

ANNUAL REPORT OF THE DIRECTOR OF PUBLIC HEALTH 2018

RUTLAND COUNTY COUNCIL

**POPULATION CHANGE, HEALTH STATUS AND MULTI-MORBIDITY
IN RUTLAND**

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Annual Report of the Director of Public Health 2018

1. Foreword

Welcome to my annual report for 2018. In my last annual report I presented an infographic picture of many different aspects of the health of Rutland.

Presenting such an analysis led to a range of further work. As can be seen in the 'update on recommendations', the report has led to detailed further work on the needs of the serving military and their families, analysis of anti-depressant prescribing within Rutland and rural poverty.

In this year's report I have focused on the ageing population and, in particular, the challenges of 'multi-morbidity'.

We are all aware of the profound changes in our population structure and the demand that places on health and council services. But, in itself, getting older is not the problem. It's the increasing number of years spent in poor health that drives demand for services.

It is important to recognise this and think about how services might be delivered in such a way that takes account of the increase in multi-morbidity. As a whole system, we need to continue our efforts to promote good health throughout all ages, if we want effective care for our future generations.

I would like to thank Natalie Davison and Kajal Lad for their tremendous work in constructing the infographics and narrative that underpin this report, and Trish Crowson and Kath Packham from Public Health for their contributions to the report and continued hard work on improving the health of Rutland people.



Mike Sandys

Director of Public Health

2. Introduction

Directors of Public Health have a statutory duty to write an Annual Public Health Report that describes the state of health within their communities.

It is a major opportunity for advocacy on behalf of the population and, as such, can be used to help talk to the community and support fellow professionals, providing added value over and above intelligence and information routinely available such as that contained within health profiles or the Joint Strategic Needs assessment (JSNA).

It is intended to inform local strategies, policy and practice across a range of organisations and interests and to highlight opportunities to improve the health and wellbeing of people in Rutland.

However, the report is not an annual review of public health outcomes and activity. The annual report is an important vehicle by which Directors of Public Health can identify key issues, flag up problems, report progress and thereby serve their local populations. It is also a key resource to inform stakeholders of priorities and recommend actions to improve and protect the health of the communities they serve.

Within this report, data is presented on the changing population of Rutland, the prevalence of individual and multiple conditions in the population and data on 'excess winter deaths' and place of death. The content should be used by commissioners and providers of services to respond to changes in the health of Leicestershire residents.

3. Recommendations and Summary

Like last year's report, I am aware that this one is 'data heavy'. Each slide should contain something of relevance for commissioners and providers of services to reflect on in their plans, as well stimulating wider public debate on the changing nature of the population's health. There are, though, actions I intend to progress through the work of the public health department and Rutland County Council more generally:

If there is one thing we can all do it is to promote 'healthy ageing'. There are many ways to do this:

Promote Social Prescribing in Rutland

'Social prescribing' is a key way in which people are supported to improve their health and wellbeing by connecting them with a range of services in their community who can provide non-medical support; including help to remain independent, social support and activities that reduce isolation and loneliness. Whilst social prescribing is for all ages it is predominantly used for those with multiple health conditions and can help promote healthy ageing. The social prescribing model being developed in Rutland recognises that many organisations and individuals have a role in this; some in more generic roles and others more specialist. A comprehensive system is being developed to connect and support cross agency referrals based on the principle that there should be 'no wrong front door'. This model is being shaped by front line workers, but to be fully successful it needs to be underpinned by an effective information system, tools and resources for staff and a secure referral system.

Falls

Falls are a serious health issue for older people, with around a third of all people aged 65 and over falling each year. Regular physical activity, can develop and maintain strength and balance in frail patients.

We will continue to support the implementation of the Falls programme with an emphasis on evaluating the effectiveness of the postural stability programmes.

Physical Activity

Physical activity is a key preventative element of healthy ageing – from protecting against some forms of dementia, to reducing the risk of depression, heart disease and the risk of a fall in older age.

Working with Active Rutland and Leicester-Shire and Rutland Sport (LRS), Public Health will ensure that muscle strengthening activity and physical activities of older people are reflected in sport and physical activity plans.

Carers

Supporting Carers and supporting them to be healthy is a key element to ensuring a good outcome for the frail and those with multiple health conditions.

The recently adopted Carer's Strategy across Leicestershire, Leicester City and Rutland sets out a broad programme of support for carers. Within public health I will ensure we play our part the implementation of the Carer's strategy, ensuring that public health information services provide good advice to carers.

Support the health care system to treat the person, not the individual condition

As the report shows healthcare systems are not currently designed to treat patients with multiple illnesses. The recently produced LLR Frailty Resource Pack is a welcome step to local health services understanding, and responding to, frailty.

Through the specialist support provided by public health consultants to CCG's and the broader health system, public health can play a part in redesigning pathways to take account of frailty and multi-morbidity. The introduction of risk stratification software in GP practices will give better quality, comprehensive data on multi-morbidity. Public Health should use this to target work and influence pathway development.

4 Population Change, Health Status and Multi-morbidity

4.1 Population

In 2017, 4.7% of the population was aged 0-4 (1,858 people), 17.1% was aged 5-19 (6,740 people), 53.7% was working age (21,192 people aged 20-64) and 24.5% was older than 65, this includes 3.3% of the total population that was aged 85 and over (1,290 people). Compared to nationally, Rutland has a higher proportion of the population aged over 65 and 85 respectively.¹

Nationally the over 65 population is predicted to grow by 42.8% and the over 85 population by 91.7% between 2019 and 2039. In Rutland, both the over 65 population and over 85 population is predicted to grow at a faster rate than nationally, by 45.0% in the over 65 population from 10,000 to 14,500 people, and by 121.4% in the over 85 population from 1,400 to 3,100 people. The largest change is predicted to be in the 75-79 age band with an increase of 1,000.²

Living alone

According to the 2011 census, 6.25% of households in Rutland were occupied by a single person aged 65 and over living alone (2,142 households). This is higher than the England value of 5.24%.³

Carers

Family carers play a key role in supporting the health and wellbeing of those they care for. The Care Act 2014 requires that carers are supported in their role by social services. The number of carers supported by Rutland County Council during 2017/18 increased by 25%, from 143 to 194 (503 per 100,000 population). In 2016/17, 62.1% reported that they were satisfied with the support they had received, relative to an English average of just 39%, and 79.5% said that they found it easy to find information about services, relative to an English average of 70.6%.

In 2017, the total number of people aged 65 and over providing unpaid care to a partner, family member or other person in Rutland was estimated to be 1,385. This is expected to increase by 33.9% to 1,855 carers by 2035.⁴

It can be difficult for carers to maintain their own connection to what is important to them while fulfilling their caring role. According to the Personal Social Services Carers

survey, the latest data from 2016/17 shows carers reported quality of life in 2016/17 was rated as 7.9 in Rutland, similar to the English average of 7.7. In the same survey less than a third (31.1%) of adult carers who use support services in Rutland and felt they have as much social contact as they would like. This is lower than the national percentage of 35.5%.⁸

4.2 Gap in healthy life expectancy at birth and life expectancy at birth

Nationally, life expectancy at birth has increased by 0.1 years for males between 2014-16 and 2015-17 whereas in females, over the last four time periods life expectancy has stabilised at 83.1 years respectively. In Rutland, life expectancy at birth has increased by 0.2 years for males and 0.3 years for females between 2014-16 and 2015-17.⁸

At a national level, healthy life expectancy at birth has increased by 0.1 years for males but decreased by 0.1 years in females. In Rutland, healthy life expectancy at birth has increased by 1.0 years for males compared to the previous time period, from 68.8 years to 69.8 years, whereas in females healthy life expectancy at birth has decreased 1.8 years from 70.2 years to 68.4 years.⁸

The gap in life expectancy at birth and healthy life expectancy at birth infers the number of years a person is likely to live in poor health. As shown by the graph, females, on average, live longer but spend more years in poor health. The latest data shows in Rutland males spend 12.5 years in poor health compared to 17.4 years in females. The national gap currently stands at 16.1 and 19.3 years for males and females respectively.⁸

4.3 Prevalence of conditions in GP Practices

With the introduction of the new General Medical Services (GMS) contract in April 2004, a quality framework of indicators (QOF) was developed for general practice, the QOF. An integral part of the QOF is the collection of prevalence data to allow practices to case find those patients that require specific management. Prevalence data within the QOF are collected in the form of practice registers. Please note, while many patients are likely to suffer from co-morbidity, i.e. are diagnosed with more than one of the clinical conditions included in the QOF clinical domain, robust analysis of co-morbidity is not possible and therefore patients may be on more than one disease register if they have multiple conditions or risk factors.

The table shows the percentage of patients recorded on a QOF disease register in Rutland General Practices. In 2017/18, over 6,000 patients (16.7%) were on the Hypertension disease register and over 1,300 patients (3.6%) were on the Depression disease register in the county. Both these percentages are significantly higher than the national percentages of 13.9% and 3.1% respectively. Over 2,000 patients aged 17 years and above (6.5%) in Rutland were recorded on the Diabetes Mellitus register.⁵ This is similar to national prevalence, but still represents a substantial burden of ill-health locally.

4.4 Loss of hearing

A person who is not able to hear as well as someone with normal hearing, hearing thresholds of 25 decibels (dB) or better in both ears, is said to have hearing loss. Unaddressed Hearing Loss can have a serious impact on health and wellbeing:

- People with hearing loss are more likely to experience emotional distress and loneliness.
- Hearing loss doubles the risk of developing depression.
- People with hearing loss are at least twice as likely to develop dementia.

Action on Hearing Loss have estimated the number of people with hearing loss of at least 25 dB in each Local Authority area in the UK, using mid-2014 ONS population estimates. In 2014, approximately 8,000 people in Rutland were estimated to be affected by hearing loss, over a fifth (21.0%) of the total population.⁶

4.5 Loss of sight

Over two million people in the UK live with sight loss. That's around one person in 30. It is predicted that by 2020 the number of people with sight loss will rise to over 2,250,000. And by 2050, the numbers of people with sight loss in the UK will double to nearly four million.⁷ This is because:

- the UK population is ageing and as we get older we are increasingly likely to experience sight loss
- there is a growing incidence in key underlying causes of sight loss, such as obesity and diabetes

Prevention of sight loss will help people maintain independent lives as far as possible and reduce needs for social care support, which would be necessary if sight was lost permanently. The counts of new completions of Certifications of Visual Impairment (all causes - preventable and non-preventable) by a consultant ophthalmologist as a rate of the resident population in the county have been examined. In Rutland the rate of sight loss certifications per 100,000 population has fluctuated to perform significantly worse (higher) and similar to the national average since 2010/11. The latest data shows in 2016/17 there were 26 new certifications in the county, which equates to a rate of 67.3 per 100,000 population. This is significantly worse (higher) than the national rate of 42.4 per 100,000 population.⁸ Whilst a higher level of sight certifications is deemed to be worse, completing the sight loss certification initiates the process of registration with a local authority and leads to access to services. This may well indicate that people with sight loss in Rutland are being proactively identified and therefore able to access the help and support they require. However sight loss can develop for a number of preventable reasons, for example related to diabetes or smoking, and therefore it is worth considering whether some of these sight loss certifications could be avoided through better diabetic control, or through improving smoking cessation rates.

Where the cause of sight loss is Age-related Macular Degeneration (AMD) or Glaucoma, the rate of new completions of Certifications of Visual Impairment due to these disorders have been examined separately. For the last six years, the rate of sight loss due to AMD in those aged 65 years and above has remained similar to the national average. The rate of sight loss due to glaucoma in those aged 40 years and above performs similar to the national average in 2016/17 with 6 new certifications.⁸

4.6 Dementia

With the introduction of the new General Medical Services (GMS) contract in April 2004, a quality framework of indicators (QOF) was developed for general practice, the QOF. An integral part of the QOF is the collection of prevalence data to allow practices to identify those patients that require specific management. Prevalence data within the QOF are collected in the form of practice registers. Please note, while many patients are likely to suffer from multi-morbidity, i.e. are diagnosed with more than one of the clinical conditions included in the QOF clinical domain, robust analysis of multi-morbidity is not possible. Identifying these patients may rely on finding those that are on more than one chronic disease (or long term condition) register.

The recorded dementia QOF prevalence examines the number of people with dementia recorded on GP practice registers as a proportion of the people (all ages) registered at each GP practice. In Rutland the dementia QOF prevalence has significantly increased over time from 0.6% in 2011/12 to 0.9% in 2017/18. Throughout this time, the prevalence in Rutland has remained significantly higher than the national average. The latest data reflects 336 patients have been diagnosed with dementia in Rutland.⁹

Increasing the number of people living with dementia who have a formal diagnosis enables patients, their carers and healthcare staff to plan accordingly and work together to improve health and care outcomes. In 2018 in Rutland, 56.5% of those patients estimated to have dementia had been diagnosed; this is significantly worse (lower) than the national average of 67.5% and significantly lower than the national benchmark of 66.7%.⁸

Examining the trend in the directly age standardised rate of emergency inpatient hospital admissions for people with a mention of dementia in any of the diagnosis code positions (aged 65 years and above) per 100,000 population is useful to understand the variation in the provision of care of people with dementia. Over the last six years in Rutland the rate has remained significantly better (lower) than the national average. The latest data shows there were 249 emergency admissions with a mention of dementia in the population aged 65 years and above in Rutland in 2017/18.¹⁰

The ratio of inpatient service use to recorded diagnoses provides an indication of the use of inpatient general hospital services for people diagnosed with dementia. The indicator illustrates the variation in the percentage of admissions for dementia (with a mention in the diagnosis code) compared to dementia primary care registers. Over the last six years in Rutland the rate has remained similar or significantly lower than the national average and the latest data shows in 2017/18 the ratio of inpatient service use to recorded diagnoses was 53.9% in Rutland, this is similar to the national percentage of 56.5%.¹⁰

4.7 Forecasted prevalence of long term conditions in people aged 65 years and above

The projected number of people over the age of 65 years with a long term condition between 2017 and 2035 in Rutland have been examined in the chart below. The numbers are based on the current prevalence rates applied to projected populations.

