Summary of the JSNA Data Pack Annexe C

Evidence of need

The JSNA data pack provides a detailed picture of the diverse health and well being needs of the people of Leeds. The quantitative data was collected in line with the original draft data set from the Department of Health. Some additional information was collected based on local need. For example a detailed revision of the data set collected in 2007 on children and young people has been revised and updated for the pack; student health has been added as Leeds has a large student population, and also a section on vulnerable groups. Not all of the final data set was able to be collected mainly as the data is not yet available.

Qualitative data was collected from a wide range of consultations that have taken place both within the PCT (for example the patient survey and the consultations on the PCT strategy) and also from the council via a stakeholder and engagement groups who pulled it all together.

It is envisaged that the data pack will be available on a web based site so that this information can be used by everyone who requires it for planning, commissioning future services in Leeds and by the communities whose needs it describes.

The data pack provides detailed information on key conditions; services; client groups and communities that can be used by the range of health and well being commissioners within the city for their specific programme areas. In order to identify some emerging themes a scoring exercise was also carried out by a number of people within the PCT and LCC . Key questions asked were:

- Is this an issue which affects a significant proportion of the population (directly or indirectly)?
- Is the problem likely to increase if there is no intervention?
- This an issue which significantly affects vulnerable groups?
- Is this issue a significant contributor to the health inequality gap?
- Is there evidence of unmet need
- How great are the costs (direct and indirect) of not intervening?
- Does this issue have the possibility of investing to save?

Key emerging themes from this fall into three categories:

Influences on health and well being - poverty/low income; housing; education and unemployment- also the economic wellbeing of children

Conditions of ill health – circulatory disease; cancer; obesity

Lifestyle issues – healthy life; alcohol;

The data pack was produced by a joint information group between the PCT and the LCC Who produced it. This also had a sub group of people working around children's issues to update the relevant data

In future it is envisaged that this gathering of data will become an integral part of the role of the Joint Strategic Commissioning structure within the city

Data Pack.
Detailed below is a summary of the information within the data pack

1. Demography
The Leeds Metropolitan District covers 552 square kilometres (217 square miles) and is the second largest Metropolitan District in England. It is recognised as one of Britain's most successful cities having transformed itself from a mainly industrial city into a broadly-based commercial centre regarded as the most important financial, legal and business service centre in the country outside London.
The city includes a vibrant city centre and the built up areas that surround it together with more rural outer suburbs and several small towns, all with their own very different identities. Two-thirds of the district is designated green-belt.

Despite the success of the city as a whole there are wide gaps between those areas that are wealthy and thriving and those that suffer high levels of multiple deprivation.

At the time of the 2001 Census Leeds had a population of 715,400 living in approximately 301,000 households. In 2005 the population of Leeds was estimated at 723,100. Following recent revisions by the Office for National Statistics to the way in which population estimates are calculated the population of Leeds is now estimated to be 750,200, an increase of 4.9% from the 2001 figure.
Leeds has a significantly higher proportion of 15 – 29 year olds when compared to both the country and the region, whilst the proportion of older people is slightly below the national and regional averages.

At the time of the 2001 Census there were almost 78,000 people from BME communities living in Leeds (10.8% of the total resident population). Geographic analysis of the Census data has shown how BME communities are concentrated in particular geographic areas of the city

Leeds is clearly becoming a more diverse place and is now home to over 130 different nationalities. This diversity is valuable and has helped fuel the prosperity of the city.

The data pack details the needs of different communities/groups living in Leeds– gypsies and travellers, migrants communities, asylum seekers, refugees, faith communities

Changing Populations
The Office for National Statistics produces population projections which indicate that the population in Leeds will increase from 750,200 in 2006 to 974,300 by 2031
There will be significant changes in the size and profile of black and ethnic minority communities in the coming years. Work done by the University of Leeds (School of Geography) for the Yorkshire Futures Group suggests that by 2030 the BME population in Leeds will increase by 55% (N.B. this work was undertaken prior to the ONS revisions to the 2006 Mid Year population estimates outlined above), the age structure of black and ethnic minority communities will also contain higher proportions of people in older age groups.

2 Key influences on Health and Well being

2.1 Social and economic context.
Although Leeds as a whole is ranked as 85th most deprived (on the average of Super Output Areas (SOAs) scores), 95 out of the 476 SOAs in Leeds are ranked in the most deprived 10% in England on the Index of Multiple Deprivation. The majority of these are located in the inner city and just under 150,000 people (20% of the resident population) live in these areas. A quarter of all children in the city live in these most deprived areas together with 18% of the city's older people. The data pack shows that people in these areas:

- Live significantly shorter lives
- Are more likely to be the victims of crime
- Have lower qualification levels, and
- Live in the poorest housing and environments

Comparison with the 2004 Index of Multiple Deprivation **(IMD)** the 2007 IMD shows an improving position for Leeds with fewer SOAs ranked amongst the most deprived in the country. Of the 476 SOAs in Leeds 415 have seen an improvement in their IMD ranking and 61 have seen their ranking fall

One approach to analysis of inequalities that is used in the data pack is to compare the most deprived parts of Leeds with the rest of Leeds. This analysis looks at those parts of "deprived Leeds" which fall within the worst 10% deprivation band in England according to the Index of Multiple Deprivation, and analysed at the level of small areas termed lower layer Super Output Areas (mean population 1500 people). Leeds has approximately twice the expected number of LSOAs graded as being 'the worst 10% most deprived nationally' i.e. 20% of Leeds LSOAs fall into the worst 10% nationally.

