LEICESTER JOINT STRATEGIC NEEDS ASSESSMENT
March 2012

OVERVIEW AND SUMMARY REPORT

V. 6 July 2012

1. CONTENTS

2. INTRODUCTION

Background

The production of a jointly produced needs assessment developed by the main commissioners of health and social care services to inform and support agreement of key strategic priorities has been government policy since 2007. The rationale for the Joint Strategic Needs Assessment (JSNA) has been restated in the Health and Social Care Act (2012). This re-emphasises the importance of the JSNA as the starting point for strategy development and commissioning decisions, but makes a clearer distinction than previously between a needs assessment and the jointly agreed strategy and priorities that should follow from it.

The Health and Social Care Act (2012) therefore requires that a strategic approach to local health and wellbeing be shaped and directed through the new Health and Wellbeing Boards, the key functions of which include:

- the oversight of the production of the Joint Strategic Needs Assessment, and
- the development and agreement of the Joint Health and Well Being Strategy (JHWS).

The Joint Health and Wellbeing Strategy for 2013/14, which will be produced later in 2012, will be informed by this JSNA report, and by its background material and the more detailed *specific* need assessments described in Appendix A. The Joint Health and Wellbeing Strategy, in turn, is intended to inform the commissioning intentions of both the NHS and local authority in Leicester.

This report

This JSNA report aims to provide an overview of the key health and wellbeing issues in Leicester. It is

- an overarching, high level needs assessment for Leicester. It has brought together a range of data and information to identify needs of broad strategic importance to the health and wellbeing of the city. This includes the recommended JSNA "core data set" and information about local health, social and other needs which have being carried out over the past few years.

- focussed primarily on adults 18 years and above. A full needs assessment relating to Children and Young People was published in June 2011. This is available on the Leicester JSNA website. However, the needs of children and young people are considered to an extent in this report, and a short summary of the Children and Young People's Needs Assessment is included, along with an assessment of its current validity.

- aiming to be brief and accessible. The report is not overladen with data tables and maps as people have said to us that sometimes it is difficult to see the wood for the trees when it is. Instead we have tried to produce succinct pen pictures of areas of need or issues. Data tables and further information is placed on the JSNA website. In this we have sought to reflect the DH draft guidance on JSNAs which says: "Data, information and intelligence underpin JSNAs, but JSNAs themselves are more than just a collection of evidence; they are an analysis and narrative on this evidence, describing what it says about the local community and its health and social care needs. The JSNA process extracts and makes sense of

evidence, and then the health and wellbeing board members plan on basis of it, using that evidence to drive strategy and commissioning."[1]

Equally, this report has its limitations and it is not:

- the *Joint Health and Wellbeing Strategy*, rather it seeks to draw the attention of policy makers and others in the city, and particularly the Shadow Health and Wellbeing Board, to some of the key issues of the city. It does aim to give a basis for partners and organisations to decide what problems need to be better solved, and sooner, together.

- in itself the basis for detailed commissioning of services in the city, though in some cases it, and the information on the website, may help. Generally this is best served through more detailed and focused needs assessment on a specific topic, service, community or condition which commissioners should consider undertaking before making major commissioning decisions. More information is provided in Appendix A about the 'JSNA Programme' in Leicester.

- a once and for all thing. The intention is that the summaries that follow will be regularly updated as will the information to be placed on the JSNA web pages. There will also be additional summaries and topics as these are identified. The intention is that the JSNA will become increasingly web-based allowing easier dissemination and feedback as well as easier updating and amendment where necessary.

Previous JSNA reports

There have been two previous JSNA reports for Leicester: a JSNA in 2008/9 focussed on strategic need in relation to adults, and the JSNA focussed on Children and Young People referred to above. In addition, Ward Health Profiles were issued in 2011 as part of the JSNA Programme.

Web pages

This and previous reports and documents can be obtained from the JSNA web page (see contact and comments, below). The web address also provides access to:

- further information relating to each section in this report. This includes tables and charts, references and web links. These JSNA sections will be subject to further improvement and updating on a regular basis. Also further topics will be available as work progresses on these.
- other information about needs assessments and health related profiles of Leicester's population.

The Public Health Outcomes Framework

From April 2013 onwards there will be a new *Public Health Outcomes Framework.* Appendix C provides a one-page overview of this. The framework will be supported by nationally collated and analysed data report which will be published in a common format by a new national organisation, Public Health England. It will be for local authorities, in partnership with health and wellbeing boards, to demonstrate improvements in public health outcomes through achieving progress against those indicators that best reflect local health need, as set out in the Joint Strategic Needs

[1]JSNAs and joint health and wellbeing strategies – draft guidance , Department of Health January 2012.p.20.

Assessment, and reflected in the Joint Health and Wellbeing Strategy. There will be a strong link between the Public Health Outcomes Framework and the "health premium" which will highlight, and incentivise action on, a small number of indicators that reflect national or local strategic priorities. More information on this is expected later in 2012.

The government is aiming to have the first full Public Health Outcomes Framework available by the autumn of 2012 to support service planning for 2013/14. When available the outcomes framework will be issued on the Leicester JSNA webpages and will be incorporated into future JSNA reports.

Public sector equality duty

The JSNA has been undertaken with regard to equalities legislation. Whilst data is not routinely available for a number of the protected characteristics, it will be seen from the body of report, and the information to be made available on the JSNA webpages, that where it has been able to do so the JSNA covers issues with regard to the following: age, gender, ethnicity, disability, pregnancy and maternity, sexual orientation and gender-reassignment and highlights issues in relation to advancement and improvement in health and wellbeing. Faith is considered as part of the make-up of the city, but no specific relevant reference is made to marriage or civil partnership. The report also takes account of socio-economic deprivation, which is not a protected characteristic but is a significant factor in the health and wellbeing of the city.

Acknowledgements

A large number of people have contributed to this report through preparing summaries, the two engagement events held in November 2011 and May 2012, through commenting on early drafts on the JSNA web pages and taking the trouble to write with detailed comments.

Contact and comments

Comments and feedback and suggestions can be fed back through the webpage below or directly to

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Leicester JSNA programme web pages
http://www.oneleicester.com/leicester-partnership/jsna/

3. THE CURRENT LEICESTER POLICY FRAMEWORK

Interim Joint Health and Wellbeing Strategy
Approved by the Leicester Shadow Health and Wellbeing Board, November 2011.

Introduction

From April 2013 it will be a requirement that Clinical Commissioning Groups(CCG) and Local Authorities jointly draw up a high level Joint Health and Wellbeing Strategy (JHWBS) through the Health and Wellbeing Board.

The Leicester Shadow Health and Wellbeing Board intends that the first full Joint Health and Wellbeing Strategy for the city will be developed between April and September 2012. Its purpose will be to inform the commissioning decisions of the CCG and the local authority for 2013/14 onwards.

The shadow Board however recognised the need for an interim statement of strategic priorities to provide a summary statement of the existing health and wellbeing priorities for Leicester and act as a guide the commissioning decisions of commissioning organisations i.e. Local Authority, Shadow CCG, LLR PCT Cluster - during the period of shadowing and transition to new organisational arrangements, including the planning for 2012/13.

The challenge in Leicester

Leicester's diverse population is marked by a greater number of younger people and a lower number of older residents, and higher rates of deprivation than England generally. The challenges the city faces has been described in a range of publically available documents[2]. A brief overview is provided below.

People in the city die early, particularly from circulatory diseases, cancers and respiratory disease. Poor health is largely driven by deprivation and exacerbated by lifestyle factors embedded within communities. The inequalities gap in health between Leicester and England is not narrowing and the gap between the more deprived and the more affluent communities within Leicester has remained a stubborn inequality. We want to improve the health and wellbeing of the poorest fastest

The need to look after the health and wellbeing of the most vulnerable in society, such as older people, those with learning disabilities, or with mental health problems is increasing. Older people are known to have particular needs in a number of areas. These include depression, dementia and mobility. Carers play a significant role in supporting the independence of people who are vulnerable, and nearly 20% of carers are themselves over aged over 65 years. The challenge in health and social care is to support vulnerable people to maintain their independence in the first place, and to regaining where these efforts are insufficient

[2] Including One Leicester Sustainable Communities strategy, the previous NHS Leicester City Commissioning and Investment Strategy 2011-2014, the emerging CCG initial strategy, Children and Young Peoples Plan 2011-2015, Health Inequalities Improvement partnership statement, the Public Health priorities agreed by the shadow Health and Wellbeing Board in August 2011, and the Joint Strategic Needs Assessment 2009 for adults and 2010 for children and young people.

The high health need in Leicester places considerable demands upon health care and social care in the city. The rate of emergency admissions to hospital are higher than the rate nationally, and particularly so in those living in the most deprived parts of the city. It is expensive, and the health care system and the social care system needs to work together to improve support in the community, develop effective discharge arrangements, reduce costs in secondary care and improve outcomes for people who need health and social care intervention.

Over a third of Leicester's children are living in poverty and this affects their life chances. For many children and young people, despite substantial improvements, there remains a need to accelerate educational attainment across all key stages. The gap between the lowest achievers and other children and young people is still too wide. Too many children are not ready for school and too few gain level two and three qualifications by the age of nineteen. Children and young people who are disabled face difficulties in accessing everyday opportunities alongside their peers. The city has high rates of infant mortality and still too many teenage pregnancies. A small number of young people are at risk of engaging in crime. Over a third of 11 year olds are overweight and we want to ensure that vulnerable children and young people and their families get early access to local targeted, joined up services.

Threats and opportunities

This is a period of increasing austerity. All public bodies are looking to reduce their spend in line with reduced budgets or the need to make savings to meet rising demand. The challenge is to increase the efficiency of what we do, while maintaining effective and acceptable services, to work in partnership to achieve this and to minimise the likelihood of unintended consequences from a lack of system coordination or leadership.

We are in an elongated period of transition, principally as a result of the Health and Social Care Bill (2011) the policies of which are to be fully implemented by the 1st April 2013. Almost all bodies that will eventually make up the health and social care infrastructure nationally and locally are currently in transition. These include locally the shadow Leicester Clinical Commissioning Group, the transfer to local authorities of some elements of the public health function, the LLR PCT Cluster, Health Watch and the shadow Health and Wellbeing Board itself. The 'interim' nature of these arrangements make it imperative that local coherence and direction is articulated, so that focus on locally agreed priority issues is maintained by the system as it sorts itself out.

A consequence of both these challenges is a reduction in management capacity and time to manage the necessary change, which urges the creation of a more "fleet of foot" partnership framework for the city: partnership arrangements that are less transactional and focused more on policy agreement, implementation and problem solving.

There are also opportunities to make a difference.

- The Health and Wellbeing Board can bring coherence and leadership to the health and wellbeing agenda in Leicester – bringing together the local authority, health care commissioning and public health and others in a new way.
- The Leicester City Clinical Commissioning Group – which by 2013 will be commissioning the majority of health care for residents of the city - has the opportunity to seek and implement clinical efficiencies in care that will improve

outcomes through far greater support and intervention in the community, and only in hospitals when it is necessary or cost effective.

- Both the above developments have the potential of a strengthened collaborative relationship between health care in the NHS and health and social care in the Local Authority, including the council's scrutiny processes, which can lead to greater integration of commissioning and services for patient and service user benefit.
- The City Council, with its leadership role for public health can seek synergies across the system that will improve population health in the short and longer term.

Strategic priorities

Within the general aim of reducing the gap in health, wellbeing and educational achievement with England and within Leicester our priorities for health and wellbeing of adults and children are therefore to:

- work to prevent and change the lifestyle factors associated with Leicester's poor health:
    - Reducing smoking
    - improving physical activity, diet, healthy weight
    - Reducing harmful consumption of alcohol.

- Improve access, take–up and quality of services, especially preventative care provided by GPs and primary care and early treatment, immunisation and screening.

- put the emphasis on providing care services and support that help people who are vulnerable to maintain and, where necessary, regain their independence in the community where they live.

- strengthen efforts to ensure that the health and social care system is high quality, safe, clinically effective and efficient - reducing emergency and avoidable admissions, diagnosing and treating in the most clinically efficient way and reducing costs where it is safe to do so.

- ensure that the health and wellbeing agenda in Leicester is coherent both in theory and practice, with an emphasis on:

    - new arrangements for joint-commissioning between health services and social care;
    - creating sustainable long term funding for cost effective services
    - ensuring "every patient contact counts" through systematic public health advice delivered by front line professionals
    - developing and supporting leadership to make the system work for Leicester's citizens
    - a synchronised agenda of key issues across partner organisations

- continue work to break the cycle of poorer health and deprivation by focusing also on wider factors that influence health over the long term. This includes further raising educational attainment across all key stages and in particular vulnerable groups, reducing poverty, and making improvements in skills, employment, housing, transport and crime.

- maintain surveillance and vigilance to ensure that the health of the population is protected from communicable disease and any new or emerging threats to health.