Please note, the numbers refer to people on individual registers i.e. people with multi-morbidities will be counted on each register, therefore the totals will be greater than projected populations for the over 65s.

The projected increase in number of people with the following conditions between 2017 and 2035 in Rutland is: Dementia (78.8%), Stroke (47.5%), Heart attack (44.8%), Bronchitis and emphysema (42.9%), Depression (41.6%), Diabetes (41.1%), Obesity (34.2%).⁴

4.8 Risk stratification using the ACG System of Rutland population

Risk stratification is a concept used to help understand the needs of the population so that services can be better planned and delivered. Risk stratification involves segmenting the local population into groups by what kind of care they need as well as how often they might need it. It then examines who, within each segment, has the greatest risk of needing intense care such as a hospital admission.

The Johns Hopkins Adjusted Clinical Groups (ACG) System is used to identify patients in Rutland with the highest burden of health needs and then identify those most likely to use health services. This approach is commonly used and based on widely available GP practice data and Secondary Uses Service data (SUS). The variables used in the ACG system fall into the 8 categories, as identified by the below figure.



Figure 1 – Overview of the ACG System Predictive Modelling Process (taken from ‘Predictive Models in the ACG System’ by Johns Hopkins)

It is important to note, the modelling processes to identify these cohort of individuals most likely to use health services are driven primarily by the concept of overall disease burden, the nature of individual diseases and co-morbidity combinations. The weights associated with prior utilisation and prior costs are very low, as admissions (for example) in the previous year are not the key determinant of high cost or admission in the future. This contrasts with the ethos behind other predictive models that assign very high weights to the number of emergency admissions in the last year and/or secondary care use.

4.8.1 Stratifying the population by cost utilisation

Running GP practice data through the ACG risk stratification tool will provide an output that shows the number of people in each risk strata based on costs. Please note, currently no costs for pharmacy or primary care costs are available but will be in later iterations of the ACG tool.

It is well known that the cost of health care is not even distributed across the population; it is concentrated in a small proportion of people. The ACG System allows

us to look at the specific figures for Rutland and ascertain how costs are concentrate within a small proportion of the population. The shares of the registered population in GP practices in Rutland are examined by secondary care costs over a period of one year. The pyramid shown in Figure 2 illustrates that around 5% of the population accounts for around half (50%) of all secondary care costs over a year. Furthermore, almost a fifth (17%) of secondary costs are concentrated in just 0.5% of the population of Rutland (c. 200 people) while the majority of the population (80%) account for just 13% of costs.

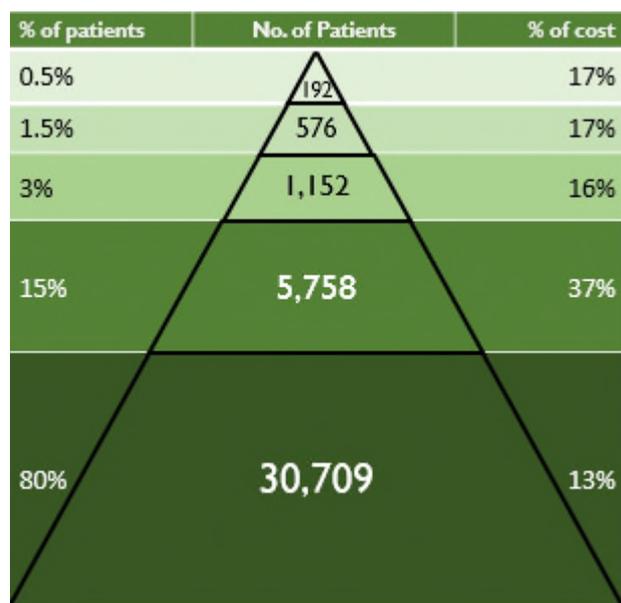


Figure 2 – All secondary care costs by population.

A similar, but more pronounced, pattern is evident for emergency admission costs. The pyramid shown in Figure 3 illustrates that around 2% of the population of Rutland (roughly 750 people) account for three-quarters (75%) of all emergency admission costs in the previous year, with specifically around 0.5% of the population of Rutland (roughly 200 people) accounting for over two-fifths (43%) of all emergency admission costs over the previous year. The majority of the population (80%) incur no emergency admission costs.



Figure 3 – Emergency care costs by population

4.8.2 Long term conditions (LTCs) by age

The number of patients with counts of long term conditions (LTCs) by age is collected through the ACG System. The data for Rutland (Figure 4) shows, regardless of gender, as we age the prevalence of multi-morbidity increases. In the county, around 1 in 4 patients (24%) aged 85 years and above have 8 or more LTCs compared to 1 in 25 patients aged 65-74 years. However, there are fewer people aged over 85 years than there are aged 65-74 years, so it is important that absolute numbers are considered alongside proportions. In terms of absolute numbers, there is a higher count of patients with 5 or more LTCs in the 65-74 years age group than those aged 85 years and above, at 918 and 720 patients respectively. When thinking about service planning and delivery it is useful to where best to target intervention to prevent escalating health care costs and improve patient outcomes. Although, there may be higher costs associated with those aged over 85 years, with 8 or more long-term conditions it may be that there is limited room to reduce or prevent health and care costs for this cohort and that they are already receiving all the health and care that they require. However, it may be that, for example, people in the 45-64 age band, with 2 to 4 long-term conditions could be an area for intervention where it is possible to improve patient outcomes and reduce or prevent escalating health and care costs.

LTC Count	0-17 yrs	18-64 yrs	65-74 yrs	75-84 yrs	85 yrs +	Total
0	81%	51%	17%	8%	3%	48%
1	15%	27%	21%	11%	3%	22%
2	3%	11%	19%	15%	9%	11%
3	1%	5%	15%	16%	11%	7%
4	0%	2%	10%	14%	13%	4%
5	0%	1%	7%	11%	14%	3%
6	0%	1%	4%	8%	12%	2%
7	0%	0%	3%	6%	10%	1%
8+	0%	0%	4%	13%	24%	2%
Total	100%	100%	100%	100%	100%	100%

1-in-4 aged 85+ has 8 or more LTC ...compared to 1-in-25 aged 65-74yrs

Figure 4 – Long Term Condition count by age bands (percentages)

Figure 5 (below) underlines the normalisation of multi-morbidity in patients of Rutland. This illustrates that all patients with heart failure have at least one other chronic condition and around two-thirds of people with heart failure have 7 or more other chronic conditions. The condition which has the highest proportion of people with no other chronic conditions is diabetes and even there only 8% of people diagnosed with diabetes have no other chronic conditions. Around a quarter of people with diabetes (26%) have 7 or more other chronic conditions. This illustrates that multimorbidity is the norm for people with long-term conditions and it varies by condition type. It also highlights that treating a single condition such as diabetes, is unlikely to have a huge

impact for that individual if their other long-term conditions are not also treated. Or, put simply, treat the person, rather than the condition.

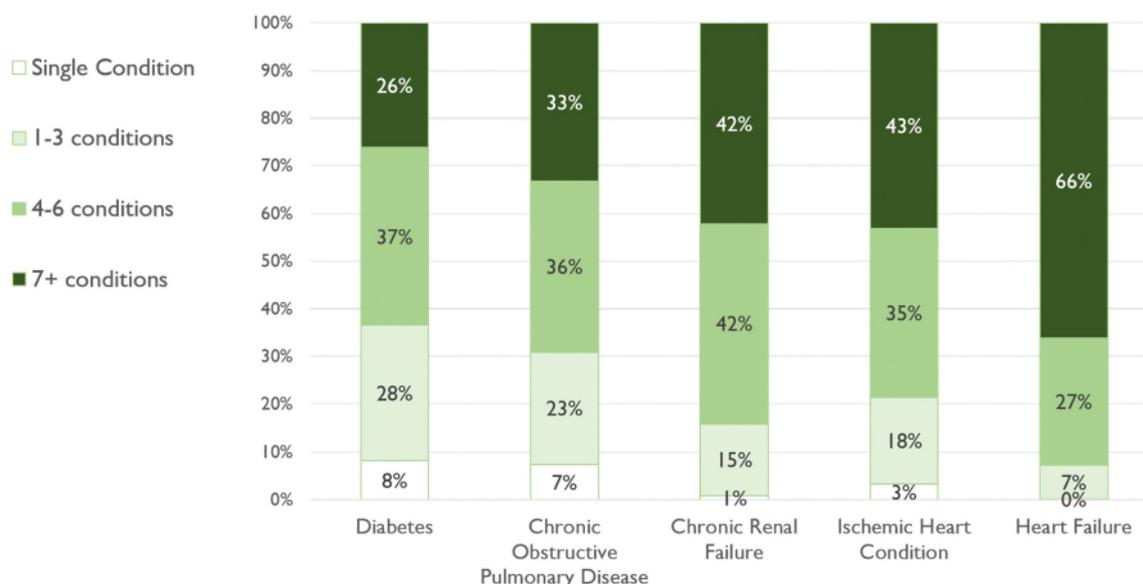


Figure 5 – Multimorbidity by condition type for Rutland patients

The table below (Figure 6) highlights that increasing multimorbidity is associated with higher costs and resource use. Multimorbidity is known to be associated with a greater use of health services, including A&E attendances, outpatient attendances, hospital admissions and polypharmacy.

As expected, the data shows people with multiple conditions were more likely to experience higher hospital admission costs than those with only one condition. For example, the average total admitted patient cost (APC) was almost £2500 higher for patients with 8 or more LTCs than for patients with one condition alone. Similarly, the annual hospital admission costs for patients with diabetes and only one other condition are £30 higher than for patients with diabetes alone.

One of the most common consequences of being affected by multiple health conditions is being prescribed multiple medications for long periods of time, a phenomenon known as polypharmacy. While some polypharmacy can be appropriate, it can be harmful if poorly managed, especially among people living with frailty. As shown by the table, the count of unique prescription types increases considerably as

the number of long term conditions a patient has increases.

The final two columns in the table in Figure 6 are risk scores calculated using the ACG System. The first of these risk columns is the 'risk of persistent high cost' and is calculated as the probability of a patient being in the top 20% of high cost patients in each of the next three 6-month periods. The second risk column is the percentage likelihood of emergency admission in the next 12 months. Both ways of calculating future risk show that risk increases as the number of long term conditions increases. For those with 8 or more long term conditions the risk of persistent high costs and of emergency admission in the next 12 months is above 50% - i.e. more likely to happen than not.

No. of Long Term Conditions	Number of patients	% of patients	Mean values									
			A&E attendances	Outpatient attendances	Elective admissions	Emergency admissions	Total APC cost	Emergency admission cost	Unique prescription types	Risk of persistent high cost	Risk of emergency admission (next 12mths)	
0	18,297	48%	0.2	0.4	0.0	0.0	£ 42	£ 20	0.8	1%	6%	
1	8,333	22%	0.3	1.0	0.1	0.0	£ 122	£ 33	1.8	2%	11%	
2	4,186	11%	0.3	1.8	0.2	0.1	£ 251	£ 68	3.0	6%	16%	
3	2,554	7%	0.3	2.3	0.3	0.1	£ 436	£ 110	4.5	10%	21%	
4	1,651	4%	0.3	3.1	0.4	0.1	£ 607	£ 144	5.7	15%	25%	
5	1,125	3%	0.4	3.8	0.6	0.2	£ 823	£ 242	6.9	22%	31%	
6	782	2%	0.5	4.3	0.7	0.3	£ 1,243	£ 452	8.0	28%	37%	
7	508	1%	0.7	5.0	0.8	0.3	£ 1,295	£ 457	8.9	34%	43%	
8+	950	2%	1.1	5.9	0.9	0.8	£ 2,578	£ 1,522	12.0	50%	56%	
Total	38,386	100%	0.3	1.3	0.2	0.1	£ 260	£ 98	2.4	6%	13%	

Figure 6 – Health service use and cost stratified by the number of long term conditions

As discussed above, multimorbidity does not just occur in the elderly. Figure 7 (below) shows the population segmented by combining two measures: the age of patients (denoted by a letter, increasing with age) and the number of chronic conditions grouped together (e.g. 0, 1, 2-4, 5-7, 8 or more). Five age bands and five bands for Multimorbidity were created as follows:

- A = 0-17 years
- B = 18 – 44 years
- C = 45 – 64 years
- D = 65 – 79 years
- E = 80+ years
- 0 = zero chronic conditions
- 1 = 1 long term condition (LTC)
- 2 = 2 to 4 LTCs
- 5 = 5 to 7 LTCs
- 8 = 8 or more LTCs

This process placed all Rutland patients into one of 26 different segments according to their age and how many long term conditions they had (e.g. B5 = people aged 18-

44years with 5 to 7 long-term conditions).

