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.

16. MEMBERSHIP OF THE COMMISSION

The Monitoring Officer's report that Councillor Bajaj has been appointed to the Commission to fill the vacancy for the Labour Group vacancy was noted. The Chair stated that he would meet with Councillor Bajaj to brief him on the work of the Commission.

17. MINUTES OF PREVIOUS MEETING

RESOLVED:

that the minutes of the meeting held on 1 July 2014 be approved as a correct record.

18. PETITIONS

The Monitoring Officer reported that no petitions had been submitted in accordance with the Council's procedures.

19. QUESTIONS, REPRESENTATIONS, STATEMENTS OF CASE

The Monitoring Officer reported that no questions, representations and statements of case had been submitted in accordance with the Council's procedures.

20. WORK PROGRAMME

The Scrutiny Support Officer submitted a document that outlined the Health and Wellbeing Scrutiny Commission's Work Programme for 2013/14.

It was noted that further consultation has started on CAHMS (Children and Adolescent Mental Health Services). The Chair indicated that he would discuss this further with the Chair of Children Young People and Schools Scrutiny Commission.

The Chair referred to the Department of Health's 'Local Authority Health Scrutiny Guidance to support Local Authorities and their partners to deliver effective health scrutiny' published in June 2014. He and Councillor Chaplin agreed to form a sub-group to look at the guidance and see if there were any implications for the Commission. They would report back to the October meeting of the Commission.

21. CORPORATE PLAN OF KEY DECISIONS

The Commission noted the items that were relevant to its work in the Corporate Plan of Key Decisions that would be taken after 1 August 2014.

22. EMAS - PROGRESS FOLLOWING RISK SUMMITS AND OUTCOME OF CARE QUALITY COMMISSION INSPECTION

East Midland's Ambulance Service NHS Trust submitted a report that outlined their achievements in relation to key national performance standards. The report also set out the challenges faced in 2013/14 and the actions taken. It also contained details of the two risk summits in 2013/14 and the progress made with the EMAS Better Care Patient Care Quality Improvement Programme. It also outlined the findings of the Care Quality Commission inspection and the actions taken to address the areas of shortfall/non-compliance. The report also identified the Trust's performance both within the context of the City and specifically compared to the East Midlands as a whole.

Sue Noyes, Chief Executive and Paul St Clair, Assistant Director Operations, East Midlands Ambulance Service NHS Trust attended the meeting to present the report and made the following comments:-

- The service had now stabilised and had moved from Phase 1 – Stabilising to Phase 2 - Transition in the Better Patient Care Programme. Phase 2 of the Programme started in April 2014.

- Performance in the last quarter had been good, although July had been

challenging with the increased levels of patients with respiratory conditions.

- A diagram showing the processes for responding to 999 calls is attached as appendix to these minutes.

- The response performance to Red 1 (immediately life threating) and Red 2 (life threatening but less time critical) and Red 19 (a patient carrying response on the scene within 19 minutes) had exceeded the performance standards for the first quarter and also July. Red 1 and Red 2 each had a performance standard of 75% and the actual performance in Leicester was 88.66% and 84.90% respectively. The target for Red 19 was 95% and the performance in Leicester was 97.09%.

- The performance for less urgent responses (Green 1 and Green 2 – 20 minutes) was slightly below the target of 85% (81.23% and 84.16% respectively). However, the Green 3 (telephone assessment within 60 minutes) and Green 4 targets (telephone assessment within 60 minutes or a vehicle response within 4 hours) exceeded the standard of 85% with local responses of 92.17% for Green 3 and 100% for Green 4.

- Further work was being carried out with the CCGs and GPs in relation to 'urgent calls' where GPs and other health professionals request ambulance transfers for their patients. Although these are classed as 'urgent requests' a GP could request a timed response of two hours or more to carry out the journey. The peak time for demand for this service was usually from 11.00am to 4.00pm, which put pressure on Ambulance attendance at University Hospitals of Leicester's (UHL) A&E Department between 12.00 noon and 2.00pm.