4. LEICESTER JSNA 2012 - HEADLINE FINDINGS

Population, deprivation and diversity	
	Leicester has…
Population	…an estimated population in 2010 is 306,600 people, with more younger and fewer older people compared with England. The population will increase to around 346,000 people by 2020.
Deprivation	…a high level of deprivation and is ranked 25th worse out of 326 local authority areas in England on the national Index of Deprivation (2010). Deprivation is wide-cast. 41% of Leicester's population live in the 20% and a further 34% live in the 20-40% most deprived areas in *England*. Within this there is variation in different parts of the city.
Diversity	… a diverse population compared with England as a whole. 36% of Leicester's residents are from Black, Minority, Ethnic (BME) backgrounds compared with only 13% in England overall. Around a quarter of Leicester's population are of South Asian origin, (mostly Indian), 4% are Black/British, 3% mixed and 3% from other ethnic origins. The age profile of Leicester's BME population is younger than the White population.
Major health conditions	
	In Leicester…
Life Expectancy – men and women	…life expectancy is improving, as elsewhere, but remains significantly worse than England and East Midlands and the life expectancy gap with England is widening. Life expectancy is a key proxy measure of overall health.
Infant Mortality	…infant mortality is decreasing, but remains significantly higher than England. Contributes significantly to the life expectancy gap with England.
Causes of Death	…rates of premature death (under 75 years) are higher than in England. Nearly 70% of all deaths and 66% of premature deaths are caused by cardiovascular disease, cancers and respiratory disease.
Cardiovascular Disease (CVD)	… the rate of death is significantly higher than England and East Midlands in all ages and under 75 year olds, but is reducing. CVD is major contributor to adverse life expectancy gap with England.
Coronary Heart Disease	...significantly higher mortality than England and East Midlands but lower identification and treatment of CHD on GP registers than expected. CHD prevalence is higher in men, higher in the over 65 and over 75 year olds and higher in White and South Asian ethnic groups. Rates of heart attacks and strokes are much higher in the South Asian population who tend to develop problems around 10 years younger than the population as a whole. Deprivation and ethnicity are both independent risk factors for CHD.
Stroke	… the rate of death is higher than in England and the East Midlands average. Stroke deaths contribute around 8% to the life expectancy gap with England.
Diabetes	…a greater proportion of the population 17 years and older diagnosed with diabetes than nationally (7% vs. 5.4%). Estimates of prevalence are higher at 10% in the city, and predicted to increase to 12.8% (some 33,000 people) by 2025. Prevalence is around four times higher in the South Asian population than in the white population and tends to develop at a younger age. A key indicator of clinical management, HbA1c , is statistically

	significantly worse than in comparator areas and in England as a whole.
Cancer	…similar rates of death to England and East Midlands but worsening. One and five year survival rates generally lower than England but improving for some cancers. Breast cancer screening lower than the England average. Cervical screening lower than England. Lower referral rate for diagnosis and treatment than England and with the lowest rates in the East Midlands and South Yorkshire cancer registry area.
Respiratory Diseases	…premature mortality from respiratory diseases is significantly worse than England and East Midlands though the trend has stabilised. Chronic obstructive pulmonary disease (COPD) mortality rates are generally higher for both males and females, with male mortality rates significantly higher than England in a number of years in the past ten.
End of life care	…in 2011, nearly 42% of people who died in Leicester, did so on in their home or care/residential home. The proportion of people dying at home increases with increasing age. Palliative care prevalence in Leicester is 0.09%, less than half the national rate (0.22%) in 2010-11.
Oral health	…over a number of years Leicester has shown significantly poorer oral health than in England or East Midlands and is the worst in its peer comparator group in relation to children.
Lifestyle and risk	
	In Leicester…
Sexual Health	…is similar to the national picture with rising numbers of sexually transmitted infections. While Chlamydia is the most commonly sexually transmitted infection. Leicester and Leicestershire have the lowest diagnosed rate of Chlamydia infection per 100,000 population for 15 – 24 year olds in the East Midlands. …nearly 700 people with HIV infection were seen In 2010 for statutory medical HIV related care - a prevalence of 3.38 per 1000 population, the highest in the East Midlands. …despite huge progress over ten years, conceptions in under 18 year olds in Leicester in 2010, were statistically significantly higher than the conception rate for England (44 vs. 35 per 1000 15 – 17 year old females).
Smoking and Tobacco	…prevalence is higher than England at 21.5% of population smoking. Local large scale surveys show prevalence of 26%. Smoking causes 70% of deaths from CHD and 84% of deaths from lung cancer and chronic obstructive pulmonary disease.
Obesity	…a similar proportion of adults is estimated to be obese than in England generally, around 24%. Levels of overweight and obesity are comparable with the England average at reception, 22.9%, and year 6, 33.1%. Only a quarter of Leicester adults eat the recommended 5-A-Day fruit and vegetables. 57% of adults report no physical activity in previous 28 days. Obesity and overweight is a contributor to CVD, cancer and poorer mental health.
Alcohol	…there are lower levels of alcohol consumption but statistically significant higher harm than nationally, shown in hospital admissions for both alcohol specific and related disease and alcohol related crime, though trend is improving. Specific Needs

	Assessment undertaken in 2011/12 to inform detailed commissioning.
Drug Misuse	…is just below national levels, but higher rate of hospital admissions and significant contribution to crime. More problematic drug users than nationally. Specific Needs Assessment undertaken in 2011/12 to inform detailed commissioning.
Children and young people	
	In Leicester…
Children and Young People	…there has been significant improvement in a range of areas but Leicester is below, or worse than, the England average for infant mortality, child mortality rate, children achieving a good level of development at age 5, GCSE achievement, those not in education, employment or training, children living in poverty (aged under 16), children who are obese, participation of at least 3 hours of sport / PE, teenage conception rate, children's tooth decay, hospital admissions due to injury, hospital admissions as a result of self-harm.
Long-term conditions requiring care and support for independence	
	In Leicester…
Mental Health	…there are high risk factors for poorer mental health and a significantly higher proportion of population registered with a mental illness than in England or the East Midlands, and the trend is worsening. By 2011-2030 there is likely to be a 16% increase in 18-64 year olds with a common mental health disease and 7% increase in those with two or more diseases
Older People	…there are fewer older people than nationally, but complex needs – isolation, poverty, frailty, increasing dementia. Increasing numbers of older people, mostly women caring for others. Prevention, early diagnosis, care or carers, integrated care pathways, collaboration between health and social care are key issues.
Dementia	…2700 people suffer with dementia, will increase to 3,700 people by 2030. Currently 800 new cases a year. 70 younger people with dementia. Early diagnosis, care of carers, integrated care pathway, collaboration between health and social care are issues. Specific Needs Assessment undertaken in 2011/12 to inform detailed commissioning.
Carers	…in 2001 the number of Leicester carers aged over 18 years responsible for giving at least one hour of care per week was 25,473. There was an additional estimated 1,128 young carers. The combined total meant that 9.5% of the city's population were carers. Two thirds of all carers were female. Significant pressures on carers health and wellbeing
Learning Disability	…there is a significantly higher proportion of over 18 year olds registered with a learning disability than is found either nationally or in the East Midlands. Estimates suggest that just under 5,900 adults with any learning disability live in the city of whom around 1,245 have needs that require social care support, 997 of whom are in receipt of this. People with learning disabilities are under-recorded on GP registers.
Physical Disability	the prevalence of physical disabilities is greater than the number of people who need services, though estimates suggest that just under 4,000 people aged 18-64 are thought to have a serious physical disability in Leicester, 234 of whom are in receipt of social

	care.
Vision Impairment	an estimated 3,000 people living with sight loss. Of the 2,233 individuals on the vision impairment register, 73% are aged over 60 years. As well social care and health needs there is a considerable primary and secondary prevention agenda including eye health, a reduction in smoking and ensuring that the potential of sight loss is clearly addressed in the on-going education and care of people with diabetes.
Hearing Impairment	population projections for Leicester show that there are an estimated 21,503 people with a moderate or severe hearing loss in Leicester and this is set to rise to 29,830 by 2030. Those with a profound hearing loss were estimated to number 454 people in 2011, set to rise to 660 by 2030. A large proportion of the hard of hearing community is over 65 years.
Housing and health	
	In Leicester…
Housing and health	…the availability and quality of an appropriate home has a substantial impact on health. Issues include decent home standard in the private sector, fuel poverty, overcrowding, homelessness and the upcoming welfare benefits reforms.
Patient and user voice	
	In Leicester…
Patient and user voice	…broadly, residents express a level of satisfaction with their local services. However, the top three reasons for Social Care complaints were lack of communication, failure to undertake a task and staff attitude or behaviour. Two of these reasons were echoed in the top three for the main Leicester NHS organisations – NHSLC, University Hospitals of Leicester (UHL) and Leicestershire Partnership NHS Trust (LPT) – which were clinical or medical care, staff attitude and communications.
Appendices	
	In Leicester…
Health of New Arrivals	…new arrivals are a substantial population likely to have differing health and social care needs and entitlements. This inwards migration adds to the already complex pattern of diversity in Leicester.
Health of lesbian, gay bisexual & transgender people	…social assumptions of heterosexuality create difficulties for LGB&T people of all social groups and at all life stages. Similar experiences place many transgender people at risk of alcohol abuse, depression, suicide, self-harm, violence, substance abuse and HIV.
Offender Health	…offenders have significantly poorer health than the general population. Of the 3,800 offenders managed by the Leicestershire and Rutland Probation Trust, 3,272 of them come from Leicester. Leicester has Local prison with an average daily population of 355 prisoners.

Notes regarding the summaries that follow

Data

The data used in this report is the most recent available.

Key to data tables in summaries

Significantly worse than England
Significantly better than England
Not significantly different to England

↑	Improving
↓	Worsening
↔	Same

Peer groups referred to in data tables

PCT Peer Group (8)

Barking and Dagenham
Birmingham East and North
South Birmingham
Leicester City
Manchester
Nottingham
Sandwell
Wolverhampton

LA Peer Group (7)

Barking and Dagenham
Birmingham
Leicester City
Manchester
Nottingham
Sandwell
Wolverhampton

SUMMARIES

(a) POPULATION , DEPRIVATION AND DIVERSITY

The East Midlands is the second smallest region behind the North East with a population of just under 4.5 million. It is a less deprived area compared to the West Midlands and the North, but more deprived than areas of the South. Leicester is the largest city in the East Midlands, with a population of 306,600[3] and covers an area of 73.3 km^2. Much of the area is urban, with a high population density of 4,182 people/km^2making it the most densely populated area in the East Midlands and the 29th most densely populated area in the country[4].

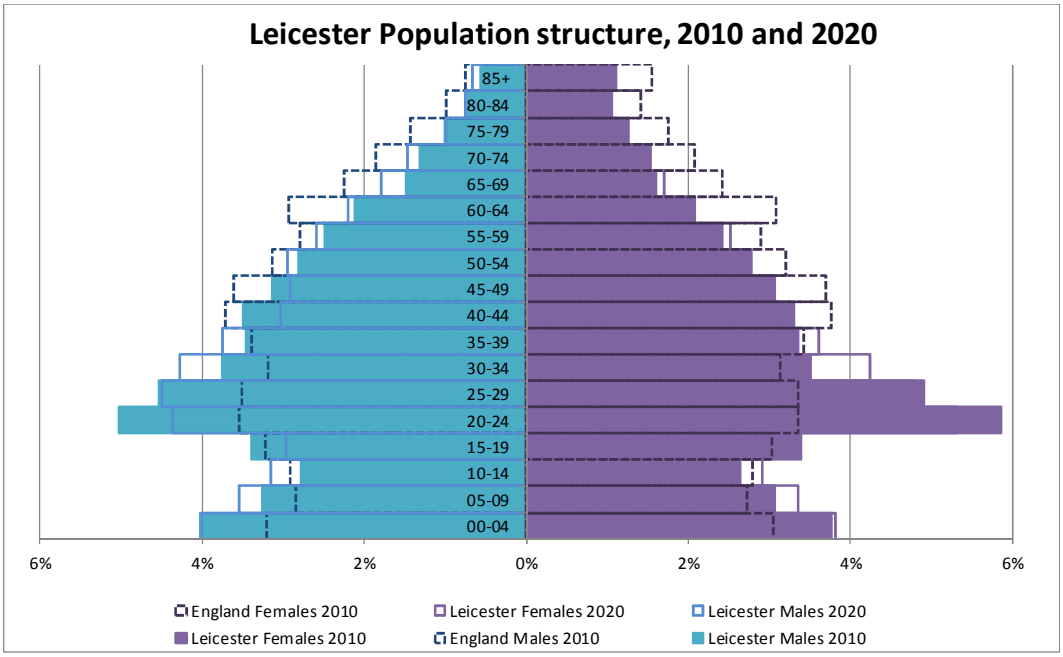
The current population estimate for Leicester City is 306,631 of which 151,277 are males (49%) and 155,354 (51%) are females. Leicester's population is relatively young compared with England; 20% (62,300) of Leicester's population are aged 20-29 years old (14% in England) and 12% (35,600) of the population are aged over 65 (16% in England) (figure 1). The large numbers of young people in Leicester are partly students attending Leicester's two universities and partly immigrants to Leicester.

This latter group reflects growth in the city's population since around the year 2000. Leicester City Council estimates that the Somali community comprises about 10,000 people, migrants of working age (from Poland, Portugal, Slovakia, Latvia and Lithuania) between 6,000 and 8,000 people including 1,000 – 2,000 people from the Roma community in Slovakia. Other new communities include asylum seekers and refugees. Leicester is National Asylum Seeker Service designated dispersal city. The maximum number of asylum seekers in Leicester at any one time is 800. In 2011-12 this number is around 450 people. Further information regarding the health of new arrivals is provided in appendix D.

The Leicester population is predicted to grow to around 346,000 by 2020[5], an increase of nearly 40,000 from 2010.

[3] Office for National Statistics mid-2010 population estimates
[4] Office for National Statistics Population analysis tool, 2010
[5] Office for National Statistics 2008-based population projections

Figure 1. Leicester population structure by 5 year age band, 2010 and projected to 2020



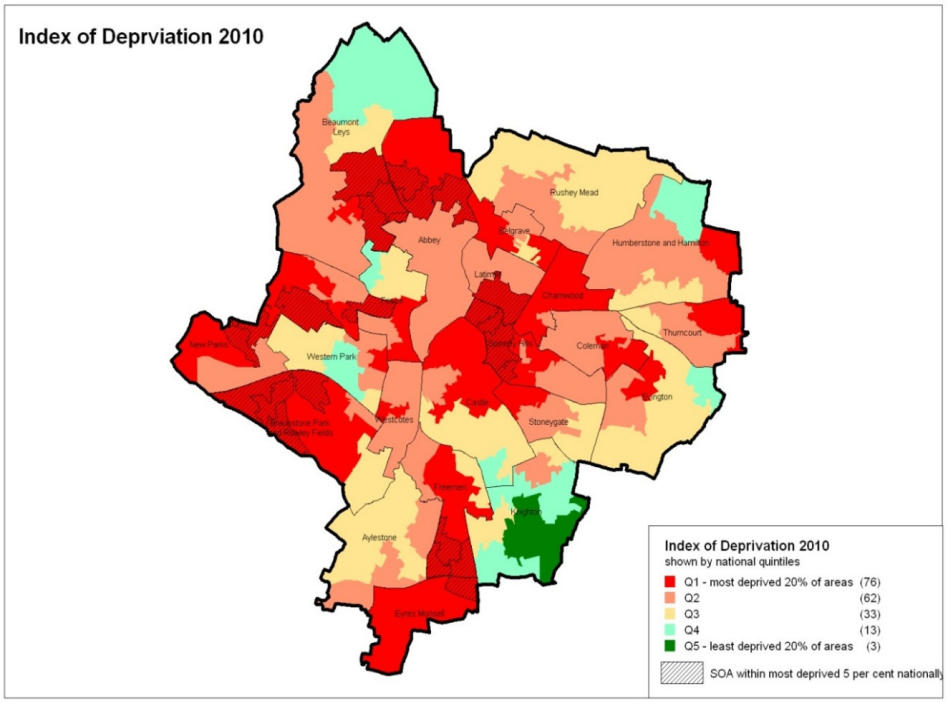
Data: ONS mid 2010 population estimates, 2008-based population projections

Deprivation

Leicester has a high level of deprivation compared to the country as a whole and is ranked 25th worse out of 326 local authority areas in England on the national Index of Deprivation (2010).41% of Leicester's population live in the most deprived 20% of areas in England and a further 34% live in the 20-40% most deprived areas. Only 1% of Leicester's population live in the 20% least deprived areas (figure 2). Across Leicester there is also a variation in life expectancy; for males there is a difference in life expectancy of 9.4 years and females 5.0 years between people living in the most and least deprived areas of Leicester[6].