Looking at the mean emergency cost for across all segments of the population shows that the highest costs are found in the population with 8 or more conditions, regardless of age. This highlights that multimorbidity more than age drives emergency admission costs. Rather than the oldest age group, age group with the highest emergency costs in Rutland is 45-64 years, followed by those aged 18-44 years (with 8 or more long term conditions).

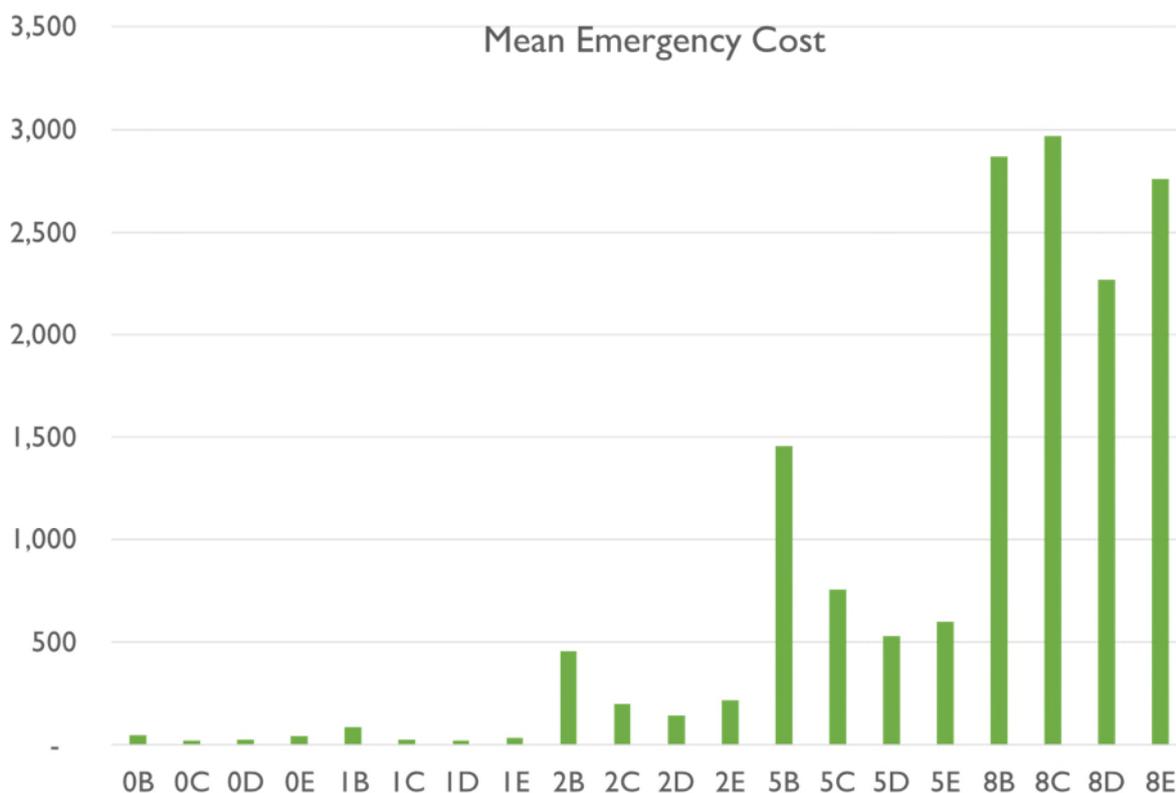


Figure 7 – Mean emergency costs segmented by age-group and multimorbidity bands

4.9 Hospital admissions

4.9.1 Emergency Admissions

Good management of long term conditions requires effective collaboration across the health and care system to support people in managing conditions and to promote swift recovery and reablement after acute illness. There should be shared responsibility across the system so that all parts of the health and care system improve the quality of care and reduce the frequency and necessity for emergency admissions.

Against a strong national trend of rising emergency admissions, the rate of emergency admissions has been maintained at a steady level in Rutland, with the 2017/18 rate only 0.5% higher than the rate in 2014-15. Non elective admissions rose by 9% in England over the same period according to national hospital activity data.¹¹

In 2017/18, the crude rate of emergency admissions for patients aged 65 years and above in Rutland is 18,815 per 100,000 population aged 65 years and above. This equates to 1,822 emergency admissions in the population aged 65 years and above in Rutland. This is the 2nd lowest rate out of the 16 CIPFA nearest neighbours to Rutland.¹²

4.9.2 Falls

Nationally falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. they are a major precipitant of people moving from their own home to long-term nursing or residential care. The highest risk of falls are in those aged 65 years and above and it is estimated that about 30% people aged 65 years and above living at home and about 50% of people aged 80 years and above living at home or in residential care will experience an episode of fall at least once a year.

The local data for Rutland shows the rate of emergency admissions for falls increases with age, with the rate of admissions for those aged 80 years and above being seven times higher than those aged 65 to 79 years. The rate of emergency admissions for falls for those aged 80 years has remained similar to the national average for five of the last eight time periods. The most recent data for 2017/18 shows there were 130 emergency hospital admissions for falls in persons aged 80 and above, an increase by 20 admissions compared to the previous year.⁸

The rate of emergency hospital admissions for hip fractures in persons aged 65 and above and in persons aged 80 and above (separately) has increased each year between 2014/15 to 2017/18. In the older age band, the national rate has declined slightly year on year.

The latest data in 2017/18 shows the rate of emergency hospital admissions for hip fractures in persons aged 65 and above and in persons aged 80 and above (separately) has increased (worsened) to perform significantly worse than the national rate. This represents an additional 22 admissions in the 65 and above age band and 26 admissions in the 80 and above age band, compared to the previous year. When

examining by gender, in 2017/18, the rate of emergency hospital admissions for hip fractures in males aged 65 and above per 100,000 population is similar to the national average, whereas the rate in females is significantly worse than the national average.⁸

4.10 Minimising unnecessary time in hospital

Delayed Transfers of Care (DToC) are the additional days that a person may stay in hospital, once medically fit for discharge, because they are unable to move on to their onward destination, e.g. because there is a lack of capacity in non-acute hospital for convalescence, or a package of care is not yet in place for them. Where DToCs can be avoided, as well as freeing up hospital capacity, this reduces the risk to individuals of hospital-acquired infections and of deconditioning due to prolonged inactivity, which can then impede recovery and independence.

DToC rates in Rutland have been reducing over time, and now match those of some of the best performing parts of the country: Rutland was ranked 19th out of 152 Health and Wellbeing Board areas in England in 2017-18 for its DToC rate, at 5.5 delays per day per 100,000 adult population. This was the lowest rate in the East Midlands, where rates ranged between 5.5 and 24.2.

4.11 Regaining the ability to manage at home after a hospital stay

Reablement helps people to learn new ways to accomplish day to day tasks that they can no longer manage as well as they used to, prolonging their ability to manage independently.

In Rutland, in 2016-17, 3.1% of people aged 65 years and over who were discharged from hospital were offered reablement services, which was similar to the England average. This is an improvement on previous patterns: in 2013-14 the rate was 2.8%, 0.5% below the then England average of 3.3%. The 2016-17 rate equals the rate of reablement being offered in Leicester and is 0.7% higher than that in Leicestershire.

Rutland has achieved very high rates of success with reablement services. In 2016-17 and 2017-18, more than 95% of individuals who received reablement services were still at home 91 days after being discharged from hospital. The 2016-17 rate of 97.2% was the best in the country.

4.12 Mortality

The directly age standardised mortality rate (ASMR) is calculated to take into account

the age structures of the population. Since 2004, the ASMR for all ages in Rutland has remained significantly lower than the national average. The latest data in 2015 shows when the ASMR is broken down into age groups, those under 65, between 65 and 74, between 75 and 84 and above 85 years all have a similar rate to the national average.⁹

In Rutland, 10.1% of all deaths in 2015 were in those aged under 65. This is significantly lower than the national percentage of 14.8% and has decreased year on year from 13.2% in 2012. Of all deaths in Rutland, 46.6% were from those aged 85 and above, this is significantly higher than the national percentage of 40.4%. The percentage of deaths in this age group has increased significantly over time, likely due to the ageing population.⁹

4.12.1 Place of death

Over a third (38.9%) of all deaths in Rutland in 2016 were in hospital, followed by: in the home (27.7%), in care homes (27.7%), hospices (3.2%) and other places (2.4%). This pattern of place of death is reflected nationally. The latest data shows Rutland has a significantly lower proportion of deaths occurring in hospital and a significantly higher proportion of deaths in care homes compared to nationally. In Rutland the trend is significantly decreasing over time for in-hospital deaths and significantly increasing over time for deaths in care homes.⁹

In Rutland, over half (51.9%) of deaths in the under 65 years age group occurred in hospital in 2016, this is the highest percentage out of all age groups. The lowest percentage of in-hospital deaths occurred in those aged over 85 years. In 2016, less than a third of deaths (29.8%) in this age group were in hospital, significantly lower than the national percentage of 43.8%. The trend of in-hospital deaths has been significantly decreasing across the 65-74 age band and 85 and above age band over time.⁹

As age increases, the percentage of deaths in care homes increases. Almost half (45.7%) of all deaths in the 85 and above age bands occurred in care homes, a significantly higher percentage to the national average (36.7%). The trend of care home deaths has been significantly increasing in the county across the 85 and above age band over time.⁹

Nationally the percentage of deaths at home decreases with age. In 2016 in Rutland, over a third (39.7%) of deaths in those aged 65-74 years died at home, similar to the national percentage of 30.3%. This was the highest percentage out of all age bands

in Rutland residents. In those aged 85 and above, a quarter (24.5%) of all deaths were in the home. This is a significantly higher percentage compared to the national average (16.4%).⁹

In 2016, hospice deaths accounted for 3.2% of all deaths in Rutland. This is similar to the national percentage of 5.7%. In Rutland the trend is significantly increasing over time for deaths in hospices.⁹

4.12.2 Deaths in Usual Place of Residence

In Rutland, over half (52.4%) of all deaths were in usual place of residence (DiUPR) in 2015, this is significantly higher than the national percentage of 46.0%. The trend has increased significantly in Rutland over time and the percentage of DiUPR has continued to have a significantly higher percentage than nationally since 2006. Two-thirds (66.1%) of all deaths from those aged 85 and above in Rutland were in the usual place of residence, this is significantly higher than the national percentage of 54.1%. The percentage of DiUPR in this age group has increased significantly over time.⁹

When examining DiUPR by cause of death in 2015, this showed Dementia and Alzheimer's disease had the highest percentage of DiUPR (87.3%), followed by Circulatory disease (49.0%), Cancer (48.0%) and Respiratory disease (32.5%). Trend analysis for Rutland shows that the percentage of deaths in usual place of residence for Cancer has shown a significant increase over time whereas Dementia and Alzheimer's disease, Circulatory disease and Respiratory disease have all shown no significant change in the percentage of DiUPR.⁹

4.12.3 Excess winter deaths

In common with other countries, more people die in the winter than in the summer in England and Wales. The Excess Winter Deaths (EWD) Index is defined as the ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths. Between August 2014 to July 2017 there were an estimated 43 excess winter deaths in Rutland. This represents a EWD Index of 12.0%, which means that 12.0% more deaths occurred in the winter months compared with the non-winter months.⁸ As it is common to observe large fluctuations in EWDs for which trends over time are often not smooth, we have presented a three-year moving average to smooth out any short-term fluctuations and make the trend over time clearer in the graphs presented.

