Implementing the Leeds Joint Strategic Needs Assessment Framework

Document Status DRAFT

Document Author		**Date**	18th February 2009
Status	Final Draft	**Current Version**	3.7
First Issued	13 October 2008	**Issued Version**	

Acknowledgements

We would like to express our thanks to the many colleagues in NHS Leeds; Leeds City Council and the voluntary sector who assisted the core programme team, operational group and project groups in the preparation and process for the development of the Leeds JSNA by sharing their information, collecting and obtaining data and contributing their expertise.

In particular our thanks go to Allison Beal Programme Manager, Charles Cross, Mark Edmonds and Tony Long (Department of Health); The members of the Programme Board and other colleagues of the Operational Group who steered the process throughout; John England , Jane Stagemen, Jacky Pruckner, Mike Simpkin, Simon Hodgeson, Stuart Cameron Strickland, John Maynard (Leeds City Council); Jill Copeland, Sharon Yellin, Lucy Jackson , Janice Burberry, Alastair Cartwright, Alison Straughan, Nichola Stephens, Paul Sandon, Richard Dixon, Chris Cooper, Brian Smith and Frank Wood (NHS Leeds).

Table of Contents

1. Foreword

Health and Social Care in Leeds faces considerable challenges over coming years as the city continues to grow.

With a predicted increase in the population, a rise in the number of older people and an increasingly diverse community, so there will be changing and expanding demands placed upon the health and social care system.

It is essential that we are able to respond to meet these challenges whilst ensuring the highest possible standards of service provision are maintained.

To assist, we must understand the type of care and the level of need we need to cater for both now and in the future. Such information is crucial in making decisions around commissioning and shaping future health and social care services.

The new requirement to prepare a Joint Strategic Needs Assessment (JSNA) for Leeds is seen as an important step in helping us to make these difficult commissioning decisions, and is a process that is fully supported by the City Council and NHS Leeds.

Both organisations have been working closely together with partners (including voluntary and community agencies) to 'pool' wide ranging information and data that provides a comprehensive picture of the health and wellbeing needs across Leeds and the issues that we will need to tackle over coming years.

Leeds has a good reputation for joint working, and the Leeds Initiative partnership has set out a challenging "Vision for Leeds". Health and wellbeing is an important part of that work and the JSNA helps provide clarity around the direction we should be taking if we are to fulfil the ambitions set for the city.

This process is not a one-off, and we will continue to work closely together to ensure this valuable work is embedded into the way we do business.

Ultimately, we hope that the findings of the Joint Strategic Needs Assessment will stimulate and guide both our organisations and our partners to work together to improve the health, well-being and independence of the community of Leeds.

We would be pleased to hear your views on either the approach we have taken to JSNA in Leeds or to this document.

Dr Ian Cameron
Director of Public Health
NHS Leeds

Sandie Keene
Director of Adult Social Services
Leeds City Council

Rosemary Archer
Director of Children's Services
Leeds City Council

2. Executive Summary

JSNA - What is it?

Leeds City Council and NHS Leeds have a new statutory duty to produce a Joint Strategic Needs Assessment (JSNA) that identifies the currently unmet and future health, social care and wellbeing needs of the local population.

The legislation intends that the JSNA will inform the plans, targets, priorities and actions necessary in reducing identified inequalities and achieving the desired health and wellbeing outcomes for Leeds.

Core to JSNA is a data pack that provides a comprehensive profile of Leeds across a number of areas crucial to the health and wellbeing of the population:

- Demography
- Socio-economic and environmental factors
- Lifestyle (particularly 'healthy living') issues
- Ill heath
- Health and Social care service provision

To complement the analysis we have drawn upon a richness of 'softer' information provided by the public, patients, service users and carers.

What have we learnt?

So what has the first JSNA process told us? It has confirmed that the priorities identified in the Leeds Strategic Plan (2008-11) and NHS Leeds's Strategy are the right priorities to be tackled at the present time. They include:

- Narrowing the gap in 'all age all cause' mortality between the average for Leeds and for people living in the more deprived areas of the city
- Addressing the increasing incidence of circulatory diseases and strokes
- Tackling obesity and raising levels of activity across all ages, but particularly the young
- Improving sexual health and reducing rates of teenage conception
- Improving mental health and emotional wellbeing
- Improving the quality and responsiveness of services that provide care and support for people
- Improving the safeguarding of children and adults

However, the analysis has also raised the need for further work in new areas, for example:

- Responding to the needs of an ageing population who are living much longer
- Ensuring that tomorrow's children and young people are healthier – unhealthy children of today will become the unhealthy adults of tomorrow
- Tackling the present Infant mortality rates which are significantly higher than the national rate. The rate in some areas demonstrates particular issues in some communities

- A need to counteract potential widening inequalities between neighbourhoods
- A continuing focus on specific health and wellbeing challenges around obesity, alcohol, drug taking and smoking.

The full data pack can be found on the websites for NHS Leeds and Leeds Initiative (www.leeds.nhs.uk; www.leedsinitiative.org) A more detailed summary of the data is included within this report

How are we going to respond? - sustaining the JSNA process

The Commissioners from both organisations identified a number of areas for future enhancement, which are included as part of the JSNA Action Plan (attached as Appendix C):

- Greater disaggregation by localities and communities of interest, linked to an ability to benchmark data across those areas
- More developed information on cost analysis and value for money
- An integration of wider social indicators with the health data
- Enhanced information on projections and trajectories to better inform longer term commissioning decisions
- 'Up to date information for commissioning to be refreshed on an ongoing basis and providing relevant information, when it is needed, which could be readily accessed by city partners

Further work is planned with Commissioners to refine thinking about useful additional data and plan for a 'refresh' of information to ensure that the JSNA information adds maximum value to future commissioning decisions.

Next steps

This first JSNA required and benefited from close working across Leeds City Council and NHS Leeds with partners. Looking ahead it is clear that this process must be more fully embedded into the existing partnership governance arrangements and better aligned with emerging planning and commissioning cycles.

Some of the key actions over the year ahead will be to:

- Embed the governance of and responsibility for JSNA into wider partnership arrangements
- Extend locality profiling to enable data to be used to build a comprehensive picture across specific local areas of Leeds
- Populate data gaps where identified, including specifically strengthening the evidence base across all equalities strands and the specific population groups set out in the previous section
- Develop and implement a shared data repository approach to ensure information is maintained and accessible

- Ensure all future qualitative information is integral to the arrangements and, like the core dataset, is readily accessible, by developing central database arrangements
- Develop longer term projections for a wider range of communities of interest, localities and city wide targets
- Develop a partnership with higher education to address identified needs in relation to further research and predictive modelling and analytical techniques
- Explore how the JSNA can be extended to support all strategic outcomes in the eight themes of the Leeds Strategic Plan 2008-11

3. Introduction

Joint Strategic Needs Assessment is a process by which the local authority and primary care trust understand the currently unmet and future health, social care and well being needs of the local population.

Understanding the current position, trends and projections will support future planning, commissioning and delivery of services. The JSNA is not a strategy or commissioning plan but should be used to inform their development, together with other commissioning intentions, the Local Area Agreement (LAA) and the Sustainable Communities Strategy (in Leeds described as the Vision for Leeds 2004-2020).

The duty to undertake a Joint Strategic Needs Assessment is set out in Section 116 of the Local Government and Public Involvement in Health Act (2007). This annual duty commenced in April 2008.

Leeds has a strong reputation for joint working, and both NHS Leeds and the City Council view the new requirements as enhancing the needs assessment work that has already been undertaken.

Core to the new arrangements has been the collation of a range of data required under JSNA, providing comprehensive information on health and wellbeing in Leeds.

A separate compendium is available that contains the complete dataset. This document, Leeds' first JSNA report, summarises the information drawing out the key characteristics for Leeds and poses a number of important questions around future priorities for the city.

This report also sets out how the JSNA arrangements will be embedded and aligned with planning and commissioning arrangements, how increasingly the data will be used to profile specific localities across Leeds, and finally how the process will extend beyond the current JSNA focus on health and wellbeing, supporting the work of all the main partner activity across Leeds, under the umbrella of the *Leeds Initiative*. This is the city's strategic partnership group that, under the leadership of the city council, brings together the public, private, community and voluntary stakeholders of Leeds.