2.2Employment Rate

Leeds has seen sustained job growth over the last 20 years and latest figures show the overall employment rate in the city to be 75.3%, which is above the current England average of 74.3%.

In 2007 gross average hourly earnings for full-time workers in Leeds was £10.84, this was below the England average of £11.58 but above the Yorkshire and The Humber regional average of £10.53

Almost 65,000 people of working age are not in employment and are claiming some kind of benefit. At 28.7% the claimant rate in the "Deprived Area" is more than double the rate for the city

2.3 Unemployment in Leeds

The estimated real level of unemployment in Leeds in 2007 according to CRESR was 29,500, a rate of 6.4%. This compared with 13,995 claimants (a rate of 3%) and 17,000 ILO unemployed (a rate of 5.3%). Thus, just over twice as many people were unemployed by CRESR's calculations than the claimant count and approximately 42% less people were counted as unemployed according to the ILO count

2.4 Benefits

Incapacity Benefit data shows that: across the city 6.5% of the working age population are claiming Incapacity Benefit while in the "Deprived Area" it rises to 12.4%, nearly twice the city average. 44% of claimants are claiming due to "Mental Disorders", in the "Deprived Area" this rises to 48% of claimants ,16% of claimants are claiming due to "Musculoskeletal Diseases.

Almost 71,000 households in the city (23%) are in receipt of local authority administered benefits, almost 12,500 of which are lone parent households. while in the "deprived area" the benefit take-up rate is 44% almost double the average for the city

2.5 Housing

Data within the pack covers key issues within housing such as availability of central heating, ownership; decency and overcrowding.

In the last ten years there have been substantial changes in housing market conditions in Leeds and in the patterns of housing choice and use made by households and individuals. With Leeds growing economically and becoming a thriving regional centre, a 'two-speed' housing market has emerged, showing a clear gap between parts of the city where there is considerable affluence and buoyant (and often overheating) housing markets, and parts

where housing is in poor condition, housing markets are frail, and where there exists significant social and economic deprivation. At the same time, throughout the city and within neighbourhoods, there have been changes in housing tenure patterns with a continuing home ownership and a substantial increase in the number of households renting privately. The share of the market taken up by social rented housing (and by Council housing in particular) has declined substantially through Right to Buy activity and demolition and disposal of stock. It is estimated that there are 51,400 private sector dwellings in Leeds that are occupied by "vulnerable households". Of these an estimated 37% are classified non-decent. In order to raise the proportion of private sector dwellings occupied by vulnerable people above the 70% threshold for decency, 3,880 dwellings will need to be made decent by 2010.

Homeless/supporting people etc

The Census data shows that almost 62,500 households within Leeds (20.7% of all households in the city) did not have central heating, affecting almost 135,900 *people* (19.3%). The Leeds 2007 Fuel Poverty Survey showed that within the private sector 30% of all households are experiencing fuel poverty, with a figure of 22% for vulnerable households.

2.6 Transport

As more people live in and travel to work in Leeds greater strain will be imposed on the transport system. Road traffic grew by 4.9% between 1996 and 2006 and further growth is predicted. In 2001 around 108,000 people commuted into Leeds daily for work and that number is estimated to have grown significantly in recent years; in 2006 the total number of trips into the city averaged about 122,500 a day.

Data from the 2001 Census of Population over 1/3rd of all households in the city (34.5%) do not own a car or van, a considerably higher proportion than for England and Wales (26.8%), rising to 58.34% over half the population) within 'deprived Leeds'

2.7 Crime

In 2007, Safer Leeds (Crime and Disorder Reduction Partnership) identified the major crime, disorder and substance misuse issues that require partnership attention. The priority issues were informed by the findings of the joint strategic assessment and public-partnership consultation (ref). The data shows that between 2005/06 and 2007/08 considerable progress was made in tackling crime across the city. In 2007, there were 85,737 recorded crimes, almost 12,300 fewer offences than in 2005/06; this is a 12.5% reduction in crime

The third biggest category of crime is violence against the person, this can include the most serious offences like murder and rape to assaults where the victims suffers relatively minor injuries. Some violence does not include physical harm for example, harassment although the psychological effects of such offences must not be under estimated.