- The service aimed to have 10 ambulances and hour at the UHL and this target was only usually exceeded by a small percentage point.

- A number of responses involve the treatment of patients at the scene and did not require the patient to be transferred to a facility for further treatment. The target of 40% of 'non-conveyance of patients' was exceeded in Leicester. Where appropriate some patients were transferred to the Emergency Care Centre at Loughborough to receive the appropriate level of care, which also reduced the pressure on the A&E Department at UHL.

- 7% of the calls to the 999 service don't require the need to despatch a response attendance, as the patient could be given tele-health advice from the qualified health professionals in the call-centre. Some patients could be treated at the scene and other patients sometimes refused to be taken to hospital. There were also 3 GPs based in response cars in the City who could also attend the patient to provide assistance. In some instances, a patient could be also referred to their own GP for treatment. However, although all these responses contributed to reducing the need

to convey patients to hospital, the overriding consideration still remained providing the right level of treatment for the patient's needs.

- In some instances, patients with heart conditions could be transferred direct to Glenfield Hospital and trauma patients would normally be conveyed to the University Hospital of Coventry or the Queens Medical Centre, Nottingham. Also, some patients could be conveyed to A&E department at Kettering General Hospital or to the Emergency Care Centre at Loughborough. All these patients would not be included in the analysis of patients treated at the UHL A&E Department.

- UHL were also looking to admit some patients direct to hospital wards rather than be admitted to the A&E Department to further reduce the pressure on A&E.

- The Assistant Director Operations had been in post since January 2014 and had responsibility for the service in Leicester and Leicestershire. Improvements had been achieved through the staff engagement process of 'Listening into Action', which took concerns and ideas from front line staff and fed them into the system.

- There had been 41 staff vacancies in January and the service should be fully staffed by October. Although the skills mix was still not ideal this would be addressed through future recruitment processes.

- There had been a recent commitment to provide 46 new front line vehicles.

- The service was working closely with all the relevant CCGs, Healthwatch and Scrutiny Committees to develop a more co-ordinated approach to joint working.

- Although questions had been raised in the risk summit about the equality of data, the data had since been audited by KPMG who were satisfied that the data collection was robust and met required standards.

- Complaints from patients had reduced by 26% compared to the previous year.

- The Trust ended the financial year 2013/14 on a break-even point and at the end of the 1st quarter in 2014/15 the Trust was showing a small surplus. This showed the Trust now had stronger management and financial management controls.

- The CQC had not yet undertaken their follow up visit, but the Trust Development Agency had taken the Trust out of the escalated measures and had reverted to the normal monitoring processes.

- The Trust was working effectively to become a more open and proactive

organisation.

In response to Members questions the following statements and observations were made:-

- The service analysed complaints and correlated these with performance analysis.

- The commissioning of non-emergency ambulance services was the responsibility of East Leicestershire Clinical Commissioning Group.

- Staff turnover was approximately 3 staff leaving per month which prompted the initiatives to look at staff issues and morale. There was now a robust and forward looking staff recruitment plan to keep the staffing levels maintained and to get the right skill mix profile for staff.

- There was a national shortage of approximately 2,000 paramedics and 5 paramedics had recently left the service for promotion to join UHL. Paramedics were required to undertake a 2 year foundation degree course and successfully undertake a 'blue light driving' skills course before being able to practice.

- The service had an entry scheme to take Emergency Care Assistants (ECA) on a short term appointment during which they undertook their 'blue light driving' skills course. Once the course was completed the ECAs could progress to be paramedics. The cost of the course was then deducted from the paramedics salary over a period of time.

- The 5 Year Integrated Business Plan was currently in draft form and it was expected to be completed in September. Although there was no requirement for a formal consultation process, the Trust would welcome views and feedback on the Plan at that stage.

