IMPROVING THE HEALTH STATUS FOR LEEDS BEYOND 2018

THE ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH IN LEEDS 2017/18

Leeds CITY COUNCIL

Introduction

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

The strategy has a wide remit, with five outcomes, 12 priority areas and 21 indicators. Seven of these 21 indicators are directly related to health status.

2016 marked the beginning of our five-year journey with the new Leeds Health and Wellbeing Strategy. As part of last year's Annual Report of the Director of Public Health, I set out our new starting position on the seven health-status indicators, alongside key indicators that relate to those public health issues described as priorities within the same strategy.

To ensure consistency, there are updates in relation to the health and wellbeing of children and young people, the health and wellbeing of adults and preventing early death, and the protection of health and wellbeing.

Rates show 'no change' unless there is a statistical difference from the earlier period, or unless rates showed an improvement or worsening on two consecutive occasions.

Improving the health and wellbeing of children and young people

Indicator no.	Indicator	England	Leeds	Direction of travel
1.a	Infant mortality	3.9	4.4	Worsening
1.b	Low birth-weight of term babies	2.8%	3.3%	No change
1.c	Smoking status at time of delivery	10.7%	10.2%	Improving
1.d	Breast feeding initiation	74.3%	68.0%	No change
1.e	Breast feeding continuation	43.8%	48.7%	No change
1.f	Teenage pregnancy	20.8	27.3	Improving
1.g	5-year-olds free from tooth decay	75.2%	68.6%	No change
1.h	Excess weight in children in Reception Year	22.6%	21.1%	Improving
1.i	Excess weight in children in Year 6	34.2%	33.7%	No change
1.j	Never taken alcohol (secondary school students)	n/a	52.0%	Improving
1.k	Never taken illegal drugs (secondary school students)	n/a	93.0%	Improving
1.l	Feeling stressed or anxious (primary and secondary students)	n/a	22.0%	Worsening
1.m	Being bullied at school (primary and secondary students)	n/a	30.0%	Improving

1.a Deaths per 1,000 live births 2014–2016; 1.b Percentage of term babies with weight measured who were under 2.5 kg, 2015; 1.c Percentage of mothers who were smokers at the time of delivery 2016/17; 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, 2015; 1.g Percentage of 5-year-olds free from obvious dental decay 2014/15 (PHE dental survey); 1.h Proportion of children aged 4–5 years classified as overweight or obese, 2016/17; 1.i Proportion of children aged 10–11 classified as overweight or obese, 2016/17; 1.j My Health, My School Survey – Alcohol Use (Q.29 Alcohol Consumption – 'Never had a drink of alcohol'), 2016/17; 1.k My Health, My School Survey – Illegal Drugs (Q.33 Used Illegal Drugs – 'No'), 2016/17; 1.l My Health, My School Survey – Stress (Q.50 Feelings, Stressed or Anxious – 'Every day' or 'Most days'), 2016/17; 1.m My Health, My School Survey – Bullying (Q.60 Bullied in school in the last year – All positive answers), 2016/17.

Infant mortality (deaths aged under one year) 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 and Wellbeing Strategy. As reported last year, the concerted focus over the last few years had seen a reduction to the lowest level ever seen in Leeds – even below the rate of England as a whole. However, there has been a rise and the Leeds infant mortality rate is now again higher than that of England as a whole.

This year's Annual Report of the Director of Public Health explores this rise further.

The number of women smoking at the time of delivery continues to decline and is below the England rate.

The rate of teenage pregnancy continues to decline and, while still above the England rate, there has been a small narrowing of the gap.

The percentage of children with excess weight continues to be lower than for England as a whole. There has been a further reduction in children with excess weight in Reception Year. Children above a healthy weight is one of the seven health-status indicators in the Health and Wellbeing Strategy.

The Leeds My Health, My School Survey supported by the Healthy Schools Programme demonstrates a continuing reducing trend in the use of illegal drugs and in under-age use of alcohol.

Children's positive view of their wellbeing is a specific indicator in the Health and Wellbeing Strategy. The Leeds My Health, My School Survey shows that around one in five children feel stressed every day or most days and this figure has continued to rise. The percentage of children who feel they have been bullied has declined, but is still around one in three children.