[66] Association of Public Health Observatories (2010) *Slope Index of Inequality for Life Expectancy - 2006-10.* [Online] Available at: http://www.apho.org.uk/default.aspx?RID=110504 Accessed on: 2nd February 2012.

Figure 2. Index of multiple deprivation by ward, Leicester, 2010



Data: Index of deprivation 2010[7]

Significant and widespread deprivation is also reflected in the proportion of primary school pupils taking free school meals, which in in Leicester is more than double the regional average, and significantly higher than that for England. It is also seen in the proportion of the population claiming benefits (see Table 1), which in Leicester is far higher than in the East Midlands or Great Britain.

Table 1: Benefit claimants in Leicester, May 2011

	Job Seeker %	Incapacity %	Lone Parent %	Other: %	Total
Leicester	5.8	7.8	2.2	3.6	19.4
East Midlands	3.4	6.1	1.4	2.9	13.9
Great Britain	3.6	6.5	1.5	2.9	14.5

Source: Department of Work and Pensions

The wealth of Leicester originated in the comparatively diverse nature of its economy. Growth substantively took in the mid-nineteenth century following early innovations in the hosiery industry. This triggered the introduction of factory-based production employing women. For men, first the growth in footwear manufacturing and then the formation of various types of engineering industry led to an expansion in employment and rising incomes. Leicester's economic expansion continued between the First and Second World Wars, driven by the use of more sophisticated machinery. By the early 1980s the situation had changed. The City's industrial

[7]Communities and Local Government (2011) *Indices of deprivation 2010*.[Online] Available at: http://www.communities.gov.uk/communities/research/indicesdeprivation/deprivation10/ Accessed on: 10th February 2012.

structure was characterised by an over-reliance on a narrow range of industries, which by this time were in decline nationally.

The outcome of these trends is that Leicester has inherited a significant proportion of its population living in municipal housing who have experienced a local economy that has made it increasingly more difficult to compete for work. The specific legacy of Leicester's economic history is twofold: higher unemployment rates – almost twice those of the rest of Leicestershire, and leading to increasing levels of poverty and deprivation; at the same time the change in the demand for skills in the city has disadvantaged many residents.

The latest overall employment rate in Leicester as at October 2010 - Sept 2011 for people aged 16-64 was 61.8%[8]. This was 9.1% points lower than the East Midlands regional average of 70.9% and 8.2% points lower than for England at 70 %. Leicester's employment rate generally reflects regional and national trends suggesting that the data used can be subject to a number of influences such as seasonal work practices and the adverse effects of the recession.

Diversity

Leicester has a diverse population compared with England as a whole; usng Census 2001 classification, 36% of Leicester's residents are from Black, Minority, Ethnic (BME) backgrounds compared with only 13% in England overall[9]. Around a quarter of Leicester's population are of South Asian origin, (mostly Indian), 4% are Black/British, 3% mixed and 3% from other ethnic origins (see below, table 2) The age profile of Leicester's BME population is relatively younger than the White population.

Table: Population estimates by ethnic group, 2009

	Leicester City		England
Ethnic group	Number	%	%
White: British	183,000	60.1%	82.8%
White: Irish	3,200	1.1%	1.1%
White: Other White	9,100	3.0%	3.6%
Mixed: White and Black Caribbean	3,100	1.0%	0.6%
Mixed: White and Black African	900	0.3%	0.2%
Mixed: White and Asian	2,900	1.0%	0.6%
Mixed: Other Mixed	1,900	0.6%	0.5%
Asian or Asian British: Indian	56,900	18.7%	2.7%
Asian or Asian British: Pakistani	14,000	4.6%	1.9%
Asian or Asian British: Bangladeshi	2,800	0.9%	0.7%
Asian or Asian British: Other Asian	5,800	1.9%	0.7%
Black or Black British: Black Caribbean	4,800	1.6%	1.2%
Black or Black British: Black African	5,800	1.9%	1.5%
Black or Black British: Other Black	1,000	0.3%	0.2%
Chinese or Other Ethnic Group: Chinese	6,500	2.1%	0.8%
Chinese or Other Ethnic Group: Other	3,000	1.0%	0.8%
All Groups	304,700	100.0%	100.0%

[8] Annual Population Survey – NOMIS
[9] Office for National Statistics (ONS) (2011) *Population estimates by ethnic group.* [Online] Available at: http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population+Estimates+by+Ethnic+Group Accessed on: 8th February 2012.

Data: ONS population estimates, 2009

It is estimated that there may be as many as 150 languages and/or dialects spoken in Leicester. Gujarati, Katchi, Punjabi, Urdu and Bengali are widely spoken and there are growing numbers of speakers of Somali, Polish or Slovak, Arabic, Tamil and various East African languages. Almost half of pupils in Leicester primary schools have a home language other than English[10].

There are a number of different faith communities within the Leicester population. The 2001 Census showed the largest faith communities in Leicester are the Christian communities (44.7% of the population), followed by Hindu (14.7%), Muslim (11%), and Sikh (4.2%). 17.4% stated they had no religion while 7% did not indicate their religion. According to the Leicester Council of Faiths, there are approximately 240 faith groups across fourteen different faiths[11].

The most recent data regarding ethnicity and employment in Leicester shows that the employment rate for what is classified as non-white groups, aged 16-64, was 58.4% in 2010. This is lower than that for the white population, 72.1%, and the overall employment rate in Leicester during that same period, 70.7%.

Patterns of residence have altered over time and it is becoming clearer that in general terms patterns of poverty and deprivation do not necessarily correspond with patterns of ethnicity. The DPH Annual Report 2010 included a 'typologies' analysis that showed that deprivation and poorer health is not even across the city.and that there is a complex interplay between ethnicity, deprivation and health.

Diversity is also reflected in other groups including lesbian, gay, bisexual and transgender people (see Appendix E).

MAJOR HEALTH CONDITIONS

(b) LIFE EXPECTANCY

Life expectancy (LE) at birth and life expectancy gap with England and East Midlands: Leicester 2008-2010

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Male LE	75.4	78.6	78.4	7/8	↑
Female LE	80.1	82.6	82.4	7/8	↑
Male Gap (years)	3.2		0.2	7/8	↓
Female Gap (years)	2.5		0.2	7/8	↓

Data: NHS Information Portal

[10]Department for Education (2011) *School Census 2011*.[Online] Available at: http://www.education.gov.uk/schools/adminandfinance/schooladmin/ims/datacollections/schoolcensus/a0064400/school-census-2011 Accessed on: 3rd February 2012.

[11]Leicester Council of Faiths. *Places of Worship in the City of Leicester*. (2004, updated)

Life expectancy at birth for men and women has been steadily increasing over the past 10 years so that males in Leicester can now expect to live 2.1 years longer and females 1.3 years longer than their counterparts born in 1988.

In Leicester women now have a life expectancy of 80.1 years and men of 75.4 years, statistically lower than that for England in both men and women. In Leicester males can expect to live 3.2 years and females 2.5 years less than the England average.

Leicester has high levels of deprivation, and areas of high deprivation show shorter life expectancy. Between the tenth most deprived areas (deciles) of Leicester and the tenth least deprived areas there is a difference of 5.0 years in life expectancy for females and 9.4 years for males[12].

There is a difference of around 10 years between the ward with the highest life expectancy (Evington, 80.5 years) and the lowest life expectancy for males (Castle,70.5 years). For females there is a difference of around 5.2 years between the ward with the highest life expectancy (Latimer, 82.6 years) and the lowest life expectancy (Westcotes, 77.4 years)[13].

The life expectancy gap between Leicester and England has been widening over the past 10 years. In males the gap has grown from 2.1 years (1998-2000) to 3.2 years (2008-2010) and in females the gap has grown from 1.4 years (1998-2000) to 2.5 years (2008-2010).

The main factors contributing to the widening gap are mortality from cardiovascular disease (CVD) and respiratory diseases. Ten years ago (1998-2000), the CVD mortality rate in Leicester was 11% higher than the national rate and although rates have fallen considerably over the past 10 years, the rate in Leicester has fallen more slowly and is now 30% higher than that of England. For premature CVD mortality Leicester's rate was 27% higher than England 10 years ago and is now 53% higher.

(c) **INFANT MORTALITY**

Infant Mortality rate

Deaths in under 1 year per 1,000 live births (2008-2010)

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Infant Mortality rate	6.4	4.6	4.7	4/8	↑

Data: NHS Information Centre Indicator Portal,

Leicester has a higher infant mortality rate (6.4 per 1,000 live births) than nationally (4.6 in 2008-2010), which equates to around 33 infant deaths each year. The majority of infant deaths in 2010 were due to prematurity (delivery prior to 37 weeks gestation – 35%) followed by congenital anomalies (20%) and sudden infant deaths (10%), but note the very small numbers involved.

[12] London Health Observatory: Slope Index of Inequality for Life Expectancy by Deprivation Deciles - 2006-10

[13] The Leicester Ward Health Profiles provide a succinct overview of the health of the population in each ward, available from http://www.oneleicester.com/leicester-partnership/jsna/previous-jsnas/leicester-ward-health-profiles-2011/

Nationally, the infant mortality rate has seen a gradual fall over the past 10 years. In Leicester, despite fluctuations due to the small number of deaths each year, there has been a reduction in the rate in 2008-2010 following an increase from 2005, which took the rate to a high of 7.3 per 1,000 live births in 2007-2010.

As the number of infant deaths per year is relatively small the rates at ward level will vary considerably with small changes in numbers. Generally areas of higher deprivation also show higher levels of infant mortality (with the exception of Eyres Monsell which has seen low levels of infant deaths over the past 5 years). Beaumont Leys, Spinney Hill and Charnwood wards all show significantly higher rates of infant mortality than nationally.

Because deaths in infancy imply a considerable number of years of life lost, they contribute significantly to Leicester's life expectancy gap with England.

(d) CAUSES OF DEATH

Cause of death as a % of all deaths in under 75s (2010):Leicester

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Cardiovascular Disease	22.9%	24.3%	24.6%	1/8	↑
Cancers	32.6%	40.4%	40.9%	1/8	↓
Respiratory Disease	10.1%	9.1%	9.0%	2/8	↓

Data: NHS Information Centre Indicator Portal, ONS mortality data

In 2010 there were 2,489 deaths to residents in Leicester, of these 586 were men aged under 75 years (24% of all deaths) and 351 were women under 75 years (14%). This is higher than nationally, where premature deaths are 20% in males and 13% in females.

In Leicester nearly 70% of all deaths and 66% of premature deaths (under the age of 75 years) are caused by:

	All Deaths	Under 75s
• Cardiovascular disease	32%	23%
• Cancers	23%	33%
• Respiratory disease	14%	10%

Deaths from potentially avoidable causes

A number of deaths in the UK are considered to be caused by conditions which are amenable to healthcare. These are deaths from causes where there is evidence that healthcare interventions and timely, appropriate care can help prevent onset as well as treatment of disease. The causes are age specific and include intestinal infections, whooping cough and measles, and respiratory disease (excluding pneumonia, influenza and asthma) in the under 14s, perinatal and maternal deaths, premature mortality from infectious diseases, and conditions such as septicaemia, diabetes, epilepsy, heart disease, stroke and cancers. Death rates from these causes should be low.

In 2010 there were 307 deaths from potentially avoidable causes in Leicester. Nationally and locally there has been a decline in the rate of deaths from potentially avoidable causes over the past 10 years.

(e) **CARDIOVASCULAR DISEASE (CVD)**

Mortality rate from Cardiovascular diseases

Deaths per 100,000 in 2008-2010

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
All ages	217.5	167.1	168.3	7/8	↑
Under 75s	103.1	67.3	68.0	7/8	↑

Data: NHS Information Centre Indicator Portal,

Cardiovascular disease is a general term for a disease of the heart or blood vessels. The most common cause of CVD is a build up of fatty substances in the coronary arteries which restricts blood flow and can lead to heart attacks and strokes.

Nationally CVD prevalence is estimated to affect nearly 12% of the adult (16+ years) population and around 9.5% of Leicester's adult population. Prevalence is similar in males and females, highest in white (10.6%) and Asian (8.3%) ethnic groups and in the 65-74s (28%) and over 75s (39%).

In 2010 there were 797 deaths from CVD in Leicester of which 215 were premature (27%), which is higher than nationally (25%). CVD is the major contributor to the adverse life expectancy gap between Leicester and England accounting for 39% of the life expectancy gap in males and 31% of the gap in females.

Of all deaths from CVD in Leicester almost half (49%) are from coronary heart disease (CHD) and a quarter from strokes. This is significantly higher than nationally where 45% of CVD deaths are from CHD.

The premature CVD mortality rate in Leicester has reduced over the last 10 years but not at the same rate as it has for England. The gap between Leicester and England has almost doubled over the last 10 years (from 27% in 1998-2000 to 53% in 2008-2010).

There are variations in premature mortality from CVD in Leicester. Eleven wards (see Leicester Ward Health Profile 2011[14]) show a significantly higher rate of deaths in under 75 year-olds than the England average. These correspond to areas of high deprivation, and to South Asian communities in the east of Leicester.

Coronary Heath Disease (CHD)

Premature Mortality rate from Coronary Heart disease

Deaths per 100,000 in 2008-2010

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Trend
Under 75s	64.1	37.2	38.9	7/8	↑

Data: NHS Information Centre Indicator Portal,

Coronary heart disease is caused by a narrowing and blockage of arteries supplying the heart which can result in angina, chest pain or a heart attack. The outcome can

[14] http://www.oneleicester.com/leicester-partnership/jsna/previous-jsnas/leicester-ward-health-profiles-2011/

be acute heart failure, sudden death or slower progression to chronic heart failure. The key risk factors for CHD are ethnicity, deprivation, ageing, smoking, poor diet and lack of physical activity.

There are 10,000 patients currently diagnosed with CHD on GP registers in Leicester, equivalent to 3.4% of the adult population. This is lower than the national prevalence of 4.2% but modelled estimates indicate there may be a number of people undiagnosed and the true prevalence in Leicester may be as high as 4.8%. Modelled prevalence is higher in males (5.8%) than females (3.9%), higher in white (5.1%) and Asian (5.3%) ethnic groups in the over 65s and 75s (23%).

The rate of acute coronary events (heart attacks and severe angina) is much higher among Leicester's South Asian population when compared to white or black ethnic groups. South Asians often develop acute heart problems around 10 years younger than the population as a whole. However, it is encouraging that Leicester's South Asians also have higher coronary intervention rates (that is healthcare), indicating a level of equity in service provision for this group.

Over 60% of excess premature CVD deaths in Leicester are attributable to coronary heart disease. Premature mortality rates from CHD have decreased over the past decade by some 40%. However, the rate for England has fallen faster (by some 47%).

Thirteen wards have significantly higher death rates from coronary heart disease than the national average. These areas also show high levels of deprivation.