Members made the following comments and observations;-

- It would be useful if future reports could contain the following information:-

    - The various response categories of Red 1, Red 2, Red 19 etc should be explained in full to say what they are and which are the principle indicators.

    - The key indicators that the service is required to meet.

    - In relation to patient's complaints, details of the numbers of complaints, the types of complaints, and an indication of where service users felt there were shortcomings in the service and a trend analysis over time.

- The Commission would welcome being consulted upon the 5 Year Integrated Business Plan as they may be able to suggest other organisers and users group who would be able to make a contribution.

- That whilst the Commission focus was primarily on the performance of the Trust in relation to the City, they were mindful that good performance in the City should not be at the cost of poor performance elsewhere in the region.

Action **The Chair stated that he would ask for further information in relation to paramedics having to pay their own 'blue light driving' course fees to determine if this issue need to be pursued.**

The Chair thanked the Chief Executive and the Assistant Director Operations for their full report and their openness in working to achieve a mutually beneficial outcome.

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 6th 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.

24. CCG JOINT COMMISSIONING WITH NHS ENGLAND

RESOLVED:
That the item be deferred until the next meeting of the Commission.

25. REVIEW OF CONGENITAL HEART SURGERY REVIEW

The Chair led a discussion on the current progress of the Congenital Heart Services Review being undertaken by NHS England.

The last update report from NHS England had been circulated to members of the Commission prior to the meeting. The link below will allow access to this and previous update reports.

http://www.england.nhs.uk/category/publications/blogs/john-holden/

Details of the current expected timetable for the review, together with a briefing paper issued by NHS England (1 August 2014), a report to the University Hospitals of Leicester NHS Trust Board (UHL) (31 July 2014) on the future provision of Paediatric Surgery at UHL and various comments received from interested parties on the review, together with a press article dated 5 August 2014 was circulated to everyone at the meeting.

The Chair stated that he wished to review the current progress as he was

uncomfortable with the recent comments and concerns expressed by some of those involved in the review. The Chief Executive of UHL had recently made an announcement that the Trust were considering a proposal to move some children's services from the Glenfield Hospital site to the Royal Infirmary site so that all paediatric services were co-located on one site. The Chair commented that this announcement had been unexpected.

The Chair also commented that some comments had been made to suggest that the principles of the Safe and Sustainable review were being re-introduced gradually as a view was emerging that there should be fewer and larger centres and the virtues of centralising services had been made in number of statements relating to trauma centre and specialist stroke care units. It was also noted that the UHL Board had approved the recommendations in the report at its meeting on 31 July 2014.

Kate Shields, Director of Strategy, University Hospitals of Leicester NHS Trust made the following comments:-

- The current expected timetable for the review had only been presented to everyone recently.

- There had been a statement in the minutes of a recent meeting of the review's Clinical Advisory Panel (CAP) that the co-location of children's services was more important than the number of operations carried out by centres. This statement had not been expected.

- Following recent discussions with the review team, there appeared to be more latitude in relation to compiling the number of operations performed by each centre.

- There had been useful discussions with Birmingham's Queen Elizabeth Hospital in relation to the review.

- There appeared to be more co-operation and trust between Clinicians reflecting the open and transparent manner in which the review was being conducted.

- Clinicians at UHL had been considering the co-location of paediatric services on one site for some time, but the statement in the CAP minutes had made the Trust look at the issue more quickly. It was proposed to take a further report on the feasibility of the proposal to the September Trust Board meeting.

- Centres such as Blackpool, Papworth and Brighton seemed to fit well with the proposed standards on their own but not in relation to transition services. Glenfield, however, could be a lead on transition care interventions from paediatric to adult services.

- It could be feasible to have children's and adults congenital services on one site.

- It was currently hard for Glenfield to get to the level of 500 operations per year within the next 12 years based upon the current criteria. It could get to 345 operations a year in the next 3 years.

- NHS England were being asked to consider commissioning at local population level. If this was the case then Glenfield could get to 500 operations per year quite quickly.

