Leeds Joint Strategic Needs Assessment (JSNA) 2015

Executive Summary: Cross-Cutting Themes

07 May 2015

Acknowledgements

We would like to express our thanks to the many colleagues and commissioners of services in NHS Leeds Clinical Commissioning Groups; Leeds City Council and the Third Sector who assisted the JSNA Steering Group and core project team with the preparation and development of the Leeds JSNA 2015, through sharing their information, collecting and obtaining data and contributing their expertise.

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Foreword **(Draft to be agreed with Cllr Mulherin)**

Leeds' Joint Health and Wellbeing Strategy sets out a vision 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 health and wellbeing of the people of Leeds continues to improve for example a key success story for the city is the inroads that have been made to reducing avoidable potential years of life lost from cardiovascular disease within deprived areas of the city. However, like other large cities, we are still faced with huge challenges of a changing population and significant inequalities in health across the city against a backdrop of reductions in public spending.

The Joint Strategic Needs Assessment (JSNA) is the key to understanding health and wellbeing needs and inequalities across and within Leeds. We have adopted a partnership approach to the JSNA, jointly led by the three Clinical Commissioning Groups and Leeds City Council, which has seen the development of a rolling programme of data collection and analysis since the JSNA's establishment in 2009. This Executive Summary presents an overview of a number of cross-cutting issues facing the city, which key stakeholders have identified as important in understanding health and wellbeing needs.

The JSNA provides a key input into the city's health and social care system, informing the priorities of the Health and Wellbeing Board and providing the primary process for identifying needs. It informs commissioning strategies and plans and the Joint Health and Wellbeing Strategy. Our approach, over time, aims to develop a comprehensive picture of the challenges facing the city, encouraging joined-up responses to key issues.

The 2015 Executive Summary has built on areas for further work that were identified in the last JSNA Executive Summary in 2012. These include analysis of:

- demographic change providing insights into vulnerable populations and communities e.g. migrant populations;
- how poverty and welfare changes impact on people's health and wellbeing;
- housing conditions and developments and the potential impact on the demand for health and wellbeing services;
- learning disabilities including the transition from children to adults;
- potential Life Years Lost (PYLL) amenable and avoidable mortality;
- life expectancy and prevalence of disease;
- the extent to which mental health is a cross cutting theme.

As we progress with this work we are identifying further gaps in our knowledge, and filling these will be part of the JSNA's forward work programme. Nevertheless from this initial work a picture of the health and wellbeing of Leeds does emerge and presents a huge challenge for improvement, in which we will all have a part to play.

Councillor Lisa Mulherin
Chair, Leeds Health and Wellbeing Board

Headline Issues

- The health and wellbeing of the people of Leeds continues to improve, however, like other large cities, we are still faced with huge challenges of a changing population and significant inequalities in health across the city against a backdrop of reductions in public spending.

- The city continues to have a relatively robust and growing economy, during the recession Leeds fared better than many of its neighbours, with workplace-based employment in the city now estimated to have recovered to pre-recession levels.

- Economic performance impacts on the rates of population growth. Leeds is a growing city, the latest Office for National Statistics mid-year projections estimate that 761,500 people live in Leeds and GP registrations put the population at 819,900.

- However, it is the change in the make-up of our population, particularly at local levels that is most striking. There have been rapid demographic changes, particularly in some of our most deprived communities, driven by a complex combination of immigration and the local housing tenure, resulting in significant impacts on the provision of services.

- The backdrop to these very localised pressures, is the wider trend of the city's ageing population; as the baby-boomer generation grows older there will be a range of implications for service provision.

- Increases in the city's birth rate appear to have plateaued in the last five years. Deeper examination of birth rates in the city's most deprived communities show higher birth rates than the Leeds average.

- The assessment of poverty in Leeds highlights the correlation between economic disadvantage and poor outcomes for children, young people and adults in the city. The clear impact of worklessness, financial exclusion and poor housing on health, educational attainment and broader life chances is concentrated in particular communities.

- According to the Index of Multiple Deprivation over 163,000 people in Leeds live in areas that are ranked amongst the most deprived 10% nationally, and this represents over 20% of the city's population. Our most deprived communities in the Inner East and Inner South areas of the city, with a further hotspot in Hawksworth in Inner West. Although the index is a snapshot, wider analysis of other indicators suggest that the same geographical areas are the focus of disadvantage.

- Our population growth and changing age profile set major challenges in providing enough quality and accessible homes, whilst protecting the quality of the environment and respecting community identity.

- Good quality housing is a pre-requisite for good health. People who live in clean, warm, safe and affordable homes are less likely to experience housing-related ill health. The continuing growth of the private rented sector is a key trend which brings with it associated challenges, particularly at the low cost end of the market where housing condition can be poor.

- Levels of poor mental health and wellbeing and mental illness are inextricably linked with deprivation within the city. Local mapping highlights these issues and emphasises the social gradient of mental health and wellbeing.

- There is evidence that some mental health problems are becoming more prevalent, particularly amongst older people. Mental health problems, particularly depression, are more common in people with a physical illness including those living with long term conditions.

- Over the last four years there has been an increase in the Leeds learning disabilities population of about 5%. This growth is particularly focussed amongst younger people with the most profound needs for care.

- Concurrent with this increase is the level of intensity of support required to meet the increasing complexity of needs. It is overwhelmingly the case in 2015 that assessed need within this population is for significantly high levels of personal support of 1:1, 2:1 and sometimes 3:1 support for individuals.

- Potential Years of Life Lost (PYLL) from all avoidable causes for Leeds as a whole has fallen in the period 2009-11 to 2011-13 by around 6%.

- The rate in deprived Leeds is reducing more quickly than Leeds as a whole meaning that health inequalities are demonstrably improving.

- The reason for this improvement has been a significantly greater reduction in PYLL due to cardiovascular disease in deprived parts of Leeds. This can be seen as evidence of a positive outcome of key public health programmes, leading to a decrease in smoking rates, the implementation of the NHS Health Check which had its initial focus on deprived Leeds, and effective management in primary and secondary care.

- The PYLL rate in deprived parts of Leeds has reduced at a slightly greater rate than the rest of Leeds for respiratory disease but the gap has remained the same for deaths caused by cancer.

Recommendations for future work streams

The JSNA Executive Summary for 2012 made recommendations for further work which has led to better understanding about people's health and wellbeing needs in Leeds in 2015. The JSNA 2015 has now highlighted further gaps – areas where we need to gain more detailed insights, greater clarity and deeper understanding with focussed analysis particularly about the needs of a changing population.

Deeper knowledge about changes in the rates of population growth and age profile, ethnic composition, changes in household make up, and the changes taking place, both within and between communities, will be critical to understanding future health and wellbeing needs in Leeds.

Leeds is often in line with regional performance but below the national position. More work is needed to consider the regional context.

Below we highlight suggestions for key lines of inquiry for the forward work programme for consideration by the Leeds Health and Wellbeing Board:

- Integrated approach to population and demographic forecasting and scenario-building;
- Better and more timely understanding of migrant populations;
- Better and more timely understanding of the city's population;
- A more coherent understanding of our collective assets – human, physical and technological ;
- Identification of children at risk and families in need linked to domestic violence, substance misuse and mental health;

- A better understanding of the barriers to learning and their impact on the life chances of young people;
- Mental health assessment refresh;
- Suicide audit refresh;
- Older people including frail older people;
- Prevalence of physical and sensory disability;
- Carers needs assessment;
- Refresh of key public health data packs such as life expectancy;
- Offender health;
- Impact of multi-morbidity.

Further work is also needed to broaden the range of information used within the JSNA and incorporate data from the third sector and private sector.

Critically, to be useful the JSNA has to be used – in particular by commissioners and decision makers. More work now needs to be done to examine how the JSNA is used, what it is used for and what the barriers are to using it effectively.

Introduction

What is the Joint Strategic Needs Assessment (JSNA)?

The JSNA is a continuous process for identifying and publishing a detailed analysis of population needs alongside the implications of those needs for the city of Leeds. The purpose is to inform commissioners and influence priorities and the use of resources as part of the commissioning strategies and plans for Leeds. The JSNA provides the most comprehensive and reliable source of data and analysis which the city uses to inform and shape its health and wellbeing agenda. The JSNA also provides the opportunity to consider how the identified needs of the population interact with key drives such as the economy and labour market. There are further opportunities the better understand the contribution and potential of our key assets.

As part of the NHS reforms set out in the Health and Social Care Act 2012, responsibility for the JSNA falls under the Leeds Health and Wellbeing Board. The JSNA will directly shape the further development of the Joint Health and Wellbeing Strategy for Leeds. To help this work, the JSNA draws together key data and information to provide a picture of the health and wellbeing needs of the people of Leeds. These needs, their implications and areas for future considerations will be used by those leading the development of the Joint Health and Wellbeing Strategy, alongside other information such as finance, current performance and quality and safety information, to influence future commissioning priorities.

This Executive Summary is a high level outline of key existing and future needs and their implications identified through elements of the ongoing JSNA work programme. It is supported by over 80 detailed reports on specific topics which are available on the Leeds Observatory Website. On the website there are also locality profiles which set out key statistics and information for a variety of geographical levels in Leeds. These include area profiles for 108 Medium Super Output Areas, 10 Area Committees and three Clinical Commissioning Groups.

How to access the JSNA

All the documents that form the Leeds JSNA 2015 are on the Leeds Observatory Website accessed by clicking on the Joint Strategic Needs Assessment icon on the Observatory homepage at http://observatory.leeds.gov.uk

How to use the JSNA

The JSNA should be used to gain insight into needs and their implications in specific areas, and for particular population groups, localities or conditions. It can inform what we are doing, what we should be doing and what we should be doing differently as a city. Users of the JSNA may wish to consider the following questions:

- How well are we doing now?
- What does this mean for how we want to work together in the future and what our ambitions are for Leeds?
- What are our strengths and assets?
- Where are we going to make the most difference?
- How does this work set the foundation for commissioning, both jointly and independently?
- What would be the impact and benefit for health and wellbeing?
- What it is like to live in Leeds or to be a child growing up in Leeds?