But that is for the future. The aims of the first JSNA in Leeds have been to:

- Describe the JSNA process within Leeds;
- Provide a profile of health and well being for Leeds;
- Draw out some of the key themes emerging from the data and how these align with existing priorities;
- Set out a how the JSNA should become more integrated into a sustainable process that is aligned to the commissioning and planning frameworks within the city; and
- Include a clear plan of action for the short, medium and longer term.

4. The JSNA Process

Context

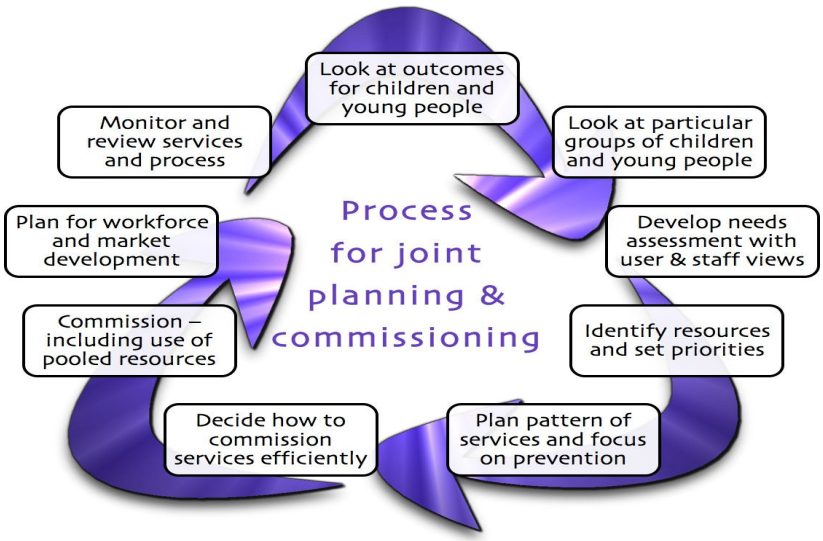
The new statutory requirement for a Joint Strategic Needs Assessment (JSNA) was first introduced in the Department of Health's *Commissioning framework for health and well-being*, published in March 2007. The JSNA is expected to "describe the future health, care and well-being needs of local populations and the strategic direction of service delivery to help meet those needs".

At the heart of the JSNA process is the need to gather data that covers a range of areas crucial to understanding the health and wellbeing of the local population [Appendix A to this document sets out the core Dataset required under JSNA, where the specific data is held and can be accessed].

Analysis of the information highlights areas of current and future needs of the population and will help the relevant health and social care organisations to reflect on existing priorities and how both the commissioning and delivery of services might need to change to meet these wider health and wellbeing ambitions.

Commissioning as a way of working encourages public sector organisations to develop a more structured approach to identifying needs, setting and reviewing priorities and deciding the best way to meet and allocate resources.

The Diagram below depicts a nine step cycle of joint planning and commissioning. This is a universal process, developed for children and young people, but which is understood by health, education and social care sectors – an important first step in creating a common language and understanding of commissioning as a dynamic process.



The cycle depicts commissioning as a continuous process designed to drive improvement. While the JSNA supports the whole commissioning cycle, it has a key role to play in four particular elements: strategic needs assessment; planning and service design, deciding how to deliver and with whom, reviewing and monitoring outcomes.

The JSNA Process in Leeds

The identified benefits for JSNA in Leeds

NHS Leeds and the City Council recognise clear benefits of co-developing the JSNA that will build upon joint working already underway in Leeds. Those benefits include:

- Improved partnership working
- Greater engagement by organisations representing the public in the JSNA process
- More effective processes for data collection and analysis
- Improved planning and decision making
- Agreed joint commissioning priorities for Leeds
- Agreed approaches for tackling inequalities

The focus on the health and wellbeing needs of the population builds on analysis already undertaken to inform the needs assessment in other statutory plans. Most notable are the recently published Children and Young Persons Plan, the Joint Strategic Assessment – Safer Leeds, the 2008 Annual Report of the Director of Public Health Report and Measuring the Gap: Tackling Health Inequalities (Healthy Leeds/Yorkshire Public Health Observatory) report which contains extensive assessments of need.

Fundamental to delivery of this first JSNA process has been partnership working, achieved through the leadership of the Director of Adult Social Services (Leeds City Council), the Director of Public Health (NHS Leeds) and the Director of Children's Services (Leeds City Council).

This joint team has guided the development of Leeds first JSNA supported by specific work streams that:

- Collected the core data set required under JSNA and led the analysis that identified the emerging themes
- Examined how the process could be embedded and the planning and commissioning cycles across the City Council and NHS Leeds better aligned for the future
- Engaged stakeholders as part of the process building upon important work conducted for the Vision for Leeds, the Leeds Strategic Plan and its Local Area Agreement.

Building Upon Current Health and Wellbeing Priorities

Although the duty to prepare a JSNA is new, there is a strong history of partnership working across the city's main stakeholder organisations. The Leeds Initiative is the city's strategic partnership group, founded in 1990, which brings together key

stakeholders in the public, private, community and voluntary sectors and sets out a long-term vision and a set of priorities for the development of the city.

The *'Vision for Leeds'* recognises that health and wellbeing inequalities exist and propose a challenging agenda to 'narrow the gap'. The articulation of these ambitions is embodied in the Leeds Local Area Agreement (LAA), a three year agreement (2008-2011) between central government and the local area (Leeds City Council and the partnership) that sets out priority areas for improvement, and is underpinned with a range of clear targets and milestones [see the text box below].

The strategic plans and commissioning arrangements for NHS Leeds and Leeds City Council therefore reflect both the priorities agreed across the partnership and nationally with Government as well as other local service specific priorities. This work will increasingly be refreshed and informed by JSNA.

The Leeds City LAA Health and Wellbeing Priorities:

1. Reduce premature mortality in the most deprived areas
2. Reduce the number of people who smoke
3. Reduce the rate of increase in obesity and raise physical activity for all
4. Reduce teenage conception and improve sexual health
5. Improve the assessment and care management of children, families and vulnerable adults
6. Improve psychological, mental health, and learning disability services for those who need them
7. Increase the number of vulnerable people helped to live at home
8. Increase the proportion of people in receipt of community services enjoying choice and control over their daily lives
9. Improve safeguarding arrangements for vulnerable children and adults through better information, recognition and response to risk

Public and Stakeholder Engagement in JSNA

It is essential that a wide range of stakeholders, including communities, are involved in JSNA. In Leeds, public and stakeholder engagement has been in four main areas:

1. **Utilising existing mechanisms** was important to this first JSNA as both NHS Leeds and Leeds City Council engage regularly with communities, and have a richness of information from which to draw. For the first time an overview of all the related consultation and engagement activity taking place across the city has been produced which summarises the key messages from public, patient, service user and carer feedback. The key sources for this information include :

   - Development of the Leeds Strategic Plan and Local Area Agreement (LAA), which was published in July 2008 and followed extensive consultation with stakeholders
   - Leeds City Council development and use of a quarterly citizens panel

- Development of numerous voluntary sector forums and involvement projects including Leeds Voice Health Forum, Volition, Leeds Involvement Project, Voluntary Action Leeds, Healthy Living Networks/Centres
- Various patient and service user groups linked to specific work streams within health and local authority services
- Community and patient surveys including the annual NHS Leeds patient survey, GPAQ GP practice patient surveys, the residents and place surveys undertaken by LCC and the annual public perception survey undertaken by NHS Yorkshire and Humber.

Additionally, elected members of the City Council were invited to contribute to JSNA. The report and particularly the findings were discussed with members of three scrutiny boards, whose views have shaped its development and the setting of consequent priorities.

2. A well attended JSNA Stakeholder Event in April 2008 included many colleagues from across the City Council, NHS Leeds, Leeds Voice Health Forum, Leeds LINk Preparatory Group and LCC Children's services unit working in partnership to explore methods of collating qualitative information and developing sustainable processes for working in the future.