Nationally, EWDs are generally higher in females and the elderly. In Rutland, for all but one data point in August 2006 to July 2009, the EWD Index for those aged 85 years and above has been consistently higher than those of all ages since recordings began. When examining by gender, on a national level, the EWD Index for females aged 85 and above has been higher than males (although not always significantly) for the last 13 time periods. In Rutland, the EWD Index for females aged 85 and above has been higher (although not significantly) than males in the same age group for the last four time periods.⁸

REFERENCES

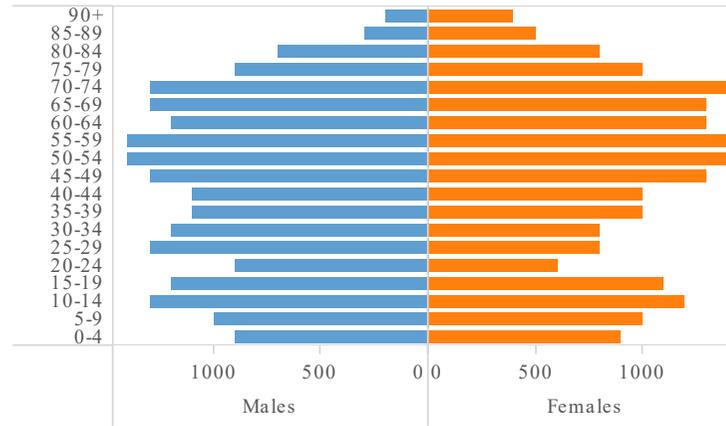
- ¹ Office for National Statistics, mid-2017 population estimates for England and Wales (2018). At <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2017/relateddata>
- ² Office of National Statistics. Subnational population projections for England: 2016-based (2018). At: <https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/datasets/localauthoritiesinenglandtable2>
- ³ Public Health England. Mental Health and Wellbeing JSNA (2019). At <https://fingertips.phe.org.uk/profile-group/mental-health/profile/mh-jsna>
- ⁴ Institute of Public Care (2018). Projecting Older People Population Information. Available at: <http://www.poppi.org.uk/>
- ⁵ NHS Digital (2018) Quality and Outcomes Framework (QOF) - 2017/18. Available at: <https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data/quality-and-outcomes-framework-qof-2017-18>
- ⁶ Action on Hearing Loss. Hearing Matters (2015). At: <https://www.actiononhearingloss.org.uk/how-we-help/information-and-resources/publications/research-reports/hearing-matters-report/>
- ⁷ RNIB (2018). How many people in the UK have sight loss? Available at: <https://help.rnib.org.uk/help/newly-diagnosed-registration/registering-sight-loss/statistics>
- ⁸ Public Health England (2019) Public Health Outcomes Framework. Available at: <https://fingertips.phe.org.uk/profile/public-health-outcomes-framework>
- ⁹ Public Health England (2018) End of Life Care Profile. Available at: <https://fingertips.phe.org.uk/profile/end-of-life>
- ¹⁰ Public Health England (2019) Dementia Profile. Available at: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia>
- ¹¹ NHS England (2018) Monthly Hospital Activity Data. At. <https://www.england.nhs.uk/statistics/statistical-work-areas/hospital-activity/monthly-hospital-activity/mar-data/>
- ¹² Department of Health and Social Care (2018) Local area performance measures: NHS social care interface dashboard. Available at: <https://www.gov.uk/government/publications/local-area-performance-metrics-and-ambitions>

2016-based population projections in Rutland

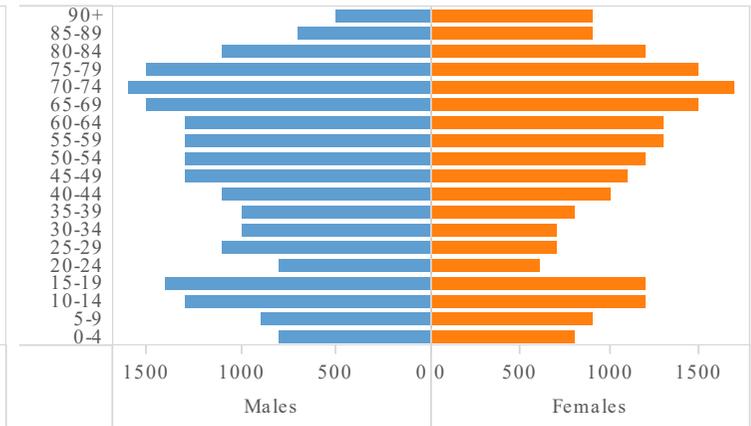
The 2016-based population projections provide statistics on the potential future size and age structure of the population. They are used as a common framework for informing local-level policy and planning as they are produced in a consistent way. The projections take the revised mid-2016 population estimates as their starting point. The projected local authority populations for each year are calculated by ageing on the population from the previous year, applying local fertility and mortality rates to calculate the number of projected births and deaths, and then adjusting for migration into and out of each local authority. The local authority fertility, mortality and migration assumptions are derived using estimated values from the five years before the base projection year.

Please note the population projections are not forecasts. They do not attempt to predict the impact of future government or local policies, changing economic circumstances or other factors that may influence demographic behaviour.

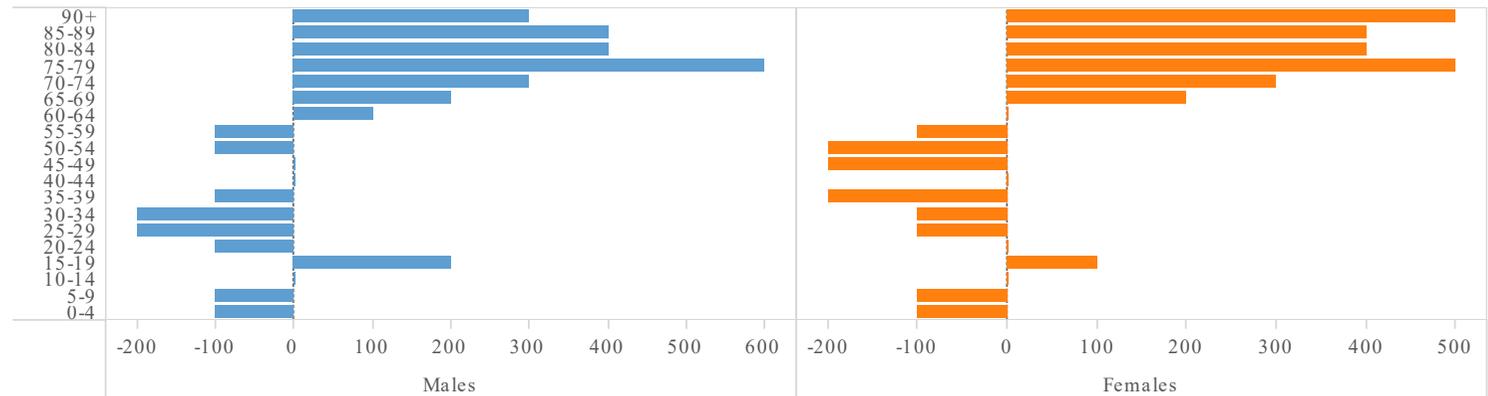
Population 2019



Population 2039



Population Change 2019 to 2039

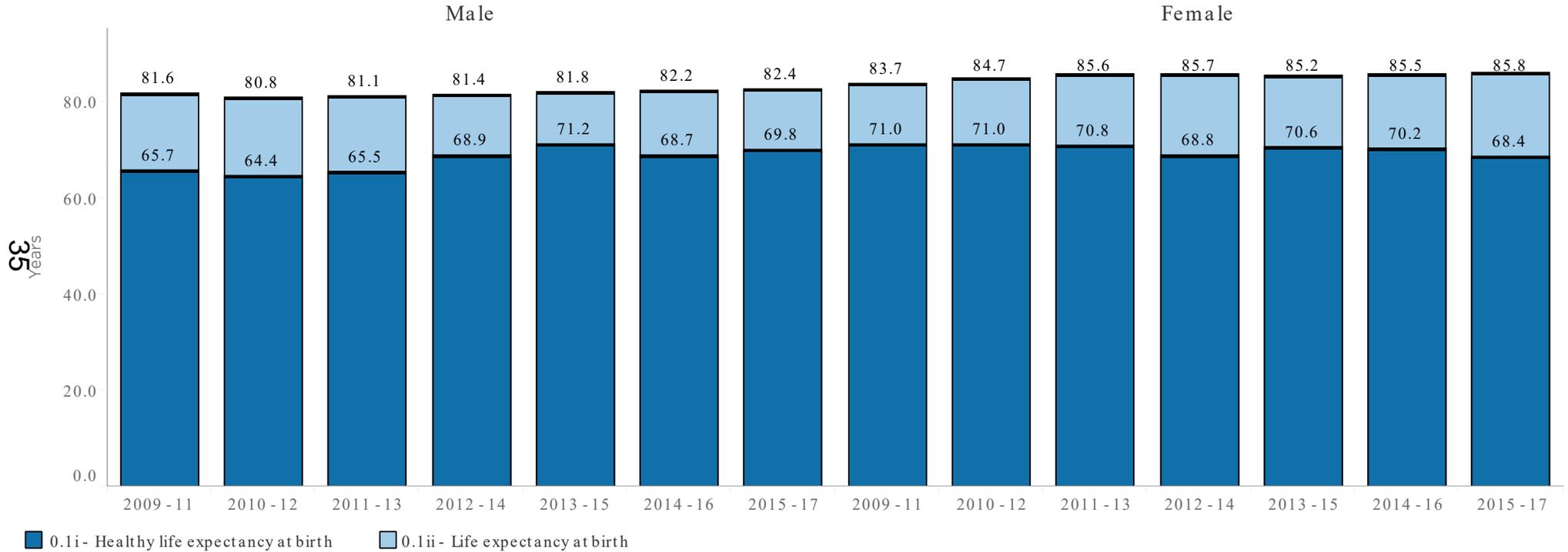


Source: Office for National Statistics (ONS), 2018.

Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

Life Expectancy at Birth & Healthy Life Expectancy at Birth in Rutland

Nationally, life expectancy at birth has increased by 0.1 years for males between 2014-16 and 2015-17 whereas in females, over the last four time periods life expectancy has stabilised at 83.1 years respectively. In Rutland, life expectancy at birth has increased by 0.2 years for males and 0.3 years for females between 2014-16 and 2015-17. At a national level, healthy life expectancy at birth has increased by 0.1 years for males but decreased by 0.1 years in females. In Rutland, healthy life expectancy at birth has increased by 1.0 years for males compared to the previous time period, from 68.8 years to 69.8 years, whereas in females healthy life expectancy at birth has decreased 1.8 years from 70.2 years to 68.4 years. As shown by the graph, females, on average, live longer but spend more years in poor health. The latest data shows in Rutland males spend 12.5 years in poor health compared to 17.4 years in females. The national gap currently stands at 16.1 and 19.3 years for males and females respectively.



Source: Public Health Outcomes Framework, PHE

Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019

QOF Recorded Prevalence in Rutland, 2017/18

With the introduction of the new GMS contract in April 2004, a quality framework of indicators (QOF) was developed for general practice, the QOF. An integral part of the QOF is the collection of prevalence data to allow practices to case find those patients that require specific management. Prevalence data within the QOF are collected in the form of practice registers. The purpose of a QOF disease register is to define a cohort of patients with a particular condition or risk factor. Please note, while many patients are likely to suffer from co-morbidity, i.e. are diagnosed with more than one of the clinical conditions included in the QOF clinical domain, robust analysis of co-morbidity is not possible and therefore patients may be on more than one disease register if they have multiple conditions or risk factors.

Indicator Name	Local Register	England Prevalence %	
Number of people with learning disabilities known to GPs: % on register	135	0.5%	0.4%
Severe mental illness recorded prevalence (QOF): % of practice register (all ages)	266	0.9%	0.7%
Stroke: Recorded prevalence (all ages)	861	1.8%	2.3%
Diabetes: QOF prevalence (17+)	2,011	6.8%	6.5%
Dementia: Recorded prevalence (all ages)	336	0.8%	0.9%
CHD: Recorded prevalence (all ages)	1,351	3.1%	3.6%
Depression recorded incidence (QOF): % of practice register aged 18+	347	1.6%	1.2%
Osteoporosis: QOF prevalence (50+)	90	0.6%	0.5%
Hypertension: QOF prevalence (all ages)	6,320	13.9%	16.7%

36

Statistical Significance compared to England

■ Higher
 ■ Lower
 ■ Similar

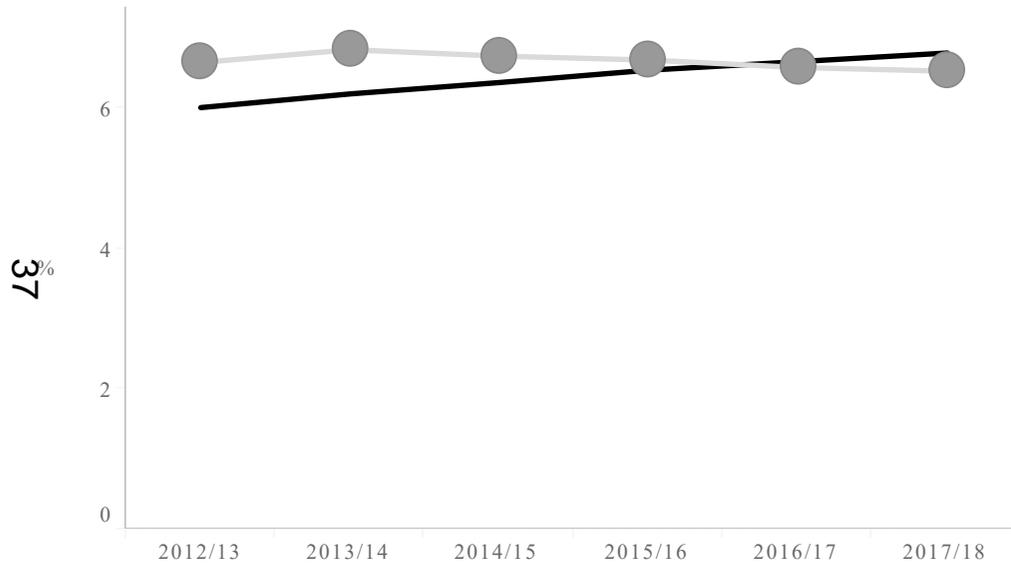
Source: Fingertips, Public Health England

Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

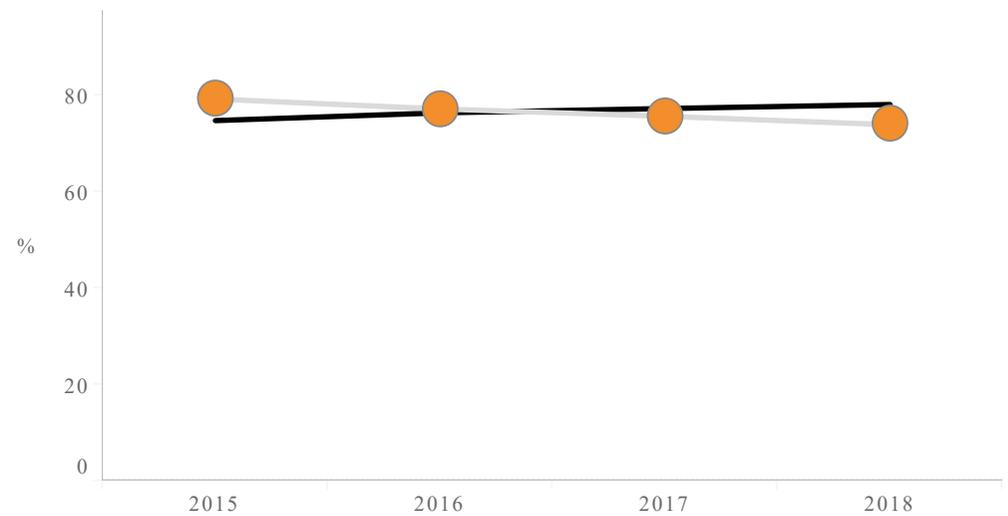
Diabetes prevalence and estimated diabetes diagnosis rate in Rutland

For Local Authorities, Clinical Commissioning Groups and local Health and Wellbeing Boards to understand the scope for prevention and make headway in tackling the rising numbers of people with or at risk of diabetes, it is important to understand not only how many people have diabetes (number of cases of diabetes recorded on QOF register) but also the estimated number of people expected to have diabetes given the characteristics of the population. This will help identify the scale of the challenge in terms of numbers and costs in developing diabetes identification and prevention programmes. It will also help monitor the progress of closing the gap (i.e. meeting previously unmet need) between observed prevalence (number of cases of diabetes recorded on QOF register) and actual prevalence in identifying people at high risk or with undiagnosed diabetes.

