSEs achieved	Significantly better
	5 Violent crime (violent offences)	Significantly better
	6 Long term unemployment	Significantly better
Childrens and young peoples health	7 Smoking status at time of delivery	No significance can be calculated or data not available
	8 Breast feeding initiation	Significantly better
	9 Obese children (year 6)	Significantly better
	10 Alcohol-specific hospital stays (under 18)	No significance can be calculated or data not available
	11 Under 18 conceptions	Significantly better
Adults health and lifestyle	12 Smoking prevalence in adults	Significantly better
	13 Percentage of physically active adults	Significantly better
	14 Excess weight in adults	Not significantly different
Disease and poor health	15 Cancer diagnosed at early stage	No significance can be calculated or data not available
	16 Hospital stays for self harm	Not significantly different
	17 Hospital stays for alcohol related harm	Not significantly different ↓
	18 Recorded diabetes	Significantly worse
	19 Incidence of TB	Significantly better
	20 New sexually transmitted infections (STI)	Significantly better
	21 Hip fractures in people aged 65 and over	Significantly better ↑
Life expectancy and causes of death	22 Life expectancy at birth (male)	Significantly better
	23 Life expectancy at birth (female)	Significantly better
	24 Infant mortality	Not significantly different
	25 Killed and seriously injured on roads	Significantly worse ↓
	26 Suicide rate	No significance can be calculated or data not available
	27 Deaths from drug misuse	No significance can be calculated or data not available
	28 Smoking related deaths	Significantly better
	29 Under 75 mortality rate: cardiovascular	Significantly better ↑
	20 Under 75 mortality rate: cancer	Significantly better
	31 Excess winter deaths	Not significantly different

Key:

- Green: Significantly better than England average
- Amber: Not significantly different from England average
- Red: Significantly worse than England average
- Hatched: No significance can be calculated or data not available
- Light blue shading: No comparison available from 2015 (either new indicator, change in definition, or comparison not possible for technical reasons)
- ↓ Rag rating has moved from green to amber or amber to red ie performance is not as good as 2015
- ↑ Rag rating has moved from red to amber or amber to green ie performance has improved from 2015

Light blue shading (no 2015 comparison) applies to indicators 1, 3, 4, 12, 13, 14, 15, 24, 26 and 27.

It is clear that Rutland performs well in many indicators. Rutland has 17 of the 31 indicators in the Health profile that perform significantly better than the England average.

There is 1 indicator where Rutland has performance significantly worse than the national average: recorded diabetes. However, it may be that higher recorded rates are actually a sign that GPs are recording diabetes more comprehensively than elsewhere.

Other indicators where the Rutland figure is worse than average, but not significantly so, are:

- Hospital stays for alcohol related harm
- Hospital stays for self harm
- Excess weight in adults
- Infant Mortality

Compared with all other county and unitary local authorities, Rutland is ranked in the best 10 performing authorities for 7 of the 31 indicators: Hip fractures in the over 65's (2nd), excess winter deaths (2nd), children in poverty (4th), violent crime (5th), smoking related deaths (6th), female life expectancy (7th),and teenage pregnancy (10th).

For the last two years (2014 and 2015) Rutland has been in the bottom 10 for performance on incidence of malignant melanoma. In 2016, though, Rutland no longer features in the bottom 10.

In 2016, Rutland has improved its performance in two indicators to now perform significantly better than the England average. These indicators are hip fractures in those 65 and over and under 75 mortality rate from cardiovascular disease.

Issues of concern

In 2016, Rutland has remained significantly worse than the England average for recorded diabetes. Rutland has decreased its rating for killed and seriously injured

on roads from ‘not significantly different to the England average’ in 2015 to ‘significantly worse’ than the England average in 2016.

There has been a decrease in rating for hospital stays for alcohol related harm from significantly better than England in 2015 to no significant difference in 2016.

It is important to remember that health profiles provide a snapshot of health over a particular reporting time period. Given statistical variation it is likely that the pattern could change next year. Further analysis of trends over time is necessary to establish what is real and enduring and what is artefact.

However, it is clear that some lifestyle behaviours present an enduring challenge to public health. The percentage of adults with excess weight (overweight and obese) adults mirrors the national trend. With around two thirds of adults being either overweight or obese being ‘amber’ compared to the national average is not a situation that allows complacency.

Whilst further analysis and interrogation of the data is needed to form a fuller picture, we need to focus the efforts of all parts of health and local government, not just the public health department in making the most of the resources and powers available to improve performance in these areas.