The event highlighted a number of population groups where it was felt that health and social care organisations needed to continue to strengthen available data as a means of better understanding need. These included:-

- Asylum Seekers and newly arrived communities
- Black and Minority Ethnic Groups
- People with Learning Disabilities
- People with problems associated with Mental Health
- Offenders and Prisoners
- People with Physical disabilities
- Vulnerable Children and Older People

Subsequent workshops have built further upon the views shared at that initial event and built these into the JSNA process and outcomes. Community representatives have been engaged in workshops and the Leeds LINk preparatory group nominated representatives to join the stakeholder work stream. For voluntary sector engagement, Leeds Voice health forum established a working sub group to support the process and nominated representatives also attended the main working group to feed any relevant issues into the process.

3.. **A Survey of Commissioners** was conducted from across Health and the City Council to better understand their views of JSNA, the gaps in information that may exist and how they will use the data to inform future commissioning decisions.

There were a number of positives, with Commissioners believing that JSNA

- Was an important starting point, providing robust citywide information to support commissioning
- Particularly helpful in identifying service development gaps
- Provided useful consolidated information regarding health outcomes for particular groups and diseases
- Would enable practice based commissioning consortia and other locality based structures to better understand the detailed needs of their local population

The Commissioners also identified a number of areas for future enhancement that have formed an important part of the JSNA Action Plan (attached as Appendix C). In summary this has included:

- Greater disaggregation by localities and communities of interest, linked to an ability to benchmark data across those areas
- More developed information on cost analysis and value for money
- An integration of wider social indicators with the health data
- Enhanced information on projections and trajectories to better inform longer term commissioning decisions
- 'Up to date information– to be refreshed on an ongoing basis and providing relevant information, when it is needed, which could be readily accessed by city partners

Further work is planned with Commissioners to refine thinking about useful additional data and plan for a 'refresh' of information to ensure that the JSNA information adds maximum value to future commissioning decisions.

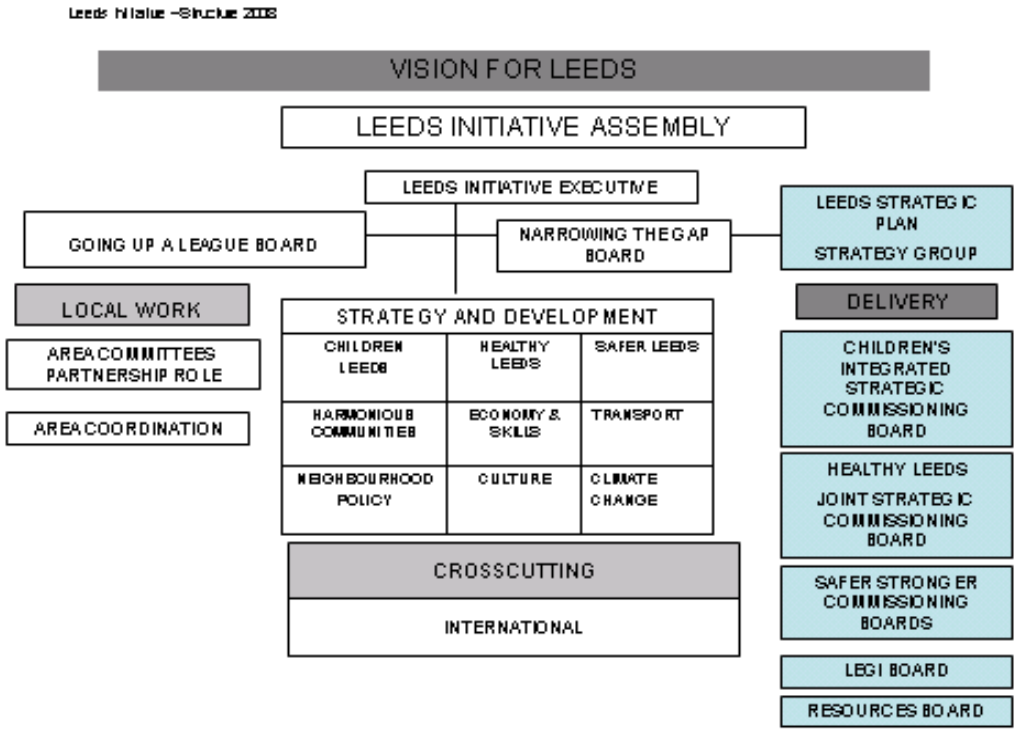
4. How the JSNA will inform commissioning in Leeds

Who are the commissioners in Leeds?

The different stages of commissioning in Leeds take place through a number of related forums. These include arrangements at individual statutory organisations (including Practice Based Commissioners), at strategic, operational, locality and individual levels, and through joint partnership bodies, including the Healthy Leeds Joint Strategic Commissioning Board, Children Leeds Integrated Strategic Commissioning Board and the Safer Leeds Commissioning Board.

The JSNA for Leeds supports these teams to develop more effective systems for data collection and analysis, improve their planning and decision making processes and agree joint commissioning priorities for the city. Diagram 2 summarises the partnership governance arrangements in the city:

Diagram 2 – Leeds Initiative: Partnership Governance



5. A Profile of Leeds

The summary below is based on the more detailed information and analysis within the Leeds JSNA data pack available on both NHS Leeds and Leeds Initiative Websites

Context

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.

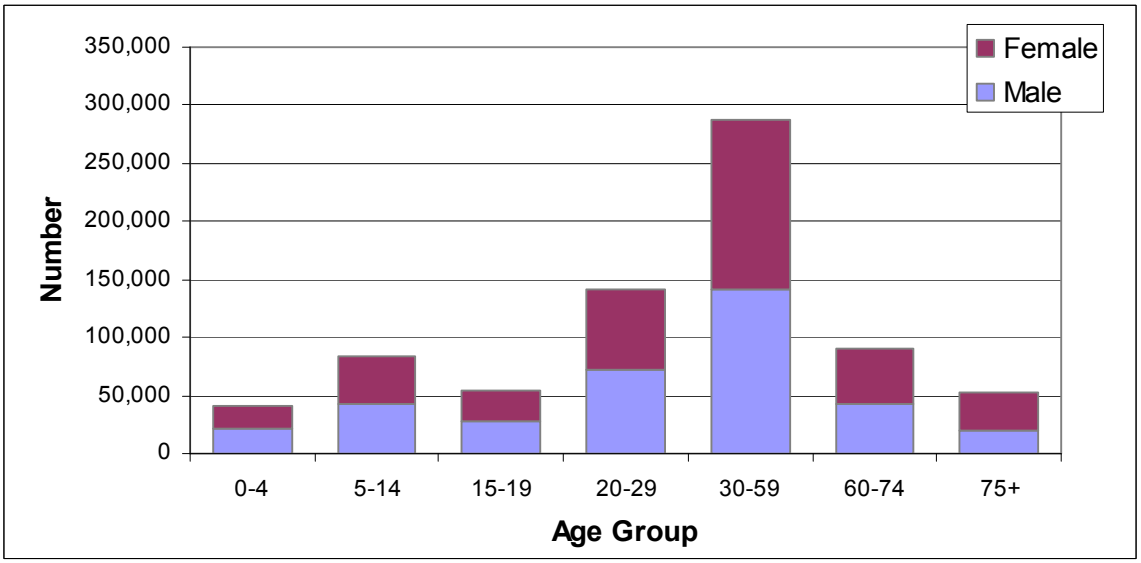
Despite the success of the city as a whole there are still unacceptably wide gaps between those areas that are wealthy and thriving and those that suffer high levels of multiple deprivation, which the city and it's partners are committed to tackling through the "narrowing the gap" agenda.

Demography

The latest available data (2006) estimates the population of Leeds to be 750,200, an increase of 4.9% since 2001.

The table below sets out the age profile for Leeds. Approximately 80% of the population are under 60 years of age with 24% aged below 20 years of age. Nearly 15% of people are over the age of retirement, which is slightly below both national and local averages.

Table 4 : Population by Age Group and Gender



Leeds has a significantly higher proportion of 15-29 year olds (26% compared to a national average approaching 20%), including a significant student population with more than 60,000 students studying in the two universities in the city. This contributes to Leeds having a particularly *transient population* with students, many of whom will live and study in the area during term time, moving away during the holiday periods.