There are parts of the city where disproportionately high levels of crime persist over time. In the twelve months from October 2006, 60% of crime happened in 30% of the 476 Lower Super-Output Areas in Leeds.

One key issues within the Safer Leeds JSNA is drug use.

National estimates of prevalence of problematic drug users have been produced by the Home Office through a study by the University of Glasgow that estimates the prevalence of problematic drug users at a local and national level. The estimated number of problem drug (opiate and/or crack cocaine) users in Leeds according to this study is approximately 6,565. In Leeds heroin is the most heavily misused drug, by 84% of drug users – a higher proportion than nationally.

In 2007/08, there were 3,554 drug users in treatment. The number of new presentations increased by 5.2% from the previous year (1145 in 06/07 and 1204 in 07/08). The largest group of known drug users is in 20-24 age range, the majority nationally are 35 and over, of known drug users the injection status of 68% is unknown. There are an estimated 515 problematic drug users unknown to services

3. Access to Services

Within the data pack there is only limited information about access to services. IN terms of prioritisation this would be an important area to consider
For the City over 80% of all Lower Level SOAs have a population weighted average road distance (PWARD) to a Food Store, a GP Surgery and a Post Office of less that half a kilometre. In addition 87% of LSOAs are within one kilometre of a primary school. Whilst almost 10% of LSOAs have a PWARD to a GP Surgery of more than two kilometres the population of only four LSOAs (less than 1%) have to travel this distance or farther to a Primary School.

4. Health and Ill Health

4.1 Life Expectancy
Life Expectancy is increasing for males and females. However there remains a marked gap between the life expectancy of males and females. 2004 – 2006 averages show a gap of 4 years. Comparing ward data for all people the difference is more extreme with a life expectancy gap of 10 years between the ward with the highest life expectancy (Adel and Wharfdale) and the lowest (City and Hunslet); this Ward differential is correlated to deprivation.

4.2 All Age All Cause Mortality
The all age, all cause mortality rate in Leeds fluctuated around the national average between 1993 and 2000 at a level below the regional average. From that point, although the rate continued to fall, it was consistently higher than the national average but remained below the regional average. In 2003-2005, compared to the core cities in England, Leeds had the lowest all age, all cause mortality rate but was significantly higher than the national average. The deprived areas of Leeds had rates that were significantly higher than the Leeds, Y&H Spearheads and national averages between 2001 and 2005.Between these years the gap between Leeds deprived and Leeds overall fluctuated

4.3 Circulatory Disease Mortality
Within Leeds the mortality rate under 75 years from circulatory diseases ranged from 50 per 100,000 in Adel and Wharfedale 224 per 100,000 in City and Hunslet electoral wards.
The deprived areas of Leeds had mortality rates under 75 years from circulatory diseases that were consistently significantly higher than the Leeds, Yorkshire and Humber Spearhead and national averages between 2001 and 2005.

4.4 Cancer Mortality
The deprived areas of Leeds had mortality rates under 75 years from cancer that were consistently significantly higher than the Leeds, Yorkshire and Humber Spearhead and national averages Although there was a reduction in the gap between Leeds deprived and Leeds and the gap between Leeds deprived and England between 2001 and 2003, the gaps have now widened . Inner West Leeds particularly has risen over 2005-7, with all the other inner areas also showing rises.

4.5 Chronic Obstructive Pulmonary Disease Mortality and Prevalence
The mortality rates for COPD demonstrate wide variation across areas in Leeds with the inner south area continuing to have significantly higher rates since 2003, and continuing to rise.

4.6 Stroke Mortality
Mortality form stroke is continuing to fall in the majority of areas since 2003. Highest rates are in inner North East, but there are also high rates within the outer East . followed by Inner South and Inner East.

4.7 Limiting Long Term Illness
At the time of the 2001 Census there were over 128,000 people living in Leeds who considered themselves to have a limiting long-term illness (18% of the total resident population). Of these people 57,732 were of working age. Geographic analysis of the Census data has shown how people with a LLtI are concentrated in particular geographic areas of the city

4.8 Top Ten Causes of Death and Admission Rates
CHD is the most common cause of death in men and is also one of the main causes of hospital admissions for males.
CHD was the most common cause of death in women in 2006, followed by cerebrovascular disease. This is not reflected in the figures for hospital admissions.

5. Healthy Lifestyles

5.1 Smoking
The pattern of deprivation and smoking is clearly seen across Leeds. It is clear that the distribution of smokers varies across the city, the highest rates being seen in inner east, inner south and inner west Leeds and the lowest in the north east. This corresponds with published synthetic estimates where even greater variations can be seen at ward level with the lowest estimated smoking level of 18% being seen in Wetherby and the highest of 46% being seen in Seacroft.

5.2 Alcohol Admissions
Within the Yorkshire and Humber Region Adults' drinking above safe levels is estimated at 155,000, of which 25,000 may be dependent. Alcohol related deaths in the region rose by over 46% in 2004 -the biggest rise in the country. Alcohol related death rates are 45% higher in high deprivation areas/
The estimated annual cost of alcohol misuse in Leeds is £275 million, of which £23 million is health related.