Recommendations

Leader and partner: That Public Health focus their work with NHS and partners on a fuller understanding of, and action on the red and amber indicators highlighted above.

4. THE ROLE OF WORKPLACE HEALTH IN IMPROVING HEALTH

4.1 HEALTH AND WELLBEING OF WORKING AGE ADULTS

Introduction

Despite life expectancy and numbers in employment being high in the UK, around 131 million working days were lost to sickness in 2013. This is equivalent to over 4 days for each working person. Minor illnesses were the most common reason given for sickness absence (30%) but more days were lost to back, neck and muscle pain than any other cause at 30.6 million days lost (Figure 2). Mental health problems such as stress, depression and anxiety also contributed to a significant number of days of work lost in 2013 at 15.2 million days (5).

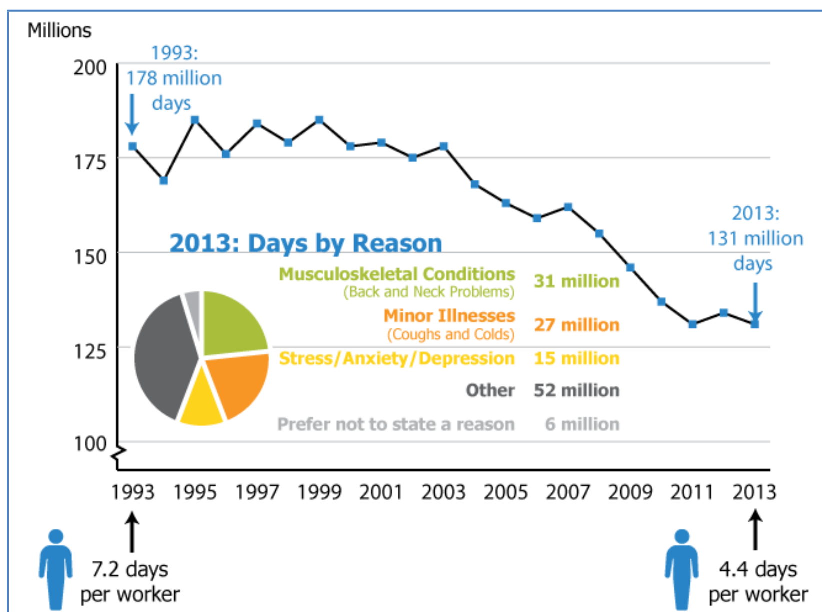

Figure 2 Number of working days lost due to sickness absence, 1993 to 2013, and the top reasons for sickness absences in 2013, UK (5).

Work and health

Employment levels provide a high-level indicator of the health of the working age population. Being in employment is a reflection of the health status of individuals, but also of the probability of being in work with a given health status (1). Between July 2015 – June 2016, in Rutland 16,700 (74.6%) people aged 16-64 were in employment; a rate that is higher than the regional (74.5%) and the national (73.8%)

average (6). A higher proportion of men (79.8%) than women (69.5%) were reported to have a job in 2015 (Figure 3).

	Rutland (Numbers)	Rutland (%)	East Midlands (%)	Great Britain (%)
All People				
Economically Active†	17,500	78.4	77.8	77.9
In Employment†	16,700	74.6	74.5	73.8
Employees†	13,100	60.1	64.5	63.1
Self Employed†	3,400	14.3	9.7	10.3
Unemployed (Model-Based)§	400	2.4	4.2	5.1
Males				
Economically Active†	9,400	84.2	83.1	83.1
In Employment†	9,000	79.8	79.5	78.7
Employees†	6,900	64.1	66.3	64.4
Self Employed†	2,000	15.7	13.0	13.9
Unemployed§	#	#	4.2	5.1
Females				
Economically Active†	8,100	72.5	72.6	72.7
In Employment†	7,700	69.5	69.5	69.0
Employees†	6,200	56.0	62.8	61.8
Self Employed†	1,400	12.9	6.4	6.8
Unemployed§	#	#	4.2	5.0

Source: ONS annual population survey
Sample size too small for reliable estimate (see definitions)
† - numbers are for those aged 16 and over, % are for those aged 16-64
§ - numbers and % are for those aged 16 and over. % is a proportion of economically active

Figure 3 Employment and unemployment (July 2015 – June 2016) – Rutland, East Midlands and Great Britain (6)

Although employment rates in Rutland are high, over 4,500 people aged 16-64 were economically inactive with nearly 3,800 (84.0%) stating that they do not want a job. Although the figures for people economically inactive account for students, individuals who are looking after family or home, or are retired, 800 people (17.4%) reported long-term sickness as the reason. This again is lower than regional and national average at 22.5% (6).