In terms of agreeing key issues, the information from the JSNA needs to be considered alongside evidence of effectiveness, economic consequences of intervention, and information on quality, safety, activity and service performance. It also needs to be considered alongside information on growth, innovation and expectations. It is

important to consider what all this information tells us about what actions might be required to acquire improved outcomes for individuals and populations.

How have we approached the JSNA this year?

Work for the JSNA 2015 has included:

- Refreshing ONS national data sets including specified additional data requirements for Leeds.
- Populating data gaps from the last JSNA (2012).
- Refresh of locality profiling for different geographies: Middle Super Output Area Profiles, Clinical Commissioning Group (CCG) Profiles and Practice Profiles, Children's clusters and reach areas.
- Development of the Leeds Observatory to publish the JSNA online as a continuous cycle of intelligent, up to date information.
- Analysis of new qualitative information e.g. Healthy Communities Survey and Migrant Survey and Third Sector insight.
- Review of individual Needs Assessments undertaken since 2012.
- Engagement workshops with partners to gather key messages and requirements of a JSNA (September - December 2014).
- Identifying the potential for work between Leeds City Council and Leeds Clinical Commissioning Groups to strengthen population forecasting and identify future demand.

The Leeds JSNA 2015 builds on learning from the Leeds JSNA 2012 and this is a continuing process. There is still much to be done to promote cross-policy linkages, engage more effectively with city partners including the third sector and the private sector. We also need to address the specific gaps in data that are identified in the recommendations for future work.

Structure of the Executive Summary

The Executive Summary gives an overview of cross cutting issues for the city of Leeds. It then seeks to identify the key needs and their implications for the various sections of the JSNA including:

- Wider factors – city context
- Cross-cutting issues
    - Population
    - Deprivation
    - Housing
    - Mental health
    - Learning disabilities
    - Potential years life lost
- Locality information including CCGs

It is important to note that the Executive Summary focuses on those primary issues identified by stakeholders and commissioners to aid the identification of strategic and operational priorities. As stated above, a more comprehensive set of analyses are available on the Leeds Observatory website.

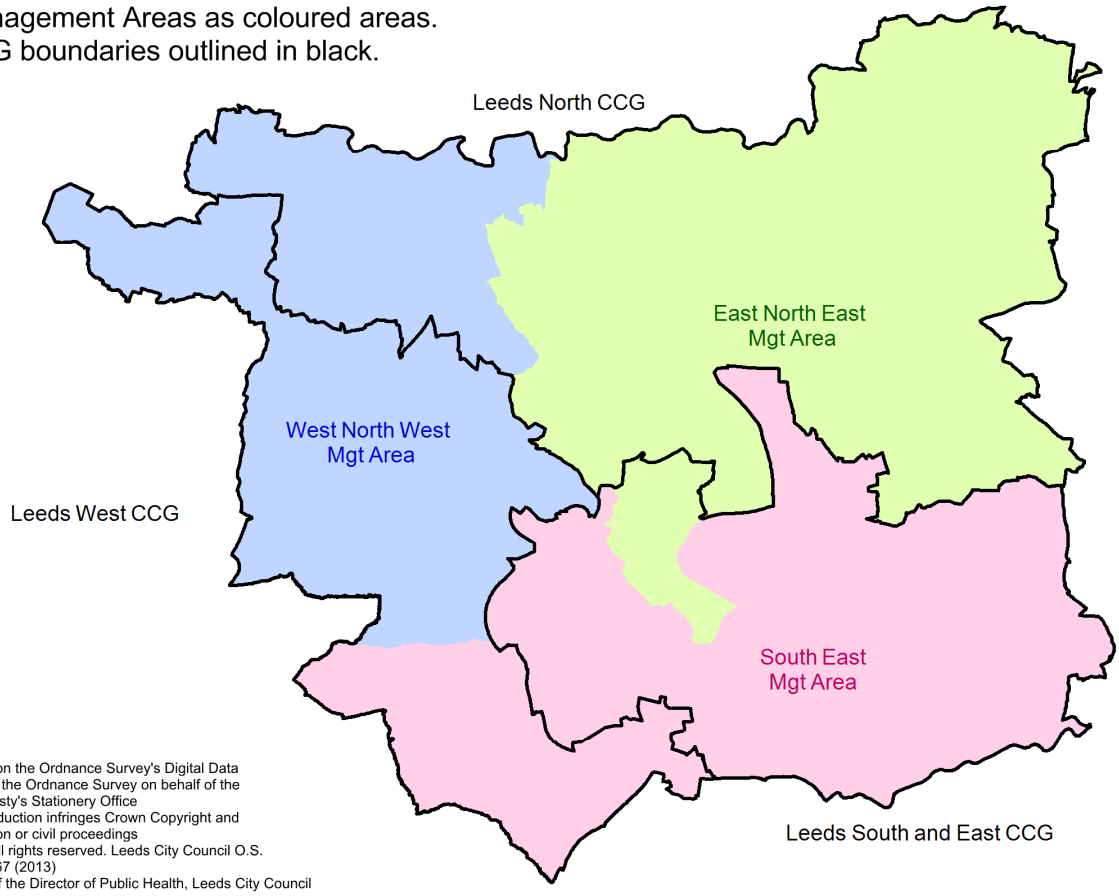
Geographic Analysis

For the Leeds JSNA 2015, information has been produced at a small area level to help identify needs in different localities. Across Leeds, different geographical areas are used by different agencies to both deliver services and work with local communities. The decision was therefore taken to create health profiles for Middle Super Output Areas (MSOAs). These are small geographical area designed to improve the reporting of small area statistics in England and Wales. MSOAs are built up from groups of Lower Super Output Areas (LSOAs). The minimum number of people living in an MSOA is 5,000 and the average is 7,000. There are 108 MSOAs in Leeds. Each of the MSOA profiles is available on the Leeds Observatory website.

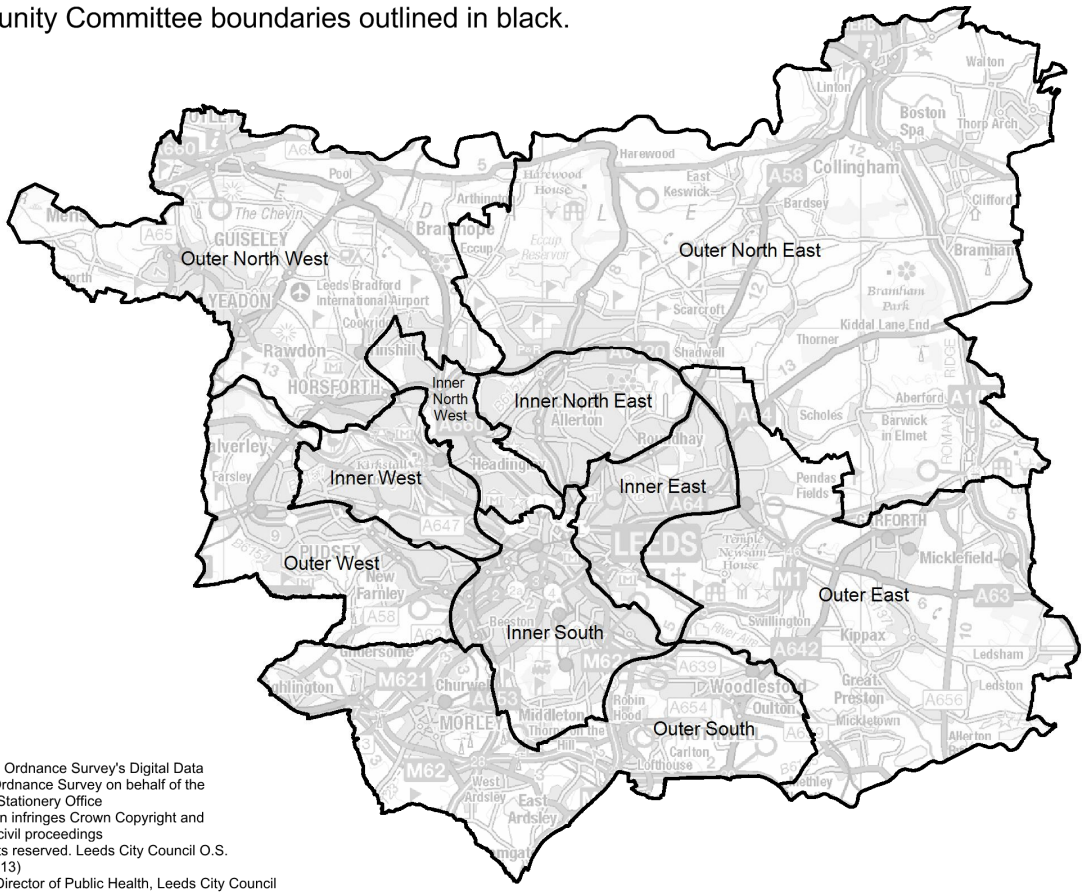
These MSOA profiles have also been used to create large area profiles for different purposes – for example, there are profiles for the ten Leeds Community Committee Areas and the three Clinical Commissioning Groups.

The map below sets out the boundaries for the three Leeds City Council Management Areas and the three Clinical Commissioning Groups, the map overleaf shows the ten Leeds Community Committee Areas.

Leeds Management Areas as coloured areas.
Leeds CCG boundaries outlined in black.



Leeds Community Committee boundaries outlined in black.



The section on Localities examines the geographical extent of some of the key issues identified in the Executive Summary.

Wider Factors - City Context

Our economy

During the two decades prior to the global financial crisis, the city's economy experienced significant growth, driven in large part by financial and business services. Leeds established itself as a vibrant, diverse and dynamic city, with a strong knowledge-based economy. During the recession Leeds fared better than many of its neighbours, with workplace-based employment in the city now estimated to have recovered to pre-recession levels of 470,000.

