Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING SCRUTINY COMMISSION

Held: WEDNESDAY, 6 AUGUST 2014 at 5:30 pm

P R E S E N T :

Councillor Cooke (Chair)

Councillor Chaplin

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## 14. INTRODUCTION AND WELCOME

The Chair welcomed everyone to the meeting and stated that due to unforeseen circumstances the meeting would not have a quorum and any decisions made at the meeting would be confirmed when the minutes of the meeting were approved at the next meeting.

## 15. DECLARATIONS OF INTEREST

Members were asked to declare any interests they might have in the business on the agenda. No such declarations were made.

## 23. DIRECTOR OF PUBLIC HEALTH'S ANNUAL REPORT

The Director of Public Health's Annual Report 2013-14 was received. The Divisional Director, Public Health gave a presentation on the Annual Report, a copy of which is attached.

A copy of the Annual Report for 2013-14 can be found at the following link:-

http://www.cabinet.leicester.gov.uk/mgConvert2PDF.aspx?ID=64402

In presenting the report the following comments were made in addition to those listed in the presentation:-

- Although there was a statutory requirement to produce a report, there was no guidance on what should be included in the report. However it was customary to include an assessment of the health of population and to make recommendations about things that the health system in general could do improve the health of population.

- One of the report's purposes was also to inform the City Council, Health and Wellbeing Board, Clinical Commissioning Group, NHS England and Public Health England and other partners about the health of the resident population and to identify key areas where improvements could be made that would benefit the health of the population. The plan also provided information on health needs overall which informs on planning and commissioning processes.

- The report also sat alongside the Joint Needs Assessment which helps the Health and Wellbeing Board to produce and review its Health and Wellbeing Strategy 'Closing the Gap'.

- In addition, the report also helps to provide a record of the health of the population which allows a comparison to be made over a period of time and with other places, both locally and nationally.

- The striking differences for Leicester from these comparisons were:-

    - Leicester was ranked 25th most deprived area out of 326 local authorities in England, and deprivation was the greatest single impact upon the health of the population.

    - Deprivation also leads to lifestyle factors and material conditions that can affect the health of people, e.g people living in cold damp conditions have a greater risk of heart problems etc.

    - The population of Leicester has a very rich diversity. There are 18 different ethnic groups in the City with populations of 1,000 or more identified in the 2011 census. (37% Asian/Asian British, 6% Black/Black British, 46% White and 4% Other White groups from Poland and other EU succession countries.

    - Different ethnic backgrounds have different predispositions to health conditions. Lifestyle factors deeply embedded in the lives of people from different cultures can impact upon health either to increase the risk of, or be a protective factor against, particular health conditions.

    - Leicester's population is relatively young in nature. 34.5% of households have dependent children (29% nationally) and 20% of the population in Leicester are aged 20 – 29 years old compared to 14% nationally.

    - There are also significant socio-economic challenges in Leicester. 29% of adults have no educational qualification and 35% of 16-74 year olds were economically inactive compared to 30% nationally.

    - All these factors had a high impact upon health and health needs.

- The top three causes of deaths in the population under 74 years old were cancer, cardio-vascular disease and respiratory diseases. Although the highest cause of deaths in Leicester resulted from cancer, the rate of deaths was comparable to the national death rate in the population. The two biggest impacts upon health in Leicester which made the most difference to health overall and, subsequently, life expectancy were cardio-vascular disease and respiratory diseases.

- Life expectancy and mortality rates were used as an overall summary measure as they reflected all factors which have influenced a person's health during their lifetime.

- There were also differences in health conditions between different groups. There were high rates of diabetes and cardio vascular disease in the South Asian and Black populations compared to the white population and these resulted mainly from the different smoking rates in the groups.

The average life expectancy for people in Leicester, compared to the national averages, had been widening for a number of years leading up to 2010. However there were some encouraging indications that the gap had been reducing over the last four years, and, whilst it was too early to identify the reasons for this or to identify it as a trend, there had been numerous partnership efforts in the last four years to improve the health of the population and these were thought to be having a cumulative positive effect upon the general health of the population.