	Rutland (Level)	Rutland (%)	East Midlands (%)	Great Britain (%)
All People				
Total	4,500	21.6	22.2	22.1
Student	900	19.6	26.0	26.1
Looking After Family/Home	1,200	26.7	25.1	24.7
Temporary Sick	!	!	1.0	2.3
Long-Term Sick	800	17.4	22.0	22.5
Discouraged	!	!	#	0.4
Retired	1,100	25.1	14.2	13.6
Other	#	#	11.4	10.5
Wants A Job	#	#	24.0	24.5
Does Not Want A Job	3,800	84.0	76.0	75.5

Source: ONS annual population survey
\# Sample size too small for reliable estimate (see definitions)
! Estimate is not available since sample size is disclosive (see definitions)
Notes: numbers are for those aged 16-64.
% is a proportion of those economically inactive, except total, which is a proportion of those aged 16-64

Figure 4 Economic inactivity (July 2015 – June 2016) – Rutland, East Midland and Great Britain (6)

Supporting more people with a health condition into work will help to achieve the Government's aim of higher employment. Nationally the employment rate for disabled people has been gradually increasing (1).

However, there is still a stark difference between employment levels for those with a disability, and the population overall. In 2014/15, the gap in the employment rate between those with a learning disability and the overall employment rate in Rutland (69.2 percentage points) was higher than the gap for England (66.9).

Similar differences in employment levels are also seen for those in contact with secondary care mental health services (Figure 5). The gap for employment rate for those in contact with secondary mental health services and the overall employment rate in Rutland for the period 2014/15 at 74.6 percentage points, is higher than the gap recorded for England (66.1).

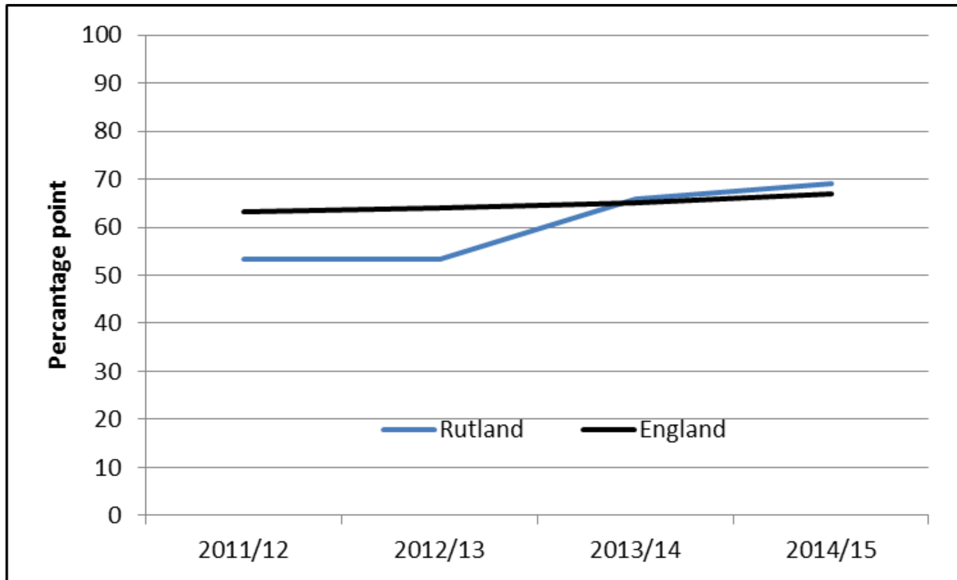

Figure 5 Gap in the employment rate between those with a learning disability and the overall employment rate