Leeds is the main driver of economic growth for the region, and has key strengths in financial and business services, advanced manufacturing, health and creative and digital industries, with a strong knowledge-rich business base. These strengths linked to Leeds' universities and teaching hospitals are innovation assets for the city. The retention and support of our existing business base will also be vital in ensuring resilience.

Leeds' retail offer is very important in maintaining and expanding the city's role as a major economic and cultural hub outside London. Retail is also important in terms of employment.

In terms of workforce skills, the proportion of people with higher level skills (NVQ4+) in the city is above the national average. However it is a less positive picture in relation to lower level skills, although the gap to the national average is closing. Our lowest qualified people are centred in those localities in the city that have long-standing challenges of disadvantage and deprivation. Many of them face a complex and inter-related set of barriers to labour market entry – such as poor housing, language and literacy skills, ill-health and care responsibilities. A priority is tackling poverty and deprivation, more effectively helping people out of financial hardship and helping people into jobs training and employment.

Leeds has very close links with its neighbours. The wider city-region is a functioning economic area, defined by the way businesses operate and residents live their lives. There are 85,000 people from outside Leeds who work in the city each day. The dynamics of the wider city-region labour market, with flows in and out of local labour markets is a vital component of a healthy economy; however, there is significant potential to increase access to employment opportunities for local communities, particularly those currently at most disadvantage.

Children and Young People

The city has a vision to be a child friendly city, with the ambition that Leeds is the best city in the UK for children, where young people enjoy growing up and achieve their potential to become successful citizens of the future. Outcomes for children and young people in Leeds are good and improving, with the overwhelming majority of children and young people having fun growing up and being ready for adult life. However, in order to fulfil our child friendly ambitions we need to improve life outcomes for all children, particularly those who are vulnerable or in care, by providing children with the learning, support, advice, guidance, care and opportunities they need to lead successful and fulfilling lives. In doing this we recognise the ongoing changes in the size and makeup of the child population.

Ensuring children and young people have a voice and develop through their childhood into active citizens is both a right and conditional to all strategies to improve outcomes.

The safeguarding of children and young people remains a key focus and pressure. For the 2014-15 year provisional information shows that there were 20,740 child protection contacts made of which 12,036 became referrals to

children's social care services. As at the end of March 2015, figures (again provisional) show 1262 Looked After Children, 648 children with Child Protection Plans and another approximately 4,400 cases being supported by the children's social work service. Central to all safeguarding work is hearing the voice of the child in all instances.

Leeds has historically had high numbers of children looked after with the significant associated financial cost implications. The March 2015 figure of 1262 children looked after is the lowest relative level in over a decade and is against a national background of heightened awareness of child protection. Children's outcomes are shaped by adults therefore our approach is a restorative and family centred approach. Supporting parents and strengthening the family networks will lead to happier and more resilient, successful children. The Leeds rate of children in local authority care is safely reducing, this is against national trends. However, given it is from a comparatively high level there is scope to reduce further and by ensuring this trend continues we can further invest in prevention and in supporting better outcomes for children and families.

Domestic violence, parental substance misuse, parental mental health and parental learning difficulty are key risk factors (especially when combined) in terms of the stability of families and the safeguarding of children. Over a third of referrals to children's social work services are found to involve domestic violence. Effective and appropriate sharing of information to support identification and monitoring of the most vulnerable children and young people is required.

Children at risk of sexual exploitation and those missing from home and care are recognised priorities. The complexities of child sexual exploitation and children missing mean these are not straightforward challenges, or ones that can be dealt with quickly or by a single agency. Leeds is committed to maintaining the impetus by building on the achievements and progress made. In terms of children missing from home or care, while the overwhelming majority return safely or are found quickly, all children who go missing are at risk. The risks associated with missing can include: forced marriage, honour based violence, female genital mutilation, and trafficking.

Children must first of all be safe and healthy but this has to be as a basis to learn and develop. The first years of life are increasingly recognised as a priority given there profound influence on the development of a child's emotional and social capacity and cognitive growth. Analysis shows that economic investment into the early years gives the greatest return, impacting on key outcomes such as emotional wellbeing, improved behaviour, school readiness and educational attainment and fulfilment of potential. Areas of focus include breastfeeding, good antenatal nutrition, the promotion of language development and perinatal mental health services. Readiness for learning at the start of school is connected to support in the early years.

Good progress and successful achievement in learning increases opportunities into adulthood and supports good health, lifestyle, career and family choices. School attendance is at the highest ever level. Ensuring children are receiving their entitlement to learning remains a priority with a focus on unauthorised and persistent absence especially in secondary schools. Being in learning is not enough, children and young people need to be making good progress and reach age 19 equipped for the next stage of their life.

In 2014 53% of young people achieved Level 3 qualifications by 19 (equivalent of 2 A levels). While improving 6.4% of young people aged 16-18 are not engaged in employment, education or training (Provisional Nov 14- Jan 15 average). Ensuring all children and young people make good progress and achieve age related expectations in English and maths remains a priority and especially at age 16 where if this is not the case it impacts on further education, training and employment opportunities.

Overall achievement in Leeds is improving in line with national averages. However at all ages there is a small percentage point gap between Leeds and national results. This points to the lower rates of achievement of children

from disadvantaged backgrounds, which is a regional as well as local challenge. Those entitled to free school meals in Leeds achieve lower results than those entitled nationally and the gap to those in Leeds not in receipt of free school meals is wider.

- At the Foundation Stage, the gap between the proportions of 5 year olds achieving a good level of development that are eligible for free school meals, compared to those who are not, is 26 percentage points in Leeds. Nationally, this gap is 19 percentage points.
- By the time young people reach the age of 19, the gap between the proportions of young people achieving a Level 3 qualification that were eligible for free school meals, compared to those who were not, is 33 percentage points in Leeds. Nationally, this gap is 25 percentage points.

The proportion of Leeds children obese or overweight is largely stable and consistent with national figures. Just under a quarter of 4-5 year olds (23%) and just over a third (34%) of 10-11 year olds are obese or overweight. Focus is given to school meal take up around reassurance that all children have access to a hot meal and around increasing the nutritional quality of those meals. All infant children in primary schools are now entitled to free school meals, in the autumn (2014) uptake in Leeds was 86%, similar to national levels.

Poor choices and risky behaviours by teenagers have shown a pattern of significant reduction in recent years; these reductions have happened faster than nationally but absolute levels remain above national levels. Teenage conception rates have fallen to 31.6 per 1000 (2013) a five year drop of a 23 percentage points, the national fall was 15 percentage points but with national levels now at 24 per 1000. The numbers of young (10-17 year old) offenders has been falling steadily, dropping by 66% since 2010 when there were 1,956 offenders compared to 2014 when there were 652 year.

Vulnerable Adults

In the 2011 Census there were almost 70,000 pensioner households in Leeds, of which over half were older people living alone. Forecasts predict continued ageing of the city's population with particular increase in those over 75.

In 2014 it is estimated that there are 8,700 people with dementia in Leeds and this is likely to increase to 12,000 in 15 years' time. There are 71,000 people in Leeds who are providers of unpaid care. Clearly unpaid carers often encounter a range of related challenges such as social isolation.

The 2011 Census shows us that over 125,000 people (16.8% of the population) feel they have a long-term illness, and of these 59,000 feel that their day to day activities are limited "a lot". Approximately 12,900 adults in Leeds have a learning disability (LD), from mild to profound. There has also been a year on year increase in the number of people with learning disabilities in Leeds needing support.

However, the biggest demographic challenge is the increase in acute levels of need, with improvements in health care meaning that more children survive into adulthood with complex physical needs and/or challenging behaviours.

Cross cutting issues for Leeds

The thematic JSNA reports provide a multi-dimensional insight into the issues for Leeds. However, there are also a number of significant cross cutting issues, which have wide and far reaching influences on the health and wellbeing of individuals, families and communities.

Population

Leeds is a growing city. Many people have benefited from the success of the city's economy over the last two decades, both within the city, and in neighbouring localities. According to the latest data from the Office for National Statistics (ONS) there are now around 761,500 people living in Leeds (Mid-Year Estimate of Population 2013).

Until 2011 the ONS mid-year estimates for Leeds population tallied closely with GP registration populations. Following the 2011 Census, ONS revised their figures downwards. The latest GP registrations data puts the population of Leeds in mid-2013 at around 819,900 based on those who are registered with a Leeds GP, and around 806,700 based on those resident in Leeds, both higher than ONS projections. The potential time-lag between GP registrations and de-registrations may be one explanation for the variation, although the possibility of Census undercounting could also be a contributing factor. In terms of trends in GP registrations, recent years have seen a steady increase in total Leeds resident registrations from 771,800 in 2006, to 819,900 in 2013.

It is the change in the make-up of our population, particularly at local levels that is most striking. We have an ageing population; as the baby-boomer generation grows older there will be a range of implications. In terms of public services, ensuring that older people get care and support when they need it and are enabled to live independently will continue to be the key challenge.

The increase in the birth rate, from 7,500 per annum in 2000/01 appears to have plateaued at around 10,000 per annum in the last five years. Deeper examination of birth rates in the city's most deprived communities show higher birth rates than the Leeds average. This is likely to be a function of the age-profile of these areas, with a greater proportion of residents of childbearing age and is also impacted by the higher birth-rate of some ethnic minority groups that tend to be concentrated in these areas of the city.

Data from the city's schools, shows there are more children and young people of black and minority ethnic heritage, particularly Black African and White Eastern European. The number of children and young people with English as an additional language (EAL) has also increased in recent years, from 13% in 2010 to 16% in 2014. Along with English there are over 170 languages spoken in Leeds schools with the main languages spoken being Urdu, Punjabi and increasingly Polish.