5.3 Obesity
In 2005, 22.1% of men and 24.3% of women were obese and almost two-thirds of all adults overweight. In 2003, nearly a quarter of males in Yorkshire and Humber (24.6%) were estimated to be obese, the highest prevalence of any region in England. The region also has the highest obesity prevalence among young adult males (aged 16-24) of any region in England (based on 2002 data).

5.4 Physical activity
In the Citizens Panel Sports Provision Survey 2000 illustrated that 50% of people in Leeds felt that participation in sport and active recreation was important to them; by 2005 this had increased to 65%. It is encouraging that there have been significant increases in the number of adults who regard taking part in sport as important, and who perceive the facilities in Leeds to be good or excellent.
A major national participation survey was commissioned by Sport England in October 2005. It shows that only 20.5% of the adult population in Leeds are participating for 30 minutes, three times a week in moderate intensity sport and active recreation, very slightly above the Yorkshire average of 20.1% but below the England average of 21%.

6. Indicator Comparison
When compared to the national average, (based on the latest data July 2007) Leeds has significantly worse values for 24 of the key indicators including all age all cause mortality, male life expectancy, smoking prevalence in long term condition patients, alcohol related admission rates, prevalence and mortality from circulatory and respiratory diseases, incidence and mortality from cancer and emergency admissions for chronic illnesses such as COPD and asthma.
Compared to the national average, of the 47 indicators compared people living in the deprived areas of Leeds experience significantly worse values for 34 of them. This pattern does not change dramatically when making comparisons between the deprived areas of Leeds and Yorkshire and the Humber region, the spearhead areas within Yorkshire and the Humber or the Leeds average.

Overall Leeds reflects the fact that Yorkshire and Humberside is an area of comparatively poor health in England and Leeds is not atypical of the region. However health in the more disadvantaged areas of Leeds, containing around 150,000 population, is significantly worse than in those areas which the government has designated as priority areas for health improvement, meaning that the challenge of narrowing the gap is significantly greater.

7. Children
Towards the end of 2007 Children's Services undertook a Needs Analysis as part of the Joint Area Review. The information in the data pack is drawn from this earlier work (updated where possible). The Needs Analysis was structured around the 5 outcomes for Every Child Matters.(ECM)

- Stay Safe
- Be Healthy
- Enjoy and Achieve
- Make a positive contribution
- Achieve economic well-being

7.1 Staying Safe
Within this section is detailed information on Looked After Children. The numbers of looked after children in Leeds are significantly higher than statistical neighbours and are increasing. At September 2007 Leeds has 1395 looked after children. If it were to reflect the same proportions of the total population of children as the average of its statistical neighbours then it would have 912. There are more boys than girls in every age group in the looked after children cohort. In total boys comprise 58% of the looked after population. This proportion has risen by 6% since 2004.Most Looked after children in Leeds have been in care for over 3 years. BME children are over-represented in the looked after population and continue to rise.
Given the current trajectory the numbers of looked after children is forecast to grow to around 1800 by 2010. This will create additional foster care costs rising to around £5.7 million per year in 2010-11 based on the 06/07 unit costs.
Other areas that are covered within this section are bullying and harassment (In the Leeds ECM survey, 46% of primary respondents and 42% of secondary respondents reported that they had been bullied at some point in school in the last 12 months, of these 5% of both primary and secondary pupils said they were bullied most days.); how Safe young people feel (the ECM survey showed around 405 children and young people (both primary and secondary) do not feel safe in the area they live after dark, although over 90% feel safe in the area they live in daylight) and Child Protection (the proportions of children who are the subjects of a child protection plan or on the child protection register is growing and is currently in line with that of national averages.)

7.2 Be Healthy

The Indicators of Child Health assessed were perinatal mortality; low birthweight and infant mortality.
- The recognised association between deprivation and higher perinatal mortality is demonstrated in the pack although the differences at small area level are not on the whole statistically significant, so differences in the rates should be interpreted with caution.
- The low birth weight rate for Leeds in 2006 was 8.0% which was similar to the national rate, and slightly lower than the regional rate (although not significantly). Over the last two decades there has been an upward trend in low birth weight rates in Leeds, rising from a rate of 7.3% in 1985, and reaching 9.0% in the late 1990s. There was a similar but less marked national trend over the same period, during which time the rates in Leeds were slightly but consistently higher than national rates. However, rates have fallen again somewhat in Leeds. Analysis of low birth weight rates (aggregated for 3 and 5 years) at local level demonstrates the recognised association between deprivation and higher rates of low birth weight.
- The 3 year aggregate infant mortality rate for Leeds (2004-6) was 6 per 1000 live births. This rate was higher than the England rate at 5 per 1000 live births, and slightly higher than the Yorkshire and Humber rate at 5.8 per 1000 live births.
3 year rolling rates show a rising infant mortality rate for Leeds, which has levelled off in the most recent year. This is in contrast to the national downward trend.
Detailed local analysis shows the association between higher rates of infant mortality and wards with high levels of deprivation