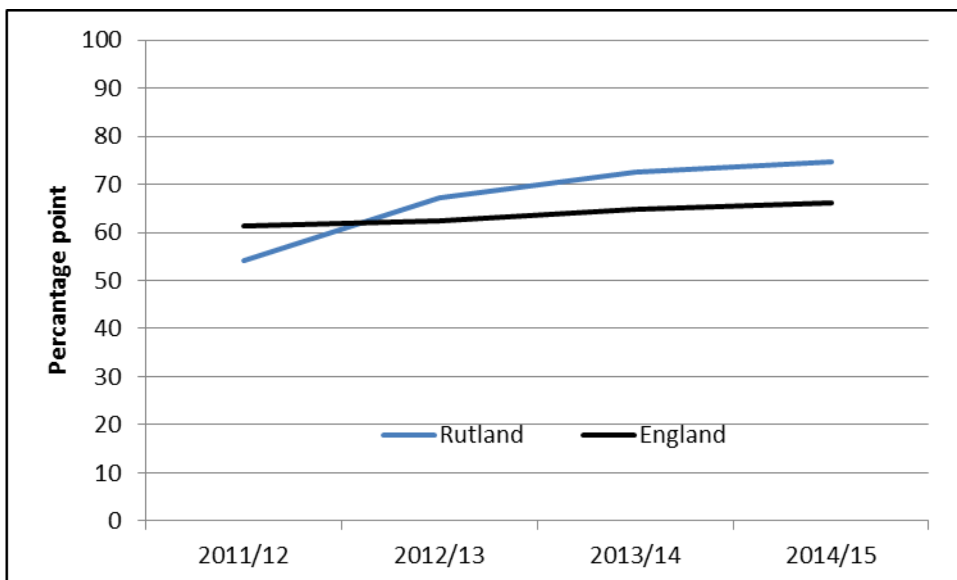

Figure 6 Gap in the employment rate for those in contact with secondary mental health services and the overall employment rate [7]

When employees develop a health condition, it does not always lead to absence from work, but can lead to reduced performance on the job. Lower productivity may

also be linked to lower job satisfaction and wellbeing, which in turn may be due to workplaces that sap morale and energy. There is growing evidence that links employee morale and satisfaction with health outcomes as well as business performance measures (1). The proportion of population affected by long-term health problems and disability increases with age, whereas the proportion of people that report their health as good or very good decreases. Although nationally the percentage of working hours lost to sickness peaks at ages 50-64, this group had the greatest fall in sickness absence rates between 1993 and 2013. Older workers, aged 65 and over, had the smallest fall at 0.5 percentage points but the rate is lower than that recorded for ages 50 to 64 (Figure 7) (6)

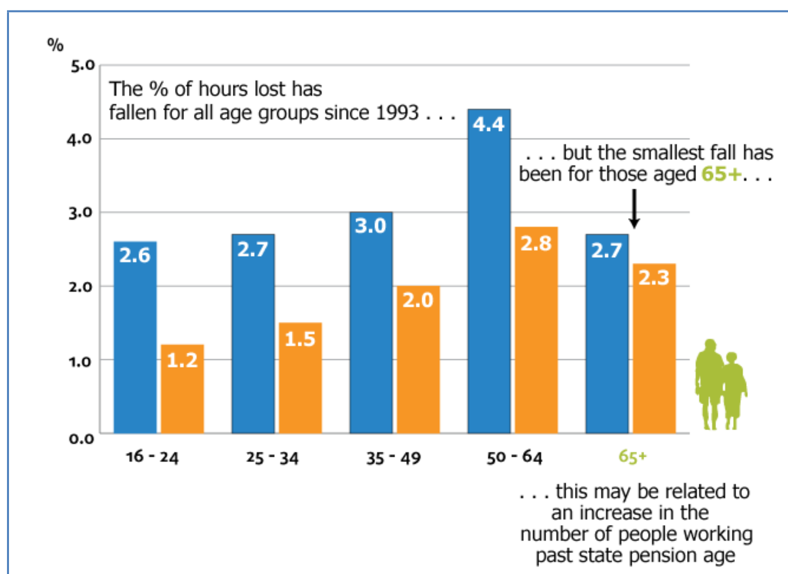

Figure 7 Percentage of working hours lost to sickness by age group – 1993 (blue) and 2013 (orange) (6)

Nationally sickness absence is generally lower than it was in the 1990s, however it is still substantial. The labour force survey provides self-reported information on the number of working days lost due to sickness absence during the previous week. According to the Labour Force survey in Rutland between 2011 and 2013, 2.0% of workers took a day off due to ill-health in the previous week. This is similar to the England average and it ranks 6 out of the 16 nearest neighbours (with 1 being the lowest value). For the same period, 1.1% of working days were lost due to ill-health. This is again similar to the England average of 1.5% and ranks 4 out of 16 nearest neighbours. Both percentages show a decreasing trend that is opposite to those

observed nationally with the former decreasing from 2.8% in 2009-11 and the latter from 1.5% (7).