In the last decade the BME population in the city has increased from 11% to 19%, and the number of residents born outside the UK has almost doubled to over 86,000 people. There have been very localised impacts across the city, with complex related issues such as the speed of change, 'national identity', language proficiency, transient populations and variations in birth rates emerging that in turn influence service provision and the wider interface between communities.

Leeds is a city of great contrasts, encompassing large rural areas such as Harewood and Wetherby, where the population are generally more affluent, as well as densely populated inner-city areas where people face multiple challenges. It is however in the outer areas where there are higher numbers of older people.

In part linked to demographic change, in part linked to wider social change, patterns of faith have also changed across the city. Different ethnic and religious groups have very different age profiles and understanding these differences is also key to helping plan and deliver appropriate services.

Leeds also has one of the highest student populations in the UK with over 60,000 students attending the city's three universities, with the student population heavily concentrated in the city centre and inner west areas.

Understanding how the population is growing and changing is critical for the effective planning of education, employment, health, housing, transport and other services across the city. The needs of this changing and expanding population will place increasing demands on the health and social care system (including not only general practice but services such as community nursing and social care) at a time of radical change in the public sector.

The pattern of needs is also changing and people will expect the quality and availability of services to increase in line with demand. As people live longer there will be an increase in people living with life-limiting conditions such as stroke, diabetes and dementia, particularly in areas of disadvantage. The rise in the number of people having more than one life-limiting condition will require a different service model of health and social care. There will be a rise in the number of older people from minority ethnic communities and services will need to be able to respond appropriately to their needs. New and emerging communities are especially vulnerable and being able to quickly identify such changes will be crucial.

Considerations for the future

Estimating the population at any given point in time is a hugely complex issue and while official projections provide a starting point for understanding population trends; local circumstances, recent local demographic data, and economic forecasts should also be considered in developing insights into local demographic trends.

Recently published official population data and projections have seen a pattern of lower and slower growth predicted for Leeds, than perhaps might be expected, with the perceived economic potential of the city. Given the vital importance of understanding the demographic dynamics of the city, not least in terms of responding to future demand, commissioning services and ensuring sufficient housing, we need to better understand what is driving this lower/slower trend in 'official data'.

The latest projections, like previous ones, are trend based on the previous five years. The extent to which the lower/slower trend results from projecting forward the recession is not explicitly addressed in the latest release. Although the methodology adopted in the development of these latest projections is yet to be fully understood, we need to consider how we can continually improve our understanding of the patterns of demographic change.

The changing child population has implications for demand for services in Leeds, whether that is for school places, early year's provision, complex needs services or an increase in the number of vulnerable families requiring support. The extent to which in-migration influences the age-profile and birth-rate may warrant further investigation.

Although we have established a robust approach to building our understanding of demographic change, not least in relation to the likely future demand for housing, strengthening our understanding of demographic change needs to be a cornerstone of the JSNA's forward work programme.

Deprivation

The detrimental effects of deprivation on health and wellbeing both direct and indirect, is a strong and consistent theme throughout the JSNA. The assessment of poverty in Leeds highlights the correlation between economic disadvantage and poor outcomes for children, young people and adults in the city. The clear impact of worklessness, financial exclusion and poor housing on health, educational attainment and broader life chances is concentrated in particular localities.

There is an obvious need to tackle the issues of multiple deprivation but, added to this, we need to take account of the impacts of public spending cuts and the changes to welfare benefits.

The scale of that challenge is confirmed by the numbers involved. According to the Index of Multiple Deprivation (IMD) over 163,000 people in Leeds live in areas that are ranked amongst the most deprived 10% nationally, and this represents over 20% of the city's population. The IMD confirms the geographic concentration of poverty, with our most deprived communities in the Inner East and Inner South, with a further hotspot in Hawksworth in Inner West.

Clearly there are links between employment and poverty, not only in terms of labour market barriers, unemployment and worklessness, but also in-work poverty. Levels of pay, regularity and sustainability of employment are also key factors. The incidence of in-work poverty is of increasing concern. In addition, working parents and those who want to work are often hindered by inflexible and expensive childcare. Evidence from the council's benefits statistics further demonstrates the issue of in-work poverty; between 2008 and 2013 the number of households with people in work claiming Housing Benefit and/or Council Tax Benefit rose by 160% (HB) and 202% (CTB) respectively.

Higher levels of poor mental health and wellbeing and mental illness are inextricably linked with deprivation within Leeds. Local mapping highlights these issues and emphasises the geographic concentration of mental health and wellbeing in our most deprived communities.

Poverty affects individuals, families and communities in many ways, and it affects people at different times in their lives. Child poverty is at the root of many poor outcomes for children and young people and their families. In 2012 over 21% of children (0-19 population (33,000 children)) were classified as living in poverty (part of families earning less than 60% of median income) compared to a national figure of 19.2%. This national definition does not fully reflect the impact of economic hardship on children and families. It predates the potential impact of welfare reform (where it is anticipated that over 30,000 children and young people living in over 15,000 households will be adversely affected). Almost 60% of families classified as in poverty contain at least one working member and it is likely that this does not fully address issues of families with adults both in-work and facing financial hardship.

While the impact of poverty on children can be found in all areas of the city it is concentrated in certain areas of the city, with two wards, Burmatofts and Richmond Hill at 40.6% and Hyde Park and woodhouse at 43.2% having over 40% of children in poverty. Child poverty is associated with poor outcomes for children and young people and for their families, not only in terms of health but also educational attainment and employment prospects. Families experiencing poverty are more likely to require support, with related increases in safeguarding concerns. This is even more so for mobile families living away and community networks. Supporting children and families to mitigate both the causes and impact of poverty is integral to all work with children and families.

Moving across the life span, deprivation is directly linked to how long we live and for how long our lives are free from disability. The average health of people in Leeds is generally worse than the England average. However this average

for the whole of Leeds masks the different experiences of people living in different parts of the city. At ward level, there is a greater than 11 year difference for women, and over 10 years difference for men when looking at the longest and shortest ward level life expectancies. (Harewood vs Headingley for women. Harewood vs Middleton Park for men. 2011-13 life expectancy at birth)

The impact of the welfare changes has seen more council tenants fall into arrears with their rent and Council Tax. Changes in recovery processes and providing support to tenants who engage with the council about their arrears have helped mitigate the impact of the changes. Issues around under-occupancy mean families must resource any increased charges they incur for their current home. Should they be unable to do so, reduced availability of suitably-sized alternative properties leaves little opportunity to move to properties that will not incur charges and arrears. The Government have announced the national roll out of Universal Credit starting from February 2015. It is likely that the first Universal Credit claims will appear in Leeds from approximately May 2015. Preparations now need to be stepped up to ensure that residents, front line workers and partners are aware and ready for the implementation of the new benefit across the city.

Considerations for the Future

Deprivation is affecting health and wellbeing now and will have a potentially greater impact in the future. This means the actions needed for change are not just the responsibility of health, adult social care or children's services; they are the responsibility of all partner agencies and communities in Leeds.

Continued priority needs to be given to our most deprived communities to:

- Give every child the best start in life, ensure that they are ready for learning and raise levels of aspiration and attainment faster for children growing up in poverty;
- Improve pathways to learning and employment by equipping those currently most distant from the labour market with the skills, motivation and experience to access current and future learning and employment opportunities;
- Improve our collective intelligence on the multiple challenges/issues facing our most vulnerable, with the aim to ensure a more co-ordinated support mechanism;
- Make the best possible use of public sector assets to deliver sustainable improvements to target neighbourhoods;
- Maximise income and benefit for families in poverty and on low incomes and provide debt advice and promote access to affordable credit.

Housing

A key challenge is to provide enough quality and accessible homes to meet the city's growing population, whilst protecting the quality of the environment and respecting community identity. Within this overall context the need for affordable housing and affordable warmth are key issues. Good quality housing is a pre-requisite for good health. People who live in clean, warm, safe and affordable homes are less likely to experience housing-related ill health.

Leeds has 335,322 households listed for Council Tax. There are 13,686 empty homes in the city, 4,725 of which have been empty for six months or more. Recent years have witnessed a decline in vacant properties; since 2010 empty homes (including those empty for more than six months) decreased by approximately a quarter.

The mix of housing tenure has changed. The continuing growth of the private rented sector is a key trend which brings with it associated challenges, particularly at the low cost end of the market where housing condition can be poor. The 2011 Census confirmed this growth in the private rented sector, which almost doubled between 2001 and 2010, to almost 18%. Nationally privately rented tenure has increased by 57% over the last 5 years.

The private-rented sector across Leeds is complex. In Harehills and Chapeltown, for example, there is a concentration of private-rented households made up of migrant workers. By contrast the private rental market in Headingley, Hyde Park and adjacent areas is driven by demand from student households, resulting in considerably higher rents. In the city centre, the rapid growth in the numbers of apartments developed since 2001 has created a new private rental market attracting yet another range of occupiers.

Like most large cities, Leeds has a substantial amount of older housing, which tends to be concentrated in more deprived neighbourhoods. What sets Leeds apart from other places, though, is the large amount of back-to-back housing still in use across the city. Most of the 19,500 back-to-backs in Leeds are in the private-rented sector and were built before 1919. As a result, many of them are in poor condition, particularly in relation to their energy efficiency.

The links between fuel poverty, poor housing and ill health are well established. Cold homes may exacerbate problems associated with cardiovascular illness and the onset of stroke or heart attacks, while damp and poorly ventilated homes are associated with a range of respiratory and allergic conditions such as bronchitis, pneumonia, and asthma. Cold homes may also impact on conditions such as rheumatism or arthritis and adversely affect people with poor mobility, increasing the risk of falls and other household accidents. Living in a cold, damp and poorly ventilated home is not only uncomfortable but may also be stressful and affect an individual's mental health. This may be compounded by anxiety about high bills, fuel debt or other fuel poverty-related factors.

The educational attainment of school age children may be adversely affected if they do not have a warm space to study and are forced to share general living space or need to take time off from school due to cold-related illness.

