Leeds Health & Wellbeing Board

Report author: Dr Ian Cameron, Director of Public Health

Report of: Dr Ian Cameron, Director of Public Health

Report to: The Leeds Health and Wellbeing Board

Date: 20 October 2016

Subject: The Director of Public Health Annual Report 2016

Are there implications for equality and diversity and cohesion and integration?	☒ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	☒ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number:	☐ Yes	☒ No

Summary of main issues
This year, 2016, both marks the 150th anniversary of the first Medical Officer of Health in Leeds, and the launch of the five year Leeds Health & Well Being Strategy 2016 – 2021. This year's digital Annual Report is entitled "1866-2016: 150 years of Public Health in Leeds – a story of continuing challenges". The report includes a film presentation and slide pack covering the first 150 years of Public Health in Leeds; the current health status of Leeds ahead of the next five year implementation of the Leeds Health and Wellbeing strategy; and a progress report on the recommendations from last year's Annual Report.

Recommendations
The Health and Wellbeing Board is asked to:

- Note the availability of:
    - This year's digital Annual Report at www.leeds.gov.uk/dphreport
    - the digital materials on 150 years of Public Health in Leeds
    - Indicators on the current health status for the Leeds population
- Support the inclusion, by Leeds City Council of improving health status as a specific objective within the new Council approach to locality working, regeneration and the Breakthrough projects as a contribution to the delivery of the Health & Wellbeing Strategy and the Best Council plan.
- Recommend that improving health status is a specific objective within the development of New Models of Care being led by the NHS, as a contribution to the delivery of the Health & Well Being Strategy.

- Note the progress made on the recommendations of the Director of Public Health Annual Report 2014/15.

1 Purpose of this report

1.1 To summarise the background and content of the Director of Public Health's Annual Report 2016 entitled "1866-2016: 150 years of Public Health in Leeds – a story of continuing challenges", which this year is in a digital format.

2 Background information

2.1 Under the Health and Social Care Act 2012 (Section 31) the Director of Public Health has a duty to write an annual report on the health of the population. Within the same section of the Act, the Council has a duty to publish the report.

2.2 This year's digital Annual Report looks to the past, the present and the future and is different to the usual format of a single hard copy report.

2.3 In terms of the past, this year, 2016, marks the 150th anniversary of the first Medical Officer of Health in Leeds. This appointment was made in 1866, ahead of this being made a statutory requirement for urban areas under the 1872 Public Health Act. Directors of Public Health are the direct descendent from those days.

2.4 The Annual Reports of the Medical Officer of Health became a statutory requirement under the 1875 Public Health Act but the Leeds Medical Officers of Health had produced such reports for earlier years.

2.5 The Annual Reports of the Leeds Medical Officers of Health and Directors of Public Health are held at Leeds Central Library and over 150 years provide an insight and a story into the different public health challenges faced by different postholders.

2.6 This year's Annual report includes a film and slide pack of a presentation given by the Director of Public Health on October 1st at the Thackray Medical Museum covering the first 150 years of Public Health in Leeds. In addition there is an accompanying trail through the Thackray Medical museum with a focus on the role of immunisation to the present day.

2.7 In April 2016, the Leeds Health & Wellbeing Board launched the Leeds Health & Wellbeing Strategy 2016-2021 looking ahead to implementation over the next five years. This year's Annual report includes the present position for Leeds on the health status indicators set out in the Leeds Health & Wellbeing Strategy. A comparison with the position for England as a whole sets outs the future challenge for Leeds if we are to realise the Strategy's ambition "to be the best city for health & wellbeing and wider Best Council Plan outcomes, notably for everyone in Leeds to enjoy happy, healthy, active lives".

2.8 This year's report also includes an update on progress on the recommendations from last year's report.

3 Main issues

3.1 1866 – 2016: 150 years of Public Health in Leeds – a story of continuing challenges

The following sections cover the three elements of this year's annual report.

3.2 1866-2016: 150 years of Public Health in Leeds.

3.2.1 The first Medical Officer of Health for Leeds was appointed in 1866.On October 1st the Director of Public Health gave a presentation at the Thackray Medical Museum on the first 150 years of Public Health in Leeds. Using their previous Annual Reports, the presentation covered the different roles, priorities, personalities and experiences of the Medical Officers of Health/Directors of Public Health for the years 1866-1913, the First World War, the inter-war years, from the creation of the NHS to 1973, 1974-2002 and to the present. During that time their base has been in the Council for 111 years and in the NHS for 39 years.