Incapacity benefits are paid to those who are unable to work because of ill-health or disability. The proportion of the working age population on incapacity benefits – or the equivalent benefits that preceded it – has been increasing from 1970s to mid-1990s, with a small decline in recent years (1). In May 2016 in Rutland, 640 (2.8%) aged 16-64 were in the receipt of the Employment and Support Allowance (ESA) or Incapacity Benefits. This was lower than the regional (6.0%) and national (6.2%) average. 130 (0.6%) people were claiming benefits in Rutland because they were disabled which is again below regional and national average (0.8% and 0.9% respectively)

	Rutland (Numbers)	Rutland (%)	East Midlands (%)	Great Britain (%)
Total Claimants	1,220	5.5	11.1	11.5
By Statistical Group				
Job Seekers	90	0.4	1.2	1.3
ESA And Incapacity Benefits	640	2.8	6.0	6.2
Lone Parents	80	0.4	1.0	1.0
Carers	210	0.9	1.7	1.7
Others On Income Related Benefits	20	0.1	0.2	0.2
Disabled	130	0.6	0.8	0.9
Bereaved	50	0.2	0.2	0.2
Main Out-Of-Work Benefits†	830	3.7	8.4	8.7

Source: DWP benefit claimants - working age client group
† Main out-of-work benefits includes the groups: job seekers, ESA and incapacity benefits, lone parents and others on income related benefits. See the **Definitions and Explanations** below for details
Notes: % is a proportion of resident population of area aged 16-64
Figures in this table do not yet include claimants of Universal Credit

Figure 8) (6)

	Rutland (Numbers)	Rutland (%)	East Midlands (%)	Great Britain (%)
Total Claimants	1,220	5.5	11.1	11.5
By Statistical Group				
Job Seekers	90	0.4	1.2	1.3
ESA And Incapacity Benefits	640	2.8	6.0	6.2
Lone Parents	80	0.4	1.0	1.0
Carers	210	0.9	1.7	1.7
Others On Income Related Benefits	20	0.1	0.2	0.2
Disabled	130	0.6	0.8	0.9
Bereaved	50	0.2	0.2	0.2
Main Out-Of-Work Benefits†	830	3.7	8.4	8.7

Source: DWP benefit claimants - working age client group
† Main out-of-work benefits includes the groups: job seekers, ESA and incapacity benefits, lone parents and others on income related benefits. See the **Definitions and Explanations** below for details
Notes: % is a proportion of resident population of area aged 16-64
Figures in this table do not yet include claimants of Universal Credit

Figure 8 Working-age client group – main benefit claimants (May 2016) (6)

Employment rates in Rutland are high. Nevertheless over 4,500 people aged 16-64 were economically inactive with 3,800 (84.0%) stating that they do not want a job and 800 people (17.4%) reported long-term sickness as the reason. There is also a gap in the employment rate between people with a long-term health condition or some of the vulnerable population groups and the overall employment. For example, the gap for employment rate for those in contact with secondary mental health services and the overall employment rate in Rutland is higher than the gap recorded for England and it ranks 15 out of the 16 nearest neighbours (with 1 showing the smallest gap).

Long-term conditions can affect people's mental health and vice versa. They can also affect the ability to work, result in work absence and can reduce quality of life. In 2014/15 a higher proportion of people in Rutland than in England were registered with their GP as having diabetes, chronic kidney disease, cancer, atrial fibrillation, heart failure, coronary heart disease, obesity, palliative care and dementia.

4.2 WORKPLACE HEALTH

Whilst ‘good’ work is recognised to be good for health, staff health and wellbeing also plays an important role in the overall health and productivity of an organisation.

As described in the previous chapter, people who work are generally healthier than the non-working population (8) but it is known that certain factors in work, such as poor leadership, can lead to stress, burnout or depression (9). Additionally there is evidence to suggest that people who go to work when they are sick are more costly to the business than absenteeism (10). It is therefore important that the working environment is a good one that promotes positive, healthy values.

The national Workplace Wellbeing Charter (11) provides employers with a way to assess and then improve their commitment to the health and well-being of their staff.

What is the Workplace Wellbeing Charter?