The affordability of housing in an economic downturn is of increasing importance. Evidence suggests there is a continuing, and often growing gap between the income of families and individuals and the cost of housing, Both in terms of access to mortgages and the cost of the rented sector.

Considerations for the Future - Sustainable housing growth

One of Leeds' biggest challenges is to provide enough housing to meet the needs of a growing population, whilst protecting the quality of the environment and local community identity.

In recent years, Leeds has been highly successful in regenerating older urban areas, including the transformation of the City Centre through new housing, office, retail and leisure developments. Despite these successes it is clear that house building in Leeds needs to significantly increase. Completions fell to their lowest level in years in 2010/11, with less than 1,200 new homes built compared to over 3,400 in 2007/08. Annual completion rates have risen since as the market has recovered and it is anticipated that over 2,300 homes will be completed in 2014/15

The Adopted Core Strategy (2014) aims to guide this future housing development and, in order to preserve and enhance what makes Leeds unique, sets out a pattern of growth focussed on existing settlements which have the capacity to grow. The main urban area provides the major focus for development, taking advantage of existing social

infrastructure mainly focussed on local and town centres. The six major settlements are also focuses for new housing (Aireborough, Morley, Rothwell, Wetherby, Otley and Garforth).

The Leeds Strategic Housing Land Availability Assessment identifies a substantial forward plan of land with potential for residential development, particularly in the east and outer south east of the city. A Site Allocations Plan will be published in 2015 identifying 750 preferred sites to accommodate 66,000 new homes. Whilst this is not yet finalised, it does present draft proposals for the Housing Market Areas expected to accommodate the greatest proportion of new housing, with the City Centre, East Leeds and Inner Area accommodating almost half the total, and the locations of the larger schemes (over 250 homes).

Mental health

Good mental health is fundamental to our physical health and wellbeing and to the way we all live our lives. It is important in our relationships, in our work and in fully achieving our potential. There are also wider social and economic benefits. Response from the Healthy Community Surveys found that, 80% of adults said they are 'satisfied' with their life overall, and a similar proportion felt 'happy'. Similarly 80% of young people said they generally enjoy life and 81% said they feel happy most or every day. However, evidence from the Mental Health and Wellbeing Needs Assessment for Leeds (May 2011) confirmed the higher levels of poor mental health and wellbeing and mental illness are inextricably linked with deprivation within the city. Local mapping highlights these issues and emphasises the social gradient of mental health and wellbeing.

There is evidence that some mental health problems are becoming more prevalent. Leeds data suggests an increased prevalence of depression, although gaps in local data suggest much under-reporting, particularly amongst older people. Only a third of older people with depression ever discuss it with their GP, yet depression is the most common mental health problem in older people. The number of older people in our population is growing, with a corresponding increase in those at risk of depression. Mental health problems, particularly depression, are more common in people with a physical illness including those living with long term conditions.

Leeds has significantly higher levels of recorded psychotic disorders than predicted from national prevalence data. This is both for males and females, but is particularly high in the number of males diagnosed (which is in contrast to the national picture which would predict a higher prevalence of psychotic disorders amongst women than men).

Other issues include: stigma and discrimination in some BME communities, increased dual diagnosis (people experiencing poor mental health and substance/alcohol use), and an increase in common mental health problems in older people.

The overall suicide rate in Leeds has risen slightly over the last decade. Local data suggests the highest suicide rate is in the 35 – 64 age range, with suicide rates in Leeds higher in under-65s than regional and national rates, and lower in the over-65 age groups. In Leeds the overall suicide rate is three times higher for males than females. Self-harm recorded through admissions to hospital for treatment show high rates of first episodes mainly due to self-poisoning. Local data shows higher rates of self-harm amongst young women. This data is limited as it only reports incidence of self-harm resulting in hospital admission.

The needs assessment identified a strong link between levels of socio-economic deprivation and higher levels of poor mental health and wellbeing. Unemployment and the legacy of the economic downturn is having an impact on mental health across the city and not just in the most deprived localities. Leeds has a relatively high level of its

working age adult population in receipt of Incapacity Benefit (IB) due to mental ill health ((50% of IB claimants identify a mental health problem). Employment rates for female users of mental health services in Leeds are significantly below the national average.

In relation to children and young people, there is increasing evidence of how experience in the critical first few years (pregnancy – 2 years) impacts on mental (and physical) health throughout the life span. Around half of all lifetime mental health problems start in childhood and are associated with multiple risk factors, including inequalities. Parental mental health is recognised as a key risk factor in terms of children coming into care or being subject to child protection interventions. Child and young people's emotional and mental health is a recognised area for focus.

Considerations for the future

- Develop and initiate a two year implementation programme for the Leeds Mental Health Framework;
- To gain a full understanding of the mental health picture for Leeds through refresh of the Mental Health Needs Assessment
- Better identification and starting initiatives early and working with families is crucial to reducing the number of mental health problems that begin in childhood and adolescence. Complete review of child emotional and mental health services in Leeds
- Undertake an offender health needs assessment taking into account offender mental health and wellbeing.

Learning Disabilities

In 2014, 3099 adults in Leeds were identified as having a moderate or severe learning disability. Over the last four years there has been an increase in the Leeds learning disabilities population of about 5%. This growth is particularly focussed amongst younger people with the most profound needs for care. These increases have been primarily driven by four significant demographic features

- Increased survival rates of children with multiple and severe disabilities;
- Reduced morbidity of older adults - life expectancy is increasing, in particular for people with Down's syndrome, with some evidence to suggest that for people with mild learning disabilities it may be approaching that of the general population;
- Changing attitudes and social circumstances - Changing attitudes are encouraging both adults with learning disabilities and their families to be more ambitious and aspirational. Increasing numbers of people from these communities want access to mainstream services, jobs and independent travel;
- Increases in the proportion of the South Asian population across the whole community - studies have shown an increased prevalence of severe levels of learning disability in the South Asian population and it is predicted that the population with learning disability from minority ethnic communities will increase over the next 20 years.

Leeds city council and local health commissioners supported 2,405 adults with learning disabilities in accommodation, day-care, outreach, homecare, and with direct payments in 2013/14. 2,061 of these were supported by the council. Population trends suggest working age population supported by the council, with moderate or severe learning disabilities, will increase by around 7.5% between 2014 and 2020, and that the number supported by the council who are over 65 years of age will remain relatively static. However, the actual rate of increase in demand by adults for services outstripped demographic increases at a rate of 3:1 over the last 5 years

and so a forecast based upon demographic changes alone is likely to produce a significant under estimate of actual activity incurred.

The number of children and adults with learning disability supported by health and social care agencies includes individuals who have demonstrated challenging behaviour present from birth, and who have experienced difficulties throughout their lives in having their needs met in children's and education services, and require a constant multidisciplinary response to manage their complex needs. A significant number of these people are already placed out of area as children and in early adulthood many require assessment and/or treatment under the Mental Health Act 1983 and, or restrictions or Deprivations of their Liberty under the Mental Capacity Act 2005.

Concurrent with this complexity of need is the level of intensity of support required to meet it. It is overwhelmingly the case in 2015 that assessed need within this population is for significantly high levels of personal support of 1:1, 2:1 and sometimes 3:1 support for individuals supported by the Pooled Budget. Since 2004 onwards there have been 84 specialist placements made out of area in which 94% of the users are under 30 years old.

If the current expenditure trend is extended over the next 5 years, the total council expenditure to support adults with learning difficulties will rise from £57m per year in 2014/15 to £90m in 2019/20 (+58%). Forecasts for health commissioners suggest a rise from £21m per year to £31m per year over the same period (+49%). Looking at council expenditure, based on the current budget, the proportion of expenditure on adults with learning disabilities will rise from around 10% in 14/15 to 17% in 19/20

In terms of children and young people, the increase in the birth rate has had significant impact on demand for all educational provision and this increased demand is predicted to continue. This includes a rising demand for support for children in schools with Special Education Needs and Disabilities (SEND), both in mainstream and in specialist provision.

Although there are challenges in using SEND data in assessing the full extent of learning difficulties and disabilities due to local variations in determining and recording SEND, it does provide the most comprehensive intelligence available. The data suggests that the number of children with SEND has grown, this is in part attributable to the wider expansion in birth rates, but and especially in early years, there is also a growing proportion of children with SEND. Within this trend the patterns of need have changed, with significant increases in the numbers of speech, language and communication needs, a more than 50% increase between 2010 and 2014, this is also the most commonly identified SEND. There have also been increases in severe learning disabilities and specific learning difficulties such as autism. Although there have been decreases in the numbers with other difficulties/disabilities and moderate learning difficulties, there has been an increase in the complexity of need with a rise in the number of children experiencing more than one type of need.

It is projected that demand for places in specialist educational provision will continue to rise from 1147 places in 2012, to approximately 1600 in 2016. Specifically, places in Specialist Inclusive Learning Centres are projected to increase to potentially approximately 1300 by 2016 (38% rise since 2009).

Demand for services is significantly greater in the inner south, inner east and the centre of Leeds where the population of children under the age of five years is more highly concentrated.

Considerations for the future

- Level of acuteness of need in Leeds is unprecedented. Particularly of note is the number of people with learning disability and complex autism. The Autism Act and development of a local diagnostic service is expected to increase demand for services;
- The number of adult service users with learning disabilities receiving a service in Leeds has increased by 16% over the last five years;
- Carer expectations are significantly high and rising;
- Continued implementation of the Children and Families Act 2013 in respect to timely and family centred support for children and young people with learning disabilities
- There are challenges in responding to the established expectations of families as young people make the transition from packages of support built around children to the level of support available for adults, this is compounded by the demographic growth in demand;
- The commissioning and financial perspective for children with learning disabilities needs to be included in future developments of the JSNA to provide a more complete picture of learning disability provision.
- Improved and more timely understanding of the Leeds' population and changing need within it

Autism

Autism is a neuro-developmental difference that affects people across the IQ range. It has only recently been fully recognised by services so, both because it affects a wide range of people in a wide range of ways, and also because health and social care services are not structured in such a way as they can meet the needs of people with autism, there are gaps both in our knowledge of need and in the provision of adequate support. Autism is a lifelong developmental condition. However, the point at which it is identified varies according social circumstances and severity (hence visibility) of the condition. Currently probably over half of the potential population are diagnosed by the time they reach 18 (CAMHS estimate). This means that there are still likely to be young adults without a diagnosis.