Stroke

Mortality rate from Stroke

Deaths per 100,000 in 2008-2010

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
All ages	50.2	42.7	41.7	6/8	↑

Data: NHS Information Centre Indicator Portal,

A stroke is caused by the interruption of the blood supply to the brain, usually because a blood vessel bursts or is blocked by a clot. This cuts off the supply of oxygen and nutrients, causing damage to the brain tissue.

In Leicester there were nearly 4,400 people recorded on GP registers for stroke or transient ischemic attacks (TIAs) in March 2011, around 1.5% of the adult population. Estimates of prevalence suggest nearly 2% of Leicester's adult population could have suffered a stroke. Prevalence is similar in males and females and higher in over 65s and over 75s.

Around 1,000 Leicester residents suffer a stroke each year and around 120 have TIAs. Of these 23% are Asian / South Asian and 2.5% are black / black British.

Stroke mortality in Leicester as fallen over the 10 years to 2010 at a similar rate to that experienced nationally (some 37%). However, death rates from stroke in Leicester males and females are higher, though not significantly, than average rates for England. They contribute around 8% of the life expectancy gap. In 2010 there were 199 deaths from stroke, 79 in males and 120 in females.

Diabetes

Diabetes is a chronic disease that occurs when the pancreas does not produce enough insulin, or when the body cannot effectively use the insulin it produces. Hyperglycaemia, or raised blood sugar, is a common effect of uncontrolled diabetes and over time leads to serious damage to many of the body's systems, especially the nerves and blood vessels.

The prevalence of diagnosed diabetes among people aged 17 years and older in Leicester is 7% compared to 6.8% in all Primary Care Trusts (PCT) with similar diabetes risk factors – that is a relatively young population with substantially greater average proportion of the population from Black and Asian ethnic groups and higher than average deprivation.

In terms of the clinical management there are indications that getting on for half (48.3%) of people in the city in 2010/11 with diabetes aged 17 years and older (who are not excepted from the NHS Quality and Outcomes Framework) have blood sugar levels (HbA1c) of 7% or less, an indicator of good control. This is statistically significantly lower than PCTs with populations with similar diabetes risk factors and statistically significantly lower than England as a whole. In the same year three-quarters (74.9%) of patients registered with diabetes were recorded as having an HbA1c of 8%, again significantly lower than the national average of 78%.

The National Diabetes Audit 2009/10 showed that 8.2 per 1,000 people with diabetes in Leicester had had a stroke and 7.3 a myocardial infarction in the previous year compared to the England averages respectively of 6.9 and 6.5 per 1,000 people with diabetes. Rates for both complications are also higher than Leicester's PCT comparator groups.

(f) **CANCER**

Premature mortality rate from Cancer: Leicester

Deaths per 100,000 in 2008-2010

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Under 75s	117.9	110.1	110.3	1/8	↓

Data: NHS Information Centre Indicator Portal,

Cancer is a term used for diseases in which abnormal cells divide without control and are able to invade other tissues. The abnormal cells can form a tumour and spread to other parts of the body through the blood and lymph systems.

Nearly 1,250 people in Leicester were diagnosed with cancer in 2009 and there are currently over 3,750 patients on a GP cancer register equating to 1% of the population.

The most common cancers are breast, lung and colorectal. In Leicester breast cancer has the highest number of new cases diagnosed each year (229 in 2009) which represents a similar incidence rate to that for England. Lung cancer is the second most common cancer (172 cases in 2009) but with a significantly higher incidence rate for both males and females than the England average. Colorectal cancer is the third most common (146 cases in 2009) with significantly lower incidence rate than the England average.

In Leicester, lung cancer mortality is higher in males than females and the rate in males is significantly higher than nationally. Breast cancer and colorectal cancer mortality rates in Leicester are similar to the national rate and prostate cancer mortality is relatively low when compared to the national average.

There has been an overall reduction in premature cancer mortality since 1998-2000 and Leicester has shown a similar trend to England up until 2007. Since then cancer mortality in Leicester has been increasing.

Cancer mortality shows variation across Leicester and early death rates are generally higher in the west of Leicester and lower in the east. There are three wards which have a significantly higher rate than England – New Parks, Fosse and Freeman.

All age and premature mortality rates from lung cancer in Leicester are significantly higher than the England average and are very strongly related to the level of deprivation. Although the inequality gap in mortality rates is smaller than nationally, lung cancer mortality rates in the most deprived fifth of Leicester's population are more than twice as high as the least deprived fifth. In contrast, the inequality gap for breast cancer mortality rates is 20%. At ward level, lung cancer deaths are significantly higher than the England rate in Eyres Monsell, New Parks, Fosse and Abbey. Three wards have significantly lower rates than nationally – Belgrave, Latimer and Spinney Hill.

Cancer patients have overall higher mortality rates than the general population, although they do not all die of cancer. The relative survival rate represents the ratio of survival rate among cancer patients to that in the general population. Although both 1-year and 5-year survival rates from all cancers have improved by around 10% in the past decade, they remain poorer than the national average, particularly 1-year survival for males with colorectal cancer and 5-year survival for females with breast cancer. Lung cancer survival rates in Leicester are similar to the national average.

Screening is the most effective way of ensuring early cancer presentation and of improving chances of survival. There are three national screening programmes, breast, cervical and bowel. Breast screening is offered to women aged between 53 and 70 every 3 years, cervical screening is routinely offered to eligible women aged between 25 and 64 every 3-5 years and bowel screening offered to men and women in their sixties every 2 years.

Leicester has a lower coverage for both breast and cervical screening than nationally. 75.8% of women in Leicester had a breast screen in the last 3 years (compared to 77.2% national average). and 75.3% a cervical smear test (compared to the 78.6 national average).

Leicester has a lower than average cancer referral rate (1,423 per 100,000 compared with the England average of 1,684 per 100,00). This rate is a proportion of cancer patients who are diagnosed following an urgent GP referral, standardised for population age). Leicester remains the lowest within the East Midlands and South Yorkshire region.

(g) **RESPIRATORY DISEASES**

Premature mortality rate from respiratory diseases: Leicester

Deaths per 100,000 in 2008-2010

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Trend
Under 75s	37.9	23.5	23.5	6/8	↔

Data: NHS Information Centre Indicator Portal,

Diseases of the respiratory system include diseases of the lung, pleural cavity, bronchial tubes, trachea, upper respiratory tract, and of the nerves and muscles of breathing. One in seven people in the UK are affected by some form of chronic lung disease, most commonly chronic obstructive pulmonary disease (COPD) and asthma.

In March 2011 there were 18,687 patients recorded on GP registers with asthma, a recorded prevalence of 5.1%, slightly lower than that for England (5.9%).

There were 4,456 patients with COPD in March 2011, a slightly lower prevalence than England, 1.2% vs. 1.6%. However, modelled estimates suggest that actual prevalence in Leicester could be as high as 3.75%, with higher rates in males (4.5%) than females (3%), black and white ethnic groups than Asians, and in over-65s (over 10%).

Deaths from respiratory disease account for nearly 14% of all deaths in Leicester, which is similar to the national rate. Pneumonia accounts for 29% of these and COPD for around 35%. Mortality rates for COPD in 2008-10 are significantly higher in Leicester overall and in Leicester males than England, in both all ages and under-75s.

There has been a gradual downward trend in COPD mortality rates in England over the past 10 years. In Leicester the rate is more variable due in the main to relatively small numbers. However, the rates are generally higher for both males and females with male mortality rates significantly higher than in England in a number of years.

Higher rates of respiratory disease mortality are generally found in the west of Leicester and similar patterns are seen for high COPD mortality (with the exception of Thurncourt and Coleman wards). Higher mortality reflects areas of higher deprivation and high smoking prevalence.

(h) END OF LIFE CARE

A working definition for end of life care is "… *care that helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both patient and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support*"[15]

There are around 2,500 deaths a year in Leicester; around two thirds of these are aged over 75 and over nationally. In Leicester, the proportion of deaths in over 75s is slightly lower (63%) due to the higher rate of premature mortality in under 75 year olds. Around a third of all deaths are caused by cardiovascular diseases, a quarter

[15]Department of Health, *National End of Life Care Strategy*, 2008

from cancer and 1 in 7 from respiratory diseases. In the over 65s, the top three causes are the same, with slightly more people dying from cardiovascular diseases, and slightly fewer from cancer.

National studies show that over half of people would prefer to die at home and 11% in hospital. In Leicester, nearly 42% of people died in their home or care/residential home in 2011:

- Children and young adults are more likely to die in hospital or elsewhere, as a higher proportion of deaths are caused by external causes and not predictable.
- The proportion of people dying at home increases with increasing age
- Adults aged 75-84 are more likely to die in hospital and those over 85 more like to die in care homes.
- Males over 75 are more likely to die in hospital (53%) than at home (43%); females over 75 show similar likelihood of dying in hospital or at home (48%)
- People living in the most deprived areas are more likely to die in hospital that at home.
  In 2010-11 there were 328 people registered on palliative care registers in Leicester, around 13% of the annual number of deaths.
- Palliative care prevalence in Leicester is 0.09%, less than half the national rate (0.22%) in 2010-11. The prevalence rate in 2009-10 was 0.7%.

(i) ORAL HEALTH

Oral health in children: Leicester

Mean number of decayed, missing, filled teeth in 5 year olds (2007-08) and 12 year olds (2008-09)

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
5 year olds	2.22	1.11	1.02	3/8	↑
12 year olds	1.31	0.74	0.74	8/8	↑

Data: NHS Information Centre Indicator Portal,

Dental decay is caused by a range of factors including high frequency intake of sugary snacks and drinks, poor oral hygiene and little exposure to fluoride. These factors are strongly determined and influenced by socio-economic and wider determinants of health. New immigrants and low income children are particular prone to developing tooth decay.

Oral health can have a significant impact on general health and wellbeing. Dental decay in children can be associated with pain, poor sleep, poor eating habits, failure to thrive and chewing and speech problems. National surveys of child dental health are performed every 10 years and generally show a steady improvement over the last 3 decades. The greatest fall in dental decay occurred between 1973 and 1983 largely due to the introduction of fluoride toothpaste. The last national survey of 5 year-olds carried out in 2007-08 showed that Leicester had a higher rate of 5 year-olds who had at least one tooth with decay, nearly 50% in Leicester and around 30% nationally. Nationally the average number of teeth that were decayed, missing or filled (dmft) was 1.1. In Leicester the figure was significantly higher with 5 year-olds having 2.2 teeth, on average, that were decayed, missing or filled.

The oral health survey of 12 year-olds in 2008-09 showed that nationally 33% had at least one decayed, missing or filled tooth with an average of 0.74 teeth. In Leicester

12 year-olds had significantly higher levels, on average nearly 56% had some decay and the average number of decayed, missing and filled teeth was 1.3.

LIFESTYLE AND RISK

(j) SEXUAL HEALTH

Sexually transmitted infections

Chlamydia diagnosis rate: Leicester

Chlamydia diagnosis rate per 100,000 15-24 year olds, 2010/11

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Chlamydia diagnosis rate (15-24)	1573.8	2146.0		1/8	

Data: Health Protection Agency Regional Chlamydia Screening Lead

Data provided by the Health Protection Agency (HPA) show new sexually transmitted infection (STI) diagnoses rose by two per cent in England in 2011, with nearly 427,000 new cases, reversing the small decline observed the previous year. Young heterosexual adults (15-24 years) and men who have sex with men (MSM) remain the groups at highest risk.

The picture for sexual health in Leicester is similar to the national one with rising numbers of newly diagnosed sexually transmitted infections. Chlamydia is the most commonly sexually transmitted infection, with 63% of chlamydia cases diagnosed in GU found in the under 25s. There is an increase in diagnoses of Chlamydia, which to some degree will be due to increased screening of young people aged 15-24 via the Chlamydia screening programme. Leicester has however a lower diagnosed rate of Chlamydia infection per 100,000 population for 15 – 24 year olds than the England average (1,506 for Leicester, against the England average of 2,219 per 1,000 15-24 year olds, in 2010).

HIV infection

HIV Diagnosed Prevalence: Leicester

Diagnosed HIV prevalence per 1,000 (aged 15-59), 2010

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
HIV diagnosed prevalence per 1,000	3.38	1.5		5/7	↓

Data: Health Protection Agency, HIV in the East Midlands, Published Dec 2011 (Annual report 2010)

The number of people in Leicester with diagnosed HIV infection and seen for medical care has increased by a quarter over the last 5 years, more in females than in men. In 2010 nearly 700 people with HIV infection were seen for statutory medical HIV related care - a prevalence of 3.38 per 1000 population and the highest in the East Midlands.

Just under two thirds of all HIV infections diagnosed are in Black Africans, 15% in White and 12% in South Asian ethnic groups. The main cause of infection is through heterosexual contact (80%). 12% of infections are contracted by men who have sex with men. 3% are the result of transmission from mother to child and 2% by intravenous drug use. There is a decreasing number of new diagnoses in Leicester each year from a peak of 148 in 2003. In 2009 there were 73 new diagnoses.

The biggest increase in the route of HIV infection is seen in heterosexual contact, although there is also a small increase in infection which is the result of men who have sex with men.

Teenage conceptions

Teenage conception rate: Leicester

Number of conceptions in under 18s per 1,000 15-17 year olds, 2010

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Under 18 conception rate	44.4	35.4	34.5	2/7	↑

Data: Office for National Statistics, Conception Statistics 2010

In 2010 there were around 232 conceptions in under 18 year olds in Leicester, a rate of 44 per 1000 15 to 17 year old females. This is significantly higher than the conception rate for England of 35 per 1000 15 – 17 year old females.

While between 1998 and 2010 the teenage conception rate in England has fallen by 24%, the Leicester rate has fallen by 31%, although there have been some fluctuations in the rate since 2001. Leicester has had the second largest decrease over the strategy period when compared to its closest statistical neighbours. Much coordinated action has been undertaken to reduce under 18 conceptions in Leicester. This includes greater access to condoms, pregnancy testing and to relationship and sex education, as well as sustained efforts to improve academic attainment in the city.

Although under 18 conception rates are higher overall in Leicester there is variation across the city. The rates in the west of Leicester are higher than the England average and in the east of Leicester the rates are generally similar to or below the England average. Wards significantly higher than national average are: Abbey, Beaumont Leys, Braunstone Park and Rowley Fields, Castle, Eyres Monsell, Fosse, New Parks, Freeman, Westcotes. Wards significantly lower for under 18 conceptions are: Rushey Mead, Knighton, Spinney Hills , Latimer and Stoneygate ,

The termination of pregnancy rate in under 18 year olds and in 18 – 19 year olds is not significantly different from the England rate (16.0 vs. 16.6 per 1,000 resident women aged 15-17 and 31.4 vs. 30.9 per 1,000 resident women aged 18-19 on the date of the procedure in 2010). For confidentiality reasons data is not always made available on the proportion of females in Leicester who conceived under the age of 18 and who continue with pregnancy. The last available data, 2007, showed that a higher proportion chose to continue with the pregnancy than did so nationally.