The Workplace Wellbeing Charter is an opportunity for employers to demonstrate their commitment to the health and wellbeing of their workforce. It is a set of independent standards against which employers can audit and benchmark, allowing them to identify what they already have in place and to identify gaps in health, safety and wellbeing for their employees. This provides employers with an easy and clear guide on how to develop their health and wellbeing strategies and plans and how to make workplaces a supportive and productive environment. It involves 94 indicators grouped into different sections such as healthy eating or leadership. Employers complete the 94 questions and are able to identify areas that are good or need developing. The charter provides a framework for this development and organisations can be assessed against the national standard to achieve award status. Achievement of the Award enhances an organisations reputation as well as benefiting staff.

How does the standard work?

There are **3** key elements (**leadership, culture & communication**) and 8 standards in the charter:

• Leadership • Absence management • Health and safety • Mental health	• Smoking and tobacco • Physical activity • Healthy eating • Alcohol and substance misuse

The Standard has three levels:

1. **Commitment**
   The organisation has a set of health, safety and wellbeing policies in place and has addressed each area, providing employees with the tools to help themselves to improve their health and well-being.
2. **Achievement**
   Having put the building blocks in place, steps are being taken to actively encourage employees to improve their lifestyle and some basic interventions are in place to identify serious health issues.
3. **Excellence**
   Not only is information easily accessible and well publicised, but the leadership of the organisation is fully engaged in well-being and employees have a range of intervention programmes and support mechanisms to help them prevent ill-health, stay in work or return to work as soon as possible.

Employers can 'self-assess' themselves against the standards. To do this they need to register as a member on the Wellbeing Charter website: http://www.wellbeingcharter.org.uk/ This enables access to the self-assessment tool and a range of useful links and information.

Organisations can also be formally assessed against the Charter standards, giving further weight and recognition of their achievement. Once accredited, the organisation receives a certificate and the organisation is listed on the national register of award holders.

Conclusions

There is overwhelming evidence of financial and operational benefits to having a healthy workforce with lower than average sickness absence levels, greater retention and recruitment of the best candidates. Organisations that tackle workplace health can identify areas for improvement to reduce sickness absence and improve satisfaction of their employees. The national Workplace Wellbeing Charter provides one mechanism of analysing and addressing workplace health in a strategic and systematic way, underpinned by evidence. Finally there is an opportunity to embed workplace health into policy and strategy within organisations and at the regional level in order to reduce health inequalities, invest in all staff, attract the highest quality employees to posts and in doing so, improve the economic prosperity in Rutland.

Recommendations

A Leader -Public Health will advocate and lead the implementation of the workplace wellbeing strategy within Rutland County Council

A Partner - As a partner to the NHS, we will work with University of Hospitals of Leicester Trust and Leicestershire Partnership Trust on joint approaches to workforce health as part of the LLR response to the NHS 5 Year Forward View.

An Advocate - The Public Health Department will advocate the use of the Workplace Wellbeing Charter in private sector employers as part of our workplace health programme.

4.3 IMPROVING THE ECONOMY AND IMPROVING HEALTH BY TACKLING THE WIDER DETERMINANTS OF HEALTH

Background

We all know the old adage ‘health is wealth’. The vast majority of researchers, though, instead present the reverse argument, that wealth is health. Recent literature, however, reflects changes in the perception of health and longevity such that they are no longer viewed as a by-product of economic development but can drive economic development.

Better health does not have to wait for an improved economy. Measures to reduce the burden of disease, to give children healthy childhoods, to increase life expectancy, themselves contribute to creating richer economies

This chapter outlines how we intend to maintain our focus on wider determinants and take advantage of the opportunity public health has now that it is back 'home' within local authorities.

Creating Healthy Places

Creating healthy places is an essential component of our focus on prevention. Healthy places can enable people to make healthy choices; promote physical activity and active travel; provide access to green spaces, healthy food and warm homes. In addition creating employment and high quality training opportunities are inextricably linked to physical and mental health and wellbeing.

Social relationships, norms and networks – or the absence of these – have an impact on the development of, and recovery from, health problems such as heart disease. They also affect:

(a) our ability to maintain independence

(b) our resilience

(c) whether we take up and maintain unhealthy behaviours such as smoking.

Health in all Policies

To support the Health and Well Being Board in focusing on its impact on the wider determinants of health and wellbeing and measuring this impact, the Health and Wellbeing Board will make use of an existing tool and systematic approach called "health in all policies" (HIAP), which builds on the application of Health Impact Assessment (HIA). HIA is a systematic and objective way of assessing both the potential positive and negative impacts of a proposal on health and wellbeing and suggests ways in which opportunities for health gain can be maximised and risks to health and wellbeing assessed and minimised. HIA looks at health in its broadest sense, using the wider determinants of health as a framework. HIA highlights the uneven way in which health impacts may be distributed across a population and

seeks to address existing health inequalities and inequities as well as avoid the creation of new ones. HIA is a tool to implement a Health in all Polices (HIAP) approach.