3.2.2 The presentation is available as a film link and as a slide presentation.

3.2.3 That journey begins when more than one in five babies died before the age of one year old and arrives 150 years later when Leeds has currently its lowest ever infant mortality rate.

3.2.4 The presentation covers the Victoria and Edwardian era when the Leeds Medical Officers of Health were dealing with a continuing cycle of epidemics against a background of appalling insanitary conditions. The presentation also covers what they believed caused these infections both before, and after, definitive evidence that "germs" were the cause.

3.2.5 The First World War saw the only time that infant mortality got worse in Leeds. This was due to the "Spanish flu" pandemic plus a measles outbreak. The presentation covers the devastating impact that the pandemic had on the lives of the people of Leeds.

3.2.6 The presentation also covers the period from 1919 to 1986 which saw considerable national criticism of public health by academics and considers whether those criticisms were justified for Leeds. The presentation also shows how the stereotypes for Medical Officers of Health/Directors of Public Health have changed over the 150 years.

3.2.7 The interwar years saw a significant rise in the influence of the Medical Officer of Health and the creation, through the Council, of a state medical service for Leeds that included taking over the Poor Law hospitals. The expectation that the Council through the Medical Officer of Health would take on the lead for the new National Health Service were not realised and were a major disappointment.

3.2.8 The Medical Officers of the 1950's and 1960's focused on the development of a wide range of personal health services for mothers, children, the elderly, those

with mental health problems, learning disabilities. Leeds Medical Officers of Health of the past had despaired about the rise in deaths caused by cancer. The action taken in Leeds, when the link between smoking and cancer was finally understood, is re-assessed.

3.2.9 In the years up to the 1974 NHS re-organisation, the Medical Officer of Health in Leeds lost responsibility for a number of services and ultimately transferred to the NHS in a different, confusing role which led to a focus on the NHS and NHS financial pressures – plus the end of Annual Reports by Medical Officers of Health.

3.2.10 The subsequent reduction in the role of Public Health and the loss of expertise became highlighted as a national problem through the disastrous handling of a salmonella outbreak at Stanley Royd Hospital, the emergence of Legionnaire's disease and HIV/AIDS.

3.2.11 The presentation covers the subsequent creation of Directors of Public Health, the re-instatement of annual reports, the swine flu pandemic and the subsequent move to the Council under the latest NHS re-organisation.

3.3 To supplement this presentation the Thackray Medical Museum with Public Health has developed a trail in the museum that links the timeline of Public Health in Leeds with a focus on immunisation going up to the present day.

3.4 **Improving the Health status of Leeds beyond 2016**

3.4.1 The Leeds Health & Wellbeing Strategy 2016 – 2021 was launched in April 2016. The strategy is described as a blueprint how the best conditions are to be put in place in Leeds for people to live fulfilling lives. The vision being that Leeds is a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest.

3.4.2 The strategy has a wide remit with five outcomes twelve priority areas and twenty one indicators. Seven of these indicators are directly related to health status.

3.4.3 The Leeds Health & Wellbeing Strategy has as its ambition to be the best city for health & wellbeing – but how will we know we have achieved this? There are 69 cities in the United Kingdom. Leeds has the second largest city population with the range down to the 1,841 people living in St David's in Wales. A comparison across 69 cities is probably not appropriate.

3.4.4 So 2016 marks the beginning of our five year journey with the new Leeds Health and Wellbeing Strategy. Let's imagine that the first Medical Officer of Health for Leeds was now arriving. He or she would want to hear our latest position against the seven health status indicators set out in the strategy alongside key indicators that relate to those Public Health issues described as priorities within the same strategy (Appendix 1).

3.4.5 Even a cursory glance at Appendix 1 highlights the scale of the challenge for Leeds. We might take a defensive position with the new first Medical Officer of

Health and describe how many of the trends for health are going in the right direction (true) and that we can demonstrate examples of where we are narrowing the health inequalities within the city (again, true). We can demonstrate progress with our first Leeds Health and Wellbeing Strategy (2013-2015) and we can point to a wealth of health data that is now available at local level http://observatory.leeds.gov.uk

3.4.6 However, on behalf of the new first Medical Officer of Health, let's take a cold eyed look at where we are now in relation to the health and wellbeing for children and young people, the health and wellbeing of adults and preventing early death, the protection of health and wellbeing. This is our new starting position.