Oral Health
The most recent national survey data (2005/06) of nearly 240,000 5 and 6 year olds across the United Kingdom suggested that the mean number of decayed, missing or filled teeth (dmft) in England was around 1.47 teeth per five year old. For Yorkshire and Humber, the mean dmft was 1.82, with the Leeds experience being similar to the region at 1.83. The survey showed that dental health was poorer in the North of England than areas in the South and Midlands.
Results from the 2005/06 survey for Leeds, compared with the region and England. Despite some marked improvements in Leeds since the 2003/04 survey, the dental health of young children in Leeds remains slightly worse than the national experience. Nearly 43% of 5 and 6 years old Leeds have evidence of some tooth decay, with more than 4 teeth being affected on average.
The ECM survey showed that only two thirds of Year 5 children are achieving the recommended frequency of teeth brushing, though this appears to increase somewhat among the older age groups.

Teenage Conceptions
The Leeds national target is to reduce the rate by 55% from 1998 baseline. The Leeds rate figure (2006) is 50.7 which is 0.4% above the 1998 baseline. This is considerably higher than the national rate, is not a reduction and is a fair way from the 2010 target rate of 22.7 per 1000 females aged 15-17
Following the Local Area Agreement negotiation, a target for the next two years was devised. The focus is on reduction in the six highest wards (Harehills, Middleton, City & Holbeck, Seacroft, Hunslet and Richmond Hill) within Leeds and the impact this will have on the whole Leeds rate

Obesity
Across all categories Leeds is very slightly below the regional and national averages at reception.1 in 5 children in Reception in Leeds have a weight which is above what is considered healthy. This equates to around 1389 children. By Year 6 almost 1 in 3 children in Leeds are either overweight or obese. This equates to around 2505 children. Levels of

obese children have almost doubled from Reception to Year 6. This is more or less in line with the picture at a national and regional level.
Levels of overweight children are slightly higher than in Reception. Levels of obesity are higher in Reception in deprived areas of the city. Though this difference is small it is statistically significant. By Year 6 rates are higher across all measurements for children living in deprived areas of the city. Again the difference is small but statistically significant.

Physical Activity

Locally Leeds has already exceeded the National Indicator target to increase the percentage of school children who spend a minimum of two hours a week on high-quality PE and school sport within and beyond the curriculum to 85 per cent by 2008. Leeds achieved 86% in 2007and is likely to achieve 90% by end of 2008
In England only half of children regularly travel to school on foot, even though many children live within 1 mile of primary school and 2 miles of secondary school. In 2007, 28% of pupils who live in Leeds travelled to school by car compared to 56% nationally. Leeds has a lower than average cycling modal split percentage 0.41% compared to a 4% national average although we are in-line with the core cities average.. When pupils were asked to give a preference as to their preferred journey mode, nearly a quarter of pupils (23%) stated a desire to cycle to school
The ECM survey also covered nutrition, smoking, alcohol, drug use, and sexual health
- *Nutrition*. The results suggest that only a third of younger children (32%) are eating the recommended 5 portions of fruit and vegetables a day, and that the trend in older age groups is for this proportion to diminish (12% in Year 11). Conversely, the trend towards eating large quantities of high calorie, high sugar snack appears to increase in the older age groups, with nearly 40% of Year 11 students consuming 3 or more portions of snacks each day.
-Smoking. 12 % of Year 9 pupils and 22% of Year 11 pupils report regular smoking (note - It is difficult to draw a direct comparison with national data, since the wording of questions and methods of data collection vary.) A recent national survey carried out for the NHS Information Centre “Drug Use, Smoking and Drinking Among Young People in England in 2007” reported that the proportion of regular smokers was 15% among 15 year olds, hence suggesting that levels may potentially be somewhat higher in Leeds
- *Alcohol.* National data from “Drug Use, Smoking and Drinking Among Young People in England 2007” (NHS Information Centre) reports that 46% of 11 to 15 year olds have never drunk alcohol (an improvement from 39% in 2003). The results of the Leeds ECM Survey suggests that 50% of Year 5 pupils have never drunk alcohol, but that this proportion falls to 6% in Year 11. Although the results are not directly comparable, this could imply that the levels of drinking are somewhat higher in Leeds than the national findings. The ECM results indicate that over a third (36%) of Year 11 pupils are drinking regularly (at least once a week). A small but worrying percentage of children and young people report drinking on a daily basis from a very young age (1% in Year 5).
- Drug Use. The Leeds ECM Survey enquired whether young people had ever used illegal drugs or glues, gases and solvents as drugs. The self-reported levels of drug use in the survey suggest that the proportion rises from 11% in Year 9 to over a quarter of young people (28%) in Year 11. The National Survey “Drug Use, Smoking and Drinking Among Young People in England 2007” found that 25% of young people aged 11-15 years said they had tried drugs at least once. Recognising that the survey cover slightly different age groups, it seems likely that the level in Leeds may be similar to the national level.
- Sexual Health. The Survey enquired whether young people had ever had sexual intercourse. The responses indicated that proportion who replied positively increased from 20% in Year 9 to 47% in Year 11. In Year 9, slightly more girls than boys (52.7% girls: 47.3% boys) had had sexual intercourse, but by Year 11 this was approximately equal. Pupils were asked what forms of protection they had used on the last occasion when they had sexual intercourse. The table shows three quarters of Year 9 pupils, but only half of Year 11 pupils,