Credible research suggests that 1.1% of the mainstream population is on the autistic spectrum. This means that for Leeds there will be approximately 7,500 autistic people, 5,700 of whom will be over 18. Up to 30% of the learning disabled population is likely to be autistic. Using a definition of learning disabled people as people having an IQ of less than 70, this means that there will be approximately 680 adults with learning disabilities and autism in Leeds.

There are relatively few people accessing specialist services. This makes it clear that it is very important to improve the quality of support from non-autism specialist services. Housing, employment, education and participation in 'mainstream' community and leisure activities are central objectives both nationally and locally for people with autism. In order to meet the needs of autistic people it is important that all agencies and services are able to meet the need for reasonable adjustments to enable autistic people.

Considerations for the future

Because autism has not been fully recognised until relatively recently there is a weakness in both diagnosis and recording in both health and social care. This means that, while we have some fairly accurate demographic information we are short of accurate information about numbers of people using services and unmet need. The figures indicate that a large number of autistic people do not receive services – we do not know as yet know what proportion of this reflects a lack of need for services or a lack of access to services.

Potential Years Life Lost

Potential years of life lost (PYLL) is a measure of the potential number of years lost when a person dies prematurely from any cause. The basic concept underpinning PYLL is that deaths at younger ages are weighted more heavily than those at older ages. This is the first time that PYLL has been used in the Leeds JSNA, and presents a different way for us to look at the health needs of the population.

It is widely accepted that the contributions of public health initiatives and of health care to improvements in population health ought to be quantified. An indicator widely used in measuring this contribution is 'avoidable mortality' (which is a subset of PYLL), which is based on the concept that premature (early, defined as being under age 75) deaths from certain conditions should not occur in the presence of timely, preventative interventions and effective health care.

We have traditionally looked at the main causes of death in the population both under 75, and all ages. The advantage of using PYLL is that deaths at younger ages may be perceived to be of less importance if cause-specific death rates alone (traditional mortality methods) were used in highlighting the burden of disease and injury, since conditions such as cancer and heart disease often occur at older ages and have relatively high mortality rates.

PYLL analysis for Leeds has been performed by the Public Health Intelligence team at Leeds City Council. Five years of data were analysed and built into three, 3-year aggregate rates, 2009-11, 2010-12 and 2011-13, to establish a trend of avoidable PYLL for various geographies.

Major groupings of causes of death:

Avoidable Mortality according to ONS is defined as a death that could be amenable to healthcare or preventable by public health interventions. Various organisations, including the Health and Social Care Information Centre, Public Health England and ONS have been producing PYLL analyses in recent years. Although the methodologies vary slightly, all use the same groupings of diseases to facilitate discussion about PYLL.

In this context "Cancers" are growths or tumours which, when they are malignant, can be described as "Cancers". This is a wider definition than Cancer would be because it includes non-malignant growths that have been the underlying cause of death of a person.

Cardiovascular Diseases (CVD), similarly covers a range of diseases including coronary heart disease (CHD) but also diseases of the circulatory system such as strokes.

The grouping of diseases classified as "Drug and alcohol related disorders" covers alcohol related deaths, in the main, but also illicit drug and alcohol related disorders. On further analysis, this grouping of causes of deaths proved to be over 90% alcohol related.

Headlines for Avoidable PYLL: Leeds and Leeds Deprived

The headline result is that Leeds PYLL, as calculated in the 3-year aggregate, directly standardised rates (DSR) per 100 000, shows an overall reduction over the three periods: 2009-11, 2010-12 and 2011-13. This reduction is being driven by a reduction in both deprived Leeds, as defined by the IMD 2010, within the worst 10% deprivation band nationally, and the rest of the Leeds district.

In deprived Leeds, the rate of avoidable PYLL in 2011-13 is over 9000, compared to less than 5000 in non-deprived Leeds. This is almost double the rate and shows the magnitude of health inequalities in the city.

It should be noted that the rate in deprived Leeds is reducing more quickly than Leeds as a whole; this means that we are demonstrably reducing health inequalities.

During the period 2011-13, 93.2% of All Causes PYLL for Leeds residents were due to the top 6 causes. The top 6 causes in descending order are: cancers; cardiovascular diseases; respiratory diseases; deliberate injuries; drug and alcohol related disorders and unintentional injuries. The top 6 causes also account for similar proportions of All avoidable Causes PYLL for Leeds deprived, the non-deprived part of Leeds and the Leeds CCG registered populations.

The top 2 causes account for over 60% of all PYLL for Leeds residents, Leeds deprived, the non-deprived part of Leeds, and the Leeds CCG registered populations. The two causes account for proportionately less of the PYLL in Leeds deprived (57.6%) than the non-deprived part of Leeds (64.1%); this is because Leeds deprived has a higher proportion of PYLL caused by respiratory disease.

Avoidable Cancer PYLL

Deaths from cancer are the largest single cause of PYLL across the city, accounting for 36.3% of PYLL. The trend is that rates of PYLL have remained static over the time covered by Public Health analysis.

The PYLL rate from cancer in Leeds deprived is 1.5 times higher than the non-deprived part of Leeds. However the proportion of total PYLL caused by cancer is lower in deprived Leeds than in the non-deprived part of Leeds at 32.7% and 38.0% respectively.

Cancer deaths remain a key driver of health inequalities, (The Segment Tool 2015 – Segmenting life expectancy gaps by cause of death, London Health Observatory. http://www.lho.org.uk/LHO_Topics/Analytic_Tools/Segment/TheSegmentTool.aspx) accounting for over 30% of the life expectancy gap between Leeds as a whole and England as a whole.

On the registration with CCG basis, the rate of avoidable cancer PYLL is significantly greater for Leeds South and East CCG (14% above Leeds average); for Leeds West CCG (3% below Leeds average); Leeds North CCG (16% below Leeds average). There is an early indication of a possible reduction in PYLL due to avoidable cancer in Leeds South and East CCG however this needs to be sustained over time; the trend for Leeds North and Leeds West is static. It needs to be noted that the rates of a CCG population mask smaller area difference and that within each CCG there is great variation.

At the Ward level, there has been a narrowing of the range of scores in the most recent 3-year aggregate rates, and a general reduction in the rate for the worst Wards in Leeds. Beeston and Holbeck Ward is the exception to this rule and with small year on year increases is now the highest scoring Ward in the district.

Cancer incidence is more common in older people. Although the cut-off point for PYLL analysis is deaths before 75, this still makes higher rates more likely in an area with an older population. However, because the PYLL rates are based on a standardised population, this should not affect the results of the analysis.

Why is it important

Cases of cancer in Leeds are likely to increase as the population grows and ages, so cancer must continue to be a local strategic priority for prevention, early intervention, treatment and recovery. Cancer is a significant cause of health inequalities, and risk factors for cancer incidence and mortality include: smoking; alcohol use; obesity; and a lack of awareness of and/or uptake of cancer screening programmes and cancer symptoms and signs. Inequalities

also exist within cancer treatment itself. These risks are linked to poverty and deprivation, and to cultural and language barriers to accessing prevention, screening and treatment.

Further reductions in rates of cancer PYLL will require:

- Continue to focus on reducing cancer inequalities through cancer prevention, screening uptake and awareness of cancer symptoms and signs, especially in deprived and high risk populations through campaigns and outreach work in local communities with a focus on breast, bowel and lung cancers and messages to increase awareness that there are effective cancer treatments available;
- Continue to focus on early diagnosis of cancer in terms of making diagnostic services timely and accessible, with as few steps in the process as possible with a focus on breast, bowel and lung cancers;
- Continue to work with primary care staff on early referral of suspected cancer in line with NICE guidance;
- Plan for increased demand for cancer treatment and survivorship services across the local health and care economy due to an ageing population, and reduce cancer inequalities within cancer treatment outcomes.

Avoidable Cardiovascular Diseases (CVD) PYLL

Deaths from cardiovascular diseases (CVD) are the second largest cause of PYLL across the city. They account for around a quarter of all deaths. There has been a reduction of almost 20% over 5 years in PYLL due to CVD, with a reduction noticeably in deprived Leeds due to reduced numbers of deaths and also an increase in the age at death (2011-13). This can be seen as evidence of a positive outcome of key public health programmes, leading to a decrease in smoking rates, the implementation of the NHS Health Check which had its initial focus on deprived Leeds, and effective management in primary and secondary care.

Why is it important

CVD accounts for a quarter of all deaths. Although the gap in CVD PYLL between deprived Leeds and the rest of Leeds is reducing, the gap remains large. The rate in deprived Leeds is over 60% higher than Leeds overall. Therefore the focus remains on the early detection and prevention of CVD as a key component in preventing premature mortality and reducing health inequalities.

Where is it important

The lowest ward for avoidable CVD PYLL is Harewood, the highest ward is Richmond Hill which has a rate, almost 4 times higher. The lowest rate for a Community Committee is Outer North, the highest is Inner East.

For registered patients of Leeds CCGs the rate of avoidable CVD PYLL is significantly greater for Leeds South and East CCG (11% above Leeds average). Leeds West CCG has a rate similar to the Leeds average. Leeds North CCG has a rate 19% below Leeds average. However it is positive that there has been a significant reduction in Leeds South and East CCG rates since 2009; unfortunately, this reduction has not been reflected in the static rates of other two CCGs. It should be noted that rates shown at the CCG registered population level of aggregation mask the variation of rates within their geographical populations.