3.5 **Improving the health and wellbeing of children & young people**

3.5.1 Infant mortality (deaths aged under one) continues to be a significant marker of the overall health of the population – and is one of the seven health status indicators in the Health & Wellbeing Strategy. The concerted focus over the last few years has seen a reduction to the lowest level ever seen in Leeds – remarkably below the rate for England as a whole. There is evidence of the benefit of sustained partnership action.

3.5.2 The focus is now on the broadened Best Start programme (from conception to two years). The proportion born with a low birth weight is significantly higher than across England, although the proportion of women smoking at the time of delivery is around the national figure. While the levels of breastfeeding at 6 – 8 weeks is high, the actual numbers of mothers starting to breast feed is lower than in England.

3.5.3 The teenage pregnancy rate is significantly higher than for England.

3.5.4 Nearly one in three children at the age of five years old have some tooth decay. This worrying position is worse than for England as a whole and has been subject of a report to the Scrutiny Board (Health & Well-being and Adult Social Care).

3.5.5 The recently launched national Childhood Obesity action plan reflects concerns over the weight of children. While the percentage of children with excess weight is lower than for England, it is clearly of concern that one in three children at the age of 10-11 years are either overweight or obese. Children above a healthy weight is one of the seven health status indicators in the Health & Wellbeing Strategy.

3.5.6 The Leeds My Health, My School survey supported by the Healthy Schools programme demonstrates a significant reducing trend in the use of illegal drugs and in under-age use of alcohol.

3.5.7 Children's positive view of their wellbeing is a specific indicator in the Health & Wellbeing Strategy. The Leeds My Health, My School survey shows that around one in five of children feel stressed or anxious everyday or most days and that around a third feel they have been bullied at school. The trends since 2009/10 appear to be getting worse for stress/anxiety and bullying.

3.6 **Improving the health & wellbeing of adults & preventing early death.**

3.6.1 Life expectancy and healthy life expectancy for males and females is below that of England. The years of life lost from avoidable causes of death is an indicator in the Health & Wellbeing Strategy – and is significantly higher than for England. The biggest gains for the Health & Wellbeing Board lie in reducing deaths from cardiovascular disease, cancer, respiratory disease for men and women plus reducing liver disease deaths for men. The suicide rate for men and women is not significantly different from that of England as a whole. Deaths from drug misuse is above the England rate.

3.6.2 Early death for people with a mental illness is an indicator in the Health & Wellbeing Strategy, recognising that there continues to be excess deaths in this population. The Leeds position is worse than that for England as a whole. More work needs to be done to determine whether this is a significant difference, but regardless, there is a specific challenge here for the city.

3.6.3 There is a concern nationally over the future health service burden due to the rising numbers of diabetics. The consistently low numbers reported for Leeds has always looked a complete anomaly to the Director of Public Health. Recent national modelling suggests an additional 9,000 cases to be identified across the city resulting in an estimated 50,000 people with diabetes.

3.6.4 There are 45,000 people who are currently known to be at high risk of diabetes. Leeds is a pilot for the National Diabetes Prevention Programme aiming to reduce those becoming diabetic by two thirds. National modelling suggests there could be an additional 19,000 people at high risk of developing diabetes in Leeds.

3.6.5 The smoking level for adults is 18.5%, which is above the England figures.

3.6.6 Physical activity is a priority area and an indicator of progress within the Health & Wellbeing Strategy. The picture of Leeds mirrors that for England with just over half the population taking more than 150 minutes of physical activity per week. Of greater concern is that, similar to England, over a quarter of adults in Leeds achieve less than thirty minutes of physical activity per week.

3.6.7 Around two-thirds of adults in Leeds are either overweight or obese

3.6.8 Life expectancy at the age of 65 years is significantly below that for England both for males and females. The number of injuries due to falls in those aged over 65 years is significantly higher in Leeds, with the number of hip fractures in females also higher.

3.7 **Protecting the health & wellbeing of all**

3.7.1 Although having a lower profile than in days gone by, infections continue to cause significant ill health with personal and organisational costs. Prevention; reducing transmission and effective treatment are still required.