Recorded QOF prevalence (aged 17+)



Trend of estimated diagnosis rate for people with diabetes aged 17+



Statistical Significance compared to England

■ Similar

Source: Fingertips, Public Health England

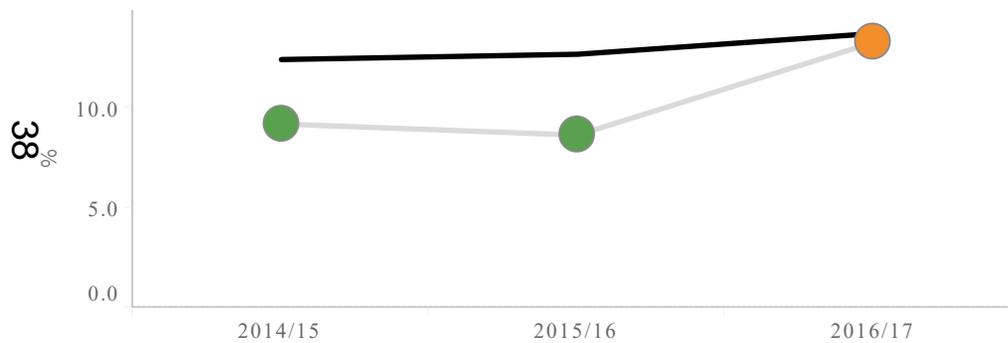
Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

Depression and Anxiety in Rutland

The depression recorded prevalence from QOF examines the percentage of the practice register with a diagnosis of depression. In contrast, the indicator reporting the percentage of depression or anxiety among patients is sourced from the GP Patient Survey. Across all time periods presented, the prevalence of depression or anxiety identified in this survey is higher (13.3% compared to 7.9% in 2016/17), perhaps because patients who have chronic conditions are more likely to respond. However, differences in the two prevalence estimates might also reflect an under-diagnosis of depression in General Practice.

It is well known that mental illnesses are frequently comorbid with physical illnesses and vice versa. The bar chart shows the prevalence of anxiety or depression in Rutland is higher (but not significantly) for those with a musculoskeletal (MSK) condition compared to those without a MSK condition. At a national level, this pattern is replicated but shows a significant difference.

Percentage reporting depression or anxiety (GPPS)

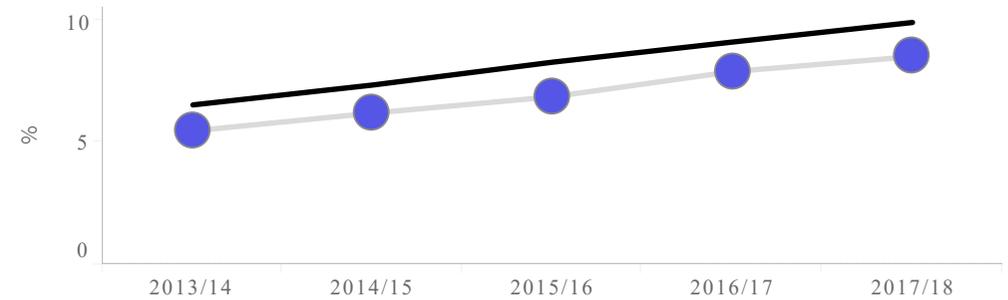


Statistical Significance compared to England:

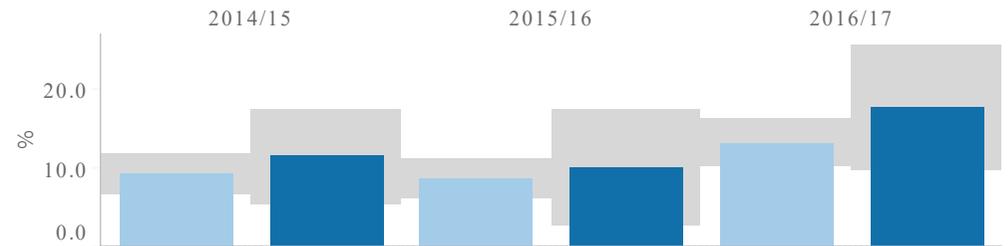
■ Better
 ■ Similar

Source: Fingertips, Public Health England

Depression recorded prevalence (QOF): % of practice register aged 18+



Percentage reporting a long term MSK problem who also report depression or anxiety (GPPS)



N.B. Grey bars display 95% confidence intervals

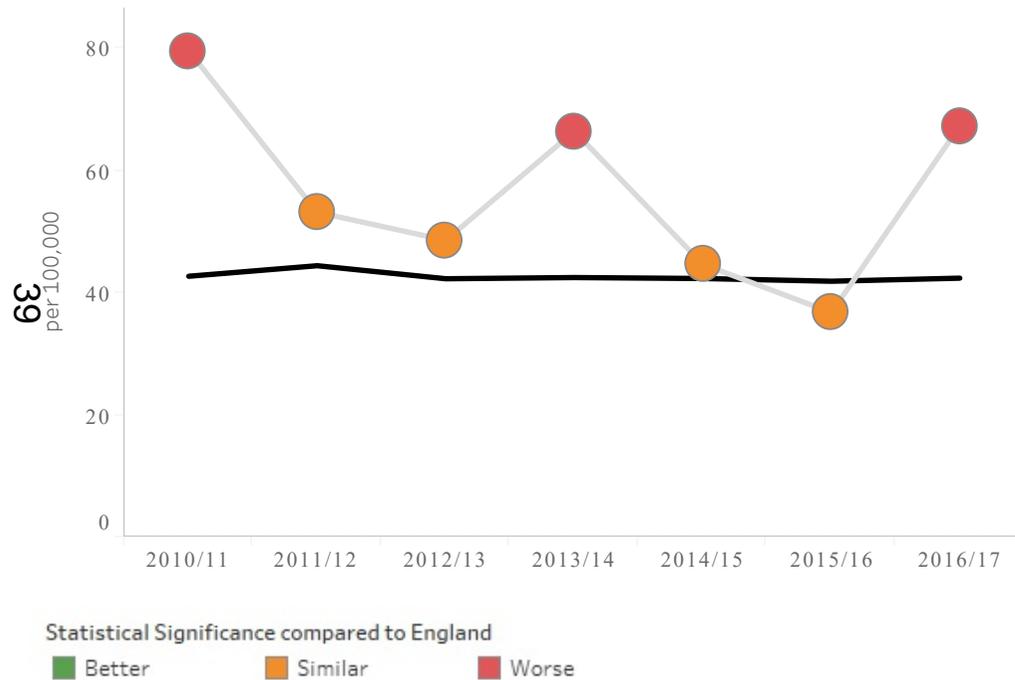
■ % reporting depression or anxiety
■ % reporting a long term MSK problem who also report depression or anxiety

Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

Preventable sight loss in Rutland

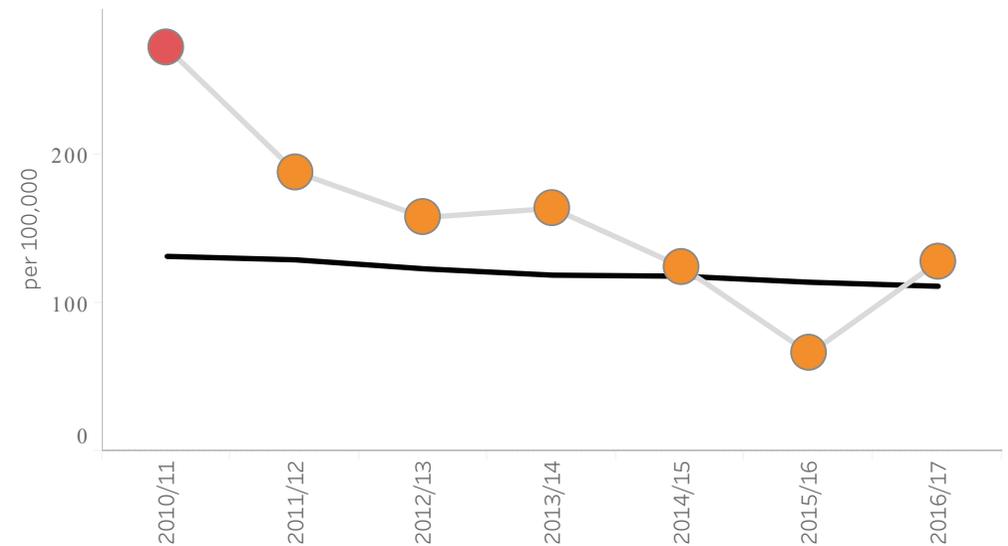
Prevention of sight loss will help people maintain independent lives as far as possible and reduce needs for social care support, which would be necessary if sight was lost permanently. The indicators presented show the counts of new completions of Certifications of Visual Impairment (all causes - preventable and non-preventable) by a consultant ophthalmologist as a rate of the resident population in the county. Where the cause of sight loss is Age-related Macular Degeneration (AMD), the rate of new completions of Certifications of Visual Impairment due to this disorder has been examined separately. Completing the sight loss certification initiates the process of registration with a local authority and leads to access to services.

Rate of sight loss certifications per 100,000 population



Source: Public Health Outcomes Framework, Public Health England

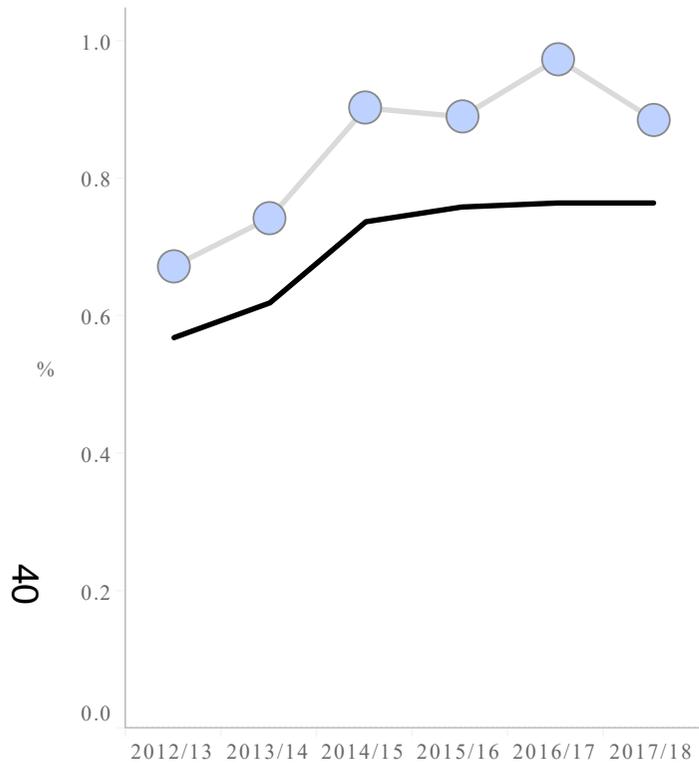
Rate of sight loss due to age related macular degeneration (AMD) in those aged 65+ per 100,000 population



