



Leeds North Clinical Commissioning Group



Leeds South and East Clinical Commissioning Group



Leeds West Clinical Commissioning Group

The Clinical Commissioning Groups perspective on reducing inequalities in Leeds: the contribution of the NHS.

An interim report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

The Clinical Commissioning Groups perspective on reducing inequalities in Leeds: the contribution of the NHS.

1. The three Clinical Commissioning Groups (CCGs), Leeds North, Leeds South & East and Leeds West endorse the principle of the Marmot Review (Fair Society Health Lives) that inequalities are a matter of life and death, of health and sickness and of well-being and misery. Because of the unique relationship of their member practices with the people of Leeds, the CCGs are very aware that people in different social circumstances experience avoidable differences in health, well-being and length of life, that is, quite simply, unfair.
2. They understand that creating a fairer society is fundamental to improving the health of the whole population and ensuring a fairer distribution of good health and that inequalities in health arise because of inequalities in society – especially in the conditions in which people are born, grow, live, work, and age. Consequently the CCGs recognise the opportunity of a “life course” approach to reducing health inequalities. They are aware that the magnitude of health inequalities is a good marker of progress towards creating a fairer society. The CCGs fully understand that taking action to reduce inequalities in health requires action across the whole of society.
3. Equally the CCGs realise that in commissioning NHS services they have a duty to reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services as outlined in the Health and Social Care Act 2012. They recognise that NHS commissioning plans must be influenced by the Joint Strategic Needs Assessment. The CCGs also recognise the need to be engaged in the development of the Joint Health and Wellbeing Strategy, and wish to be actively involved in the Health and Wellbeing Board (including monitoring progress).
4. The CCGs are clear they have a lead role to play in reducing health inequalities in terms of preventing people from dying prematurely whilst reducing the gap between communities as well as supporting people to live healthy lifestyles and make healthy choices. Equally The CCGs recognise the lead role of Leeds City Council in the wider determinants of health and wellbeing and a need to work with partners to deliver improvements against the wider factors that affect health and wellbeing and health inequalities. The CCGs therefore fully endorse and recognise the contribution to the Leeds City Priority Plan 2011/15, in particular the priority under Health and Wellbeing - to make sure the people who are the poorest improve their health the fastest.
5. The diagram below illustrates the balance between *lead roles* but recognises there are legitimate roles for the NHS and City Council at either end of the spectrum. The CCGs also recognise the need to engage patients, people, their communities, providers of NHS care, as well as the Voluntary, Community and Faith sector and others such as police, businesses and schools.

Diving Deeper: Killers Today ... and Tomorrow

NHS Responsibility		City Council Responsibility
What kills people now and what makes them ill	Behaviours that are going to kill people and make them ill	Wider determinants of health
Cardiovascular disease Cancer Excess winter deaths Long-term conditions Alcohol / drug related issues Mental health problems	Smoking Alcohol / drug consumption Inactivity Being overweight / obese Vascular risk Lack of awareness of early symptoms Not using screening services	Educational attainment Income Employment Decent housing Community support networks Safe communities Language

- The CCGs are shaping their action plans as part of their authorisation process and this is necessarily a developmental process. The approach will involve commissioning at a micro and macro level. This is best illustrated by the approach to commissioning mental health services. It will involve the proactive, systematic management of common mental health problems in primary care targeting those communities most in need with good partnership working within communities (micro level), plus at macro-level investment/disinvestment in effective specialist mental health services informed by population need, ensuring good access for those populations with high levels of poor mental health.
- The range of actions the CCGs will be considering as part of the NHS contribution to reducing inequalities include:

What kills people and makes them ill	Behaviours that are going to kill people and make them ill	Wider determinants of Health
Ensuring: 1. Systematic primary care management <ul style="list-style-type: none"> • Risk stratification of practice population health needs • Integration of Health and Social Care services • Self management enabling people to understand and manage their own health needs 2. Equitable access to specialist services	1. Risk stratification of practice population health needs 2. Systematic approach to behaviour change in primary care 3. Equitable access to specialist services eg smoking cessation, 4. weight management and drugs and alcohol 5. Engage with cancer awareness and early intervention programmes 6. Implementation of NHS Health Check	1. Systematic signposting to services eg debt management, fuel poverty, housing etc 2. Supporting Safeguarding 3. Supporting partnership working 4. Advocacy

Reducing Inequalities: contribution of the NHS 4/4/12

8. These and other interventions will contribute to the NHS and Public Health Outcome frameworks key priorities. In addition the CCGs recognise there is national work to develop a child health outcomes framework and will ensure appropriate NHS action once the framework is published.