used a condom. A worrying 15% of Year 9 pupils and 20% of Year 11 pupils did not use any form of protection at all.

Other areas covered within Be Healthy include:
-Immunisation
The data shows that overall uptake rates for DTP have fluctuated, but in recent years have remained below the target level of 95% required to achieve 'herd immunity' (the level of immunity in a population which would prevent the spread of an epidemic), dropping to around 92% coverage in 2007. However, uptake levels for MMR are considerably lower, reaching around 80% in 2006 and 2007, which reflects some improvement over the previous years.

- Vulnerable children – including looked after children, gypsy and traveller children and asylum seeker children
-Local statistics suggest that Leeds had 1281 looked after children and young people in 2007/8, as well as 83 unaccompanied asylum seeking children. 251 of these looked after children (excluding asylum seekers) were from black and minority ethnic groups. This is a proportion of nearly 20%, which is an over-representation compared to the ethnicity of the child population of Leeds (14%).Leeds appears to be achieving lower levels of coverage of health needs assessments and dental check-ups than the region or England as a whole, and considerably poorer levels of immunisation coverage. It also suggests a slightly higher level of substance misuse problems in the looked after population, although this may reflect better recognition and response to problems, since Leeds also reports that 96% of these young people received an intervention for their substance misuse problem during the year, which is amongst the best practice in the country, and better than the performance for England as a whole (62%).
-The Gypsy and Traveller population has a higher proportion of children and young people than the Leeds population in general (44% of the Gypsy and Traveller population is under 17 years, compared to 20% for Leeds as a whole). The proportion of people aged over 60 in the Gypsy and Traveller population is dramatically lower than for Leeds in general, reflecting the lower life expectancy of this population group. The census report highlights that average life expectancy for Leeds in general is 78 years, but for Gypsies and Travellers is 50 years.
- Statistics for children in the Asylum system have to be obtained from various sources including the City Council & CART. In July 2008, of 2146 individuals who were seeking asylum, 493 were under 18 years old and a dependant of an adult claimant

7.3 Enjoy and achieve

This section details education achievement and attendance, play, exclusions and preventing offending. Overall this is a positive picture of how Leeds is improving
Primary - The expected level of achievement at KS2 is level 4. Outcomes have risen by 1% across all subjects in Leeds. This rise has been mirrored nationally and Leeds remains in line with national attainment except in science where Leeds remains 1 percentage point below the national figure. Leeds is in line with outcomes in comparative authorities for English, but 1 percentage point below for maths and 2 percentage points below for science. After a drop in attendance in primary schools in 2005/06, attendance rose in 2006/07. Attendance in Leeds primary schools is now at it's highest level and remains higher than national levels of attendance.
Secondary -Results for achievement at Key Stage 4 show that GCSE results in Leeds are at an all time high, with the percentage of pupils achieving 5 or more A*-C grades at 55.9%. This is 3.5 percentage points higher than the 2006 figure. Although Leeds' performance is still below the levels reached nationally and by comparative authorities, there is a clear indication of above average improvement. The gap between the Leeds and national figure has closed from 5 percentage points in 2005 to 4 percentage points in 2007.

Unlike in primary schools, attendance in Leeds secondary schools is below national and comparative authorities.

Over 70% of both primary and secondary pupils who responded to the Every Child Matters survey had visited a local play area or park in the last four weeks. Participation in the majority of activities is higher for primary than secondary age pupils, particularly swimming, sports clubs and after school or breakfast clubs.

Preventing offending **-L**eeds YOS has successfully reduced the number of new first time entrants into the criminal justice system by 11.8% from 2005/06 to 2006/07.
Exclusions From School -65 pupils were permanently excluded from maintained Leeds schools in 2006/07. The number of permanent exclusions in Leeds schools has fallen significantly in recent years. There has been a 61% reduction since 2003/04. This pattern of reducing exclusions is not matched nationally, where the percentage of pupils permanently excluded has not reduced significantly.