HIAP describes a collaborative approach which emphasises the connections and interactions which work in both directions between health and policies from other sectors. Central to HIAP is the concept of addressing the social determinants of health.

During 2015/16 the Public Health Department piloted an approach to HIA/HIAP in Rutland focusing on healthy places.

Health in All Policies Case Study - Langham Neighbourhood Plan consultation response

The following comments from Rutland Public Health are in response to the Langham Neighbourhood Plan. Ideally a full health impact assessment would have been carried out in conjunction with the development of the plan but in the absence of this and in view of the quick turnaround required for comments, a brief scoping exercise has been carried out. This was a desk top exercise that reviewed the plan from a public health perspective. It has aimed to make comments that help to enhance the positive health aspects of the plan and mitigate any potential negative aspects that may be apparent.

Documents that have supported this process include:

- Improving the public's health: A resource for local authorities. By: David Buck and Sarah Gregory. The King's Fund.
- Mental well-being checklist. The National Mental Health Development Unit
- Health impact assessment: A practical guide. Wales HIA Support Unit

The plan only has a very small section under health which predominantly focuses on the need to have more access to a local GP and nurses – the remit of the CCG. However the themes and issues raised throughout the plan are important aspects of both physical and mental health and comments are included to highlight this.

1. Community asset: sense of community

It is apparent from the plan that Langham has a strong sense of community. There are a number of community initiatives, groups and information mechanisms that help to enhance this. A strong community can help to support community resilience, social capital and mental well-being: it therefore makes sense to use and support this asset wherever possible and appropriate. Conversely a strong sense of community can be potentially isolating requiring a need to identify those not involved. As an example there is recognition that there is little activity for teenagers within the village but no obvious consultation with teenagers on what they might like.

The plan highlights the risk of isolation in elderly housebound residents and a potential way to mitigate this could be by providing support to existing community groups and building on the assets that already exist. This could involve for example:

- Developing a befriending scheme for elderly residents
- Increasing support to ensure local information newsletters reach all houses

2. Community asset: environment

The plan is very clear on the need to recognise, maintain and enhance its natural and landscaped environment. Access to green space and natural environment is an important contributor to mental well-being and physical health. There are proposals to develop more appropriate footpaths and walking routes, particularly for those with reduced mobility and those who do not want to walk on bridleways. This would enhance the ability of all to access the surrounding countryside. Developing existing walking groups to include supported walking groups for those with limited mobility, for example, would support this process.

The organisation Living Streets (www.livingstreets.org.uk) work to enhance the safety and attractiveness of living spaces including streets. They have written a number of health, economic and social appraisals of better walking environments and may be able to provide support and advice on ways to enhance the walking environment of Langham.

The plan has proposed that the children's playground is developed. When doing this it may be useful to consider play activities for a wider range of children including teenagers, walking routes to and from the play area and seating areas.

The need to ensure green spaces including gardens into all new developments is a positive feature of the plan and helps to promote both mental and physical health. Gardens would need to be accessible and manageable by everyone including the elderly.

3. Community asset: community buildings

Langham has a number of 'community' buildings that help to support its sense of community. These include two pubs, a village hall, a school and churches. Community activities mainly take place in the village hall. The plan discusses the community wish to have a local shop but it is not clear that this would be financially viable. It may be more effective to either support the 'pop up' shop to increase its wares and hours or to develop the village hall to increase its capacity.

The village hall is an apparent focus of community activity and it may be worth exploring potential ways to enhance or develop this asset for the future.

There is recognition that the school has a number of assets such as its sports fields that could be better used by the community. Providing support to the school to carry out a cost effectiveness analysis of doing this may be a useful way forward particularly now that the school is an academy and so needs to be income generating.

4. Traffic and parking

Traffic and parking are common themes throughout the plan. Problems are increased by the main road running through the village, the lack of parking and the many houses that do not have off street parking spaces; parking is particularly problematic during school drop off and pick up times. The plan proposes that there is a 20mph zone introduced, HGVs over 7.5 tonnes are banned from the village, there are increased crossing places and that pavements are widened and improved.

The Department of Transport has produced a speed limit appraisal tool that helps councils assess the costs and benefits of introducing particular speed limits. This could potentially support the proposal to reduce speed limits; it may also be worth considering and assessing a further reduction in speed limits during school times.