(a) Preventing people dying prematurely (NHS and Public Health outcome)

Objective – reduce numbers of people living with preventable ill health and people dying prematurely while reducing the gap between communities. (*This outcome is to be led by the NHS and is a main role for CCGs*)

(b) Health Improvement (Public Health outcome)

Objective – people are helped to live healthy lifestyles, make healthy choices and reduce health inequalities. This outcome is to be led by the Local Authority but CCGs have a key role in ensuring their services are commissioned effectively in relation to their clinical value, and impact on the outcome above. Practices also have a key role in delivering a number of these services and motivating/supporting people to change their lifestyle. (This joint working will be through the Health Improvement Board.)

(c) Improving the wider determinants of health (Public Health outcome)

Objective – improvements against the wider factors that affect health and wellbeing and health inequalities. This outcome will be led by Local Authority with wider partners such as the police, schools, businesses, third sector etc. However the CCGs and its practices have a role in contributing to the headline health inequalities indicators in City Priority Plan i.e. “reduce the differences in life expectancy between communities” and “reduce the difference in unhealthy life expectancy between communities, particularly in terms of signposting and working in partnership with the local agencies within their populations. (This will be a key factor for the CCGs Stakeholder Engagement strategies).

Key local issues

9. The key issues related to each CCGs population are shown at Appendix A. The CCGs recognise that city wide coordination is vital in delivering reduction of inequalities but are aware that this can also present a risk of diluting the necessary focus on key segments of the local populations. CCGs will therefore be taking great care to balance commissioning at a local level with the city wide responses required to deliver this agenda. This will necessarily involve working with local partners including local Councillors, Area Committees, Area Partnerships, the Third Sector, Schools and statutory bodies such as the police.

Conclusion

10. This approach to addressing health inequalities builds upon current practice and learning in Leeds. The approach is developed within the new political and organisational context of CCG development and new responsibilities for health and wellbeing for Leeds City Council. Local action plans will be developed for each CCG, together with local partners. This approach will be developed and supported as part of the ‘core offer’ of Healthcare Public Health Advice to CCGs within the new public health arrangements.

Reducing Inequalities: contribution of the NHS 4/4/12

References

<http://www.publications.parliament.uk/pa/cm201011/cmbills/132/11132.24-30.html#j036a> accessed 28 March 2012

<http://www.instituteoftheequity.org/projects/fair-society-healthy-lives-the-marmot-review> accessed 28 March 2012

Headlines on health needs for Leeds North CCG population

Gap in life expectancy – is not narrowing

For Leeds North CCG this gap is 9.5 years – however for males there is a 13.3 years. The highest mortality rate is in Seacroft North (which is the second highest in the city, and the lowest mortality rate is in Wetherby West.

Just over a fifth of the population of Leeds North CCG live in the most deprived quintile of Leeds

Impact of population increase – for example 55% increase in over 75s; 25% rise in birth rate in the last 10 years – impact for health and social care especially when combined with wider factors that influence health - increasing numbers of older people living on their own; impact of fuel poverty etc

Different communities – Citywide 18% of the population are from BME communities. For Leeds North CCG - from Origins date 78% of the population is made up of British origin, (slightly lower than the Leeds average). The origin group that is higher than Leeds average is from South Asia

Key health and well being issues:

Specific conditions:

Overall premature mortality rates decreasing but gap between Leeds and Leeds deprived for long term conditions not closing and in some cases increasing. The highest number of mortality in the population is due to ischemic heart disease, then cerebrovascular disease and then respiratory .Across the CCG population age standardised rates for CHD, Cancer and diabetes are near to the Leeds average with rates for COPD being below that for Leeds. However there is great variation within the CCG which will be seen in the practice profiles .COPD, CHD and diabetes rates are rising higher than the Leeds average, Cancer rates are rising slower than the Leeds average

Behaviours

Smoking and obesity are rising slower – with recorded smoking rates even decreasing

Wider factors that influence health – increasing fuel poverty and social isolation

Service utilisation

Example - Emergency admission follow a similar pattern of increase (except for the 16 – 65 year olds for Leeds – but are below the Leeds average, compared to outpatient first attendance which are above the Leeds average- except for children which is similar. Future work will consider the pattern of different service usage in relation to population need.