- Great Ormond Street Hospital held consulting clinics all over the country and patients from these clinics counted towards their operating figures. Patients in Northamptonshire were now travelling to London for specialist services instead of Southampton as previously. It would be helpful if NHS England allowed more leeway for these patients to be able to be counted into Glenfield's figures.

- UHL were working closely with Leicester University, DeMontfort University and Loughborough University on research projects related to sport and exercise to maintain health and there was Big Lottery Bid for a project to have better life chances.

- There were some opportunities arising from the review for Glenfield to also look at the possibility of establishing vascular-cardiac or cardiac-thoracic specialist units.

In response to a question on the co-location of children's services on one site, the Director of Strategy commented that this only related to acute services and not community services such as CAMHS which were provided by the Leicestershire Partnership NHS Trust. The Better Care Together programme, could however, be a suitable vehicle for working with Leicestershire Partnership NHS Trust to develop a model of care for young people that were not hospital based services.

RESOLVED:

1) That the current progress on the review be noted and the Director of Strategy's offer to brief the Deputy City Mayor on the review be accepted.

2) That the Council should assist the Trust wherever possible to engage with the community and community groups on any proposal put forward by the Trust.

26. NHS QUALITY ACCOUNTS

The Chair provided feedback on discussions with the Healthwatch representative on how the Commission should consider the Quality Accounts in the future, as agreed at the last meeting of the Commission. A draft paper outlining the process was circulated to everyone present at the meeting.

RESOLVED:

1) That the process outlined in paragraphs 4.1 to 4.9 be adopted for the future consideration of Quality Accounts and that the relevant providers of healthcare services in the City, who are required to submit Quality Accounts, be advised of the Commission's process.

2) That a meeting of the Commission be arranged in early June in future years to enable the Commission to consider Quality Accounts and submit comments to the providers in order to allow them to submit the final Quality Accounts to the NHS Choices' website by 30 June each year.

27. ITEMS FOR INFORMATION/NOTING ONLY

The following items and information were noted by the Commission:-

a) Public Health England - Leicester Health Profile 2014

Public Health England published the Health Profile 2014 for Leicester on 8 July 2014.

b) Review of Mental Health Services for Young Black Men

Two further meetings had been arranged for the review as it was evident, after the first two meetings to gather evidence, that evidence from further interested parties was required. The meetings had been arranged for 10 and 30 September 2014 at 5.30pm.

The Chair agreed to note the following item which had been made public since the agenda had been published.