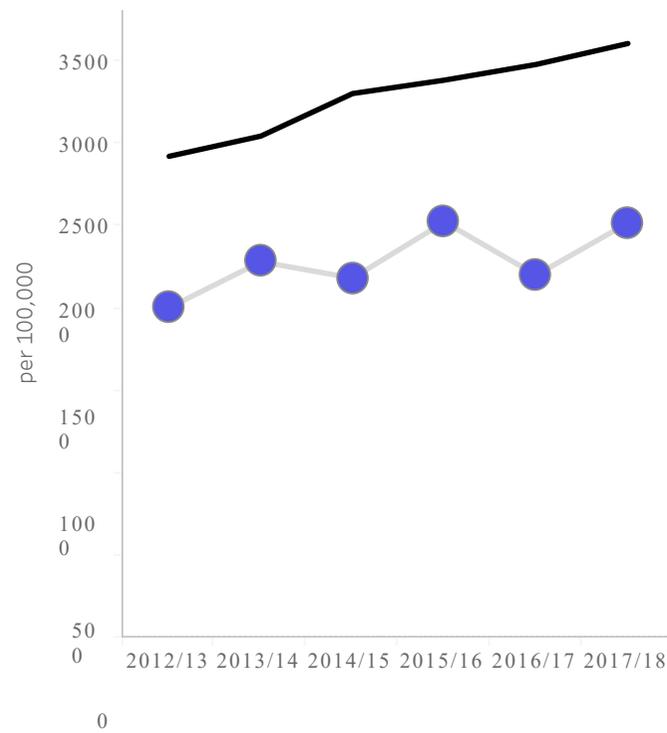
Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

Dementia prevalence and emergency admissions rate in Rutland

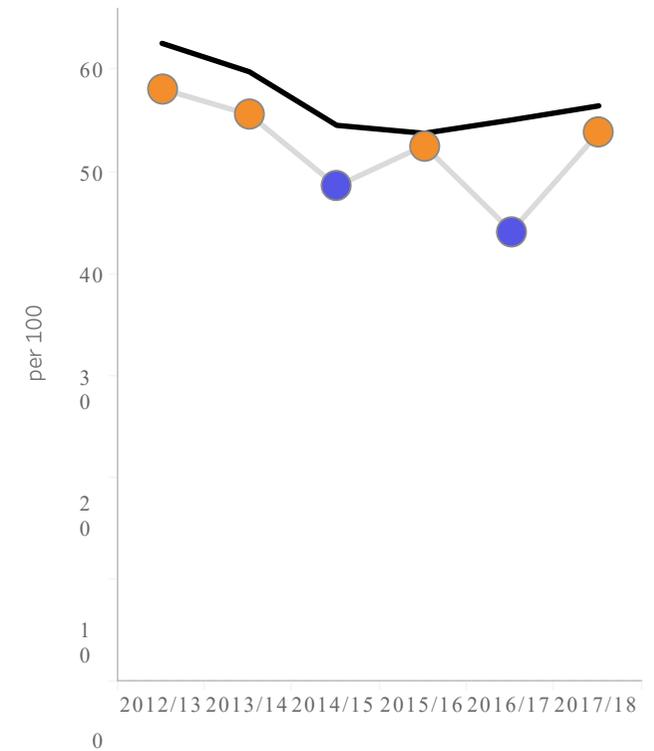
Dementia: Recorded prevalence (all ages)



Dementia: Direct standardised rate of emergency admissions (aged 65 years and over)



Dementia: Ratio of inpatient service use to recorded diagnoses



■ High Statistical Significance
■ Compare to England
■ Similar

Forecasted prevalence of limited long term conditions in people aged 65 and above in Rutland

The chart shows the projected number of people over the age of 65 with a long term condition between 2017 and 2035 in Rutland. The numbers are based on the current prevalence rates applied to projected populations. Please note, the numbers refer to people on individual registers i.e. people with multi-morbidities will be counted on each register, therefore the totals will be greater than projected populations for the over 65s. The projected increase in number of people with the following conditions between 2017 and 2035 in Rutland is: Dementia (78.8%), Stroke (47.5%), Heart attack (44.8%), Bronchitis and emphysema (42.9%), Depression (41.6%), Diabetes (41.1%), Obesity (34.2%).



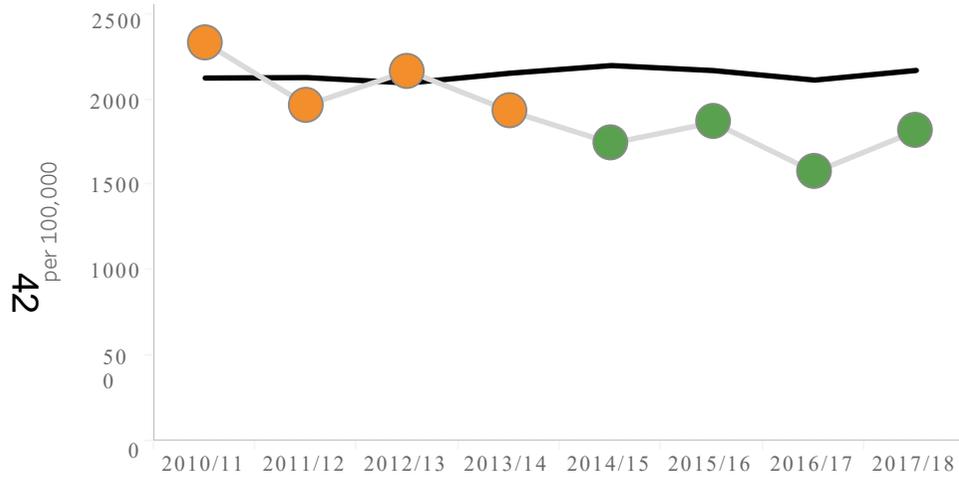
Source: POPPI

Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

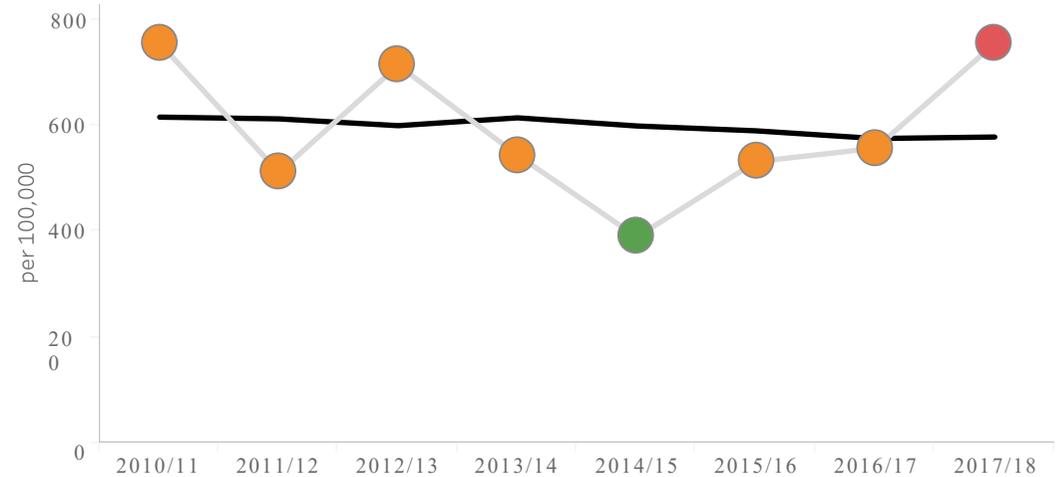
Emergency admissions (aged 65+) due to falls and hip fractures in Rutland

Falls are the largest cause of emergency hospital admissions for older people, and significantly impact on long term outcomes, e.g. they are a major precipitant of people moving from their own home to long-term nursing or residential care. The highest risk of falls is in those aged 65 and above and it is estimated that about 30% people aged 65 and above living at home and about 50% of people aged 80 and above living at home or in residential care will experience an episode of fall at least once a year. Hip fractures may result from a fall. Hip fracture is a debilitating conditions with only one in three people that suffer a hip fracture return to their former levels of independence. The condition is so debilitating that one in three sufferers end up moving into long-term care facilities.

Emergency hospital admissions due to falls in people aged 65 and over, directly age standardised rate per 100,000 population



Emergency hospital admissions due to hip fractures in people aged 65 and over, directly age standardised rate per 100,000 population



Statistical Significance compared to England
■ Better ■ Similar ■ Worse

Source: Public Health Outcomes Framework, Public Health England

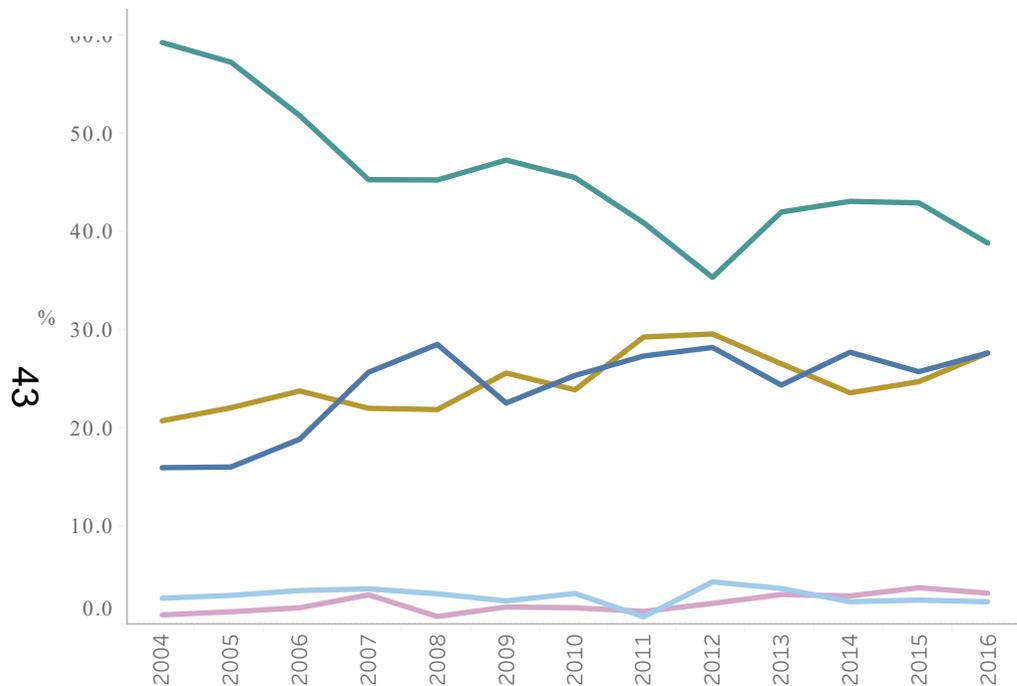
Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

Place of death in Rutland

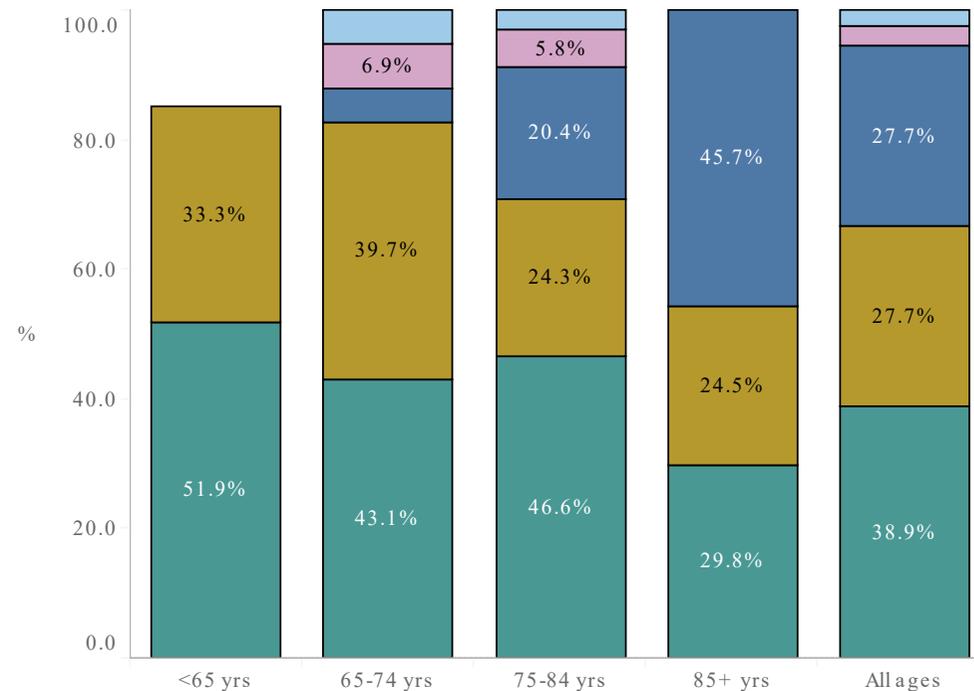
Age Range
All ages

The following indicators have been examined to understand the trends and variations in place of death as proxy indicator for quality of end of life care. The data shows the majority of people die in hospital; however the proportion of deaths in this location has shown a significant decline over the last five years. The latest data from 2016 shows as age increases, the proportion of people dying in a care home increases while the proportion of home deaths and deaths in hospices decreases.