(k) SMOKING AND TOBACCO

Adult smoking in Leicester

Estimated % of smokers aged 16+ years, 2009/10

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Smokers 16+ years	21.5%	21.2%	21.4%	5/7	↑

Data: Integrated Household Survey (IHS), 2009-10
**NB: Lifestyle Surveys suggest smoking prevalence is higher in Leicester (26% in 2010)*

Smoking is known to be the principal cause of avoidable premature deaths in the UK and accounts for around one fifth of all UK deaths (112,000 per year). Smoking causes :

- 84% of deaths from chronic obstructive pulmonary disease
- 84% of all deaths from lung cancer
- A third of all deaths from cancer, including cancer of the mouth, lip, tongue, stomach, liver, lung, pancreas, kidney, bladder, cervix and leukaemia
- A ten to 16 fold raised risk of peripheral vascular disease (causing around 2000 amputations each year)
- 70% of deaths from coronary heart disease

An estimated 19% of adults currently smoke in England, 20% of men and 17% of women[16]. Prevalence is highest for 25- 34 year olds and lessens as people grow older.

Leicester, when measured through two large lifestyle surveys in 2002 and 2010, has a higher smoking prevalence than nationally (26%), with 29% of males and 22% of females currently smoking. There are higher levels of smokers in the younger age groups and fewer smoking over the age of 55 years. Among different ethnic groups, white groups have the highest prevalence (34%), Asian British groups (13%) and Black/British with the lowest prevalence of 11%. Smoking rates vary, both geographically, as seen below, and within these ethnic categories. For example, although a small proportion of the Leicester population, the General Houshold Survey 2006 found that the Bangladeshi population has a similar prevalence (26%) to the white population, and markedly higher smoking rates in Bangladeshi men (45%).

Nationally there has been a reduction in overall smoking prevalence from 29% in 2000 to 19% in 2010[16]. It is likely the reductions have also occurred in Leicester, however prevalence data has not been systematically collected nationally to confirm this.

Smoking prevalence at ward level is estimated from the Leicester lifestyle Survey, which provides a guide to prevalence. The highest rates were reported in Eyres Monsell (43%), and New Parks (38%), and the lowest in Knighton (9%), Stoneygate (11%) and Latimer (12%) wards. Rates of smoking broadly reflect the pattern of deprivation in the city with the most deprived wards showing the highest prevalence of smoking.

[16] General Lifestyle Survey, Office for National Statistics 2010

Smoking levels in pregnancy have shown a general downward improvement over the past few years both locally and nationally. Leicester has fallen from over 20% in 2006/07 to 12.7% in 2010/11, so that overall levels are now lower than nationally (13.5%). As with smoking levels generally, there is variation across the city, and higher rates of smoking in pregnancy are seen in the west of the city.

Smoking rates, like those for alcohol consumption and drug misuse, are higher in those involved with the criminal justice system. Information about offender health is included in appendix F.

(I) OBESITY

Obesity prevalence

Estimated % of population with BMI over 30, 2006-08

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Obesity in 16+ years	23.4%	24.2%	22.4%	3/8	↑

Data: Health Survey for England, modelled estimates

Obesity in Children
% of primary school children who are overweight or obese, 2010-11

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Overweight in Reception Year	12.4%	13.2%	13.2%	3/8	↓
Obesity in Reception Year	10.5%	9.4%	9.0%	3/8	↑
Overweight in Year 6	12.5%	14.4%	14.2%	1/8	↑
Obesity in Year 6	20.6%	19.0%	18.3%	1/8	↑

Data: National Child Measurement Programme, 2010-11

Obesity is the accumulation of body fat resulting from an energy imbalance, where over a period of time energy intake from eating is greater than energy expenditure, from an individual's metabolism and physical activity.

The body mass index (BMI) is the widely accepted measure of weight, and is based on the ratio of someone's weight to their height.

Compared with national levels, Leicester has a comparable proportion of adults who are estimated to be obese.

Obesity is a risk factor for the development of a range of diseases, for example increasing the risk of diabetes twelve fold in women and myocardial infarction three fold . Recent research from the UK has found that excess body weight and alcohol consumption act together to increase the incidence of liver cirrhosis.

It is estimated that mortality rates would decrease by 14% if all the population was a healthy weight . The prevalence of obesity is increasing, with estimates that 40% of the population will be obese by 2025. National trends show that there are higher levels of overweight and obesity in areas of higher deprivation. National data also shows that rates are also higher for certain minority ethnic groups - Black African, Black Caribbean women, Irish men and Pakistani women .

The prevalence of obesity related conditions varies by ethnic group. South Asian populations are at greater risk of ill health at a lower BMI level than European populations. South Asians have a higher prevalence of cardiovascular disease, hypertension and type 2 diabetes.

Only a quarter of Leicester adults (25.8%) eat the recommended 5-A-Day fruit and vegetables compared to an England average 28.7 % based on modelled estimates using HSE 2006 – 08 (revised) (DH, 2011 Health Profile Leicester). The Leicester Lifestyle Survey 2010 reports a lower percentage of 23% eating 5-A-Day. Further analysis also indicates lower levels for people with compounding disadvantage or vulnerability i.e. smokers (15%), most deprived quartile (17%) and those with poor mental well-being (11%).

The DH (2011) Start active, Stay active UK Physical activity guidelines recognise the health benefits of people taking regular physical activity, and that even small increases in physical activity levels can offer some protection against many chronic conditions.

Local area estimates for adult participation in sport and active recreation (formerly NI8) is measured by Sport England's Active People Survey, and includes recreational walking and cycling. Data from Active People Survey 4 (2009/10) and 5 (2010/11) suggest low participation rates (between 12 – 28 days of participation in the past 28 days) at 16.8%, with only 8.5% being active on 20 – 28 days of the last 28 days, and 57.3% reporting no activity[17].

National Child Measurement Programme data for the 2010/11 school year shows that levels of overweight and obesity are comparable with the England average with reception year levels at 22.9% and Year 6 at 33.1 %.

National Child Measurement Programme data for the 2010/11 school year shows that levels of overweight and obesity (combined) are comparable with the England average with reception year levels at 22.9% and Year 6 at 33.1%. However, levels of obesity in Leicester for both years are significantly higher than the England rate.

The PE and Sport Strategy for young people (PESSYP) survey reports annually on the percentage of children participating in at least 3 hours per week of high quality PE and sport at school age (5 – 18 years). The Leicester Child Health Profile reports the England average as 55.1, with Leicester being significantly lower at 47.5.

Maternal obesity – analysis of data for pregnant women (at the time of booking for their first midwife appointment) in 2010/11 shows that 18% were obese (BMI of over 30), and a further 26% were classified as overweight.

[17] http://www.sportengland.org/research/active_people_survey/active_people_survey_51.aspx accessed 13.4.12. NB due to change in survey methodology no current national comparison is available.

(m) ALCOHOL CONSUMPTION AND HARM

Alcohol-related hospital admission rates

Age-standardised rate per 100,000, 2010-11

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Alcohol-related admission rate	2,078	1,898	1,816	5/8	↑

Data: North West Public Health Observatory, (NI39)

Alcohol is a social drug enjoyed by many people in Leicester and plays a significant role in the economy. However, excessive and frequent drinking can damage health as well as lead to anti-social behaviour, violence and accidents. Alcohol misuse increases the risk of developing a range of conditions including high blood pressure, heart disease, strokes, cancer and liver disease.

Rates of alcohol consumption in Leicester are estimated to be below national rates, however there is a statistically significantly higher rate of alcohol-related deaths and hospital admissions as well as alcohol related crime. Death and hospital admission rates are much higher in males. Leicester has the 14th highest alcohol-attributable death rate for males and the 35th highest for females (out of 326 local authorities). Leicester also has the 37th highest hospital admission rate. In 2010/11 there were over 7000 alcohol-related hospital admissions of Leicester City residents.

There is a clear east/west split in relation to alcohol consumption and subsequent outcomes e.g. hospital admissions. Many wards in the west of the city have higher consumption rates, hospital admission rates and alcohol-related crime.

The Leicester Lifestyle Survey (2010) showed that just over half of all respondents (53%) drank alcohol. Significantly more white respondents (68%) stated that they drank alcohol compared with the ethnic minority population (30%). Of those that reported drinking alcohol, over half of these reported drinking above the recommended limits on a typical day when they were drinking.

Those who are male, white and aged 16-24 are more likely to misuse alcohol and be using treatment services. This group are more likely to have poor mental health, diets and smoke, highlighting the importance of having more integrated interventions.

Alcohol-related recorded crime rates have decreased in the last few years both nationally and in Leicester, with nearly 4,000 alcohol-related crimes recorded in Leicester in 2010-11. Alcohol-related violent crime rates show a general downward trend between 2006/07 and 2010/11 both nationally and in Leicester. However both alcohol related crime and violent crime, although on the decrease, are statistically significantly higher than the England average, and Leicester is worse when compared with peer PCT areas. Alcohol-related violent crime rates have remained fairly stable between 2006/07 and 2010/11 nationally, whilst Leicester has seen a slight fall in the rate

Alcohol related offences are most common amongst 16-24 year olds and decrease with increasing age, suggesting that younger people are at the greatest risk of alcohol-related crime.

Reported levels of drinking amongst children in Leicester is lower than the national rate with 20% reporting ever having an alcoholic drink compared to 42% nationally.

The majority of children (82%) who reported drinking had not been drunk in the last four weeks compared to 68% nationally. The alcohol-related hospital admission rate for under 18s is also lower than the national rate.

Young people in alcohol treatment have more complex issues than our comparator areas, and traditionally the majority of referrals have come via the Youth Offending Service(YOS) where there has been a relatively strong link between alcohol and offending in some wards in the west of the city. Non-criminal justice community based services have been tasked with increasing their contact with young drinkers in an attempt to offer earlier interventions-over 2011-2012 they increased the numbers in alcohol treatment by 50%, although more young drinkers were still in contact with YOS services over this period. Planned exits(77%) from drug and alcohol treatment were on a par with the national benchmark over 2011-12 and there was an overall average reduction in days alcohol use for this group when they left treatment.

Alcohol misuse is high amongst offenders. After heroin, alcohol was the second highest presenting substance use need amongst adults in HMP Leicester. Within the criminal justice system as a whole, there is a confusing picture of the needs of alcohol misusers. There is a clear pathway for treatment of offenders with alcohol needs in the community, However once within the custodial treatment services there is a lack of clearly defined services and responsibility for care co-ordination and delivery of interventions. This includes, different services working in silo assessing need differently, providing various interventions, with varying degrees of data completeness.

It is vital that effective treatment and recovery services are provided. Alcohol treatment is cost-effective. Research shows that for every £1 spent on treatment, the public sector saves £5. Recovery goes beyond medical or mental health issues to include dealing with the wider factors such as housing needs, employment, education and debt advice that will help to promote recovery. A range of these 'wraparound' services exist in Leicester to provide support for those who misuse alcohol

A full specific needs assessment for drugs and alcohol is available on the JSNA webpages.

(n) DRUG MISUSE

Drug Misuse

Estimated problem drug users (PDUs) using crack and/or opiates per 1,000 16-64 year olds, 2008-09

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Problem drug user rate (16-64)	13.0	9.4	8.9	3/7	↑

Data: University of Glasgow Drug Misuse Research

Survey data for Leicester reports levels of drug use lower than the national level with 6% reporting taking drugs in the last 12 months compared to 8.8% nationally. However, the estimated number of problem drug users (those using crack or opiates) is higher than the national rate. Drug-related hospital admissions are also higher than the national rate. There are a small number of drug related deaths each year, with the majority caused by opiate use.

There is a clear east/west split with reported use and subsequent outcomes, with the wards in the west reporting misusing drugs more than in the east of the city, having higher rates of hospital admissions, higher crime rates and higher numbers in treatment.

If you are male, white and aged 16-24 you are more likely to misuse drugs and be in treatment services. This group are more likely to have poor mental health, diets and smoke, highlighting the importance of having more integrated interventions. However there appears to be a changing culture/attitude in the South Asian community, which may change this picture in the future.

There is a clear link between mental health problems and drug misuse (dual diagnosis), with many clients being seen in drug treatment that have been identified as having mental health problems.

There is a link between drug use and blood borne viruses, with injecting drug users and those who share drug using equipment being at greater risk of acquiring a blood borne virus such as hepatitis or HIV.

Local Police data indicates that young people (16-24 years), Black ethnic and some other BME groups are much more likely to have a drug related offence.

Drug services obtain a high proportion of their clients through the criminal justice system. Young people in treatment have more complex issues than that of our comparator areas. Cannabis is the main drug being used by young people in drug treatment (84% over 2011-12) Planned exits(77%) from drug and alcohol treatment were on a par with the national benchmark over 2011-12 and there was an overall average reduction in days Cannabis use for this group when they left treatment, although a reduction was not achieved for the very small number using stimulants.

As with alcohol misuse, it is vital that effective drug treatment and recovery services are provided. Research shows that for every £1 spent on drug treatment, £2.50 is saved to society. Drug treatment protects public health by preventing drug related deaths, restricting blood borne viruses, and reducing the burden on the NHS. Full recovery goes beyond medical or mental health issues to include dealing with the wider factors such as housing needs, employment, education and debt advice that will help to promote recovery and reintegration.

A full specific needs assessment for drugs and alcohol is available on the JSNA webpages.

(O) CHILDREN AND YOUNG PEOPLE

Children living in Poverty

% of children under 16 living in families in receipt of out of work benefits or tax credits where income is less than 60% of the median income, 2008

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
% children under 16	33.10%	21.9%	18.40%	3/7	↑

Data: HMRC Child Poverty Statistics,

Around 26% of the Leicester population is under the age of 20. Around 65% of school children are from a black or minority ethnic group. The 2009/10 JSNA focussed specifically on children and young people. The full report is available from the JSNA website. It identified the range of issues facing the city including high child poverty, poorer levels of income and resources generally in the deprived areas of the city and a higher proportion than nationally of children of young who were not in employment, education or training (NEETs). It drew out the need to continue to improve educational outcomes for all children and for children with special needs, and to address the large difference in health outcomes found across the city. The JSNA identified geographical areas in Leicester where particular focus was required as well as the need for specific groups effected by multiple disadvantage. The JSNA for 2009/10 informed the current Children and Young Peoples Plan 2011-2015.