The main lifestyle issues affecting the local population were:-

a) Whilst the majority of adults were non-or low risk drinkers, there were higher rates of alcohol related conditions and harm and higher rates of hospital admissions in Leicester compared to the East Midlands. However Young people were less likely to report having a drink - 20% of 11-15 year olds in Leicester compared to the national rate of 42%.

b) Smoking was the greatest single cause of preventable premature deaths and 20% of adults in Leicester smoked. On average ½% of 11 year olds smoked which rose to 11% for 15 years olds. Public Health staff were working closely with schools to avoid young people becoming replacement smokers in future years.

c) The levels of overweight and obesity were increasing. Whilst the rates for adults were similar to national rates, there were significantly higher rates of obesity for children aged 4-5 and 10-11 years old. Efforts needed to be concentrated around these groups.

d) Diagnosis for acute STIs were above the regional and national averages and Leicester was the 6$^{th}$ highest prevalence area for HIV outside of London. This was an area for concern and needed work in the future to reduce these rates.

e) Rates of teenage pregnancy had dropped since 1998 and the rate in 2011 was 30.7% per 1,000 compared to 33% nationally

f) Oral health for children under 5 years old having decayed, missing and filled teeth was the worst in England and a strategy had been put in place to promote oral health in pre-school children. The Commission had considered this at a previous meeting.

It was also noted that 23% of the total burden of health in UK was attributable to mental health diseases and illness. In Leicester this equated to 10-15% of young people having a recognised mental health problem and 36,000 people of working age having a mental health condition. Approximately 8,000 of people over 65 years old suffered from depression and 3,000 had dementia. There were a number of recommendations in the strategy in relation to mental health.

The report also showed that the long term conditions affecting the population aged 65 years and above were predominately diabetes, depression, dementia, CHD, strokes, bronchitis & emphysema and all these conditions were expected to continue to rise over time.

Other health factors mentioned in the report were:-

a) The rates of tuberculosis in Leicester were the highest in the East Midlands and higher than England but the rates was consistently falling.

b) There had been an uptake of childhood vaccinations in recent years and this was important to maintain.

c) Cervical screening rates have been declining and remained significantly lower than the national average.

d) Bowel cancer screening rates were lower in Leicester than elsewhere and twice as many tests in Leicester had a positive result.

Leicester had one of the highest uptakes of NHS Health Checks with approximately 72% of those eligible between the ages of 40 and 74 years old having received one by the end of 2013/14. 20% of those receiving the checks needed further treatment for previously undiagnosed conditions. 4,900 people were now being treated to prevent more serious conditions or existing conditions from deteriorating. Work on prevention of illness and stopping conditions deteriorating was an essential element of the Better Care Together strategy.

The Health and Wellbeing Board had received the report at its meeting on 3 July 2014 and had asked all partner organisations to give a formal response to the recommendations.

The Divisional Director, also stated that ward profiles were being produced for October, but there was some risk of misinterpreting data when it was used for analysis at low statistical levels. He would look if any further reliable data was

available and if it was possible to identify meaningful trends at ward level.

Members made the following comments during and after the presentation:-

- The Chair saw the Commission's role as scrutinising how the Health and Wellbeing Board used the information in the report to implement measures to address the health and wellbeing of residents and to give appropriate priorities to the issues and recommendations mentioned in the report.

- The use of life expectancy/death rates may be too crude an indicator compared to morbidity rates which were more of an indicator of lifestyle and quality of life and these and the wider determinant of health should be included as well in future reports.

- It would be helpful to have more information on the age profiles of those taking up various health screening measures.

- It was understood that cervical screening test could be undertaken by both GPs and Family Planning Clinics and the communication between the two systems seemed unclear.

- The '5 ways to wellbeing' contained in the report was welcomed and this should be included in the discussions on mental health at the next meeting. It would also be useful for this to be used by the City Council to consider how these principles could impact upon decisions being made in relation to recreational and other facilities which have health benefits.

- Members welcomed the distribution of the Annual Report to the voluntary and community sector and that any feedback was taken into account for future plans and priorities.