3.7.2 The overall mortality rate for communicable diseases (including influenza) is below that of England as a whole. Vaccination rates are at or above national levels.

3.7.3 In terms of sexual transmitted infections, there are higher levels of gonorrhoea diagnosed in Leeds and the same is for HIV. The detection rate for chlamydia in Leeds is higher than for England which is positive but this also reflects the high levels of chlamydia in the 15-24 yr population.

3.7.4 The number of new cases of tuberculosis has currently fallen to below the rate for England.

3.7.5 Excess winter deaths relate in particular to respiratory infections and also cardio-vascular events due to the cold and Leeds mirrors the England rates.

3.7.6 Air pollution affects mortality from cardiovascular and respiratory conditions, including lung cancer. Poor air quality in Leeds has been estimated to be attributable to the equivalent of 350 deaths per year in those aged over 25 years.

3.8 Progressing health status improvement 2016 and beyond

3.8.1 For the Health and Wellbeing Board to demonstrate meaningful progress with the new Health & Wellbeing Strategy, this will require an improvement in the health status of the Leeds population as a whole against the health of England.

3.8.2 The Council's intention to enhance locality working to reduce inequalities within the city should include specific objectives to improve health of those populations. In a similar way the Breakthrough projects should have a greater focus on those health challenges already highlighted.

3.8.3 The NHS is going through significant changes in response to the current financial problems. This includes developing New Models of Care involving primary care and community health services. This should be seen as an opportunity to narrow the health gap and not end up solely focusing on the financial gap.

3.9 Progress update on the recommendations from the 2014/15 Annual Report of the Director of Public Health.

3.9.1 The Annual Report of the Director of the Public Health 2014/15 – won the Association of Director of Public Health Annual report competition beating just under 100 submissions. This success has followed the previous year's report which was awarded second prize in that year's competition.

3.9.2 Progress on the recommendations are summarised in appendix 2.

4 Health and Wellbeing Board Governance

4.1 Consultation and Engagement

4.1.1 Various initiatives described in previous recent Annual reports have been developed with the public.

4.1.2 Members of the public have helped write previous annual reports through personal stories and experience.

4.1.3 The public have the opportunity to use the trail developed by the Thackray Medical Museum.

4.2 **Equality and Diversity / Cohesion and Integration**

4.2.1 There are no direct implications on equality and diversity, from this report. However, it is worth noting that there equality and diversity implications with the Leeds Health & Wellbeing Strategy (2016 – 2021).

4.3 **Resources and value for money**

4.3.1 The costs of producing the Annual Report of the Director of Public Health are contained with in the ring fenced Public Health Grant.

4.4 **Legal Implications, Access to Information and Call In**

4.4.1 Publication of the Annual Report of the Director of Public Health will enable the Council to meet its statutory requirements under the Health and Social Care Act 2012.

4.5 **Risk Management**

4.5.1 There are no risks identified with the publication of the Annual Report of the Director of Public Health.

5 Conclusions

5.1 This year's digital Annual Report has, through the Annual Reports of Medical Officers of Health & Directors of Public Health, set out the 150 year story of Public Health in Leeds, from 1866 to the present day. A review of the current health status baseline for the new Health & Wellbeing Strategy highlights where there needs to be focus and significant improvement over the next five years if Leeds is to be the "best city for health & wellbeing".

6 Recommendations

6.1 The Health and Wellbeing Board is asked to:

- Note the availability of:
    - This year's digital Annual Report at www.leeds.gov.uk/dphreport
    - the digital materials on 150 years of Public Health in Leeds
    - Indicators on the current health status for the Leeds population

- Support the inclusion, by Leeds City Council of improving health status as a specific objective within the new Council approach to locality working, regeneration and the Breakthrough projects as a contribution to the delivery of the Health & Wellbeing Strategy and the Best Council plan.

- Recommend that the Health & Wellbeing Board ensures that improving health status is a specific objective within the development of New Models of Care being led by the NHS as a contribution to the delivery of the Health & Wellbeing Strategy.

- Note the progress made on the recommendations of the Director of Public Health Annual Report 2014/15.