Headlines on Health Needs for Leeds West CCG Population

1. Life expectancy gap
 - Within the population of Leeds West CCG, there are communities with some of the lowest average life expectancy rates in Leeds. For example, out of 108 MSOA in the city, Armley and New Wortley has the 2nd lowest life expectancy within the city for men – 70.8 years.
 - The differences in life expectancy within the LWCCG population are wide, e.g. the gap in male life expectancy is 13.3 years (based on MSOA level data).
 - 23% of the LWCCG's population are within the "Hard pressed" category (ACORN profile)
2. The distribution of need is scattered across the population of LWCCG, and is best captured through data on a smaller geography. The levels of health need within these areas are amongst the greatest within the city. Data on a whole CCG level often masks this variation of need when combined with the rest of the CCG population.
3. As well as inequalities in health between geographical communities within the LWCCG population, there are also communities with specific need eg offenders, students and gypsies and travellers
4. The prevalence of some Long Term Conditions (specifically COPD, CHD and diabetes) within the whole population of LWCCG is lower than the Leeds average. However, more local data contained within the MSOA profiles shows higher rates of Long Term Conditions in some communities eg Farnley, Broadleas, Ganners, Sandfords. Other areas within the LWCCG population reflect very different needs e.g. in Hawksworth Village, Tranmere Park numbers of Adult Social Care Referrals are relatively high.
5. The LWCCG health profile is informed by the emerging local health profiles as part of the JSNA process. The Leeds JSNA includes a wider range of data and shows, for example, higher rates of mental health problems and substance use within Inner West Leeds.
6. There are significant differences in healthy lifestyle behaviours relating to health, which are predominantly linked to levels of deprivation. For example, within the areas of Bramley Hill Top, Raynville and Wyther Park all rates for smoking, obesity and alcohol admissions are above Leeds average.
7. Within the LWCCG population, higher levels of health need is closely associated wider factors affecting health eg poor health outcomes, low income and low educational attainment are often inter-related, for example in Armley and New Wortley.

Headlines on health needs for Leeds South and East CCG population

Health Needs Assessment

Know Your Numbers

258,436 Patients

50 % Male

44 Practices

40 % Population considered living in "Hard-Pressed" conditions

9.5 Years Difference Between Highest and Lowest Life Expectancy

81 % of LS&E Black African population live in deprived Leeds

Health Needs Assessment

Population Health

Leeds S&E Utilisation and Prevalence Rates Compared with Leeds

A&E Attendances



Obesity



Outpatient First Attendances



Smoking



Inpatient Emergency Admissions

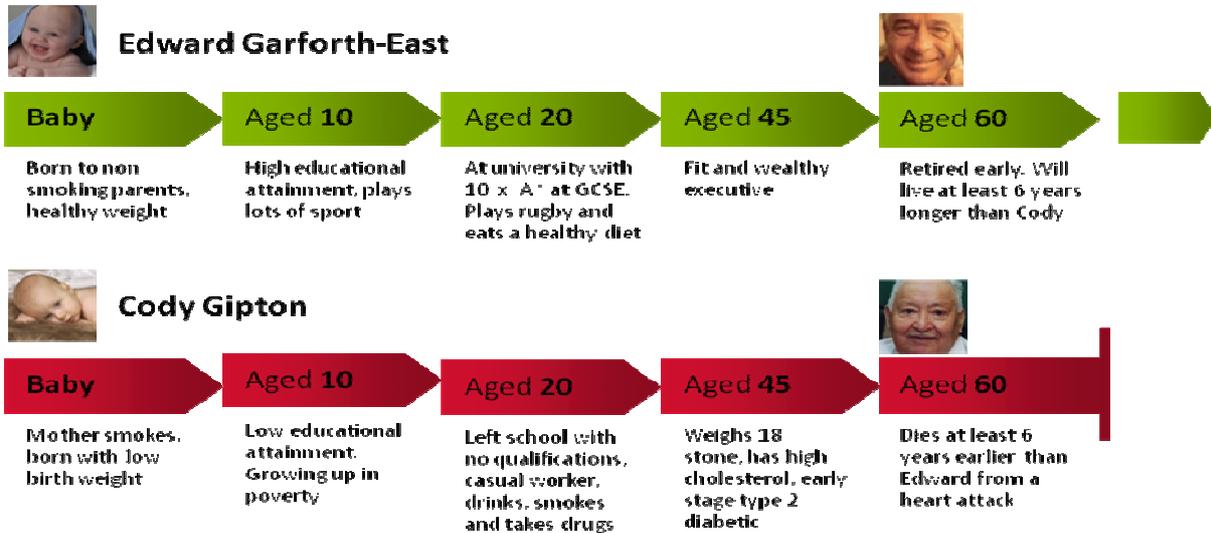


Chronic Diseases *



* Includes Diabetes, CHD, and COPD

Diving Deeper: Health Inequalities



6.3 miles apart

Major Conclusions

Insights	Implications
<ul style="list-style-type: none"> • Health inequalities are at levels inexcusable in this day and age with the expertise and knowledge we have in our health system • Our patients are in much poorer health compared with the rest of Leeds and this will only worsen with the aging population and rising incidence of lifestyle and chronic diseases • City wide coordination is vital but can present a risk of diluting the necessary focus on key segments of the Leeds S&E population • Blurred division of accountability between the NHS and Local Council creates sub-optimal outcomes 	<ul style="list-style-type: none"> • Addressing health inequalities is central to our identity as a champion for health and as the voice of the population • Embracing prevention and empowering patients to better manage their own health is necessary to achieve financially sustainable health economy • We need better, more integrated coordination of primary, secondary, social and preventive care for patients at home (or as close to home as possible) and at general practices • Continue to invest in capabilities that will enable our transformation from a reactive to proactive mode of managing the health economy