Leeds is a culturally diverse population. In mid 2006 ONS estimated that 15.1% of the total resident population comprised people from *Black and Minority Ethnic Communities* (including the Irish and other white populations). The 2006 BME population for England was estimated at 15.8%.

Socio-Economic Context

Deprivation

The Government produced Indices of Deprivation provide a detailed analysis of the range and extent of deprivation across England.

Although Leeds as a whole is ranked as 85th most deprived area (on one of the district measures), 95 out of the 476 small areas in the city that are used to calculate these statistics are ranked in the most deprived 10% in England. The majority of these are located in the inner city and just fewer than 150,000 people (20% of the resident population) live in these areas. A quarter (25%) of all children in the city live in these most deprived areas together with 18% of the city's older people.

Employment Rate

Leeds has seen sustained job growth over the last 20 years and latest figures (2006-2007) show the overall employment rate in the city to be 75.3%, which is above the current England average.

This is expected to rise further over the coming ten years with in excess of 21,000 jobs being created within finance and business services and the public service sector, accounting for approximately 45% of the city's total net employment growth. However the rapid recession of late 2008 could have a significant impact on these predictions.

Worklessness

Despite this growth and the ongoing programme of city-wide regeneration not all people currently enjoy the relative prosperity, with almost 65,000 people of working age not in employment and claiming some kind of benefit. The estimated 'real' level of unemployment in Leeds in 2007 was 29,500, a rate of 6.4%

At 28.7% the claimant rate in the Leeds "deprived area*" is more than double the rate for the city, whilst across the city 6.5% of the working age population are claiming Incapacity Benefit, rising to 12.4%, nearly twice the city average in the "deprived area".

[* footnote: In the report 'Measuring the Gap: Tackling Health Inequalities' the 'deprived area' was defined as the 100 Super Output Areas ranked in the most deprived 10% nationally on the 2004 Index of Multiple Deprivation.]

Earnings

In 2007 gross average hourly earnings for full-time workers in Leeds were £10.84. This was below the England average of £11.58 but above the Yorkshire and The Humber regional average of £10.53 [See table 5 below]. Although the rate for men is higher than that for women, the gender pay gap in Leeds was smaller than both the national and regional rates, and has fallen since 2002.

Table 5 : Average earnings for full-time workers

	Hourly (£)	Weekly (£)	Annual (£)
	Median	Median	Median
England	11.58	462.60	24,428
Yorkshire & The Humber	10.53	425.00	22,369
Leeds	10.84	429.20	22,591

Local Authority administered benefits

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. By contrast in the "deprived area" the benefit take-up rate is 44% almost double the average for the city.

Housing and Living Arrangements

The latest available data (2007) shows there to be just under 322,500 households in Leeds of which 77% are privately owned (either by owner occupiers or for private renting), 18.5% are local authority owned and 4.5% are owned by other Registered Social Landlords. This is an increase of 21,500 households since 2001.

There is a clear link between high standards of accommodation and improved health outcomes and improving homes to decent standards remains a priority for action. By March 2008 77% of local authority owned homes complied with the Decent Homes Standard, and the target is to bring all council owned stock up to the decency standard by the end of 2010/11.

Similarly the City Council undertook a "Private Sector House Conditions Survey", which estimated that there were 247,850 private sector dwellings in Leeds (either owner occupied or privately rented), of which 67% could be classified as decent.

6. Ill Health

Introduction

All Age All cause Mortality (AAACM) is an overarching measure for a number of the mortality data sets within the JSNA data pack. This work is also supported by the national inequalities target which aims that by 2010:

- the average life expectancy at birth in England will be increased to 78.6 years for men and to 82.5 years for women
- there will be a reduction in health inequalities as measured by infant mortality and life expectancy at birth

The current position is set out below, but in summary the AAACM rate for Leeds is around the national average, and in line with national trends, is continuing to fall.

However the trajectory for narrowing the gap between Leeds overall and deprived Leeds is of significant concern. The deprived areas of Leeds have mortality rates significantly higher than Leeds, Yorkshire and Humber spearheads and the national average.

Ill Health : key facts and figures

The data sets have highlighted a number of important characteristics in respect of ill health:-

Life Expectancy

People in Leeds on average can expect to live until the age of 79. Men generally live less long than women and the gap on 2004-6 figures was 4 years. But the biggest difference is correlated to deprivation. There is a life expectancy gap of 10 years between the ward with the highest life expectancy (Adel and Wharfedale) and the lowest (City and Hunslet);

All Age All Cause Mortality

In the 1990s the all age, all cause mortality rate for Leeds as a whole tended to be around the national average and below the regional average. Since 2000 all three rates have tended to fall but the national mortality rate has fallen faster than the rate in Leeds. During this period the mortality rates in the deprived parts of Leeds have remained significantly higher than in comparable areas with little improvement in comparison to the Leeds and national averages.

Circulatory Disease Mortality

Within Leeds the mortality rate under 75 years from circulatory diseases ranged from 50 per 100,000 in Adel and Wharfedale to 224 per 100,000 in City and Hunslet electoral wards.

Mortality rates under 75 years in the deprived areas of Leeds from circulatory diseases were consistently and significantly higher than the Leeds, Yorkshire and Humber Spearhead and national averages between 2001 and 2005.

Cancer Mortality

Mortality rates under 75 years from cancer in the deprived areas of Leeds were consistently and significantly higher than the Leeds, Yorkshire and Humber Spearhead and national averages Although there was an initial 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 2005-2007, with all the other inner areas also showing rises.

Chronic Obstructive Pulmonary Disease (COPD) Mortality and Prevalence

For men, COPD is the fourth highest cause of death and hospital admission in Leeds. For women it is the fifth highest. 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. The recorded prevalence of COPD in Leeds is 1.6% (QOF data 2005/6) compared to the national rate of 1.4% for England. However the prevalence rate in “Leeds deprived” is 2.2%

Stroke Mortality

Mortality from stroke has continued to fall in the majority of Leeds areas since 2003. Highest rates are in the inner North East area, but there are also high rates within the outer East.

Limiting Long Term Illness (LLTL)

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 that people with an LLtI are concentrated in particular geographic areas of the city

Main 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.
Similarly, CHD was the most common cause of death in women in 2006, followed by cerebrovascular disease, though this is not reflected in the figures for hospital admissions.

7. Healthy lifestyles

Introduction

Encouraging healthy lifestyles is important to improving the overall health and wellbeing of the Leeds population. One key stream of work to reduce health inequalities is around behavioural change, encouraging people to stop smoking, drink responsibly, eat better and exercise regularly.

The data sets have highlighted a number of important characteristics in respect of health and well being in Leeds:-

Healthy Lifestyles : The key facts and figures

Smoking

The link between deprivation and smoking is clearly seen across Leeds. 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 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.

Alcohol Admissions

Alcohol consumption in Leeds is of particular concern with an estimated 155,000 adults drinking above the 'safe drinking' guidelines, and an estimated 25,000 thought to be dependent. In 2004 the number of deaths linked to Alcohol across the Yorks and Humber region rose by more than 46%, the largest rise in the country. Alcohol related death rates are 45% higher in high deprivation areas.

The annual cost of alcohol misuse in Leeds is estimated to be at £275 million, of which £23 million is health related.

Obesity

In 2005, 22.1% of men and 24.3% of women were obese and almost two-thirds of all adults overweight.

In 2003 it was estimated that nearly a quarter of males in Yorkshire and Humber (24.6%) were obese and that the region had the highest obesity prevalence among young adult males (aged 16-24).

Physical activity

The Citizens Panel Sports Provision Survey 2000 found 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.

However by contrast, a major national participation survey commissioned by Sport England in October 2005 showed 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% and below the England average of 21%.

8. Children and Young People

Introduction

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

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

The current position in Leeds is set out below:

The key facts and figures

Staying Safe

The focus here is information in respect of Looked After Children. The numbers of looked after children in Leeds are significantly higher than statistical neighbours and are increasing.

At September 2007 Leeds had 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.

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 JSNA data 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).

- 3 year rolling rates showed a rising infant mortality rate for Leeds. Though this has levelled off in the most recent year, it remains in contrast to the national downward trend.