Further reductions in rates of CVD PYLL will require:

- Early identification of Atrial Fibrilation (AF) and decrease unwarranted variation of its management to prevent strokes
- Ensuring that there is effective management of all those on a hypertension register, reducing any unwarranted variation.

- Early identification and effective management of people at high risk of Type 2 diabetes.
- Comprehensively implement Year of Care in primary care; and offering evidence based support to ensure people are supported, and in control of their own health.
- lifestyle advice and referral to healthy living interventions and support of the patients' own plans to reduce their risks.

Avoidable Respiratory PYLL

Deaths from respiratory disease are the third single cause of PYLL in Leeds. The rates are significantly higher in deprived Leeds than the non-deprived part of Leeds. Rates have decreased slightly but not statistically significantly over time. Smoking is the key contributor to respiratory disease, and smoking rates reflect this pattern.

Where is it important

The rates for deprived Leeds are more than double those in the non-deprived part of Leeds. The rate of PYLL in Inner West Community Committee is significantly higher than any other community committee and is seven times the rate of the Outer North West (the lowest). The highest Ward rate is Cross Gates, the lowest Ward is Garforth.

Registered CCG population rates vary around the Leeds rate; the rate in Leeds North CCG is substantially lower than Leeds (47%); the rate in Leeds West slightly higher (8%) and Leeds South and East significantly higher (25%). The rate in Leeds North is the only CCG to be showing a decline. It needs to be noted that the rates of a CCG registered population mask smaller area difference and that within each CCG there is great variation.

Further reductions in rates of respiratory PYLL will require:

- Remaining focussed on decreasing smoking rates in the population, targeting areas of high deprivation
- A targeted focus on those over 35 years to stop smoking who are not on a respiratory register
- Continue focus on smoking cessation in the most deprived communities
- Pneumococcal vaccination and an annual influenza vaccination should be offered to all patients with COPD
- Ensure there is effective management of those on a primary care COPD register in line with NICE guidelines Reduce unwarranted variation in corticosteroid prescribing across primary care
- Provide pulmonary rehabilitation for those with MRC score 3 and above
- Ensure effective support for those with COPD to manage their condition
- Comprehensively implement Year of Care in primary care to ensure people supported and in control of their own health

All Avoidable Causes PYLL

Leeds North and Leeds South and East CCG registered and resident populations show a steady and statistically significant reduction in avoidable PYLL which is falling faster in deprived resident populations. This trend is not replicated in Leeds West CCG population, where the trend appears to be static for the registered and resident populations, though the deprived resident population's rate is falling.

Look at all avoidable causes of PYLL in Leeds, City and Hunslet ward appears to be improving its position on the basis of a year on year improvement in PYLL for cardiovascular disease (CVD). Burmantofts and Richmond Hill ward has seen a small rise and then an overall reduction in CVD PYLL but has not kept pace with Hyde Park and is now the highest scoring ward. Alwoodley and Harewood have the lowest scoring rates for avoidable PYLL recorded.

All three CCGs are recommended to use this new PYLL analysis to inform their strategic plans with a focus on improving CVD and cancer outcomes in areas of high deprivation as priorities.

Definition of Amenable, Preventable and Avoidable mortality (http://www.ons.gov.uk/ons/dcp171778_311826.pdf)

Amenable mortality*: A death is amenable (treatable) if, in the light of medical knowledge and technology at the time of death, all or most deaths from that cause (subject to age limits if appropriate) could avoided through good quality healthcare.*

Preventable mortality*: A death is preventable if, in the light of understanding of the determinants of health at time of death, all or most deaths from that cause (subject to age limits if appropriate) could be avoided by public health interventions in the broadest sense.*

Avoidable mortality*: Avoidable deaths are all those defined as preventable, amenable or both, where each death is counted only once. Where a cause of death is both preventable and amenable, all deaths from that cause are counted in both categories when they are presented separately.*

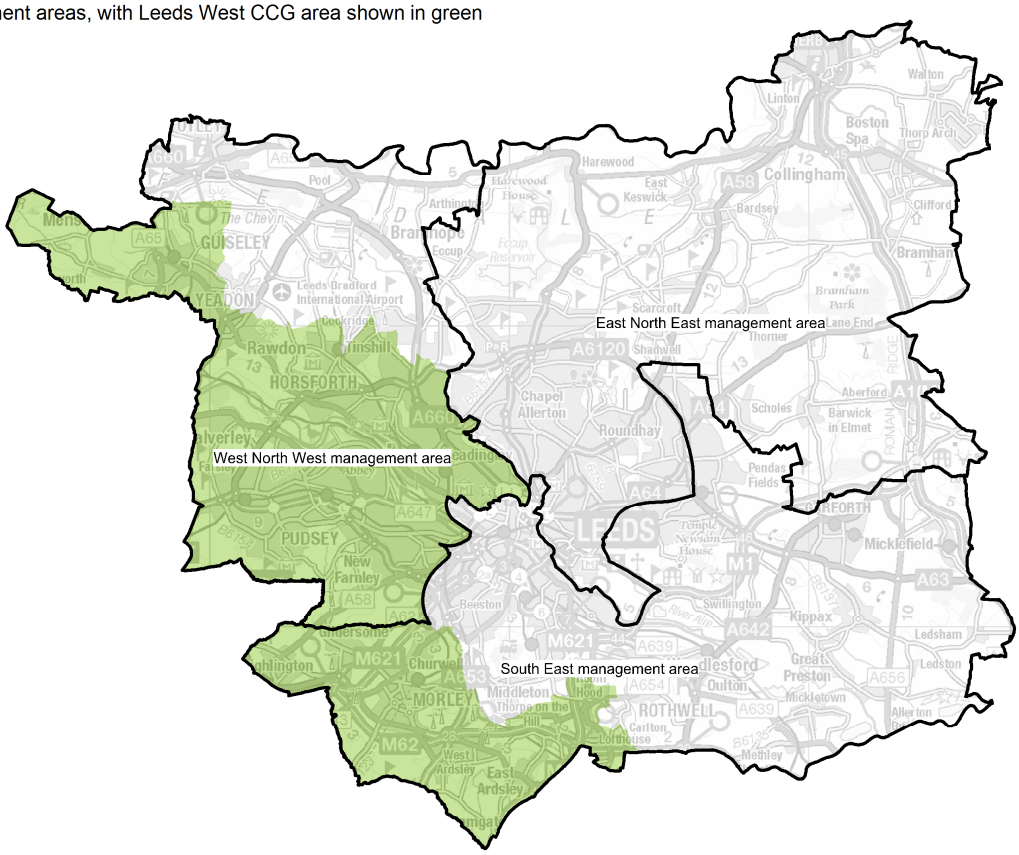
Localities

Detailed below are some of the emerging issues, particularly on life expectancy and health conditions, for the three areas covered by Leeds City Council and the Clinical Commissioning Groups. The geographical areas covered by the two organisational structures are slightly different and where this is the case, the difference is highlighted.

It is important to note that data on a large area such as management areas combine figures across these areas masking significant variation; therefore it is necessary to look at these figures at smaller geographies within the areas such as ward.

West North West /NHS Leeds West Clinical Commissioning Group

Local Authority management areas, with Leeds West CCG area shown in green



The population of Leeds City Council and Clinical Commissioning Group (CCG) geographical areas are similar. The key differences are that Morley falls within the Leeds West CCG but outside the City Council West North West area, and Otley falls within the West North West area but outside Leeds West CCG.

Within these areas, the distribution of need is scattered across the population and is best captured through data on smaller areas.

Within the Council's West North West area, 'Adel and Wharfedale' ward has the highest average life expectancy for women at 86.7 years, and for men at 82.9 years. Yet there are communities in this area with some of the lowest life

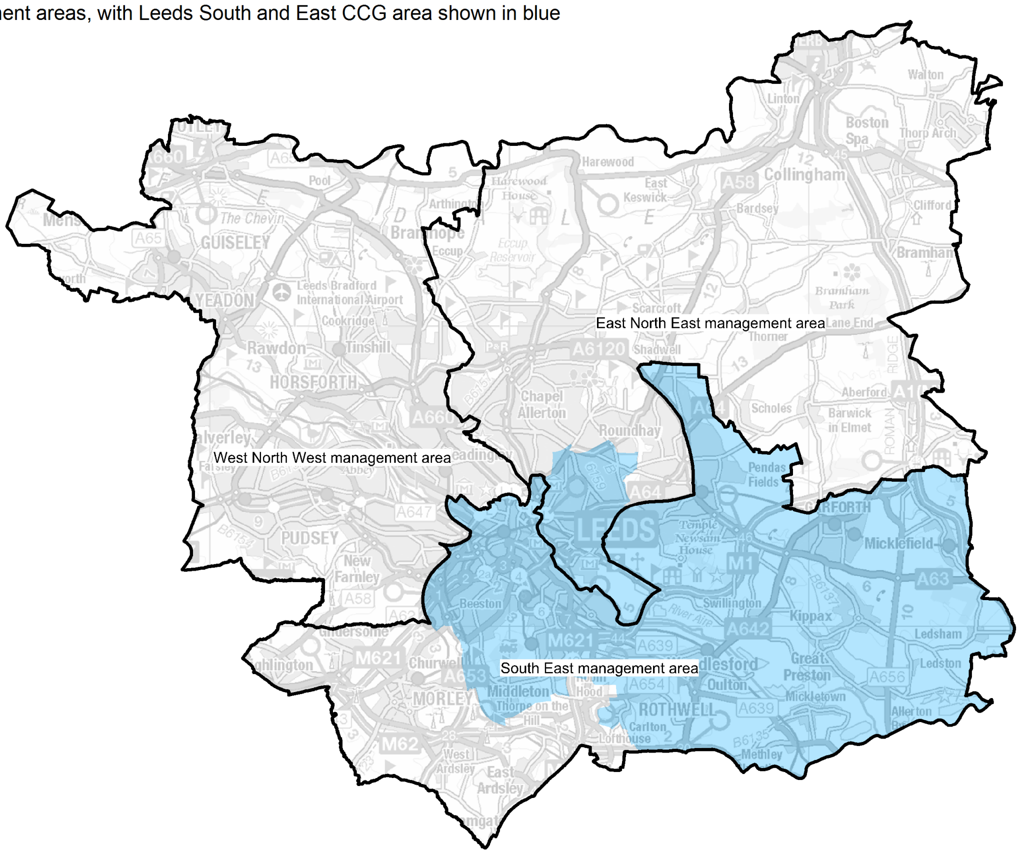
expectancy rates in Leeds; women in 'Headingley' ward have lowest life expectancy in Leeds at 76.8 years. Men in 'Armley' ward, have almost the lowest life expectancy within the city at 75.2 years.