7.4 Achieving Economic wellbeing

Children and poverty -The data shows that 1/5th of all children in the city live in families where no-one is in work. In the "deprived area" over 40% of children live in workless households – double the city average
Information on young people Not in Education Employment or Training after Year 11(NEET) in 2006, was 8.2%, the same as in 2005..NEET for year 11 leavers is higher for young people resident in deprived areas, with the percentage NEET almost double the Leeds average for pupils eligible for free school meals. Pupils with Special Education Needs and Looked After Children also have higher levels of NEET after leaving school. Overall, pupils BME heritage had lower levels of NEET than the Leeds average in 2006. However, some ethnic groups have higher levels of NEET, particularly Traveller groups and Black Caribbean heritage.
For young people Aged 16-18 NEET the percentage fell from 10.4% in 2005/06 to 9.1% in 2006/07, this is lower than in statistical neighbours, but higher than national levels of NEET for this age group. In July 2006/07, 17% of 16-19 year old pupils with LDD were NEET in Leeds, compared to 19% in West Yorkshire

7.5. Consultation

Following the Joint Area Review a number of themes have been identified through engagement processes which impact on the health and wellbeing of children and young people. The main themes are: access to services for adolescent mental health and emotional wellbeing; child poverty; impact of domestic violence; substance misuse

8. Older people

The latest information from the Office for National Statistics shows that there are currently 110,700 people in Leeds who are aged 65+. This number is predicted to rise by almost 40% to 153,600 in 2031
Pension Credit provides financial help for people aged 60 and over whose income is below a certain level. The data shows that there are just over 34,500 pension credit claimants in the city (27.2% of the post-working age population) Even though the outer areas have higher proportions of older residents the Pension Credit claim rates in all five outer areas are lower than their inner area counterparts
At the time of the 2001 Census there were over 70,000 pensioner households (defined as females aged 60+ and males aged 65+) in Leeds of which just over 43,000 were older people living alone. The Census data shows that almost 24,000 people in Leeds aged 65

and over were living in households without central heating ;that there were just over 41,300 pensioner households without transport (59% of all pensioner households). Of the 43,312 pensioner households that were living alone just over three-quarters (32,956 households) were living alone without transport. At the time of the 2001 Census there were over 70,000 pensioner households (defined as females aged 60+ and males aged 65+) in Leeds of which just over 43,000 were older people living alone. The POPPI system has produced projections for the numbers of older people living alone by applying percentages from the 2004 General Household Survey to local population these are detailed in the pack

9. Adult social care

During 2007/08 there were 9101 people aged 18 or over who received a completed assessment. Of these, 7366 were elderly (aged 65 and over) and 1735 were adults aged 18-64. In around 70% of cases it was determined that the person was eligible to receive services either directly provided or else commissioned by the department through another agency.
There was significant variation in the number of people assessed based on which ward they were living in, with numbers varying between 89 in Headingley and 374 in Middleton Park
There was some variation between the various areas in reaching the target completion time. In most areas of Leeds around 78% of assessments were completed within 28 days. However, in the south this figure rose to 86%.

9.1 Service Provision.

At 31/3/08 there were 15,756 people aged 18 or over who were in receipt of services provided through the adult social care process. Of these 10,983 were elderly people aged 65 and over and the remainder (4,773) were adults aged 18-64.
Looking separately at elderly care users and those aged 18-64 there is a significant difference between where they are located. Of elderly community based service users around 23% are living in on of the 10% most deprived areas (which it should be remembered, comprise around 20% of the areas in Leeds). For people aged 18-64 the proportion is far higher, with around 30% of service users located in one of the 10% most deprived areas. This suggests a clear correlation between deprivation and need for those aged 18-64.

9.2 Speed of Service Provision

One of the key measurements by which adult social care departments are judged is the speed with which services, having been agreed upon, are subsequently provided. National Indicator NI 133 measures the percentage of new elderly (age 65+) service users receiving services within 28 days of the decision being made to provide such services. During 2007/08 85.3% of new elderly service users received their services within the required 28 days. This is deemed to be 'good' by the Commission for Social Care Inspection, to whom this information is reported. At ward level there were significant differences in the overall number of elderly people receiving services following assessment, varying from a low of 43 in Headingley up to 238 in Middleton Park. Insofar as the timeliness of service provision was concerned variation between wards was significantly greater than at an area level. In Gipton and Harehills 96.5% of people received their services within the designated 28 days compared to 77.0% in Rothwell. As with the direct payment figures these variations suggest that in order to improve performance the authority should be targeting particular areas.
Looking at service provision times by deprivation of the areas in which the person was living the best performance was in the 20% most deprived areas. This perhaps reflects that people living in such areas are often deemed to have the greatest level of need and are therefore responded to more quickly.

9.3 Carers

During the year 2007/08 2,984 carers of people aged 18 or over were offered some form of assessment or review. Of these, 2,300 went on to be offered a service to support them in their caring activities. In 1,005 instances this service took the form of providing a respite placement for the person being cared for, in order to give the carer a break from looking after them.