Teenage Conceptions

- The Leeds national target is to reduce the rate by 55% from 1998 baseline. The Leeds latest rate figure (2006) is 50.7 per 1000 females aged 15-17 which is 0.4% above the 1998 baseline. This is considerably higher than the national rate, is not a reduction and at present achievement of the 2010 target rate of 22.7 per 1000 females aged 15-17, represents a significant challenge.

Obesity

- Across all categories Leeds is very slightly below the regional and national averages at reception. However 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 which is broadly 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 and is on target to achieve 90% by end of 2008

The Every Child Matters survey also covered nutrition, smoking, alcohol, drug use, and sexual health. The main findings suggest:-

- *Nutrition.* Only a third of younger children 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).
- *Smoking.* 12 % of Year 9 pupils and 22% of Year 11 pupils report regular smoking
- *Alcohol.* 46% of 50% of Year 5 pupils have never drunk alcohol, but that this proportion falls to 6% in Year 11. Survey 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 survey suggest that the proportion of pupils indicating that they have used illegal drugs rises from 11% in Year 9 to over a quarter of young people (28%) in Year 11
- *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.

Enjoy and achieve

This area 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 its 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.

Achieving Economic wellbeing

- ***Children and poverty -***The data shows that 1/5th of all children in the city live in families where no-one are in work. In the "deprived area" over 40% of children live in workless households – double the city average
- ***Young people Not in Education Employment or Training*** after Year 11(NEET) in 2006, was 8.2%. 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.

9. Adults and Older People

Introduction

The 2001 Census reported that Leeds had a population of 715,400 but the Office of National Statistics (ONS) estimates that the mid 2007 Leeds population was around 761,124 of whom 449,400 were of working age and 128,500 were of pensionable age (<60M <65F). There were just under 110,000 people aged 65 or over.

A significant proportion of adults require support and services from Adult Social Care and other services. In addition a large number of community based organisations are funded by Adult Social Care to provide preventive services for people with lower level needs.

Trends show that the requirements for social care services are growing as people live longer. It is predicted that the number of people aged 65 and over will rise by almost 40% to 153,600 in 2031. Whilst people are healthier and living longer generally, the incidence of physical disability and mental health problems increase significantly with age. Dementia is a condition that particularly affects older people with prevalence rising from 5% of those aged 65 to 75 to 20% of those aged over 80. In Leeds this equates to approximately 6,000 older people.

Demographic and other changes (such as shorter stays in hospital) are also having an impact on other groups who require Adult Social Services including people with learning disabilities. It is estimated that by 2011 there will be an 8% increase in the numbers requiring services. A further impact is the increased requirement to provide support for unpaid carers. In Leeds 14.4% of women and 10.7% of men are carers.

One response has been to promote independent living. Supporting people in their own homes is both a preference expressed by people and an economic response to reducing the costs of supporting people in residential or nursing homes and in hospital.

The Key Facts and Figures

Health and Emotional Wellbeing

- In 2007 the level of fuel poverty in Leeds was estimated as being 30% of private sector households, 22% of which are deemed vulnerable.
- At the time of the 2001 Census there were over 70,000 pensioner households (<60M <65F) in Leeds of which just over 43,000 were older people living alone. The national POPPI system projects that the number of people aged 65 or over living alone will have increased by 24% in 2025 (30% for people aged 75 and over).
- People aged 65 and over make up around 16% of the Leeds population but occupy almost two thirds of general and acute beds. National policy aims to prevent unnecessary hospital admissions particularly for older people.
- Admissions for conditions such as dementia and falls can be reduced by preventative interventions. The Leeds POPP Programme succeeded in reducing

hospital admissions for older people with dementia by 77.5% where dementia was the primary diagnosis and 15% where dementia was a subsidiary diagnosis).

Quality of Life

- In 2008/9 Leeds invested just under £12.5 million in community based services to support people with lower level needs. During 2008 Adult Social Care provided a service to around nearly 16,000 people of whom about 30% were of working age. Of the total, around 16% were receiving residential care.
- There are approximately 2,500 people with learning disabilities in Leeds who receive statutorily funded accommodation and support services arranged by the Council.
- There are approximately 52,800 carers of working age in Leeds. Of these, 66% are combining caring with paid employment.
- During the past year 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.
- There is a variation between different parts of the city in the support offered to carers. The number 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 varies from 21% & 19% in the South and West respectively, down to 16% in the North East and North West.
- Although around 25% of service users live in the parts of Leeds deemed to be in the 10% most deprived areas of the country, fewer people identify themselves as carers (8.94% compared to 9.85% for Leeds as a whole). And of the carers who were offered a service, only 401 (17%) lived in these areas.

Making a Positive Contribution

- Research by the University of Leeds found that volunteering primarily by older people generated the equivalent of £6,000,000 worth of services.
- Leeds Involvement Project supports representatives from across a range of groups to contribute to the development of health and social care services. They report being in touch with 419 service users and carers. These include a wide range of people from BME and disability groups.

Choice and Control

- During 2007/08 there were 9101 people aged 18 or over who received a completed social care assessment. Of these, 7366 were 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 commissioned by Adult Social Care through another agency.
- 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%.

- 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. During last year 85.3% of new elderly service users received their services within the required 28 days. This is rated 'good' by the regulatory body, the Commission for Social Care Inspection.
- Waiting times for service provision in the most deprived areas showed the shortest waiting time.
- There is a National requirement for Adult Social Care to move towards personalised services. 803 people across service user groups are currently provided with direct payments in Leeds. A target has set that by 2001 it will provide 30% of all services through self directed support.

Equality Issues

- In 2006 ONS estimated that 118,200 (93%) Leeds pensioners were White British, 2,600 White Irish, and 1,700 Other White. The number of pensioners in other ethnic classifications included 1200 Indian, 800 Pakistani, 200 Bangladeshi and 1300 Black Caribbean elders.
- Work by the University of Leeds suggests that by 2030 the BME population in Leeds will increase by 55% and this will include significantly higher proportions of people from BME groups in older age groups.
- ONS estimated that in 2006 there were 53,400 people aged 75 or over of whom 20,200 were men and 33,200 were women.

Economic Wellbeing

- Pension Credit provides financial help for people aged 60 and over whose income is below a certain level. 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.
- The 2001 Census shows that almost 24,000 people in Leeds aged 65 and over were living in households without central heating and 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.

Personal Dignity and Respect

- 99% of all older people receiving an assessment from Leeds Adult Social Care received a copy of their care plan.
- Leeds received 645 safeguarding referrals in 2007/08. There has been an increase in referrals and it is envisaged that these will increase further as there is a heightened awareness of the need to safeguard vulnerable people from abuse. This will become an even greater priority with an increase in self directed care.

10. Desired Outcomes: The key issues for Leeds Now

Introduction

This chapter considers the data and how it impacts upon the current priorities set out in the Leeds Strategic Plan. In summary it re-affirms that the current focus for both Leeds City Council and NHS Leeds is the right one and continues to be where the resources of both organisations need to be directed. The following chapter considers those emerging areas of concern around which future commissioning and resourcing decisions will need to be made in the medium to longer term.

The process of analysis

The data produced for the JSNA paints a picture of Leeds as one of two cities**,** with diverse health and well being needs. Overall Leeds is recognised as one of Britain's most successful cities outside London, but despite this success there are wide gaps between those areas that are wealthy and thriving and those that suffer high levels of multiple deprivation.

Analysis of the JSNA data has been undertaken in three ways. These have been independent but have come up with similar answers and a broad consensus on the emerging questions for Leeds:

1. **A scoring tool was applied to a wide range of topics in the data pack**

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?
- Is 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?

2. Analysis conducted by the **York Health Economics Consortium** which focused upon the JSNA data pack making suggestions for embedding the process and improving priority setting.

3. **A separate control exercise** was conducted to analyse the dataset, draw out the key issues emerging and consider alignment with existing priorities.