7 Background documents

7.1 None.

8 Appendices

8.1 Appendix 1: Health status indicators

8.2 Appendix 2: Progress report on the recommendations from the Director of Public Health Annual Report 2014/15

8.3 Appendix 3: Equality, Diversity, Cohesion & Integration Screening (EDCI)

Appendix 1

Leeds CITY COUNCIL

Director of Public Health Annual Report 2016

Improving the Health Status for Leeds beyond 2016

Improving the health and wellbeing of children and young people

Indicator No.	Indicator	England	Leeds	Direction of Travel
1.a	Infant Mortality	4.0	3.6	Improving
1.b	Low birth-weight of term babies	2.9%	3.4%	Worsening
1.c	Smoking Status at time of delivery	11.4%	11.9%	Improving
1.d	Breast feeding initiation	74.3%	68.0%	Worsening
1.e	Breast feeding continuation	43.8%	48.7%	No change
1.f	Teenage Pregnancy	22.8	29.4	Improving
1.g	5 year-olds free from tooth decay	75.2%	68.6%	Improving
1.h	Excess weight in children in Reception Year	21.9%	21.5%	No change
1.i	Excess weight in children in Year 6	33.2%	33.0%	No change
1.j	Never taken alcohol (secondary school students)	n/a	50.2%	Improving
1.k	Never taken illegal drugs (secondary school students)	n/a	92.6%	Improving
1.l	Feeling stressed or anxious (primary and secondary students)	n/a	20.0%	Worsening
1.m	Being bullied at school (primary and secondary students)	n/a	31.9%	Improving

1.a Deaths per 1000 live births 2012-2014; 1.b Percentage of term babies with weight measured who were under 2.5Kg, 2014; 1.c Percentage of mothers who were smokers at the time of delivery 2014/15; 1.d Percentage of mothers who partially or entirely breast fed their baby at delivery 2014/15; 1.e Percentage of mothers who partially or entirely breast fed their baby at 6 to 8 weeks, 2014/15; 1.f Conceptions in women aged under 18 per 1,000 females aged 15-17, 2014; 1.g Percentage of 5 year olds who are free from obvious dental decay 2014/15 (PHE dental survey); 1.h Proportion of children aged 4-5 years classified as overweight or obese, 2014/15; 1.i Proportion of children aged 10-11 classified as overweight or obese, 2014/15; 1.j My Health My School Survey Alcohol use (Q.24), 2014/15; 1.k My Health My School Survey Illegal Drugs (Q.28), 2014/15; 1.l My Health My School Survey Stress (Q.41), 2014/15; 1.m My Health My School Survey Bullying (Q.48), 2014/15

Improving health and wellbeing of adults and preventing early death

Indicator No.	Indicator	England	Leeds	Direction of Travel
2.a	Life Expectancy at birth (Males)	79.5	78.4	Improving
2.b	Life Expectancy at birth (Females)	83.2	82.4	Improving
2.c	Healthy Life Expectancy at birth (Males)	63.4	60.6	No change
2.d	Healthy Life Expectancy at birth (Females)	64.0	62.1	No change
2.e	Preventable Mortality (Persons All Ages)	182.7	209.1	Improving
2.f	Cardiovascular disease mortality (Males under 75)	106.2	127.0	No change
2.g	Cardiovascular disease mortality (Females under 75)	46.9	53.8	Improving
2.h	Cancer Mortality (Males under 75)	157.7	181.5	Improving
2.i	Cancer Mortality (Females under 75)	126.6	140.9	Improving
2.j	Respiratory Disease Mortality (Males under 75)	38.3	47.6	No change
2.k	Respiratory Disease Mortality (Females under 75)	27.4	37.6	Worsening
2.l	Liver Disease Mortality (Males under 75)	23.4	26.5	No change
2.m	Liver Disease Mortality (Females under 75)	12.4	11.8	Improving
2.n	Suicide Rate (Males)	15.8	17.4	No change
2.o	Suicide Rate (Females)	4.5	3.3	Improving
2.p	Deaths from drug misuse (Persons All Ages)	3.4	3.7	No change
2.q	Excess under 75 mortality in adults with serious mental illness	351.8%	395.1%	Improving
2.r	Smoking Rate (adults)	16.9%	18.5%	Improving
2.s	Physically Active Adults	57.0%	56.3%	No change
2.t	Physically Inactive Adults	28.7%	28.9%	No change
2.u	Excess weight in adults	64.6%	62.3%	Not known
2.v	Life Expectancy at 65 (Males)	18.8	17.9	Improving
2.w	Life Expectancy at 65 (Females)	21.2	20.2	No change
2.x	Falls (Persons over 65)	2125	2382	No change
2.y	Hip fractures (Females over 65)	1895	2031	No change