Trend of place of deaths by All ages in Rutland



Place of death by age in Rutland, Persons, 2016



Place of Death

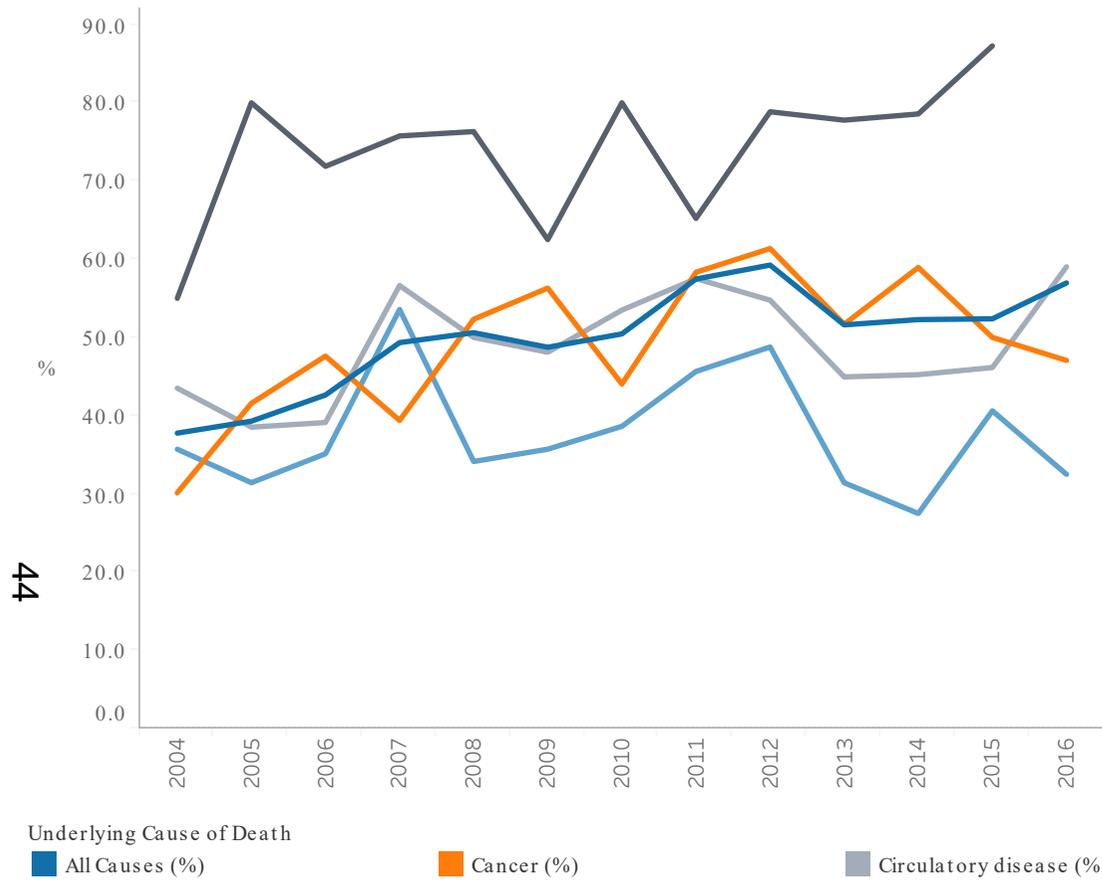
- Care home deaths (%)
- Deaths in Other Places (%)
- Home deaths (%)
- Hospice deaths (%)
- Hospital deaths (%)

Source: End of Life Care Profile, PHE

Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

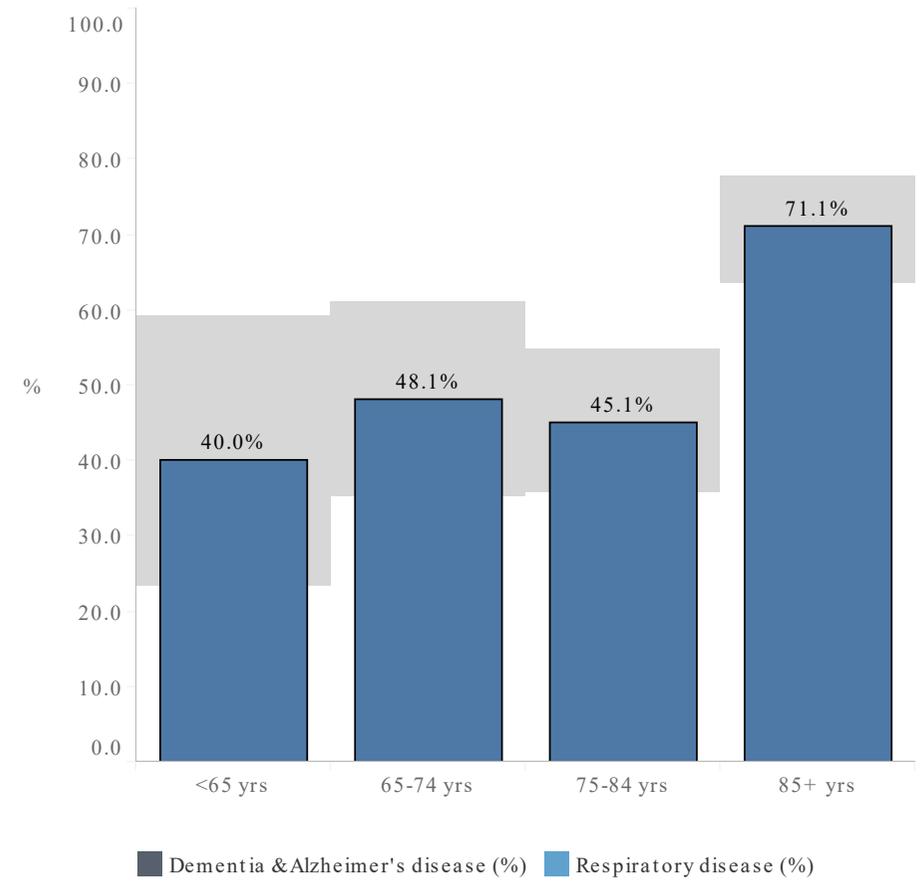
Death in Usual Place of Residence (DiUPR) in Rutland

Trend of DiUPR by Underlying Cause of Death in Rutland



Source: End of Life Care Profile, PHE

DiUPR by age in Rutland, Persons, 2016

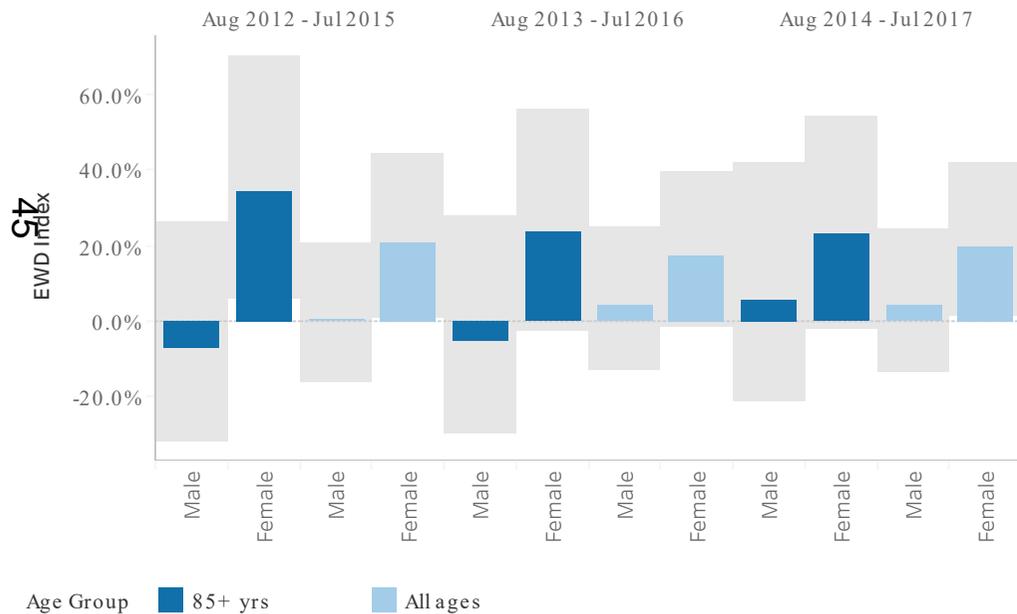


Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

Excess Winter Deaths in Rutland

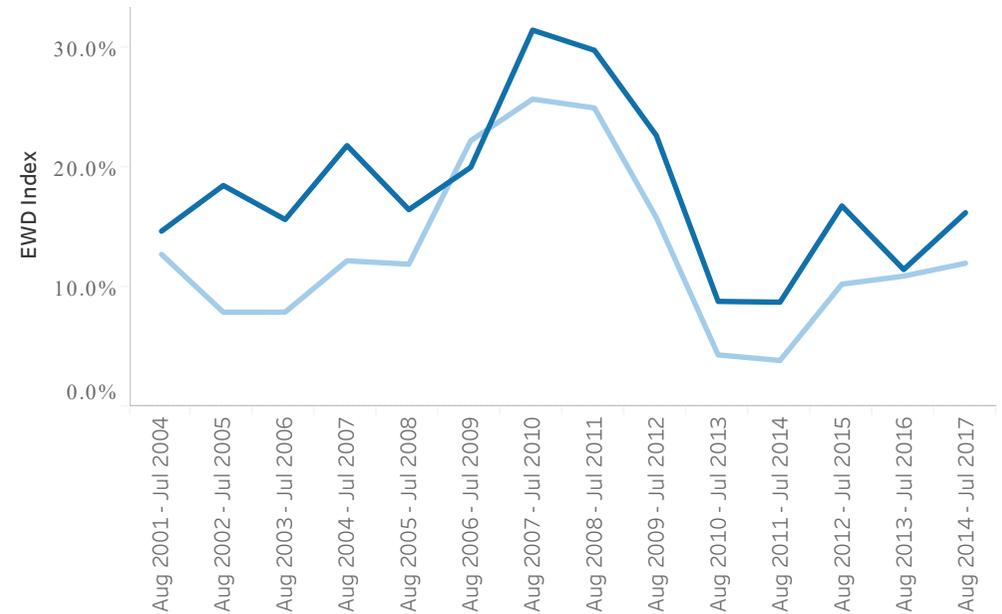
In common with other countries, more people die in the winter than in the summer in England and Wales. The Excess Winter Deaths (EWD) Index is defined as the ratio of extra deaths from all causes that occur in the winter months compared with the expected number of deaths, based on the average of the number of non-winter deaths. Between August 2014 to July 2017 there were an estimated 43 excess winter deaths in Rutland. This represents a EWD Index of 12.0%, which means that 12.0% more deaths occurred in the winter months compared with the non-winter months. As it is common to observe large fluctuations in EWDs for which trends over time are often not smooth, we have presented a three-year moving average to smooth out any short-term fluctuations and make the trend over time clearer in the graphs presented. Nationally, EWDs are generally higher in females and the elderly. In Rutland, for all but one data point in August 2006 to July 2009, the EWD Index for those aged 85 years and above has been consistently higher than those of all ages since recordings began. When examining by gender, on a national level, the EWD Index for females aged 85 and above has been higher than males (although not always significantly) for the last 13 time periods. In Rutland, the EWD Index for females aged 85 and above has been higher (although not significantly) than males in the same age group for the last four time periods.

Excess Winter Deaths Index (3 years) by sex and age group



Source: Public Health Outcomes Framework

Trend in Excess Winter Deaths Index (3 years) by age group



Produced by the Strategic Business Intelligence Team, Leicestershire County Council, 2019.

5. Feedback on recommendations for 2017

Recommendations and summary

Military Health

The military population has a significant bearing on the population of Rutland and its use of health and other services. Although there are good links between public health and the military on specific issues, the importance of serving military, veterans and their families in Rutland calls for a review, in line with national publications, on the links between the military defence services and public health.

Response:

A detailed Health assessment of the needs of the serving military and their families has been undertaken. Originally, to be the subject of this report, it is currently undergoing review and comment by the Army. It is intended that a summary version will now form the basis of the 2020 Public Health Annual Report.

Mental Health

Mental health problems are widespread, at times disabling, yet often hidden. We shall undertake a piece of work examining the link between anti-depressant prescribing and mental health in Rutland.

Response: Investigations found anti-depressant prescribing in Rutland was in line with East Leicestershire and Rutland and West Leicestershire CCGs. Much work this year was devoted to updating the Joint Strategic Needs Assessment (JSNA) for Rutland which was been published in December 2018, this included a stand-alone chapter on Mental Health in Adults in the county. This needs assessment found the GP recorded prevalence for depression in Rutland is significantly lower compared to national; however, the prevalence has significantly increased over the past five years. This increasing trend is also witnessed nationally.

Poverty

Rutland is one of the most affluent counties in the country, however, it is fundamental that we are able to disaggregate our population and pinpoint pockets of deprivation that exist among rural affluence. We shall undertake a detailed piece of work examining poverty in Rutland, drawing on the scrutiny commission work done on poverty previously.

Response: The recently completed Joint Strategic Needs Assessment (JSNA) sets out data on the health and wellbeing needs of Rutland both now and into the future. The JSNA sets out the key rural health issues that should be borne in mind by commissioners and providers.

Farmers and other agricultural workers are included amongst occupational groups that are at particularly high suicide risk (other groups include nurses and doctors). For example, GPs in rural areas, aware of the higher rates of suicide in farmers and agricultural workers, will be well prepared to assess and manage depression and suicide risk.

The recently launched 'Start a Conversation' campaign tackling attitudes and stigma towards death by suicide, recognises the importance of rurality as a risk factor. The Leicestershire and Rutland Rural Partnership holds a series of suicide prevention awareness training workshops.