The issues emerging – Questions for Leeds

The work of York University has helped inform the future direction for the JSNA process set out in section 12. The scoring and control exercise has however confirmed a number of common issues for Leeds:-

Theme 1: Changes in population

Key issues emerging

- Impact of increase in life expectancy
- Particular increase in the number of older people

- Changing age profile of BME communities
- Impact of migrant workers

Theme 2: City-wide variation in need. Ill health areas include

Key issues emerging

- Circulatory Disease Mortality
- Rise in cancer mortality
- The rising rate of Chronic Obstructive Pulmonary Disease
- Patterns of rising incidence of Stroke Mortality
- Infant Mortality

Theme 3: Healthy Lifestyles

Key issues emerging

- Rise in alcohol related deaths and healthcare costs
- Smoking – wide variation across Leeds
- Obesity – particularly 16-24 year olds and younger children
- Drugs - > use particularly among younger children
- Physical inactivity

Theme 4: Children and Young People

Key issues emerging

- Projected rise in Looked After Children
- High rates of infant mortality
- Higher NEET among school pupils with SEN and Looked After Children
- Teenage Conception

Theme 5: Adults and Older People

Key issues emerging

- The increase in numbers of people over 75, general increase in older people and catering for their needs (health care, housing and independent living)
- Linked to above a rise in cases of dementia is noted and although data is currently weak in this area, this is expected to become an increasing issue for city commissioners

11. Implications for Future Commissioning

Introduction

The Leeds Joint Strategic Needs Assessment (JSNA)

Leeds City Council and NHS Leeds have a new statutory duty to produce a Joint Strategic Needs Assessment that identifies the currently unmet and future health, social care and wellbeing needs of the local population.

The first Leeds JSNA was carried out during 2008 and confirms that the priorities identified in the Leeds Strategic Plan are the right priorities to be tackled at the present time.

However, the JSNA has also raised the need for further work in new areas, for example:

- **An Ageing Population:** As in most areas of the country, Leeds has a growing proportion of older people who are living longer than previous generations. The pattern of needs is therefore changing.
- **Infant Mortality:** Improvement in Infant Mortality rates is positive for Leeds as a whole, but there are some communities of Leeds with higher levels of risk.
- **Children's Health:** We need to ensure that children and young people are healthier – unhealthy children of today will become the unhealthy adults of tomorrow!
- **Neighbourhood Needs:** Existing inequalities and differences in health experience between neighbourhoods may widen without specific measures to counteract this.
- **Specific Challenges**: We need a continuing focus on specific health and wellbeing challenges, particularly obesity, alcohol, drug taking and smoking.

From the broad range of themes identified there are four main areas with a number of particular issues for commissioners to take into account in future:

- Responding effectively to demographic change
- Responding effectively to specific health and wellbeing challenges
- Targeted work to improve health and well being outcomes for specific groups.
- Counteracting widening inequalities between neighbourhoods

Responding effectively to demographic change

- **An ageing population.** People will expect the quality and availability of services to increase in line with demand. However as people age and live longer, there

will be an increase in life-limiting conditions such as stroke, diabetes and dementia, particularly in areas of disadvantage. At the same time there are already difficulties in recruiting people into personal care roles as the proportionately of younger adults in the population falls. There will also be more older people from minority ethnic communities. Part of the solution will be investment in services which help people keep fitter for longer; services which provide early support; and social and environmental interventions which promote and prolong the possibility of independent living but we need to develop wider discussion and engagement around this issue.

- **Children and Young People** Unhealthy children of today will become the unhealthy adults of tomorrow. The importance of ensuring the effectiveness of programmes that tackle childhood obesity, emotional wellbeing, teenage conception and sexual health cannot be under estimated, both from an individual and a population perspective. The health of children in disadvantaged neighbourhoods and the projected increase in the proportion of children from new or minority ethnic communities highlight the need for more targeted action. One focus will be on reducing infant mortality as the data shows that in some communities the rates are within the lowest nationally, in contrast with the overall rate for Leeds, which compares favourably with the national rate.

Specific health and wellbeing challenges which require an effective response

- **Obesity** – Overweight and obesity have been shown to be associated with significant risks to health and a large decrease in life expectancy. The National Health Survey for England has found that in 2007 41% of men and 32% of women were overweight with a further 24% of both men and women being classed as obese (compared with 13% of men and 16% of women in 1993. Obesity among women is more common at lower income levels. The same is true for men but less pronounced. Yorkshire and Humber has the highest standardised rate for overweight and obesity (measured by Body Mass Index) of any English region and the issue has been identified by *Yorkshire Futures* as being the main threat to public health in the future.

- **Alcohol** – National surveys show that adults in all age groups except the oldest tend to be drinking above the recommended limit and the consumption is more than twice above the recommended limit for younger age groups. The latest alcohol profile for Leeds (2008) estimate hazardous and harmful drinking in Leeds to be significantly higher than the national average, with alcohol related admissions to hospital higher in Leeds than the average across England and increasing. With the estimated cost of alcohol misuse in Leeds to be £275m, this represents a significant challenge for those responsible for commissioning and delivering programmes and services. The city's Alcohol Strategy is showing some results, requiring a focus on high impact preventative action, perhaps combined with increased use of available regulatory powers.

- **Drugs -** Existing data does not give a clear message on trends. The number of young people using drugs, whilst a concern, is in line with the national rate, but the proportion of drug users aged 15-64 is higher than the national average. Around one third are unknown to treatment and 84% of drug users in treatment in Leeds use heroin, a higher proportion than nationally. There are signs of a

changing pattern of use: younger drug users are choosing cocaine rather than opiates. Commissioners of statutory services also need to address the significant social impact of drugs usage.

- **Smoking –** Although trends are going in the right direction there will continue to be a sizeable proportion of smokers, with the highest rates (46%) being found in inner east, inner south and inner west Leeds. The take up of smoking amongst young people and particularly amongst women appears to remains a problem pointing to the need to continue with current smoking cessation programmes with more funding from mainstream sources.

Targeted work to improve health and wellbeing outcomes for specific groups

Whilst there are important health and well being issues for all sectors of the population, the JSNA process, particularly through stakeholder events, has highlighted the need to develop better data, analysis and understanding of the health and well being needs of particular groups including:

- People with a learning disability
- Gypsy and travellers
- People with dementia
- Asylum seekers and newly arrived communities
- Looked after children and young people

Some of this work is already under way and will be used to inform commissioning plans.

Counteracting widening inequalities between neighbourhoods

- The national Index of Deprivation is the main source for ranking areas of Leeds in relation to each other and to other parts of the country and for identifying those which fall into the most deprived 10% nationally. As we target improvements on these areas, it is hoped that they will improve both absolutely and relatively to elsewhere. Already we have seen a few areas move out of the most deprived group while others are included. However any such marginal improvement is likely to leave a smaller number of areas which remain deprived and become relatively more disadvantaged, both generally and in relation to health.

- It is also possible that this acceleration of difference will include a fragmentation of community and an accelerated development of particular needs concentrated in what may be quite small neighbourhoods within those areas. These needs will include health dimensions (direct and indirect). As city leaders, the City Council will (with its partners) wish to direct commissioning priorities to manage any increase in potential fragmentation across neighbourhoods and communities.

- To meet changing patterns of need (particularly in relation to the effects of economic downturn) it is likely that NHS Leeds, as a partner, would have to consider whether and how it could use its commissioning process in meeting

wider social, economic and infrastructural challenges which impact on health inequalities and affect the overall health and wellbeing of the whole Leeds population.

12. Next Steps – A Sustainable Framework for Leeds

This first JSNA required and benefited from close working across Leeds City Council and NHS Leeds. Looking ahead it is clear that this process must be more fully embedded into the existing partnership governance arrangements and better aligned with emerging planning and commissioning cycles. Proposals to achieve this are set out below and in a summary action plan in Appendix C.

Setting a Vision for JSNA

1. Supporting city ambitions

Leeds considers the JSNA process to be the beginning of a journey that will in time be fully embedded into supporting the work of wider stakeholder organisations through the Leeds Initiative. The Vision for Leeds is based on the principles of sustainable development – *"making sure everyone has a better quality of life now and for generations to come"*.

The JSNA process has provided a vehicle for assimilating core data necessary to support the assessment of health and social care needs across the Leeds area.

It is our clear intention to extend this approach to other themed areas set out in the *Vision for Leeds* and related Strategic Plans and Agreements.