The Child and Maternal Health Observatory (CHIMAT) has recently issued the Leicester Child Health Profile March 2012[18]. This shows that:

- a range of factors, e.g. child immunisations, chlamydia diagnosis, family homelessness, children and young people using alcohol, and hospital admissions for mental health conditions are all better in Leicester than the England average.
- on the England average are the first time entries to the youth justice systems, children killed or seriously injured in road traffic accidents and teenage mothers (aged under 18 years), hospital admissions due to alcohol specific conditions, hospital admissions due to substance misuse, children and young people using drugs, children and young people smoking, breast feeding initiation, smoking in pregnancy and the numbers of children reporting that they have someone to talk to.
- Where Leicester is below, or worse than the England average is in the infant mortality rate, the child mortality rate, children achieving a good level of development at age 5, GCSE achieved, those not in education, employment or training, children living in poverty (aged under 16 years) children in care, children who are obese (at age 4-5 and 10-11 years), participation in at least 3 hours of sport/PE, teenage conception rate (aged under 18 years), children's tooth decay (at age 12), hospital admissions due to injury, hospital admissions as a result of self harm.

The CHIMAT Profile does not draw out trends and it is known that across a range of the above indicators there has been significant progress. For example, children's attainment at all ages has improved year on year since 2007, there is an increasing number of good and outstanding schools, and there has been a reduction in teenage conceptions from 365 in 2008 to 232 per 1000 15 to 17 year old females in 2010. And the the city's has seen the numbers of those not in employment, education or training (NEETs) has reduced year on year. The CHIMAT report does however

[18] available from www.chimat.org.uk

confirm that the health and wellbeing of children and young people remains a high priority for focus in Leicester.

LONG-TERM CONDITIONS REQUIRING CARE AND SUPPORT FOR INDEPENDENCE

(o) MENTAL HEALTH

Prevalence of Mental Ill Health

% of all population registered with a mental illness, March 2011

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
All ages	0.95%	0.79%	0.70%	6/8	↓

Data: Quality Outcomes Framework (GP registers)

Mental illness is the largest single source of burden of disease in the UK. It can affect anyone of any age. It is associated with social exclusion, deprivation, domestic violence, low income, unemployment, poor housing and low educational attainment. Mental ill health is also associated with poor physical health and high risk taking behaviour. Those who care for a relative or friend suffer high rates of mental illness.

Leicester has significantly worse rates of unemployment among working-age adults and is on the national average for people aged 16-18 not in employment, education or training. Rates for admissions for alcohol attributable conditions are significantly worse for Leicester than the national and regional averages and almost one person in six reports that they have a limiting long-term illness. There is also lower participation in activities that are protective of mental health and wellbeing. For example, fewer adults and children participate in physical activity.

Reflecting the presence of these high risk factors there is a significantly higher proportion of the population registered with a mental illness than in England and the East Midlands, and the trend is worsening, see table above. The estimated number of people in Leicester with serious and enduring mental illnesses, such as schizophrenia, bipolar affective disorder and other psychosis, is about 3,400 people. The estimated number of people with anxiety and depression is about 30,000 and prescriptions for anti-depressant medications are increasing. Leicester has higher rates than nationally of emergency admission for self harm, and a high indirectly standardised mortality rate for death from suicide and undetermined injury.

BME groups are, on average, three times more likely to experience psychosis than white British ones. In the South Asian population the rates of severe mental illness with an admission to hospital are lower than the Leicester average, and they are almost twice as high in the black community. Local analysis of the *Count Me In Census* reports for 2006-10 show that Black/Black British groups are over represented as inpatients in local secondary care mental health facilities.

Many people will suffer mental illness over their lifetimes. Perinatal maternal mental illness is particularly important because it occurs in such a crucial time in the lives of mothers, their babies and families. Failure to treat perinatal maternal mental illness may have a harmful effect on the relationship between mother and baby and on the child's subsequent cognitive, emotional and social development. It is estimated that 150 women per year are likely to have a major perinatal depressive illness in the city of Leicester

Projections of working age adults with a range of mental ill-health problems in Leicester 2011-2030 estimate that there will be a 16% increase in 18-64 year-olds with a common mental disorder and a 7% increase in those with 2 or more psychiatric disorders.

Provision of mental health care for the elderly is an urgent problem. Between 10% and 16% of people over the age of 65 will develop clinical depression, whilst 25% of people over 85 suffer with dementia. Such problems exert a large socio-economic cost, with treatments for Alzheimer's disease likely to exceed the costs of treating illnesses such as heart disease and cancer.

(p) OLDER PEOPLE

Data: Quality Outcomes Framework, ONS mortality data, NHS Information Centre Indicator Portal

Older People

People aged 65 and over predicted to have dementia, 2011
Emergency hospital admissions for fractured neck of femur in over 65s: Standardised rate per 100,000, 2009-10

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Prevalence of dementia	7.2%	7.2%	7.0%	2/7	
Excess winter deaths	16.5	18.1	17.2	2/7	
Hip fractures	527.2	457.6	470.0	6/7	↑

Approximately 11.3% of the Leicester population, or 35,600 people, are aged over 65, a lower proportion than both the regional or national averages. Of the over 65's in Leicester some 5,200 people are aged over 85. Although declining death rates and fertility means that the number and proportion of people aged 65 and over is projected to increase to 51,300 (13.6% of the total projected population) by the year 2030, the proportion of people over 65 years in Leicester will remain lower than the national average.

The majority of older people are female. At present there are relatively fewer people aged >65 years from BME communities, than the city population generally. But as Leicester is a diverse city, the proportion of older people from BME backgrounds will increase.

High numbers of older people live in ward areas such as New Parks and Knighton. Over 13,000 older people live alone and projections suggest that this will rise to nearer 20,000 by 2030[19].

[19] POPPI: Projecting Older People Population Information System Please note throughout the sections on Older People, Dementia, Learning Disability and Physical and Sensory Disability, unless otherwise indicated the data and projections is drawn from estimates provided by Projecting Adults Needs and Service Information (PANSI) pansi.org.uk and Projecting Older People Population Information (POPPI) poppi.org.uk. Both systems aim to assist local (social) care services anticipate likely demand for services and models on best available evidence likely numbers and projections of people with various conditions or needs to be found in the population.

The majority of older people live in privately owned property. However, 1,250 live in nursing or residential care and this will also rise to over 1,900 people by 2030.

The leading causes of death in those aged over 65 years in England are circulatory disease, followed by cancers and respiratory disease. In Leicester these causes of death accounted for deaths in 76% of men and 70% of women in the period 2008-10, less than the national average.

Susceptibility to common health problems increases with age, and the ability to perform activities of living is affected by chronic diseases, such as arthritis, and sensory impairments. Dementia is a serious and urgent problem which is more common in the over 65s than the population generally. It is estimated that by 2025 there will be 3,357 people with dementia in Leicester. Mental health problems, such as depression, are common in older people and are often linked to isolation, long term conditions or becoming carers. It is estimated that 735 people over the age of 65 years in Leicester currently have a learning disability. Of these there are 99 people who have a moderate or severe learning disability, and hence likely to be in receipt of services. It is estimated that around half of Leicester's population over 65 are living with a limiting long term illness; an estimated 12% have diabetes, 7% have dementia and many have longstanding health conditions caused by a heart attack (5%) and stroke (2%). Over 40% have moderate or severe hearing impairment, 9% have moderate or severe visual impairment, approximately 16% suffer with bladder problems, 18% are unable to manage at least one mobility activity on their own and 11% are predicted to have depression.(POPPI 2011).

Falls are a common and potentially serious problem for older people. They are often linked to frailty, multiple prescription medicines and underlying illnesses. Falls often resulting in injury, such as fractures, but they can lead to further fear of falling, social isolation and death. The population aged 65 and over predicted to have a fall in Leicester is 9,462 people.

POPPI data suggests that over 6,600 people of the population aged 65 and over are unable to manage at least one self-care activity on their own. This is projected to rise to 9,500 by 2030. Most carers are female. Currently there are 3,800 carers aged over 65 in Leicester and this is projected to rise to 5,456 by 2030.

People aged over 65 years disproportionately use health and social care services compared with other age groups. A total of 8,064 people received a service provided or commissioned by Leicester City Council Adult Social Care during 2010/11. 5,219 (65%) of those who did so were aged 65 and over, and 2,260 (28%) of were aged 85 and over.

The over 65s account for over 30% (some 12,000) of all emergency hospital spells in Leicester, and nearly 60% of the total cost of emergency admissions. The top three causes of hospital emergency admissions in over 65 year olds are CVD (16%), respiratory conditions (15%) and injuries (13%).

Although the number and proportion of people over 65 years in Leicester is lower than the regional and national averages, they are set to increase. As the numbers of older people in the population expand, the demand for health and social care services will also increase
It is critical that older people spend extra years in good physical and mental health. Effective treatments for circulatory conditions and early intervention in dementia and depression will improve wellbeing. Integrated health and social care services will help to maintain quality of life and independent living for as long as possible.

(q) DEMENTIA

Prevalence of Dementia

% of population registered with dementia, March 2011

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
All ages	0.39%	0.48%	0.51%	6/8	↓

Dementia describes a set of symptoms, including memory loss, mood changes and problems with communication and reasoning. These symptoms are more severe than those experienced in normal ageing and occur when the brain is damaged by certain diseases, such as Alzheimer's disease, or damage caused by a series of small strokes. These symptoms will gradually get worse, and different needs emerge as the illness progresses. Of the different types of dementia Alzheimer's disease is the most common, accounting for more than 60% of cases. Dementia related to vascular disease is the next most frequent (17%). A further 10% of cases are related to a combination of the two.

There are approximately 2,700 people with dementia in Leicester. The risks of having dementia increase with age, so most people with dementia are aged 65 and over and dementia affects 7.6% of the population in this age group. There are about 70 younger people with dementia. There will be around 3,700 people with dementia in Leicester by 2030.

There is a clear need to improve rates of early diagnosis. Currently less than half of the estimated population with dementia is recorded on primary care disease registers in Leicester. If people are diagnosed earlier they will get earlier access to the important information relevant to people with dementia and their carers and they may be able to benefit from medication. Better rates of early diagnosis and improvements in dementia care can only be achieved by the developments across the whole of the dementia care pathway, including commissioned memory assessment services, general hospital liaison care and care for people living in the community.

Early diagnosis is likely to have an impact on prescribing rates. There is already a general upward trend in the cost of prescribing drugs, such as acetyl cholinesterase inhibitors, which have some therapeutic effect on Alzheimer's disease. Whilst the patent to one of these drugs expired in February 2012, making the medication less expensive, recent NICE guidance releasing the medication memantine, for cases of moderate to severe dementia is a risk to prescribing budgets.

The health and wellbeing of carers is also an immediate urgent need. Early diagnosis should allow more timely access to information about dementia. It should also give patients and carers the opportunity to look at support options. These options are likely to be tied closely to the agenda for personalised budgets, respite care, care home support and end of life care. These factors mean more social care developments, better training for all of those involved in dementia care and closer working between clinical staff in primary care and dementia care co-ordinators.

The dementia care pathway should offer support which maintains independence, enabling those who wish to remain at home to do so if they can. There should be a flexible approach to respite; including enough respite in the home where a person with dementia is less likely to become confused, and a carer may be able to take time away from caring responsibilities. As there are high rates of physical and

mental health problems amongst carers, it is also important for carers to have access to an annual review of their health and wellbeing.

(r) CARERS

A carer spends a significant proportion of their life providing unpaid support to a relative, partner or friend who is ill, frail, disabled or has a mental health or substance misuse problem. Everyone is potentially a carer. The experience of caring can depend on the circumstances of the person being cared for, cultural expectations and support from family members or local groups.

Responding to the needs of people who care is a major challenge. Carers often experience high rates of depression and stress. They can become isolated. Working age adults who provide a lot of care tend to have lower incomes, poorer health and are less likely to be in work. Children and young people need to be protected from inappropriate caring and to be able to have support so that they may learn and develop. Older people who care may have their own ill health problems; they may also be providing long term care for an older person with complex needs. An inability of a carer to cope is often the cause of hospitalisation and admission into residential care.

In 2001 the number of carers in Leicester, aged over 18 years, responsible for giving at least one hour of care per week was 25,473. There was an additional estimated 1,128 young carers. The combined total meant that 9.5% of the city's population were carers. Two thirds of all carers were female. More recent national evidence suggests that this gender gap is narrowing, primarily because of the rising number of older male carers, related in its turn to the ageing of the population

In Leicester the highest numbers of carers aged 18-64 years were found in Spinney Hills ward (1,658 carers); the highest numbers of carers aged over 65 years were found in Knighton ward (351 carers). The highest proportions of carers (as a percentage of ward population) were found in Evington and Latimer wards (carers aged 18-64 years) and Eyres Monsell and Knighton wards (carers aged over 65 years).

As carers are likely to have higher rates of stress, depression and physical ill health there are a number of policy initiatives aimed at supporting carers. Under the Carers and Disabled Children Act 2000, carers are entitled to have an assessment of their needs, including respite care. This provides the opportunity for carers to have their need for respite care met before a crisis situation develops. The Leicester, Leicestershire and Rutland Carers' Strategy includes an action plan to address the needs of carers.

(s) LEARNING DISABILITY

Learning Disability

Percentage of Population aged over 18 registered with a Learning Disability

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
% with a Learning Disability (18+)	0.51%	0.43%	0.47%	8/8	↔

Data: Quality Outcomes Framework, March 2011.

A learning disability is a lifelong condition which affects around 1.5 million people in England. It refers to a large group of people who have a wide range of different abilities and needs, defined by the Department of Health[20]as a combination of :-

- a significantly reduced ability to understand new or complex information, to learn new skills: along with
- a reduced ability to cope independently
- an onset of disability which started before adulthood, with a lasting effect on development.

The national and local vision remains, as set out in *Valuing People* in 2001, that all people with a learning disability are people first with the right to lead their lives like any others, with the same opportunities and responsibilities, and to be treated with the same dignity and respect. They and their families and carers are entitled to the same aspirations and life chances as other citizens.

It is estimated that there are currently around 5,136 people aged 18 – 64 with any learning disability in Leicester. Of these of these around 3,990 are likely to require no or limited care and support services except in crises. Some will live independently, others will be living with family members. However, some 1,146 people 18-64 years will have high support needs and be likely to need care services. In those aged over 65 years there is an estimated 735 people with a learning disability. Of these 99 are expected to have a moderate or severe learning disability and so also likely to require support. In total around 1,245 people will have needs estimated to require care services.

People with learning disability need a range of support. Employment is an anxiety for individuals and their families, particularly aspects of safety and the impact of wages on benefits. The physical health of people with learning disability has been found to be variable and poorer than those without. A total of 1,132 people with a learning disability were recorded on GP registers in Leicester in December 2011, suggesting in itself under-recognition of the condition.

Accommodation and support is also crucial. Around half of adults, 18-64 years, in Leicester with any learning disabilities live with their families, 30% live in residential care, 15% have a secure long term tenancy or their own home and around 5% rent. Around 23% in the 18-64 age group with a moderate to severe learning disability, around 260 people, are currently supported by social care in residential and nursing care homes. By 2030 this figure is projected to increase by some 4 percentage points to 294.