If one examines the numbers of carers offered a service as a percentage of the number of people living in an area who were in receipt of community based services then this varies from 21% & 19% in the south and west respectively, down to 16% in the north east and north west, suggesting that perhaps carers services should in future be slightly more targeted towards these areas.

Looking at carers receiving services split by deprivation it can be seen that of those carers who were offered a service 401 (17%) were caring for people living in areas deemed to be in the 10% most deprived areas of the country. This compares to the fact that among service users around 25% were living in such areas, suggesting that the authority ought perhaps to concentrate future efforts on encouraging carers for people living in such areas.

This section also details information on direct payments and people supported to live at home

10. Patient and Public Views

As part of the JSNA qualitative data was also analysed .Themes from Health have predominantly come from patient surveys and public perception surveys.

Key issues included: Commissioning of primary care services (in particular more NHS Dentistry and GP out of hours);the top conditions that people say are important are – Heart related diseases, Arthritis, Asthma and depression; people highlight the need for recruitment of more clinical staff (GPs and Nurses);the most important services for people are – Heart failure clinics and Child health services;the results from this years patient survey the PCT scored quite low on (In the last 12 months, have you been asked by someone at your GP practice/health centre about how much alcohol you drink).

Themes identified through the new Local Involvement Network Preparatory Group were existing priorities developed by the previous Patient and Public Involvement Forums.

Further work in future years will be necessary to secure the LINk's contribution in information the themes for the JSNA process.

The Previous PCT PPI Forum priorities were: access to out of hours and urgent healthcare. Patient Medication Reviews for Elderly Patients ;Oral Health; access to primary care services for deaf and hard of hearing people.

Four other themes have now been identified as current issues.

- Quality in maternity services particularly following the healthcare commission survey for 2007/08
- Discharge from hospital is an ongoing issue for many people, in particular, lack of care packages being in place and lack of communication between organisations
- Accessible information for people with literacy problems
- Access to services and information for vulnerable groups and BME communities

10.1 Voluntary, Community and Faith Sector

Some emerging themes coming from the VCFS have been developed by a sub group of the Leeds Voice Health Forum.

This has been based on the current collated research done across Leeds highlighting a few key areas. This will be developed to give a more comprehensive picture.

- Accessible information on health came out strongly as important to a number of groups including ensuring information is in formats that are easy to read, in appropriate languages and readily available.
- Mental health and support for people and communities suffering from emotional distress was highlighted in a number of areas.
- The quality and attitude of health service staff was highlighted including the need for services to be culturally 'competent'.
- Transport to and from health services was seen as a big issue.

10.2 Leeds Strategic Plan

Finally the themes developed from consultation on the Leeds Strategic Plan focussing on health and wellbeing were taken into account. These were broad ranging and covered all areas of the city and communities of interest.
The top priorities following the outcome of the consultation were:

- Priority 27 – Reduce obesity and raise physical activity for all
- Priority 29 – Promote emotional well-being for all
- Priority 32 – Increase the proportion of vulnerable adults helped to live at home.

It was identified that further work needs to be identified to support a couple of key areas which were not highlighted in the plan's priorities.

- The need for more priorities that promote healthy lifestyles
- The need for more recognition and support for people with mental health issues

11. Emerging questions and themes/analysis

The data pack paints a picture of Leeds as one of two cities with part of the city moving up in terms of economic; social ; and health outcomes whilst a core part (the size of a small town|) experiencing the opposite outcomes. This area (known in the pack as 'deprived Leeds) experiencing outcomes as bad if not worse than those areas identified by the Department of Health as most 'deprived' within England.
Many of the issues addressed in the pack are problems of lifestyle, behaviour, education economic and social circumstances. The emerging themes coming from the scoring exercise demonstrated this.
Influences on health and well being - poverty/low income; housing; education and unemployment- also the economic wellbeing of children
Conditions of ill health – circulatory disease; cancer;
Lifestyle issues - healthy life; alcohol, obesity
One of the key issues is the impact of the changing population which is described in the pack, and also the intra Leeds issues of deprivation, vulnerable groups and broader community well being.

12. Commissioning impact and improved outcomes

The data pack details the underlying scale of the problem but would need to be considered in line with effective interventions, and cost effectiveness intelligence.
The data could lead to two approaches for joint commissioning across the city. Both of which would form part of the new joint commissioning structures.
The first would be within the realm of the priority groups, children and older peoples commissioning groups where joint priorities of those most in need can be agreed and the effective interventions can be identified.
The second is based on a neighbourhood approach to intelligent commissioning. The PCT and LCC have already agreed a focus on the 10% worst SOAs within Leeds. This provides the ideal opportunity to agree neighbourhood plans for meeting the identified needs. A range of the data can be compiled at a neighbourhood level (as per the example with the data

pack). From this data a joint approach to key deliverables and outcomes within each of these neighbourhoods can be agreed.