The eight themes for Leeds set out in Vision for Leeds 2004-2020:-

1. Cultural Life
2. Enterprise and the economy
3. Environment city
4. Harmonious communities
5. **Health and Wellbeing**
6. Learning
7. A modern transport system
8. Thriving places

Much information already exists, and in some areas local agreements exist to maintain and share particular datasets. We will extend this approach and create a core process that sets out clearly what information is held and how it can be accessed to prepare reports on a range of factors and influences that decision makers and commissioners need to be able to utilise to determine priorities and shape service delivery.

Critical to this will be the need to supplement 'hard data' with the qualitative information that is sourced from the range of forums and networks that Leeds is able to draw on. The information from this will be better collated and held centrally.

Ultimately it is the intention that a web-based on-line database be available in the city which will enable a broad range of self-sufficient partner users to inform all aspects of the commissioning cycle as and when they tackle them.

2. Locality Profiling

One important aspect of JSNA has been to demonstrate how harnessing data, information and technology can build a profile not just of Leeds as a whole but also of defined localities.

An 'anonymous locality' example of this has been included as part of the JSNA process to depict the type of information that could be provided for particular areas of Leeds. This is also available on NHS Leeds and Leeds Initiative websites.

NHS Leeds and the City Council have used this process as a means of expanding the concept of locality planning. We have sought to use a full range of available data, beyond the core data required of the Leeds JSNA to build a profile of a particular area.

The ability to define the boundaries of a locality and use hard data to build a picture of the locality is an incredibly powerful tool which enables a range of organisations to pinpoint areas of particular need and to target resources accordingly.

Work is already underway to develop and expand the concept of an enhanced area profiling system at the neighbourhood (Middle Super Output Area) level, through a "Neighbourhood Index". It will provide the Council, its partners and potentially area committee leads, with robust information about each locality, and seek to measure the impact of interventions in a local area relative to others.

The development of such an index would represent phase 1 of a programme to improve area profiling capabilities. The index will be based on selected and weighted data categories but in the longer term the vision is for the Index to draw from a corporate data warehouse that will contain an expanded range of data which can be accessed to supplement the Index, but that can also be used to profile different sets of boundaries (e.g. wards).

3. Future Commissioning Arrangements

This first JSNA has confirmed the rationale for the priorities set in the Leeds Strategic Plan and the NHS Leeds' Strategic Plan. The targets and trajectories in the Leeds Strategic Plan and the NHS Leeds Strategic plan are to be refreshed annually and this 'refresh' will draw where appropriate on the issues raised by the analysis of the 2008-09 JSNA data. The JSNA will also be one of the evidence bases used to inform the review and refresh of the Vision for Leeds 2004-20.

Actions to strengthen (and streamline) the influence of commissioners in guiding data requirements, analysis and future predictions include :considering what forums might best enable Strategic Commissioners and Information leads to meet for this purpose;

guide data requirements, analysis and future predictions; exploration of the implications of developing a more comprehensive shared data repository; development of a joint information group and development of the Neighbourhood Index (Locality profiles) and commissioning more in-depth needs assessment. Details are in Appendix C.

4. Stakeholder Engagement and Consultation

It is apparent from the consultation that has taken place to inform the Vision for Leeds, the Strategic Plan, Local Area Agreement and now the JSNA that there is a wealth of information from which to draw using the range of networks and consultative mechanisms in place.

An important issue identified for JSNA has been how to collate the qualitative information collected by various stakeholders to ensure that it sits alongside the core dataset so that it can be accessed and used by commissioners, area based representatives and other decision makers.

One future answer is to build a citywide central database of the results from consultation and engagement. One immediate option is to use the City Council 'Talking Point' system which is accessed through the City Council's website and could be made readily available for consultations undertaken by NHS Leeds and potentially by other partners.

This work will be explored by a new joint consultation and engagement group that will meet quarterly and include representatives from a range of organisations including:-

- Leeds City Council
- NHS Leeds
- Children Leeds
- Leeds Teaching Hospitals Trust
- Leeds Partnership Foundation Trust
- Leeds Voice Health Forum
- Leeds Local Involvement Network (LINk)
- Leeds Initiative

5. Governance and ownership of JSNA

Section 4 described the existing partnership governance arrangements and we intend that future work on Leeds JSNA be integrated into those arrangements, fully supporting and informing their work.

Strategic Context

The Department of Health set the JSNA as one of the core demonstrators of World Class Commissioning capability in its World Class Commissioning programme. NHS Leeds will be required to demonstrate its increasing levels of competence against a range of attributes, including the interrelationship between future Local Area Agreements and JSNAs for Leeds.

Although World Class Commissioning originated as a health concept it is now also advocated by the Department of Children and Families. It is anticipated that over time commissioning partners in the city will move towards a shared set of commissioning competencies.

A first step on this journey is Leeds City Council's commitment to 'A One Council Approach'. This is establishing a common commissioning framework for the way the Council commissions goods, works and services but has sufficient flexibility to recognise that 'one size does not fill all'. This common commissioning framework provides greater clarity to work on a partnership basis in the city with other partners and providers.

Within the partnership context, JSNA will be delivered under the remit of the Healthy Leeds Joint Strategic Commissioning Board for which responsibility is set out in the constitution of that Board. See diagram 6 below

Diagram 5 – Healthy Leeds Partnership

6. Next Steps

Effective use of the JSHA requires the needs assessment to become embedded within the planning and commissioning arrangements of both Leeds City Council and NHS Leeds.

Appendix C sets out some of the key actions that we propose to take over the short, medium and longer term. These are underpinned by a robust action plan.

Some of the key actions over the year ahead will be to:

- Embed the governance of and responsibility for JSNA into wider partnership arrangements

- Extend locality profiling to enable data to be used to build a comprehensive picture across specific local areas of Leeds
- Populate data gaps where identified, including specifically strengthening the evidence base across all equalities strands and the specific population groups set out in the section 11.
- Develop and implement a shared data repository approach to ensure information is maintained and accessible
- Ensure that the capacity to incorporate qualitative information is integral to the arrangements and enable information like the core dataset, to be readily accessible, through a new form of central database.
- Develop longer term projections for a wider range of communities of interest, localities and city wide targets
- Develop a partnership with higher education to address identified needs in relation to further research and predictive modelling and analytical techniques
- Explore how the JSNA can be extended to support all strategic outcomes in the eight themes of the Leeds Strategic Plan 2008-11

.

Appendix A Core Datasets (nationally defined)

The information provided in this report has been produced jointly by NHS Leeds and Leeds City Council to support the development of the Joint Strategic Needs Assessment for the city.
It forms a small part of a much wider and more detailed data pack that reflects requirements set out in the minimum core dataset.
The table overleaf sets out the data that was nationally defined and is included in the data pack. The non shaded areas set out those indicators not included in the data pack with reasons why.

Data has been included for the following domain areas:-

- Demography
- Social and Environment
- Lifestyle / Risk Factors
- Ill Health
- Health and Social Care Services

Additional relevant information has also been included within the pack, over and above the core datasets.
For general information about the data or to access the complete data pack, the relevant websites have been included:-
www.leeds.nhs.uk; www.leedsinitiative.org

Domain: Demography

Sub-Domain	Indicator	Commentary
Population Numbers	Estimated and projected population by age band and gender	
Births	Current births	
Ethnicity	Estimated population by ethnic group	
Disability	Estimated number of disabled people, overall and by impairment group	Currently only includes LLTI (Limiting Long Term Illness)
Religion	Estimated population by religious group	
Migrant population	Estimated population by migrant status	
Local Area	Number of households	
	Breakdown of area into constituent communities / neighbourhoods	
	Deprivation Band	
	ONS classification	
	Social marketing categories	
	Urban / rural classification	