[20]Department of Health, Valuing People: A New Strategy for Learning Disability for the 21st Century. 2001

Outside of those in residential or care homes, many other people with a learning disability are cared for by carers within the family home or supported to live independently through self-directed support and/or direct payments. The services provided include day care facilities, help with domestic tasks and personal care.

Around 11% of carers in Leicester in 2009/10 said they did so mainly because the person they cared for had a learning disability or difficulty. Such carers were more likely to be caring for 20 or more hours per week than those caring for people with other conditions. Some 57 people over the age of 45 with a moderate to severe learning disability are living with a parent, suggesting that these "parent-carers" are retired and ageing. Data from POPPI for 2011 suggests that some 50% of people over the age of 65 have a limiting long term illness. These illnesses may ultimately prevent the parent over the age of 65 from continuing their caring role.

People with learning disabilities from BME communities can experience a double discrimination and are more likely than white people to find it difficult to access services, which underscores a continuing need to ensure culturally specific interventions.

In Leicester there has been a shift to giving people much more choice and control over their lives and over the key decisions that affect them – including the type of care and support they receive. This new, flexible way of working is being enabled by shifting budgetary control towards the people using services through such initiatives as direct payments and personal budgets. The local authority provides support for people with substantial and critical needs. Latest figures show that 977 adults aged 18 + with learning difficulty received packages of care. 90% (879) of these were aged 18 – 64 and 10% (98) were aged 65+. There remains a gap between those currently receiving services (977 individuals) and the estimated prevalence of people likely to have comparable need, as indicated above some 1,245 people. The extent of unmet need is therefore in the region of some 268 people likely to have substantial or critical needs.

It should be noted that some 2,063 adults in Leicester have autistic spectrum conditions and that around 130 people aged 18 – 64 have Down's Syndrome, predominantly in the group 25 – 49 age group.

The numbers of people aged 18 – 64 with Down's Syndrome, dementia and challenging behaviour comprises a relatively small proportion of those expected to have learning disability. However the cost of supporting these service users can be high so that a small increase can cause a large increase in support costs.

Projections from PANSI indicate that the proportion of people aged 18 – 64 with any learning disability may increase in Leicester by around 14% by 2030. This is twice the rate of increase than that projected for England and the East Midlands. The largest increases by 2030 are likely to be seen in the proportion with moderate and severe learning disabilities, some 19%.

The projected growth of people with any learning disability aged 65 and over is likely to be slightly slower than that in England or the East Midlands. Nevertheless there is likely to be an increase of some 46% by 2030. The increase in people who are likely to be known to services is higher – 49%. There are no estimates for people with both learning disabilities and dementia because it is difficult to identify the onset of dementia from the general age related worsening of the learning disability.

Younger people with diagnoses of Learning Disability are considered in the JSNA report focussed on Children and Young people (2011). In Leicester currently around 584 15-19 year olds have a learning disability, a population projected to increase by some 9% by 2030. Of these, around 143 are predicted to have a moderate or severe learning disability, where the projected increase by 2030 is 17%, over three times that expected regionally or nationally. There is an increasing recognition, by commissioners of Children and Young People's, Adult Social Care and Health Services locally of the need to improve transition planning and support as younger people with learning disabilities move into adulthood. This involves ensuring continuity of care and support for the young people and their families and opportunities to participate in education, training or employment.

(t) PHYSICAL AND SENSORY DISABILITY

A physical or sensory disability can be defined as a disability which reduces the individual's movement, sight, hearing, communication and/or the ability to carry out activities of living. Different levels of severity present different issues in terms the services which are required. Physical disability can leave people feeling isolated, disempowered and depressed. The loss or impairment of vision and hearing can substantially reduce one's quality of life. Many people with physical disabilities are reliant on carers.

Physical disability

Physical Disability
Percentage of Population aged over 18-64 with a moderate/severe Physical Disability, 2011 (POPPI)

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Moderate or severe disability (18-64)	8.79%	9.97%	10.18%	3/8	**n/a**

The prevalence of physical disability is higher than the number of people who need services. PANSI data suggests that just under 4,000 people aged 18-64 are thought to have a serious physical disability in Leicester; 234 of whom are in receipt of social care through self-directed support and/or direct payments, with 86 in residential care.

Visual Impairment

Visual Impairment
Percentage of Population aged 65 and over with a moderate/severe Visual Impairment, 2011 (POPPI)

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Moderate or severe visual impairment (65+)	8.92%	8.85%	8.75%	2/8	**n/a**

It is estimated that more than 3,000 people in Leicester are living with sight loss or vision impairment. Some of the most common eye conditions that cause this are macular degeneration, glaucoma, detached retina, diabetic retinopathy and

cataracts. People from African or African-Caribbean backgrounds are four times more likely to develop Glaucoma than the general population; and diabetic retinopathy is more prevalent in the South Asian population, reflecting the higher prevalence of diabetes.

In 2010 there were 2,233 individuals on the visual impairment register in Leicester, 57% women, 43% men, 35% from an Asian/Asian British ethnic background and 63% from a White/White British ethnic background. 73% are aged over 60 years, and of those aged 18 years and under, more than half were from an Asian/Asian British ethnic background.

By 2030 the number of people with sight loss is predicted to increase in Leicester to around to 4,700 people. PANSI and POPPI data suggest that whilst the number of people with visual impairment will increase, the most marked increase will be in people aged over 65 years. The data suggests that the number of people with visual impairment aged below 65 years in Leicester is projected to rise by a small number of cases; from 134 in 2011 to 154 in 2030, a rise of about 15%.

As well as responding to the social care and health needs of people with sight loss or impairment there is a considerable primary and secondary prevention agenda. Vision impairment can be reduced through the promotion and adoption of eye health, a reduction in smoking - which more than doubles the risk of developing age related macular degeneration, the main cause of sight loss, and increases the risk of cataracts - and through ensuring that the potential of sight loss is clearly addressed in the on-going education and care of people with diabetes.

Hearing Impairment

Hearing Impairment

Percentage of Population aged 65 and over with a moderate/severe Hearing Impairment, 2011 (POPPI)

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
Moderate or severe hearing impairment (65+)	42.78%	42.87%	42.11%	1/8	**n/a**

Hearing impairment is the commonest sensory impairment worldwide, it can present at any time from infancy to old age. The precise size of the deaf community is unknown. POPPI and PANSI population projections for Leicester, show that there are an estimated 21,503 people with moderate or severe hearing loss in Leicester, and this is set to rise to 29,830 by 2030. A large proportion of the hard of hearing community is over 65 years old. Those with profound hearing loss were estimated to number 454 people in 2011, and this is set to rise to 660 by 2030.

A significant and increasing number of people in Leicester have a physical or sensory disability which requires continuing efforts to enhance inclusion, participation and independence of people with a physical disability, promoting dignity, self-respect and individuality. In addition there is a need to improve the ear and eye health of the people of Leicester and to eliminate avoidable hearing and sight loss.

HOUSING, HEALTH AND WELLBEING

(u) Housing, health and wellbeing

Housing

Statutory homeless households, crude rate per 1,000 estimated households, 2009-10

	Leicester value	England	East Midlands	Peer ranking: (1 = best)	Local Trend
HB claimants per 1,000 households	259.2	185.8	161.7		n/a
Homelessness	0.6	1.9	1.7	1/7	↑

The availability and quality of an appropriate home has a substantial impact on health and wellbeing. A warm dry and secure home is associated with better health. Poor housing is associated with increased risk of cardiovascular disease, respiratory disease and depression and anxiety. It has been estimated that poor housing costs the NHS at least £600 million each year. The dimensions of housing in relation to health and wellbeing in Leicester include access, quality, deprivation and poverty, overcrowding and homelessness

Planning projections indicate a need for 25,600 new homes to be built in Leicester between 2006 and 2026. To achieve this level of new provision will require a step change in housing delivery, some 1,280 homes annually, which is a 50% increase on average annual house building rate achieved in 2001 – 2006. Similarly, the 2008 strategic housing market assessment estimated that there was a requirement for 790 social housing units (affordable housing for those who cannot meet their housing costs through the market) per year up until 2015.

The main type of social housing required are two and three bedroom properties (approximately three quarters of provision). It is important to note that a proportion of the requirement (in the region of 4%) is for sheltered and supported housing, which supports some of the most vulnerable groups across the city. These target and aspirations will be extremely challenging due to the housing market downturn from 2008 onwards, which has had significant impact on new house building starts of any kind.

In terms of affordable housing there is a gap between demand and supply. In 2010/2011 there were 2,017 council or housing association relets in Leicester, while the housing register – the record of those applying for social housing in the city - stood at some 8,942 households.

In recent years there has been significant modernisation of Leicester Council owned housing stock and this now meets the requirements of the Decent Homes Standard, as does that of housing associations. The issue of quality is now pronounced in privately owned housing.

The Leicester 2010 Private Sector Stock Survey found that just over two fifths (41.7%) of private sector homes fail the Decent Homes Standards – some 34,000 households in total –a higher level of failure than found in England more generally (35.8%). The major immediate reasons for the failure are the hazards presented through exposure to excess cold, falls associated with stairs and steps and the risk of fire. The cost of rectifying these and other failures has been estimated as being around £60 million. An added dimension to this is that in Leicester some 40% of

household considered vulnerable, that is in receipt of one of the principal means tested benefits, live in privately owned houses that do not meet the Decent Homes Standard. In these cases the cost of necessary repairs appears prohibitive .There are implications in this for the delivery of social care to vulnerable people who live in privately rented housing or who are low income owner occupiers.

The major background reasons for the high level of failure of the Decent Home Standard in private sector housing in Leicester is that the city has an older than average private sector housing stock than generally found in England, combined with a higher level of deprivation, implying insufficient resources to maintain homes adequately. The government has abolished the private sector renewal budget. To help address the lack of assistance for those in need, the City council will be introducing a scheme to provide repayable Home Repair Grants.

These difficulties of housing in Leicester are compounded by the economic situation and there are now twice as many households in fuel poverty (11,397 in December 2011) than there were March 2011, following the utility price rises of that year.

The LCC 2010 Compulsory Spending Review Equalities Impact Assessment found the potential impact of the governments welfare benefit reform to be significant across a number of areas including homelessness, with families of 3 or more children hit hardest and poverty arising from reduced benefits.

The 2001 Census found that 10.6% of all Leicester's households were overcrowded, compared with 7.1% nationally and 4.5% for the East Midlands. A third of households on the Housing Register are overcrowded. Overcrowding puts children at greater risk of sudden or unexplained death infectious diseases, respiratory infections and there is also evidence of a long-term impact of overcrowding on children's health into adulthood, linking it to respiratory problems, heart disease, cancer and depression.

Homeless people are a group with some of the most severe and costly health needs in our communities and it has been estimated nationally that this group uses hospital services at a rate 4 to 8 times greater than the general population. It is difficult to estimate the total numbers homeless, though there is also clear evidence of an increase in homelessness. In 2011/2012 (LCC Housing Options data) there were:

- 1,635 families and single people threatened with homelessness (a 15% rise on the preceding year)
- 204 families into hostels and into bed and breakfast (a 27% rise on the preceding year)
- 460 single people in hostels (no change on the preceding year).
- In an average week there will be 22 people sleeping rough in the city

Leicester faces serious challenges in relation to housing for its population with significant shortfalls in all housing and in affordable and social housing in particular. Some 40% of private sector housing fails to meet the national Decent Homes Standard. The current economic climate does not lend itself to easy solutions.

PATIENT AND USER VOICE

(v) Patient and user voice

Currently, in both health and social care services there are range of opportunities for patient, client and public involvement and many mechanisms for obtaining feedback. These include access to specific groups, databases, complaints and commendations,

contract monitoring processes, consultations/surveys, public meetings/events, working through third sector agencies/providers, using media, social marketing, and leaflets/newsletters, and assessment and reviews.

Local Involvement Networks (LINks) are independent fora which give people an opportunity to input into the planning and delivery of local health and social care services. In Leicester the Local Involvement Network (LINk) is currently organised by the Carers Federation (the 'host' agency). The NHS reforms plan to replace LINks with HealthWatch. The latter will have more responsibility and power to scrutinise services and the involvement of patients in the decisions made of those services.

In addition to these mechanisms, there have been a number of surveys of citizen's views on a range of issues relevant to the city and its services.

Information drawn from these sources give some insight into the views and experience of the residents of Leicester. Surveys have shown that most people are generally satisfied with their local area as a place to live. Broadly, residents are satisfied with their local services. Leicester performs well in respect to refuse collection services, the degree to which residents feel able to influence local decisions and the perception that anti-social behaviour and crime are successfully addressed.

Around three-quarters of users, when surveyed, express high satisfaction with primary health care There continues to be issues around awareness of extended hours in general practice and being able to book advance appointments. There have been improvements in both satisfaction with Leicester NHS dentists and a greater proportion achieving appointments with Leicester NHS dentists. Both waiting times in Accident & Emergency (A&E) and the length of time it takes to get an appointment with a General Practitioner (GP), present as areas for improvement.

NHS Leicester City (NHSLC) and the Leicester LINk ran a range of consultations with patients and the public. These presented a variety of service and topic specific and general issues, particularly around a need for improved communications and information and patient preferences in regard to service delivery.

The top three reasons for Social Care complaints were lack of communication, failure to undertake a task and staff attitude or behaviour. Two of these reasons were echoed in the top three for the main Leicester NHS organisations – NHSLC, University Hospitals of Leicester (UHL) and Leicestershire Partnership NHS Trust (LPT) – which were clinical or medical care, staff attitude and communications

APPENDIX A

The Leicester JSNA Programme

In Leicester a JSNA Programme is led by a JSNA Project Board on behalf of the Shadow Health and Wellbeing Board. In essence the Project Board's job is to ensure that joint needs assessments provide a sound basis for commissioning decisions.

Recognising that this work is taking place at a time of organisational uncertainty against a general background of reduced funding, the principles guiding the JSNA Project Board, and considered and supported at the October 2011 stakeholder event, are that progress on the JSNA will be:

Incremental– we will not get everything right at once, but we do want to get it right, both in the reports we produce and how we do it;
Collaborative– we will work with others and seek and use feedback;
Communicative– we will aim to keep people informed about the JSNA Programme;
Developmental – we recognise that we need to plan for a number of years ahead and to support training and development for needs assessment We want people from different sectors to be involved in needs assessments and for there to be greater support for needs assessment as a key part of the commissioning cycle.

The Project Board has sought the views of commissioners of services to understand how the JSNA could be made relevant to commissioning decisions. This has led to the understanding that no one document or process will meet the demand for both a high level strategic overview of key health and wellbeing issues on the one hand, and for the detailed understanding that is required for specific commissioning in specific areas, on the other.