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	78.3	No change
2.b	Life expectancy at birth (females)	83.1	82.1	Worsening
2.c	Healthy life expectancy at birth (males)	63.4	61.2	Improving
2.d	Healthy life expectancy at birth (females)	64.1	62.1	No change
2.e	Preventable mortality (persons, all ages)	182.8	213.1	Worsening
2.f	Cardiovascular disease mortality (males under 75)	102.7	125.0	No change
2.g	Cardiovascular disease mortality (females under 75)	45.8	53.0	No change
2.h	Cancer mortality (males under 75)	152.1	172.8	Improving
2.i	Cancer mortality (females under 75)	122.6	131.6	Improving
2.j	Respiratory disease mortality (males under 75)	39.2	46.7	No change
2.k	Respiratory disease mortality (females under 75)	28.7	39.3	Worsening
2.l	Liver disease mortality (males under 75)	23.9	27.1	No change
2.m	Liver disease mortality (females under 75)	12.8	13.8	Worsening
2.n	Suicide rate (males)	15.3	18.3	Worsening
2.o	Suicide rate (females)	4.8	3.9	No change
2.p	Deaths from drug misuse (persons, all ages)	4.2	6.2	Worsening
2.q	Excess under 75 mortality in adults with serious mental illness	370.0%	452.1%	No change
2.r	Smoking rate (adults)	15.5%	17.8%	Improving
2.s	Physically active adults	64.9%	62.1%	No change
2.t	Physically inactive adults	22.3%	24.8%	No change
2.u	Excess weight in adults (new method)	61.3%	60.9%	No change
2.v	Life expectancy at 65 (males)	18.7	17.8	No change
2.w	Life expectancy at 65 (females)	21.1	20.3	No change
2.x	Falls (persons over 65)	2169	2391	No change
2.y	Hip fractures (females over 65)	710	771	No change

2.a Life expectancy at birth (males, 2013–2015); 2.b Life expectancy at birth (females, 2013–2015); 2.c Healthy life expectancy at birth (males, 2013–2015); 2.d Healthy life expectancy at birth (females, 2013–2015); 2.e Age-standardised mortality rate (all ages) from causes considered preventable per 100,000 population, 2014–2016; 2.f Cardiovascular disease mortality (males under 75), per 100, 000 (DSR), 2014–2016; 2.g Cardiovascular disease mortality (females under 75), per 100,000 (DSR), 2014–2016; 2.h Cancer mortality (males under 75), per 100,000 (DSR), 2014–2016; 2.i Cancer mortality (females under 75), per 100,000 (DSR), 2014–2016; 2.j Respiratory disease mortality (males under 75), per 100,000 (DSR), 2014–2016; 2.k Respiratory disease mortality (females under 75), per 100,000 (DSR), 2014–2016; 2.l Liver disease mortality (males under 75), per 100,000 (DSR), 2014–2016; 2.m Liver disease mortality (females under 75), per 100,000 (DSR), 2014–2016; 2.n Suicide rate (males) per 100,000 (DSR), 2014–2016; 2.o Suicide rate (females) per 100,000 (DSR), 2014–2016; 2.p Drug misuse mortality (persons, all ages), per 100,000 (DSR), 2014–2016; 2.q Ratio of rate of mortality for people with severe mental illness compared to the general population, 2014/15 (new method); 2.r Smoking prevalence in adults (Annual Population Survey), 2016; 2.s Physical activity > 150 minutes per week (percentage), 2015/16; 2.t Physical activity < 30 minutes per week (percentage), 2015/16; 2.u Percentage of persons aged 18+ who were overweight or obese, 2015/16; 2.v Life expectancy for males aged 65, 2013–2015; 2.w Life expectancy for females aged 65, 2013–2015; 2.x Injuries due to falls in persons 65 and over per 100,000 (DSR), 2015/16; 2.y Hip fractures in women aged 65+ per 100,000 (DSR), 2015/16.

Life expectancy for males and females continues to be below that of England and Wales. The previous improvements in life expectancy for both males and females in Leeds have ceased. There has been a decline for women and a static position for men. The reasons for this are explored in the Annual Report of the Director of Public Health.