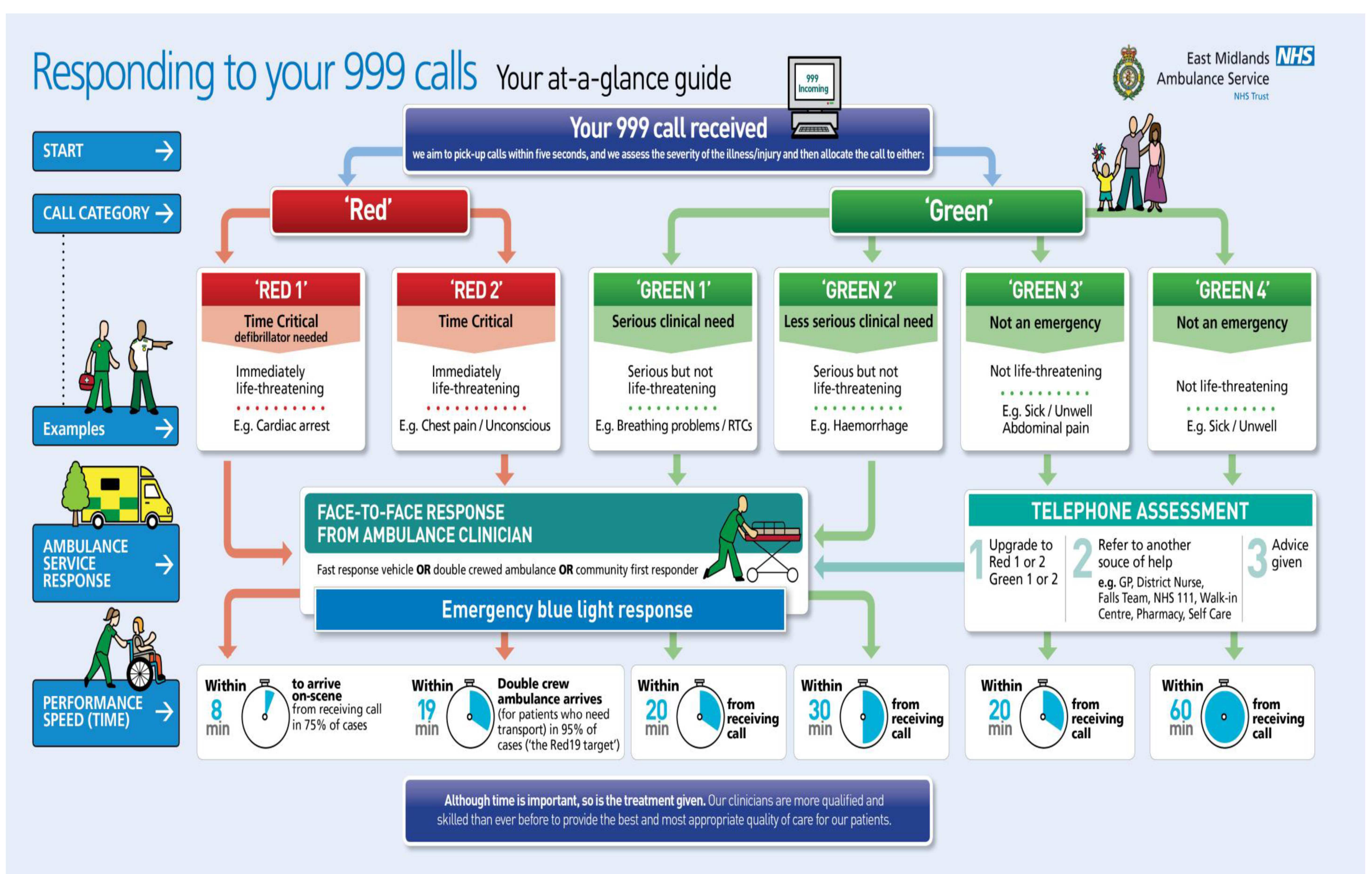
c) Summary Hospital Level Mortality Indicator – (SHIM) UHL NHS Trust

Summary Paper on Learning Lessons to Improve Care – a joint review of quality of care delivered to patients who died in Leicester, Leicestershire and Rutland 2012-13.

The Chair indicated that this may be considered at a future meeting of the Commission.

28. CLOSE OF MEETING

The meeting closed at 7.50 pm.



Minute Item 22

Director of Public Health Annual Report 2013/14

Deb Watson, Strategic Director, Adult Social Care and Health

Minute Item 23

Background

- All Directors of Public Health are required to produce an independent annual report on health of population.
- Inform the City Council, the Health and Wellbeing Board, the Clinical Commissioning Group, NHS England, Public Health England, other partners and the public about the health of the resident population, identifying areas for improvement.
- Provide information on health needs to inform the planning and commissioning of health improvement services, health protection and health and care services.
- Provide a record of the health of the population for comparison over time and with other places.

People in Leicester

Deprived – 25th worse out of 326 local authority areas.

Diverse – BME and White ethnic groups each make up 50% of the population.

Young – fewer older people and more under 35 year-olds than in England. Projections indicate further increases in under 5 year olds.

Socio-economic challenges – some 29% of adults are without educational qualifications.