2.a Life Expectancy at birth (Males 2012-2014); 2.b Life Expectancy at birth (Females 2012-2014); 2.c Healthy Life Expectancy at birth (Males 2012-2014); 2.d Healthy Life Expectancy at birth (Females 2012-2014); 2.e Age-standardised mortality rate (All Ages) from causes considered preventable per 100,000 population, 2012-2014 ; 2.f Cardiovascular disease mortality (Males under 75), per 100 000 (DSR), 2012-2014; 2.g Cardiovascular disease mortality (Females under 75), per 100 000 (DSR), 2012-2014; 2.h Cancer Mortality (Males under 75), per 100 000 (DSR), 2012-2014; 2.i Cancer Mortality (Females under 75), per 100 000 (DSR), 2012-2014; 2.j Respiratory Disease Mortality (Males under 75), per 100 000 (DSR), 2012-2014; 2.k Respiratory Disease Mortality (Females under 75), per 100 000 (DSR), 2012-2014; 2.l Liver Disease Mortality (Males under 75), per 100 000 (DSR), 2012-2014; 2.m Liver Disease Mortality (Females under 75), per 100 000 (DSR), 2012-2014; 2.n Suicide rate (males) per 100 000 (DSR), 2012-2014; 2.o Suicide rate (females) per 100 000 (DSR), 2012-2014; 2.p Drug misuse mortality (Persons All Ages), per 100 000 (DSR), 2012-2014; 2.q Ratio of rate of mortality for people with severe mental illness compared to the general population, 2013/14; 2.r Smoking prevalence in adults (Annual Population Survey), 2015; 2.s Physical activity > 150 minutes per week; 2.t Physical activity < 30 minutes per week; 2.u Percentage of persons aged 16+ who were overweight or obese, 2014-2014; 2.v Life expectancy for males aged 65, 2012-2014; 2.w Life expectancy for females aged 65, 2012-2014; 2.x Injuries due to falls in people 65 and over (persons), 2014/15; 2.y Hip fractures in women aged 65+ per 100 000, 2014/15

Protecting the health and wellbeing of all

Indicator No.	Indicator	England	Leeds	Direction of Travel
3.a	Mortality from Communicable Diseases (including influenza)	10.2	8.8	Improving
3.b	Gonorrhoea - Diagnosis Rate	70.7	78.5	Worsening
3.c	HIV - New Diagnosis Rate	12.3	15.1	Worsening
3.d	Chlamydia - Detection Rate	1887	2433	No change
3.e	Tuberculosis incidence	13.5	12.7	Improving
3.f	Excess Winter deaths	15.6	18.1	No change
3.g	Fraction of Mortality attributable to particulate air pollution	5.3%	5.0%	No change

3.a Mortality from communicable diseases (including influenza) per 100 000 person, DSR, 2012-2014; 3.b Gonorrhoea diagnosis crude rate per 100 000 persons, 2015 (PHE Sexual Health Profile dataset); 3.c Rate of new diagnosed cases of HIV per 100 000 persons aged over 15 years, 2014 (PHE Sexual Health Profile dataset); 3.d Rate of Chlamydia detection per 100 000 persons aged between 15 and 24, 2015 (PHE Sexual Health Profile dataset); 3.e Rate of TB incidence, crude rate per 100 000 persons, 2012-2014; 3.f Excess winter deaths index, persons all ages, 2011-2014; 3.g Percentage of deaths attributable to PM2.5 particulate air pollution, 2013

Notes:

Unless otherwise stated, all variables presented in the 3 tables above were sourced from the Public Health Outcomes Framework dataset produced by Public Health England.

DSR means Directly Standardised Rates, which are used to remove the effect of differing population age structures on the rates produced; this allows Leeds to be compared with England in an accurate way, despite the impact of the university student and other population differences on the age structure.

Appendix 2

Director of Public Health Annual Report 2015

1. Leeds City Council Public Health Directorate should be involved in early discussions relating to all new major housing developments, ideally at the pre-application stage, to ensure that health impacts are considered.