There are three major killers – cardiovascular disease, cancer and respiratory disease. Of these, mortality from cancer has continued to improve and the gap with England has narrowed. Respiratory mortality in women has worsened both nationally and in Leeds.

There has been a rise in mortality in women from liver disease. This is related to alcohol and is a subject covered in the Annual Report of the Director of Public Health.

There has been a rise in mortality in men from both suicide and drug-related deaths. These are both covered in the Annual Report of the Director of Public Health.

Early death for people with mental illness is an indicator in the Health and Wellbeing Strategy. The way information is collected for deaths with serious mental illness is such that it is not possible to compare different years. This may change in the future but all we can say at present is that the Leeds position is worse than for England as a whole.

The number of years of life lost from avoidable causes of death is an indicator in the Health and Wellbeing Strategy. In light of the rises in mortality described above, there has been no significant progress since last year and Leeds continues to be worse than England as a whole.

The smoking rate for adults is 17.8%. While above the England figure, this is the lowest figure ever recorded for Leeds and the smoking rate shows a continuing decline. This is a key health-status indicator in the Health and Wellbeing Strategy.

Physical activity is a priority area, and key indicator, within the Health and Wellbeing Strategy. There has been no change since last year.

Around two-thirds of adults in Leeds are either overweight or obese. While there appears to be a decline from last year, there has been a change in the method of calculation and it is therefore best to make no judgement about trends at this stage.

There has been no change in life expectancy for people at 65 years and no change in injuries due to falls in people 65 years and over.

Protecting the health and wellbeing of all

Indicator no.	Indicator	England	Leeds	Direction of travel
3.a	Mortality from communicable diseases (including influenza)	10.7	10.4	Worsening
3.b	Gonorrhoea – diagnosis rate	64.9	81.0	Worsening
3.c	HIV – new diagnosis rate	10.3	10.3	Improving
3.d	Chlamydia – detection rate	1882	2599	Improving
3.e	Tuberculosis incidence	10.9	11.5	No change
3.f	Excess winter deaths	17.9	17.2	No change
3.g	Fraction of mortality attributable to particulate air pollution	4.7%	4.3%	Improving

3.a Mortality from communicable diseases (including influenza) per 100,000 persons (DSR), 2014–2016; 3.b Gonorrhoea diagnosis crude rate per 100,000 persons, 2016 (PHE Sexual Health Profile dataset); 3.c Rate of new diagnosed cases of HIV per 100,000 persons aged over 15 years, 2016 (PHE Sexual Health Profile dataset); 3.d Rate of chlamydia detection per 100,000 persons aged 15– 24, 2016 (PHE Sexual Health Profile dataset); 3.e Rate of TB incidence, crude rate per 100,000 persons, 2014–2016; 3.f Excess winter deaths, index score, persons all ages, August 2013– July 2016; 3.g Percentage of deaths attributable to PM2.5 particulate air pollution, 2015.

Although having a lower profile than in days gone by, infections continue to cause significant ill health and this carries both personal and organisational costs. Prevention, reducing transmission and effective treatment is still required.

The overall mortality for communicable diseases (including influenza) in Leeds has worsened, although it is still below that of England as a whole.

In terms of sexually transmitted infections, there continue to be higher levels of gonorrhoea in Leeds at a time when there has been a national reduction in diagnosis rates. Not reflected in these figures is the increasing concern about antibiotic-resistant cases of gonorrhoea, both in Leeds and nationally. There has been a significant reduction of new cases of HIV in Leeds. The detection rate for chlamydia in Leeds continues to be higher than for England, but the improvement in detection rate reflects the work of the Leeds City Council newly-commissioned integrated sexual health service.

There has been a decline in the number of new cases of TB.

Excess winter deaths relate in particular to respiratory infections and also cardiovascular events due to the cold. The figure for Leeds is now a little below the England figure.

Air pollution affects mortality from cardiovascular and respiratory conditions, including lung cancer. This indicator relates to particulate matter, which is thought to be the main factor affecting health. The level in Leeds is estimated to be the equivalent of 350 deaths per year in those aged over 25 years. More recent work has been looking at the additional mortality contribution from NOX. That mortality is not covered by this indicator.

NOTES:

Unless otherwise stated, all variables presented in the three 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.