Key areas of work for the JSNA Project Board therefore are:

1. Producing the high level Joint Strategic Needs Assessment (JSNA) integrating a range of data and information and identifying needs of broad strategic importance to the health and wellbeing of the city. Its purpose is to inform and underpin the future Joint Health and Wellbeing Strategy

2. Producing Joint Specific needs assessment(JsPNA) – which are assessments of needs, trends, current performance against evidence of effectiveness, models and other factors to inform in greater detail commissioning in particular areas for particular need. For example, dementia, smoking, cardio vascular disease, end of life care. Two such needs assessments are currently underway (March 2012), one on dementia and one on alcohol and drugs. Others are planned. Over a number of years we would expect to see more detailed needs assessments covering most key areas of need and service. The priorities for JsPNA in 2012/13 are mental health, learning disabilities, carers and disabilities in children.

3. Making both these types of needs assessments accessible through web access and improving web availability in response to opportunities and demand.

4. Further developing capacity and capability across the system to undertake or contribute to needs assessments. A first training course has been held in 2011/12 with participants from the local authority, the health system and the voluntary sector. It is the intention to offer further courses and development opportunities.

JSNA Project Board

Rod Moore, Deputy Director of Public Health & Health Improvement, CHAIR
Trevor Pringle, Divisional Director Planning and Commissioning, Children, Leicester City Council
Tracie Rees, Director of Strategic Commissioning, Leicester City Council
Sarah Prema, Head of Commissioning, Leicester City Clinical Commissioning Group
Hasmukh Jobanputra, Chair, Leicester Local Involvement Network
David Barsby, Voluntary Action Leicester shire
Jay Hardman, Research and Intelligence Manager, Leicester City Council
Helen Reeve, Principal Public Health Analyst, NHS Leicester City
Ashok Chotalia, Commissioning Manager, Drug & Alcohol Action Team, Leicester City Council

APPENDIX B

The JSNA refresh 2012 has been produced on behalf of the JSNA Project Board by information/analytic staff of NHS Leicester City and Leicester City Council.

In doing this there has been:

- Engagement with wider stakeholders at an early point in the process through an event held at Voluntary Action Leicester in October 2011 designed to increase understanding of the JSNA, and to get ideas about how it could be made more effective.
- Feedback by stakeholders to some early sections of the JSNA placed on the JSNA website – this has led to revision and to further sections being added to the JSNA.
- A further stakeholder event in May 2012 to sense check and assist in drawing conclusions from this summary document. Changes have been made to this document following the stakeholder event.

APPENDIX C

Appendix A: Overview of outcomes and indicators

Vision

To improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest.
Outcome measures
Outcome 1: Increased healthy life expectancy, ie taking account of the health quality as well as the length of life.
Outcome 2: Reduced differences in life expectancy and healthy life expectancy between communities (through greater improvements in more disadvantaged communities).

1 Improving the wider determinants of health

Objective

Improvements against wider factors that affect health and wellbeing and health inequalities

Indicators

- Children in poverty
- *School readiness (Placeholder)*
- Pupil absence
- First time entrants to the youth justice system
- 16-18 year olds not in education, employment or training
- People with mental illness or disability in settled accommodation
- *People in prison who have a mental illness or significant mental illness (Placeholder)*
- Employment for those with a long-term health condition including those with a learning difficulty/ disability or mental illness
- Sickness absence rate
- Killed or seriously injured casualties on England's roads
- *Domestic abuse (Placeholder)*
- *Violent crime (including sexual violence) (Placeholder)*
- Re-offending
- *The percentage of the population affected by noise (Placeholder)*
- Statutory homelessness
- Utilisation of green space for exercise/health reasons
- Fuel poverty
- *Social connectedness (Placeholder)*
- *Older people's perception of community safety (Placeholder)*

2 Health improvement

Objective

People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities

Indicators

- Low birth weight of term babies
- Breastfeeding
- Smoking status at time of delivery
- Under 18 conceptions
- *Child development at 2-2.5 years (Placeholder)*
- Excess weight in 4-5 and 10-11 year olds
- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- *Emotional wellbeing of looked-after children (Placeholder)*
- *Smoking prevalence – 15 year olds (Placeholder)*
- Hospital admissions as a result of self-harm
- *Diet (Placeholder)*
- Excess weight in adults
- Proportion of physically active and inactive adults
- Smoking prevalence – adult (over 18s)
- Successful completion of drug treatment
- People entering prison with substance dependence issues who are previously not known to community treatment
- Recorded diabetes
- Alcohol-related admissions to hospital
- *Cancer diagnosed at stage 1 and 2 (Placeholder)*
- Cancer screening coverage
- Access to non-cancer screening programmes
- Take up of the NHS Health Check Programme – by those eligible
- Self-reported wellbeing
- Falls and injuries in the over 65s

3 Health protection

Objective

The population's health is protected from major incidents and other threats, while reducing health inequalities

Indicators

- Air pollution
- Chlamydia diagnoses (15-24 year olds)
- Population vaccination coverage
- People presenting with HIV at a late stage of infection
- Treatment completion for tuberculosis
- Public sector organisations with board-approved sustainable development management plans
- *Comprehensive, agreed inter-agency plans for responding to public health incidents (Placeholder)*

4 Healthcare public health and preventing premature mortality

Objective

Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

Indicators

- Infant mortality
- Tooth decay in children aged five
- Mortality from causes considered preventable
- Mortality from all cardiovascular diseases (including heart disease and stroke)
- Mortality from cancer
- Mortality from liver disease
- Mortality from respiratory diseases
- *Mortality from communicable diseases (Placeholder)*
- *Excess under 75 mortality in adults with serious mental illness (Placeholder)*
- Suicide
- *Emergency readmissions within 30 days of discharge from hospital (Placeholder)*
- Preventable sight loss
- *Health-related quality of life for older people (Placeholder)*
- Hip fractures in over 65s
- Excess winter deaths
- *Dementia and its impacts (Placeholder)*

Source: Public Health Outcomes Framework. Department of Health, January 2012. http://www.dh.gov.uk/health/2012/01/public-health-outcomes/

APPENDIX D

Health of new arrivals

The term 'New Arrivals' is used to describe a range of individuals, including asylum seekers, refugees, European Union (EU) migrants and third country nationals who have recently migrated to the UK. These people are likely to have differing health and social care needs and entitlements. This inwards migration adds to the already complex pattern of diversity in Leicester.

There are three different groups who can be described as 'new arrivals' in Leicester. The largest is the Somali community which predominantly arrived in Leicester from the Netherlands from 2002-2004. Generally, they are EU nationals having received asylum in the Netherlands, or Sweden or Denmark. The second group are asylum seekers and refugees who first began arriving in the 1990s mainly from the Balkans, followed by Iraq, Iran, Afghanistan and Kurdish people from Turkey. Most recently there have been people from sub-Saharan Africa, predominantly Zimbabwe and Nigeria. The third group are economic migrants from Eastern Europe and Leicester now has a large predominantly Polish population.

Leicester City Council estimates that the Somali community comprises about 10,000 people, mainly resident in St Matthews and Highfields with some people living in Beaumont Leys. Many economic migrants are of working age and around 70% are from Poland, followed by Slovakia (13%), Portugal, Latvia and Lithuania. Estimates from National Insurance records suggest that there are 6,000 – 8,000 people from these communities, including 1,000 – 2,000 people from the Roma community in Slovakia. Some members of the Polish community live in the Narborough Road and Evington areas. The members of the Slovak Roma community are mainly located in the Evington Road and East Park Road areas.

With regard to asylum seekers and refugees, Leicester is National Asylum Seeker Service designated dispersal city. The maximum number of asylum seekers in Leicester at any one time is 800. The Zimbabwean population is the largest group and is estimated to number 2000 – 3000 people. In addition, the city is also known to be home to significant numbers of failed asylum seekers and illegal immigrants. The details of these people are unknown, and they survive by sofa surfing and hand-outs from local, mainly faith groups and charities. It is estimated by Leicester City Council that there could be as many as 3000 'hidden people' living in the city. It is thought that these people are mainly male and from countries such as Afghanistan.

The health and social care needs of new arrivals to Leicester is different to other disadvantaged and vulnerable groups, due to language and cultural issues with the addition of specific mental and physical health issues. These include the fact that many asylum seekers and refugees have faced imprisonment, torture or rape prior to migration, and loss of family and identity. The effects of these traumas are life long and mean that asylum seekers and refugees take a long time to live positively in the city. They may have come from areas where healthcare provision is poor or had been at risk of the effects of malnourishment and communicable diseases as part of the journey to the UK.

Asylum seekers often have poor physical and mental health. In addition, on arrival in the UK many have difficulty accessing healthcare services; they may not be aware of their entitlements and there are language barriers which prevent them from being able to explain adequately their needs. Problems may be exacerbated if a person's

leave to stay has been refused. Their health needs may be worsened because of social isolation, loss of status, difficulties in adapting to new surroundings, housing difficulties, poverty and loss of choice and control.

For people from African communities there are health issues regarding diet, hypertension, diabetes, female genital mutilation, women not accessing ante and post-natal care, substance misuse and smoking. For people in the Roma community there may be health and social care problems related to a reluctance of community members to engage with statutory service providers.

With regard to economic migrants, most are young, fit and healthy but their needs increase as they become more settled and start families, or bring their families to Leicester. At the moment the reduction in the number of jobs in certain sectors has led to an increase in homelessness amongst EU migrants in Leicester. In the winter of 2011-12 half the 50+ homeless people in Leicester were members of this group. By the time a person becomes homeless there are often a number of issues which have compounded their situation, including alcohol and drug dependency, smoking, poor diet, heart disease and mental ill health.

APPENDIX E

The health of lesbian, gay bisexual and trans-gender people

As individuals have so far not been asked to define their sexual orientation in the UK census, there are no accurate figures for the number of lesbian, gay, bisexual and trans people in Leicester. The Department of Health briefing papers indicate that there are an estimated 3.6 million LGB&T people living in the UK who make up approximately 5% of the total population, with some 10% living in London.

A number of publications, including Department of Health briefing papers[21], have highlighted the poorer health of lesbian, gay, bisexual and trans people (LGB&T) generally in England. Whilst some research has been undertaken into the health experiences of Leicester city's lesbian, gay and bisexual (LGB) population, the marked absence of monitoring of sexual orientation by health and social care providers and researchers means that little is known locally about the health outcomes for this population. Locally, an assessment of the health and social care needs of lesbian, gay and bisexual people was undertaken in 2006/7, drawing upon the Sexuality Matters survey[22].

Overall this assessment found that social assumptions of heterosexuality create difficulties for lesbian, gay and bisexual people of all social groups and at all life stages. Access to health and social care facilities and provisions is problematic, as is support from legal and police services. A lack of awareness of LGB needs, alongside stereotypical assumptions of LGB social and sexual practices causes many screening and treatment needs to be negated or ignored. Stigmas prevail that marginalize and exclude people and diminish social confidence, causing a higher

[21] Fish, J. (2007) Reducing Health Inequalities for lesbian, gay, bisexual and trans people: Briefing Papers for Health and Social Care Staff. London: Department of Health. Available on DH Website: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078347

[22] The Health and Social Care needs of Lesbian, Gay and Bisexual people in Leicester, Report to the Leicester Public Health Partnership, September 2006 (updated May 2007) http://www.oneleicester.com/leicester-partnership/jsna/needs-assessments/

likelihood of mental and physical ill health, educational underachievement and economic disadvantage. LGB people can choose to identify with wider LGB community activity which, though often positive and supportive, can place people in situations potentially dangerous to health and wellbeing.

LGB people are subject to bullying and intimidation which for those affected can lead to feeling uncomfortable and unsafe, and which can be detrimental to physical and mental health and wellbeing. LGB people are statistically as likely as the general population to use alcohol and other drugs and to misuse substances when young, but are more likely to maintain that level of use in later life. There is a greater tendency (when compared to the general population) amongst the LGB population to self-harm, attempt suicide and achieve suicide. Marginal groups such as older people and vulnerable people with learning and/or physical disabilities are assumed to be homogenous and asexual. This makes problematic the evidence that vulnerable men with learning disabilities who have sex with men have a greater exposure to HIV infection and the fact that there are no social care services designed to meet the specific needs of older people who are LGB.

Trans' (T) is an umbrella term for people whose identities do not conform to typical ideas about sex and gender. Trans includes transgender, transsexual and intersex people. There is no ready availability of the numbers of people affected. Like lesbian, gay and bisexual people, trans people often meet with discrimination and prejudice in their everyday lives. Many, regardless of social position or class, experience isolation and face limited understanding of their lives. These experiences place many trans people at risk of alcohol abuse, depression, suicide, self-harm, violence, substance abuse and HIV.

APPENDIX F

Offender Health

Compared with the general population, mental and physical health problems are worse amongst people who have been convicted by a court or other judicial process of committing a criminal offence than in the general population.

At 31st December 2011 there were 2,922 offenders managed by the Leicestershire and Rutland Probation Trust (LRPT) of whom 1,578 (54%) were resident in Leicester. HMP Leicester is a Category B Local Prison, for male prisoners with a large throughput of prisoners, including those on remand, with an average daily population of 355 prisoners, not all of who are from Leicester

Offenders in LLR, like their counterparts elsewhere, are far more likely to be unemployed, have accommodation problems, drink hazardously, take illegal drug and be without qualifications than the general population. 14% of LLR offenders had psychological problems which have been diagnosed by a clinician, such as obsessive compulsive behaviours, anorexia, schizophrenia and bipolar disorder. 27% had inflicted injury on themselves.

Evidence from HMP Leicester showed that prisoners there reflected this picture - with very high rates of smoking, alcohol dependence, drug dependency and blood born infections. Prisoners had high rates of asthma and epilepsy, sensory issues such as hearing and visual loss, skin problems such as athletes' foot and eczema, traumatic injuries, back pain and dental problems.

National data indicates that about two thirds of prisoners have mental health problems that require a referral. Women report higher rates of a range of physical problems than women in the general population, including asthma, epilepsy, stomach complaints, period and menopausal problems, sight and hearing difficulties, and kidney and bladder problems.

Despite high levels of need, many prisoners and offenders are less likely to access services before, and on discharge from, prison or community sentence. An audit of computerised records showed that some 10% of prisoners in HMP Leicester had no GP (other surveys have suggested that up to half may not be) and many prisoners do not access drug and alcohol services when needed.

Health Care in HMP Leicester is commissioned by NHS Leicester City (and from April 2013 by the NHS Commissioning Board). The Leicestershire and Rutland Probation Trust provides and is commissioned by the NHS to provide some health improvement services and support with substance misuse and mental health.

Commissioners in health, offender management and the local authority with regard to offenders should seek improvements in prison health care through all the mechanisms available; strengthen and further develop common pathways of care for people with drug and alcohol problems in both the criminal justice system and in the community so that engagement with services is sustained, and consider further the health access issues of offenders in the community and work to improve these.