Health Inequalities

- Top three causes of all deaths and early deaths are cancer, cardiovascular disease (heart disease and strokes) and respiratory disease.
- The principal contributors to the life expectancy gap with England are cardiovascular and respiratory disease. Infant mortality significantly higher than England.
- Lower life expectancy in areas of higher deprivation.
- Increased risk of diabetes and heart disease emergency admissions for South Asian and Black residents, but lower for lung cancer and respiratory disease.
- The life expectancy gap between Leicester and England appears to be narrowing.

Health Inequalities (cont.)

Figure 8: Average life expectancy at birth for men in England and Leicester, 1998-2012

Life expectancy in years: 72–80

1998-2000, 1999-2001, 2000-2002, 2001-2003, 2002-2004, 2003-2005, 2004-2006, 2005-2007, 2006-2008, 2007-2009, 2008-2010, 2009-2011, 2010-2012

England Males
Leicester Males

Figure 9: Average life expectancy at birth for women in England and Leicester, 1998-2012

Life expectancy in years: 76–84

1998-2000, 1999-2001, 2000-2002, 2001-2003, 2002-2004, 2003-2005, 2004-2006, 2005-2007, 2006-2008, 2007-2009, 2008-2010, 2009-2011, 2010-2012

England Females
Leicester Females

Source: Health and Social Care Information Centre; Information portal http://indicators.ic.nhs.uk

Main Lifestyle Issues

- Alcohol – majority of adults are non or low risk drinkers, but Leicester has significantly higher hospital admission rate for alcohol-related conditions than East Midlands or England. Young people less likely to report “ever having an alcoholic drink”.
- Smoking - Smoking is the greatest single cause of preventable premature death and over 20% of adults in Leicester smoke. Two thirds of smokers begin smoking before the age of 18 years.
- Obesity - Population levels of overweight and obesity increasing. Adult overweight and obesity similar to England but a significantly higher prevalence of obese children at ages 4-5 and 10-11.

Main Lifestyle Issues (cont.)

- Sexual Health and HIV –diagnosis rates for acute STIs is above regional /national averages and Leicester is 6th highest prevalence area for HIV outside of London.
- Leicester rate of teenage pregnancy dropped +/-50% from the 1998, with a low of 30.7% per 1,000 in 2011.
- Oral Health – Leicester children at age 5, have the worse level of decayed, missing and filled (dmft) teeth in England. Over half of Leicester 5 year olds have experience of decay.

Mental Health

- Leicester has high risk factors for mental health but relatively low recorded rates for anxiety and depression (18% expected,10% identified).
- Higher hospital admission rates for mental health (454 per 100,000 population vs 243 England).
- Need to recognise earlier, improve access, including through the voluntary and community sector.
- Need to build up emotional resilience, particularly in children and young people (50% of lifetime mental illness arises by the age of 14).
- Promote the Five Ways to Wellbeing.

Mental Health (cont.)

Long Term Conditions

Figure 31: Estimated burden of long-term conditions in Leicester between 2012 and 2020 (ages 65 and above)

Number (1,000)

Year	Other	Bronchitis & emphysema	Stroke	CHD	Dementia	Depression	Diabetes
2012	5.1	0.6	0.9	1.9	2.8	3.3	4.7
2014	5.3	0.7	0.9	1.9	2.9	3.4	4.9
2016	5.3	0.7	0.9	2.0	2.9	3.5	5.0
2018	5.5	0.7	1.0	2.1	3.0	3.6	5.2
2020	5.7	0.7	1.0	2.1	3.1	3.7	5.2

Source: Institute of Public Care (IPC): Projecting Older People Population Information 2013