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RUTLAND HEALTH AND WELLBEING BOARD

25 June 2019

LEICESTER, LEICESTERSHIRE AND RUTLAND HEALTH PROTECTION ASSURANCE REPORT

Presented by:	Dr Kath Packham	LLR Public Health
Report Author(s) and contact details:	Dr Mike McHugh, Consultant in Public Health Leicestershire and Rutland County Councils Email: Mike.McHugh@leics.gov.uk Tel: 0116 3054236	

RECOMMENDATIONS

That the Rutland Health and Wellbeing Board;

1. Receives the Health Protection Board Report January 2018- December 2018.
2. Notes the specific health protection issues that have arisen locally, and steps taken to deal with these.
3. Notes the focus for particular areas of work in the coming year

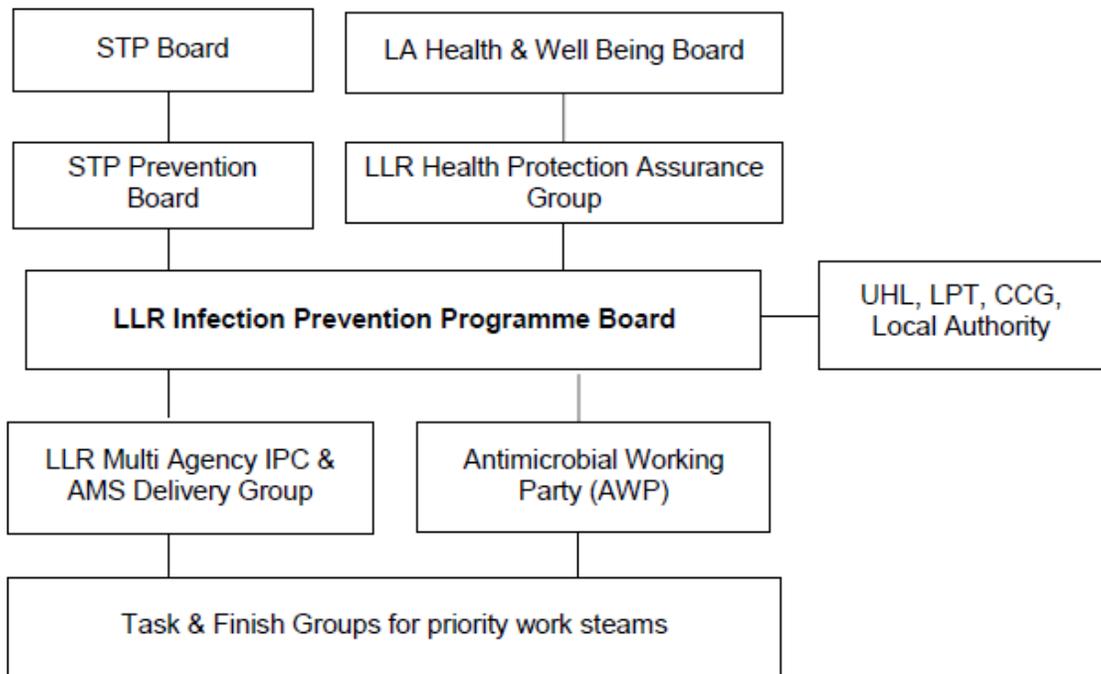
1. PURPOSE OF THE REPORT, INCLUDING LINKS TO HEALTH AND WELLBEING PRIORITIES

- 1.1 The purpose of this report is to provide a summary of the assurance functions of the Leicestershire, Leicester and Rutland (LLR) Health Protection Assurance Board. It also updates the Health and Wellbeing Board on Health Protection performance, key incidents and risks and other significant matters considered in the past year that have emerged from January 2018 to December 2018.
- 1.2 Health protection assurance is a statutory duty of the local authority, via the Director of Public Health (DPH). It is therefore a key element of the Joint Health and Wellbeing Strategy and of Rutland County Councils core business. It is an essential element in local health and social care strategies and initiatives including Better Care Together/Sustainability Transformation Plan, and to urgent care work streams.

2. BACKGROUND AND MAIN CONSIDERATIONS

Policy Framework and Previous Decisions

- 2.1 On 1st April 2013 implementation of the new NHS and Social Care Act (2012) resulted in most of former NHS Public Health responsibilities being transferred to upper tier and unitary local authorities (LAs) including the statutory responsibilities of the Director of Public Health.
- 2.2 Each local authority is now required, via its Director of Public Health to assure itself that relevant organisations have appropriate plans in place to protect the health of the population and that all necessary action is being taken. The scope of health protection in this context includes these key domains:
- Prevention and control of infectious diseases
 - National immunisation and screening programmes
 - Health care associated infections
 - Emergency planning and response (including severe weather and environmental hazards)
- 2.3 The Local Authority does not commission the majority of services which contribute to protecting the health of the population, but the Director of Public Health should be absolutely assured that arrangements are robust and that they are implemented in a way which meets the needs of the population for which they are responsible.
- 2.4 This is a local leadership function which requires the DPH and wider public health team to identify issues and advise appropriately; and to work in close liaison and cooperation with other contributing organisations. Responding to the Director of Public Health's information and advice is the responsibility of these other contributing organisations, who will also be accountable should unheeded advice result in any adverse impact.
- 2.5 The Leicestershire, Leicester and Rutland Health Protection Assurance Board is a sub-group of the three Health and Wellbeing Boards for Leicester, Leicestershire and Rutland (LLR) and enables local authorities to discharge their health protection assurance responsibilities.
- 2.6 Quarterly dashboard reports and/or updates are received and reviewed at the quarterly Assurance Board. They cover the key domains identified above. This data is reviewed by the group and if needed, stakeholders are asked to produce more detailed assurance for the group on an exception basis. The Health Protection Assurance Committee is linked into a number of other Health Protection groups across the local system:



Key domains of health protection assurance

3. PREVENTION AND CONTROL OF INFECTIOUS DISEASES

Organisational Roles/Responsibilities

- 3.1 Public Health England (PHE) leads on the epidemiological investigation and the specialist health protection response to public health outbreaks/incidents and has responsibility to declare a health protection incident, major or otherwise.
- 3.2 NHS England is responsible for ensuring that their contracted providers are mobilised to deliver an appropriate clinical response to outbreaks/incidents. This responsibility devolves down to local Clinical Commissioning Groups to use contractual arrangements with provider organisations to make relevant resources available (includes screening/diagnostic and treatment services).
- 3.3 The Local Authority through the Director of Public Health has overall responsibility for the strategic oversight of an incident/outbreaks and to gain assurance that the local health protection system is robust enough to respond appropriately.

Sexual Health

Table 1 in **Appendix 1** summarises the latest diagnostic and treatment rates for the main sexually transmitted infections in Leicestershire.

- 3.4 Leicestershire and Rutland Public Health commission the integrated sexual health services which detect, prevent and treat sexually transmitted infections in our local population. The service has comprehensive arrangements including online testing for Sexually Transmitted Infections and a variety of testing options for HIV.
- 3.5 The main Sexual Health contract covering Leicestershire, Leicester and Rutland was re-tendered in 2018 and the new contract commenced 01/01/19. There is now a greater emphasis on self-managed care whilst preserving the quality of testing, results notification and partner notification. The main site of delivery of services has moved to the Haymarket Shopping Centre Leicester.
- 3.6 Chlamydia Screening:
Whereas the chlamydia detection rate is lower than the benchmark and England average, the prevalence rate in Rutland is lower than national average. Our aim is to screen those at highest risk. The newly procured Sexual Health Service model of delivery is providing increased access to on-line self-sampling tests for Rutland residents and this will potentially increase screening rates.

Key Issues for 2019 (Sexual Health)

An action plan has been developed with key actions for 2019/20 relating to:

- Improving promotion of offer of STI tests using wider range of social media options.
- A review of STI screening in wider services such as prisons, termination of pregnancy services and maternity pathways to improve offer and uptake.
- Improving partner notification systems in integrated sexual health service to increase uptake of partner testing and retesting.

Tuberculosis (TB)

- 3.7 Prevalence of TB remains relatively low in Rutland. See **Appendix 2**

Key Issues for 2019 (TB)

- Continue to explore options and opportunities to provide TB screening and active case finding among migrants and other under-served populations.
- Review commissioning arrangements for paediatric TB patients
- Explore the potential for use of mobile x-ray units (MXUs) for use in prison.

- Clearly agree and outline local sustainable funding arrangements for TB incidents and outbreaks.

Other Outbreaks

Multi-Drug Resistant Organisms (MDROs)

- 3.8 During the summer of 2018 there was an outbreak of a Carbapenemase Resistant Organism (CRO), at the University Hospitals of Leicester (UHL). Further outbreaks have occurred sporadically over recent months. CRO are increasingly prevalent pathogens in hospitalized patients and can cause a variety of infections such as urinary tract infections, wound infections and respiratory tract infections.
- 3.9 The importance of CRO derives from the fact that they can spread rapidly in the hospital setting, and that they are commonly multidrug resistant (MDR). There are still few therapeutic options available to treat these MDR pathogens. Health and care partners across LLR are working collaboratively to (1) screen for CRO in high risk patients and (2) effectively manage those patients who are shown to be positive whether in hospital or community settings. Public Health England have developed a set of toolkits to support this work:

<https://www.gov.uk/government/publications/carbapenemase-producing-enterobacteriaceae-non-acute-and-community-toolkit>

Key Issues for 2019 (CRO)

- Fully embed practical advice to prevent or reduce the spread of Carbapenemase Resistant Organisms (CRO) in community and non-acute healthcare settings.

4. IMMUNISATION AND SCREENING

Organisational Roles/Responsibilities

- 4.1 NHS England commission most national screening and immunisation programmes through their Local Area Teams.
- 4.2 PHE is responsible for setting screening and immunisation policy through expert groups (the National Screening Committee and Joint Committee on Vaccination and Immunisation). At a local level, specialist public health staff, employed by PHE are embedded in the NHS Local Area Teams to provide accountability for the commissioning of the programmes and provide system leadership. PHE provides quarterly surveillance reports for each of the national immunisation and screening programmes.

- 4.3 Local Authorities through the Director of Public Health require assurance that screening and immunisation services are operating safely whilst maximising coverage and uptake within their local population.

Immunisation

- 4.4 Coverage of childhood immunisations continues to be higher than the England average in Rutland. However, coverage for 2nd dose MMR at age 5 is consistently below the levels recommended to build 'herd immunity' (95%). Good coverage helps ensure that the local population is protected and does not become susceptible to outbreaks of vaccine preventable diseases. Further work is needed in Rutland to improve uptake of childhood vaccination particularly where there are pockets of lower levels of vaccination in order to avoid potential outbreaks in the future. See **Appendix 3** for childhood immunisation cover.

Seasonal Flu

- 4.5 Flu uptake rates remain sub-optimal and there is an ongoing need to strengthen flu vaccine uptake. See **Appendix 4**.

Key Issues for 2019 (Immunisation)

Further work is required to increase uptake of childhood immunisations, particularly:

- MMR in Rutland. NHS England commission immunisation programmes through their Local Area Teams in which specialist public health staff are employed by PHE to provide accountability for the commissioning of the programmes and to provide system leadership. NHS England local area immunisation teams need to further strengthen links to local communities through local authority and voluntary sector partners and with primary care to maximise immunisation uptake.
- Introduction of HPV vaccine for boys in year 8
- Ongoing need to increase flu vaccine uptake particularly in people with susceptibility due to underlying health conditions.

Screening

- 4.6 Both cancer and non-cancer screening coverage continues to be higher than the national average in Rutland.
- 4.7 Cervical screening coverage remains below the national target of 80% and this reflects recent national trends. Breast screening coverage in 2017/18 is stable and meets the national target of 80%. Bowel screening coverage increased in 2017/18 in all areas and also remains above the national target of 60%. Performance in the abdominal aortic aneurysm (AAA) screening programmes continues to be excellent, and coverage is stable and meets acceptable national standards.

Key Issues for 2019 (Screening)

- Continue to strengthen collaborative multi-agency action plans to target areas of poorer uptake and coverage for each of the screening programmes.
- Need to strengthen relationships between local authority, NHS England and CCGs
- Move to primary HPV testing for cervical screening
- Introduction of FIT testing to bowel screening programme

5. HEALTH CARE ASSOCIATED INFECTIONS

- 5.1 Many healthcare associated infections are preventable. When they do occur, they can have a significant impact on patients and on the wider NHS and care systems.

Organisational Roles/Responsibilities

- 5.2 The NHS Outcomes Framework (NHS OF) is a set of indicators developed by the Department of Health and Social Care to provide a framework in which to measure and monitor how well the NHS is performing. NHS England hold local CCGs to account for performance against indicators under this domain, which includes incidence of preventable healthcare associated methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia and incidence of *Clostridium difficile*.
- 5.3 PHE through its consultants in communicable disease control will lead the epidemiological investigation and the specialist health protection response to health care associated infection outbreaks and has responsibility to declare a health protection incident.
- 5.4 The Local Authority through the Director of Public Health has overall responsibility for the strategic oversight of a health care associated infections impacting on their population's health. See **Appendix 5**.

MRSA

- 5.5 NHS Improvement has continued to set healthcare providers the challenge of demonstrating a 'zero' tolerance of MRSA blood stream infections (BSI) however in March 2018 NHS Improvement announced a change in how MRSA BSI cases were to be reviewed. From April 2018 University Hospitals of Leicester (UHL) and the three local Clinical Commissioning were exempt from completing a formal post infection review as this was now only for organisations with the highest rates of infection.