   😐 *There have been examples of public health involvement in housing developments in Aire Valley, Skelton and proposed Climate Innovation District in Hunslet. Little London and Holbeck Moor are further illustrations of developments with a strong focus on health and community.*

   A more systematic and targeted approach to public health involvement still has to be developed. When Planning Briefs for new housing developments are prepared, this would be a good opportunity to require potential developers/architects to involve Public Health at an early stage. This would only apply to LCC Regeneration Schemes and could be limited by commercial sensitivities. There is a national proposal that Health Impact Assessment will be included as part of the Environmental Impact Assessment process which would be a positive step if implemented.

2. Developers should follow the principles set out in the *Neighbourhood for Living* document and use this Annual Report of the Director of Public Health as a complementary guide that draws out the public health benefits of good design.

   ☺ *Neighbourhood for Living is a source of reference for developers as it is an adopted Supplementary Planning Document. It has recently been updated with reference to the Leeds Standard for Housing. While The Annual Report of the Director of Public Health has no weight in making planning decisions it can be used as a point of reference by Planning Officers. It was circulated to officers and publicised to increase awareness and usage of the document. In addition the Annual Report should be used to guide strategic (Forward) planning by influencing high level policy. An example of this is evidenced in the 21st September 2016 Executive Board report on the adoption of "Integrating Diversity and Inclusion into the Built Environment" which references the Annual Report.*

3. The three Leeds Clinical Commissioning Groups (CCGs) should actively engage with the planning process in their areas as they take on responsibility for the commissioning of primary health care services.

   ☺ *Each CCG has identified a lead and prepared a report looking at the potential impact of housing growth on primary care.*

4. Leeds City Council Public Health Directorate should promote the NICE recommendations on physical activity and the environment.

   ☺ *Physical activity is being considered as a priority under the Early intervention and reducing inequalities breakthrough project. The importance of the influence of the environment was promoted at a large Outcome Based Accountability workshop in July 2016 involving partners from across the city. Public Health are involved in supporting the active travel agenda to promote walking and cycling. The principles in the NICE guidance have informed a number of projects and funding bids including City Connect. The Sport Leeds Board is the strategic body in Leeds for sport and physical activity and now has a transport representative among its membership.*

5. Developers should consider design principles around food and climate change that are not covered specifically in *Neighbourhood for Living*:

    a. Avoid the local food supply being monopolised by a single provider, enabling choice.
    b. Wherever possible, safeguard allotments, good agricultural land, gardens or other growing land.
    c. Wherever possible, build cooking facilities into community facilities and schools.
    d. Consider measures to prevent overheating of homes including passive ventilation, providing cool and attractive outdoor areas, and the use of plants to create shade.

☺ *Many of these issues are covered in 'Building for Tomorrow Today (BFTT) – Sustainable Design and Construction' Supplementary Planning Document which is the Council's guidance document for sustainable development. For example food growing is encouraged in the BFTT doc. There are instances namely 'Greenhouse' and LILAC (p24 of the report) where developers incorporated allotments within developments. In addition the Core Strategy (CS) contains Climate Change policies EN1 and EN2. The City Centre team have been asking for EN1 and EN2 compliance since the CS was adopted. This approach could be expanded to other areas.*

In terms of food outlets there is currently a review of Planning guidance around Hot Food Takeaways the outcome of which will be reported to the Plans Panel.

Appendix 3
Equality, Diversity, Cohesion and Integration Screening

As a public authority we need to ensure that all our strategies, policies, service and functions, both current and proposed have given proper consideration to equality, diversity, cohesion and integration.

A **screening** process can help judge relevance and provides a record of both the **process** and **decision.** Screening should be a short, sharp exercise that determines relevance for all new and revised strategies, policies, services and functions. Completed at the earliest opportunity it will help to determine:

- the relevance of proposals and decisions to equality, diversity, cohesion and integration.
- whether or not equality, diversity, cohesion and integration is being/has already been considered, and
- whether or not it is necessary to carry out an impact assessment.