As mentioned previously, Living Streets may be able to provide support and advice on enhancing the local walking environment including its safety.

The school is a focus for traffic and parking issues. There are not enough parking spaces for school and nursery staff and over half of the 218 pupils come from surrounding areas. There are a number of potential initiatives that could help to address this but all require a safe walking environment:

a. The development of school 'walking buses' where two volunteer adults walk children in 'high viz' jackets to and from school, picking them up and dropping them off at 'bus stops' along the way. A rota of volunteer parents would be required; a number of organisations provide donations of 'high viz' jackets including the Co-op.

b. The development of a staff and parent car share scheme

c. Negotiation with businesses, buildings or houses in the locality of the school that would allow on site staff parking during school hours that staff could then walk to school from.

d. Negotiation with business, buildings or houses in the locality of the school where parents driving in from surrounding areas could park temporarily to drop off or pick up their child.

Increasing walking has an added benefit of increasing physical activity levels and could usefully form part of a healthy school approach. Healthy schools adopt a 'whole school' approach to improving health that include healthy diets, physical activity, building self-esteem and supporting resilience. More information, if required, is available from Public Health.

5. Changing population

The number of elderly residents within the village is expected to increase. The main issue noted in the plan for this changing demographic is the lack of local GP services. This falls under the CCG remit. Other issues to consider include:

- Residents who may be asset rich but cash poor so have large houses but no ready cash for home improvements or keeping their homes warm. Older people living in cold houses are more likely to become ill in the winter and die.
- Increasing risk of isolation in older residents. People who are isolated are more at risk of physical and mental ill health.
- Reducing mobility. Older people with restricted mobility are at risk of falling and subsequent hospitalisation.

Ways to mitigate some of these risks include:

- Promotion of home improvement schemes such as warm home
- Developing village befrienders
- Developing community activity classes particularly for older residents
- Supporting older residents with garden maintenance

6. Other points of note

a. Housing development: future housing will be developed to strict criteria that will support health such as energy efficiency, green spaces etc. It is presumed that new houses will have space for off road parking and will be well connected with appropriate and adequate footpaths.

b. There are a growing number of home workers and developing a home worker network may help to decrease any isolation.

Health in All Policies Recommendations

A Leader – We build HIAP into work to maximise health benefits and mitigate health harms in all major RCC procurements.

5. FEEDBACK FROM RECOMMENDATIONS 2015

The co-creation of the new integrated wellbeing service has taken forward a number of recommendations made in the Annual Report last year in relation to involving community organisations in service design and commissioning and extending partnership working to more fully involve communities as the next step in engagement in planning.

Community engagement recommendations have been progressed in a number of ways including trialling approaches such as in-depth service user qualitative interviews to improve support people are offered in a particular service and ways of optimising self-care.

The approach taken in Langham has shown that HIA is a tool that can help highlight and promote the health improving opportunities of developments.

Progress has also been made on my recommendation on making it easier for people to find out what is available to support health and wellbeing locally with the re-development of the Rutland Information Service and the new integrated prevention and wellness service and pilot wellbeing advisor service.

REFERENCES

1. Black C. (2008) Working for a healthier tomorrow, London: TSO (The Stationery Office).
2. Waddell, G. and Burton A.K. (2006), Is work good for your health and well-being?, London: TSO (The Stationery Office).
3. Foot J. (2012), What makes us healthy? The asset approach in practice: evidence, action, evaluation.
4. Dahlgren G. & Whitehead M (1991), Policies and strategies to promote social equity in health, Stockholm: Institute for Futures Studies.
5. Office for National Statistics (2014), Sickness absence in the labour market: February 2014. Analysis describing sickness absence rates of employees in the labour market, Accessed online (06/07/2016): http://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/articles/sicknessabsenceinthelabourmarket/2014-02-25
6. Office for National Statistics (2016), Annual population survey.
7. Public Health England (2016), Public Health Outcomes Framework.
8. DWP (2012) https://www.gov.uk/government/collections/health-work-and-wellbeing-evidence-and-research
9. Government Office for Science (2008) https://www.gov.uk/government/publications/mental-capital-and-wellbeing-making-the-most-of-ourselves-in-the-21st-century
10. Centre for Mental Health (2011) http://www.centreformentalhealth.org.uk/managing-presenteeism
11. http://www.wellbeingcharter.org.uk/index.php