Protecting Health in Leicester

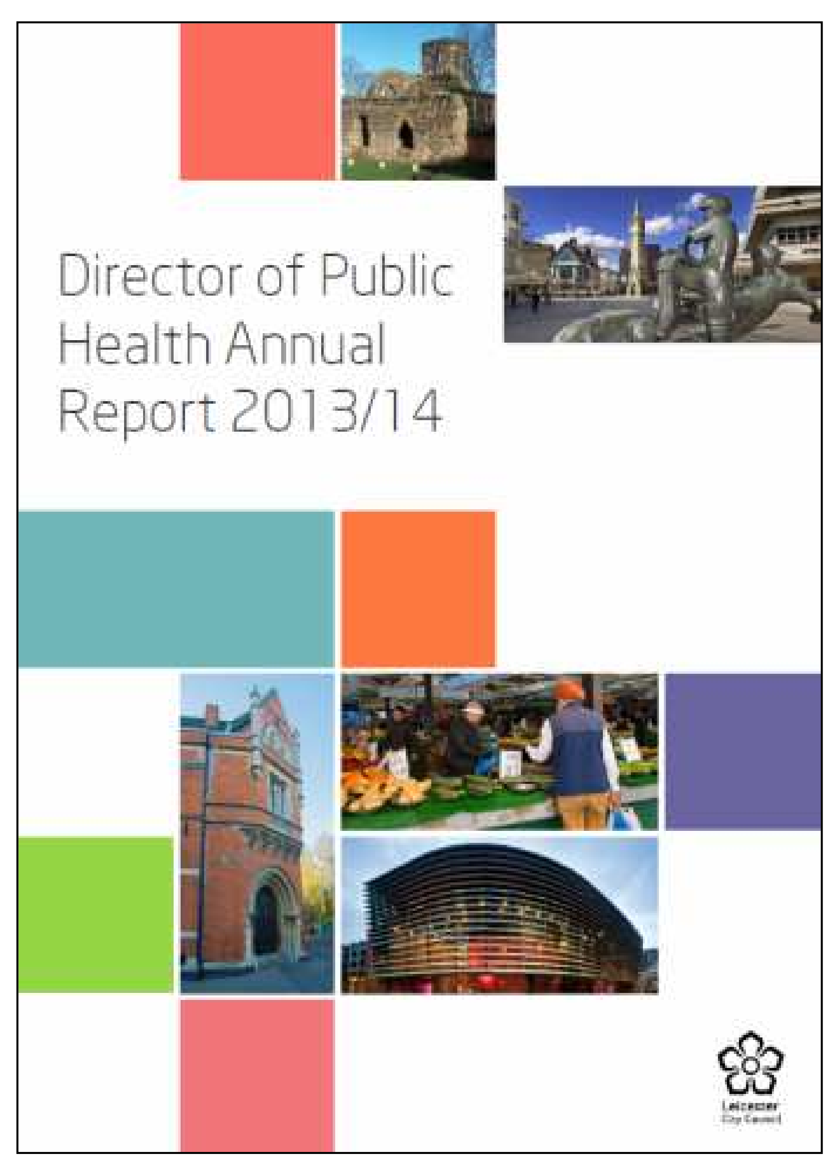
- Tuberculosis - Leicester has the highest rate of TB in the East Midlands and is higher than England, but the Leicester rate is consistently falling.
- Childhood Immunisation - Improved uptake of childhood vaccination in recent years and important to maintain.
- Screening - Uptake rate of cervical screening has been decreasing and remains significantly below the national average. Bowel cancer screening acceptance rate lower in Leicester than elsewhere and twice as many tests in Leicester have a positive results than expected.

Recommendations

- In each section of this report recommendations have been made. These:
  - are aimed at the policy and strategy level in the main;
  - are focussed on what the city council, the NHS and other partners can do to improve population health and public health systems, rather than commenting on specific care services;
  - resonate with Closing the Gap and the CCG’s strategic priorities;
  - are for consideration by both individual organisations and partnerships.

Summary and Conclusions

- This report provides an overview of health in Leicester and makes recommendations aimed at improvement.
- Population health in Leicester is relatively poor compared with the England average.
- Good progress has been made in may areas and there are some encouraging signs of measurable improvement.
- Complex challenges remain and require sustained partnership effort.



Report available from
http://www.leicester.gov.uk/your-council-services/health-and-wellbeing/reports/

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