Directorate: Public Health	**Service area: The Office of the Director of Public Health**
Lead person: Dr Ian Cameron	**Contact number: 0113 247 4414**

1. Title: Director of Public Health Annual Report 2016: 1866 – 2016 150 years of Public Health in Leeds – a continuing story of challenges
Is this a: [ ] **Strategy / Policy** [ ] **Service / Function** [x] **Other** **If other, please specify DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT**

2. Please provide a brief description of what you are screening
The Director of Public Health is required to produce an Annual report on the health of the population. This year the report focuses on the first 150 years of Public Health in Leeds; a review of current health status indicators and an update on recommendations from last year's report.

3. Relevance to equality, diversity, cohesion and integration

All the council's strategies/policies, services/functions affect service users, employees or the wider community – city wide or more local. These will also have a greater/lesser relevance to equality, diversity, cohesion and integration.

The following questions will help you to identify how relevant your proposals are.

When considering these questions think about age, carers, disability, gender reassignment, race, religion or belief, sex, sexual orientation. Also those areas that impact on or relate to equality: tackling poverty and improving health and well-being.

Questions	**Yes**	**No**
Is there an existing or likely differential impact for the different equality characteristics?	x	
Have there been or likely to be any public concerns about the policy or proposal?		x
Could the proposal affect how our services, commissioning or procurement activities are organised, provided, located and by whom?	x	
Could the proposal affect our workforce or employment practices?		x
Does the proposal involve or will it have an impact on • Eliminating unlawful discrimination, victimisation and harassment • Advancing equality of opportunity • Fostering good relations		x

If you have answered **no** to the questions above please complete **sections 6 and 7**

If you have answered **yes** to any of the above and;

- Believe you have already considered the impact on equality, diversity, cohesion and integration within your proposal please go to **section 4.**
- Are not already considering the impact on equality, diversity, cohesion and integration within your proposal please go to **section 5.**

4. Considering the impact on equality, diversity, cohesion and integration

If you can demonstrate you have considered how your proposals impact on equality, diversity, cohesion and integration you have carried out an impact assessment.

Please provide specific details for all three areas below (use the prompts for guidance).

- **How have you considered equality, diversity, cohesion and integration?**

(**think about** the scope of the proposal, who is likely to be affected, equality related information, gaps in information and plans to address, consultation and engagement activities (taken place or planned) with those likely to be affected)

The section in the Annual Report on the current health status of Leeds is based on the seven health status indicators within the new Leeds Health & Well Being Strategy 2016 – 2021 plus those public health issues identified in the Strategy. This Strategy was launched in April 2016 and included an Equality, Diversity, Cohesion & Integration screening. The report merely describes the health status based on that Strategy.

- **Key findings**

(think about any potential positive and negative impact on different equality characteristics, potential to promote strong and positive relationships between groups, potential to bring groups/communities into increased contact with each other, perception that the proposal could benefit one group at the expense of another)

The report identifies that the health of the whole of Leeds is behind that of England. Gender differences are noted.

- **Actions**

(think about how you will promote positive impact and remove/ reduce negative impact)

Recommendations in the report centre around using changes in locality working within the Council, plus the emphasis on Breakthrough projects as a means of improving the health status of the whole Leeds population in relation to overall national position.

5. If you are **not** already considering the impact on equality, diversity, cohesion and integration you **will need to carry out an impact assessment**.	
Date to scope and plan your impact assessment:	
Date to complete your impact assessment	
Lead person for your impact assessment (Include name and job title)	

6. Governance, ownership and approval Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Dr Ian Cameron	Director of Public Health	22 September 2016
Date screening completed		**22/09/2016**

7. Publishing	
Though **all** key decisions are required to give due regard to equality the council **only** publishes those related to **Executive Board**, **Full Council, Key Delegated Decisions** or a **Significant Operational Decision.** A copy of this equality screening should be attached as an appendix to the decision making report: • Governance Services will publish those relating to Executive Board and Full Council. • The appropriate directorate will publish those relating to Delegated Decisions and Significant Operational Decisions. • A copy of all other equality screenings that are not to be published should be sent to equalityteam@leeds.gov.uk for record. Complete the appropriate section below with the date the report and attached screening was sent:	
For Executive Board or Full Council – sent to **Governance Services**	Date sent: 22.09.2016
For Delegated Decisions or Significant Operational Decisions – sent to appropriate **Directorate**	Date sent:
All other decisions – sent to equalityteam@leeds.gov.uk	Date sent: 22.09.2016