The differences in life expectancy within the population of the Leeds West CCG area are also wide. For example, the gap in male life expectancy is 5.6 years (based on data at ward level). For males the highest life expectancy is 80.7 years, in 'Weetwood', and the lowest is 75.2 years in 'Armley'. For females the highest life expectancy is 84.9 years in 'Horsforth' ward, and the lowest is 76.8 years in 'Headingley' ward.

There are also communities in the West North West management area of Leeds and Leeds West CCG with specific needs, such as offenders, students and gypsies and travellers. Long term conditions and lifestyle factors which contribute to ill health are more widespread (prevalent) in some communities than others: for example, there is a high prevalence of CHD (heart disease) in 'Otley and Yeadon' ward; high cancer prevalence in 'Adel and Wharfedale' ward; high diabetes prevalence in 'Otley and Yeadon' ward; and high smoking prevalence in 'Armley' ward. Prevalence is an indicator of people who have been identified by GP practices and are therefore being proactively managed for the condition. Death rates also help us to analyse needs in a given community. The fourth highest rates of premature mortality (death under the age of 75) from cancer in the city are found in the West North West management area, in 'Bramley and Stanningley' ward. A higher level of health need is closely associated with wider determinants of health such as low income, lower levels of community safety, poor housing, and low educational attainment. Over fourteen percent of the Deprived Leeds population live in the Inner West and Outer West areas of the city. The most deprived areas within these boundaries are around Hawksworth, New Wortley, Gamble Hill, and Upper Armley.

South and East/NHS Leeds South and East Clinical Commissioning Group

Local Authority management areas, with Leeds South and East CCG area shown in blue



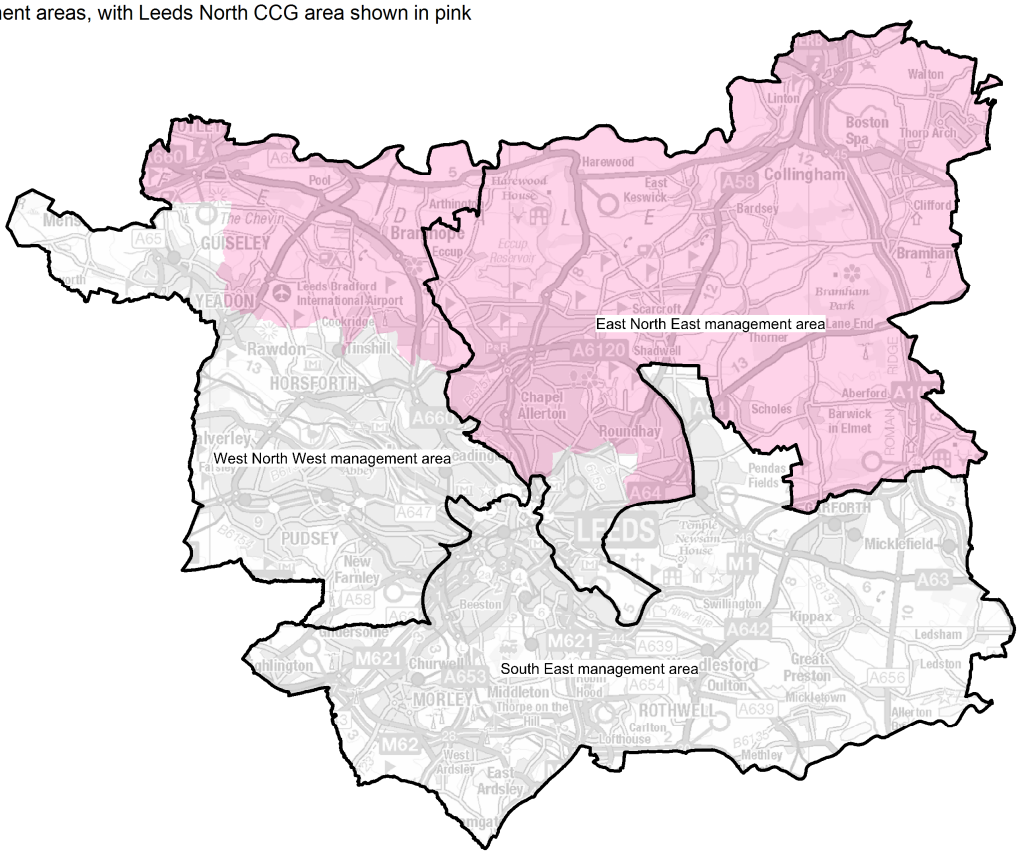
NHS Leeds South and East Clinical Commissioning Group (CCG) also covers parts of the Inner East area – such as Harehills, Gipton, Lincoln Green and Richmond Hill and so needs to be considered with some of the information below on the City Council East North East area.

Over 40% of the population of the Leeds South and East CCG area live within the most deprived areas of Leeds and have significant health and wellbeing issues linked to wider factors such as poverty, educational attainment, and unemployment. Crime is also a significant issue. 'City and Hunslet' ward has the lowest female life expectancy in the CCG area at 77.2 yrs.

Within the Council's South East Management Area, the Inner South Community Committee Area has the second highest premature mortality rate for all causes in the city as well as the highest rate of premature mortality from respiratory disease. 'City and Hunslet' ward has the second lowest life expectancy in the city for women at 77.2 yrs, while 'Middleton park' ward has the lowest male expectancy in the city at 74.8 yrs. 'Beeston and Holbeck' ward in the South East Management area has the second highest death rate in the city for cancer (under 75s), and 'City and Hunslet' ward has the highest rates of early death from respiratory disease in Leeds. In terms of prevalence rates for long term conditions, 'Garforth and Swillington' ward has the highest rate for coronary heart disease in the city, obesity rates are highest in the city in 'Middleton Park' ward, (smoking rates are second highest in Leeds here too. Almost a third of the population of deprived Leeds lives within this area.

East North East/NHS Leeds North Clinical Commissioning Group

Local Authority management areas, with Leeds North CCG area shown in pink



Leeds North Clinical Commissioning Group (CCG) covers the majority of the same population as Leeds City Council East North East area. North CCG also extends to areas within the Council's West North West area – including Otley and Yeadon.

Women living in 'Harewood' ward have the highest life expectancy in the city at 88.5 years. Within Leeds North CCG, at ward level, there is a 8.5 year difference in male life expectancy, and an 7.3 year difference for women. When deprivation is analysed at Lower Super Output Area (LSOA) level (the smallest areas for which we have data), three areas (LSOAs) in Leeds North CCG are within the five most deprived in the city; they are in Parklands, Sheepscar, and Buslingthorpe.

In the City Council East North East area there are considerable variations in population, physical environment, income and associated health experience. 'Harewood' ward has the highest life expectancy for the city overall (84.9 yrs men, 88.5 yrs women); 'Burmantofts and Richmond Hill' ward has the lowest life expectancy for this area overall (75.2 yrs men, 78.7 yrs women). Cancer mortality (under 75s) in the East North East area encompasses the highest and very lowest rates in Leeds within 'Killingbeck and Seacroft' and 'Harewood' wards respectively. When analysed by Community Committee, the Inner East area has the highest and second highest early death rates in Leeds for all causes and cancer respectively. In terms of recorded prevalence on GP registers, 'Harewood' ward has the highest prevalence in the city for cancer, 'Killingbeck and Seacroft' ward has the second highest prevalence in Leeds for COPD (Chronic Obstructive Pulmonary Disease); 'Gipton and Harehills' ward has the third highest prevalence for diabetes with 'Moortown' close; and 'Burmantofts and Richmond Hill' ward has the highest smoking rates in the city.

Implications

The clear message is that there is significant variation within each locality in how well people live, what health conditions they will face, how long they will live and what opportunities they have to lead healthy lives and fulfil their potential. The implication is that Leeds City Council Community Committees, Leeds City Council Area Leadership Teams and each NHS Clinical Commissioning Group must work together to tackle local, and sometimes very local, health and wellbeing issues. This means agreeing priorities and focusing actions.

Support for children and families, at universal and targeted levels, is increasingly coordinated by local cluster partnerships. These have strong links with specialist safeguarding services and strengthening links with other services that work with children and families at the local level.

The role of the Clinical Commissioning Groups is to lead in preventing people dying prematurely, particularly from the key long term conditions highlighted. This includes action to improve early diagnosis and equitable access to services. The role of Leeds City Council is to lead in minimising the impact of the wider factors such as lack of employment, poor housing, lack of education, and social isolation. Both partners will lead together on health improvement programmes to reduce unhealthy behaviours such as smoking, obesity and high alcohol consumption.

Crucially all these roles overlap and require partnership working between the statutory services, the third sector, the private sector, local communities, families and individuals.

Sources: Mortality rates 2011-13 ONS deaths extract, GP registered populations. Life Expectancy 2011-13 ONS deaths extract, GP registered populations. Prevalence of conditions January 2015 Leeds GP data collection. Populations in deprived areas January 2015 GP registered populations, 2011 LSOAs with IMD 2010 ranks.

Further information

Further information is available on the Leeds Observatory Website at http://observatory.leeds.gov.uk .This includes:

- Profiles at various locality levels
- School cluster information
- Detailed health and wellbeing statistics
- Over 80 JSNA reports
- JSNA 2015 Executive Summary.