Domain: Social and Environmental Context

Sub-Domain	Indicator	Commentary
Poverty	Proportion of children in poverty (NI 116)	Proxy: Children in out of work families
LivingArrangements		
Housing	Housing Tenure	
	Overcrowding	
	Adults with learning disabilities in settled accommodation (NI 145 and Vital Sign VSC05)	New indicator – data not currently
	Adults in contact with secondary mental health services in settled accommodation (NI 149 and Vital Sign VSC06)	as above
	Living Alone (Older People)	
	Central heating (Older People)	
Transport	Access to car or van	
Economic		
Employment	Overall Employment Rate (NI 151)	
	Working Age people on out of work benefits (NI 152)	
	Working Age people on out of work benefits in the worst performing neighbourhoods (NI 153)	
	Adults with learning disabilities in employment (NI 146 and Vital Sign VSC07)	New indicator – data not currently available
	Adults in contact with secondary mental health services in employment (NI 150 and Vital Sign VSC08)	as above
	Unemployment Rate	
	Claimant count	
Other	Average Incomes	
Environment – Isolation	Access to Services	
Voice – Satisfaction	Satisfaction of people over 65 with home and	New indicator. Data to

	neighbourhood (NI 138)	be derived from Place Survey

Domain: Lifestyle / Risk Factors

Sub-Domain	Indicator	Commentary
Behaviour		
Smoking	Modelled and / or recorded smoking prevalence	
	Quit rates (NI 123 and Vital Sign VSB05)	
Eating habits	Modelled and / or recorded eating behaviour	
	Prevalence of breast-feeding at 6-8 weeks from birth (NI 53 and Vital Sign VSB11)	
Alcohol	Alcohol harm related hospital admission rates (NI 39 and Vital Sign VSC26)	
	Modelled and / or recorded drinking behaviour	
Physical Activity	Participation in sport and active recreation	
Teenage Pregnancy	Under 18 conceptions (NI 112 and Vital Sign VSB08)	Available in The Sexual health Needs Assessment Data Pack
	Under 16 conceptions	Available in The Sexual health Needs Assessment Data Pack
Other		
Hypertension	Modelled and / or recorded hypertension	
Obesity	Modelled and / or recorded obesity (adult)	
	Obesity among primary school age children in Reception Year (NI 55 and Vital Sign VSB09)	
	Obesity among primary school age children in Year 6 (NI 55 and Vital Sign VSB09)	

Domain: Burden of Ill-Health

Sub-Domain	Indicator	
Misc.		
All Causes	All age all cause mortality (NI 20 and Vital Sign VSB01)	
	Infant Mortality	
	Life Expectancy	
	Main Causes of Death	
	Hospital Admissions – top 10 causes	
	Self reported measure of overall health and wellbeing (NI 119)	New national indicator
	Healthy Life Expectancy at age 65 ~(NI 137 and Vital Sign VSC25)	
Causes considered amenable to healthcare	Mortality rate from causes considered amenable to healthcare (Vital Sign VSC30)	
Due to smoking	Deaths attributable to smoking	
Diabetes - General	Modelled and recorded prevalence	Available in Measuring the Gap Report
	Estimated excess deaths among people with diabetes	
Circulatory		

General	Mortality rate from all circulatory diseases under 75 (NI 121 and Vital Sign VSB02)	
CHD	Mortality	
	Modelled v. recorded prevalence	
	Hospital admission rate for MI (proxy for incidence)	
	Admissions for cardiac revascularisation	Available in Measuring the Gap Report
Stroke	Mortality	
	Hospital admission rate for stroke (proxy for incidence)	Available in Measuring the Gap Report
Cancer	General: Mortality rate from all cancers under age 75 (NI 122 and Vital Sign VSB03)	
	By Site: Cancer Registrations	Available by web link
COPD	COPD Mortality	
	COPD Modelled v. recorded prevalence	Available in Measuring the Gap Report
Infectious		
TB	TB notifications	
STIs and HIV	KC60.GUM STI data, particularly gonorrhoea	Available in The Sexual health Needs Assessment Data Pack
	New diagnoses of HIV / AIDs	Available in The Sexual health Needs Assessment Data Pack
	Late diagnoses of HIV / AIDs	Available in The Sexual health Needs Assessment Data Pack
	Uptake of Chlamydia screening in under 25s (NI 113 and Vital Sign VSB13)	Available in The Sexual health Needs Assessment Data Pack
Dental Health	% dmft in 5 year olds	
Mental Health		
Dementia	Prevalence of dementia	Currently Dementia Admissions
Suicide	Suicide and injury of undetermined intent mortality rate (Vital Sign VSB04)	
Mental Illness	Mental illness needs indices and prevalence rates	To be included within the planned Mental Health needs Assessment
Trauma		
Falls	Hospital admissions for fractured proximal femur (proxy for incidence)	
Road Accidents	People killed or seriously injured on roads	
	Children killed or seriously injured on roads (NI 48)	
Injuries	Hospital admissions caused by unintentional and deliberate injuries to children and young people (NI 70 and Vital Signs VSC29)	
Musculoskeletal:	Admissions for hip and knee replacement	

Arthritis		

Domain: Services

Sub-Domain	Indicator	Commentary
Social Care: Numbers	Physical disability, frailty and sensory impairment 1. Number of clients 2. Number receiving services in the community	
	Learning Disability 1. Number of clients 2. Number receiving services in the community	
	Mental Health 1. Number of clients 2. Number receiving services in the community	
	Substance Misuse 1. Number of clients 2. Number receiving services in the community	
	Vulnerable People 1. Number of clients 2. Number receiving services in the community	
Social Care: Standards of Service	Timeliness of social care assessment (NI 132 and Vital Sign VSC12) and packages (NI 133 and Vital Sign VSC13)	
	People supported to live independently through social services (NI 136 and Vital Sign VSC03)	
	Carers receiving needs assessment or review and a specific carer's service, or advice and information (NI 135)	
	Adults and older people receiving direct payments and / or individual budgets per 100,00 population aged 18 and over (Vital Sign VSC17, NI 130)	
Health Services		
Maternity	Early access for women to maternity services (NI 126 Vital Sign VSB06)	Available within the Children's Report
Dental Health	Number of people accessing NHS dentistry (Vital Sign VSB18)	
Preventative Screening	Uptake rates for flu jab	
	Proportion of children who complete immunisation by recommended ages (Vital Sign VSB10)	
Preventative Screening	Proportion of women aged 47-49 and 71-73 offered screening for breast cancer (Vital Sign VSA09)	
Sexual health	Offer an appointment at a GUM service within 48 hours	
	Long acting reversible contraception methods	
	Access to NHS funded abortions before 10 weeks gestation	
Mental Health	Proportion of people with depression and / or anxiety disorders who are offered psychological therapies (Vital	To be included within the planned Mental

	Sign VSC02)	Health needs Assessment
Long-term conditions	Proportion of people with long-term conditions supported to be independent and in control of their condition (NI 124 Vital Sign VSC11)	
Voice		
User perspective on social care	The extent to which older people receive the support they need to live independently at home (NI 139)	
	User reported measure of respect and dignity in their treatment (NI 128 Vital Sign VSC32)	
	Self reported experience of social care users (NI 127)	
User perspective on health care	National Patients Survey Programme findings for local institutions	
	Parental experience of services for disabled children (NI 54 Vital Sign VSC33)	
	Patient experience of access to primary care (Vital Sign VSA06)	
	User reported measure of respect and dignity in their treatment (NI 128 and Vital Sign VSC32)	

Additional Information supplied in the Data Pack

General • Major regeneration activities • Incapacity Benefit claimants • Take up of local authority administered benefit • Financial Exclusion and Over-Indebtedness • Fuel Poverty • Air Quality • Climate Change • Street Cleanliness • Crime, Disorder and Drugs Misuse Associated Harms • Housing Needs	**Children** • Looked After Children • Low Birth-weight • Lifestyle Choices (Nutrition, Teeth Brushing, Smoking, Alcohol, Drug Use and Sexual Health) • Disabled Children (Pupils with SEN) • Emotional Health (CAMHS data) • Educational Attainment, Attendance and Exclusions • NEET
Older People • Pension Credit • Projected Needs	

Appendix B Locality Profiling

The range of data now available through the JSNA process can increasingly be used to establish a profile for particular geographies. This provides the opportunity to begin to explore issues of inequality and will also facilitate area based analysis should this be required:

- City wide
- Area Committee
- Middle Super Output Area
- Electoral ward
- Practice Based Commissioning Consortia
- Leeds “deprived” area

These data files are currently held by the NHS LEEDS and work is underway to identify how these can be shared and accessed more effectively in future. In the interim NHS Leeds has published a variety of datasets and interactive maps which can be found on their website.

As an example of utilising available data a Locality Profile has been produced and is also available on the websites

Appendix C Action Planning

The report has recognised that this first JSNA represents the beginning of a journey.

Whilst the work undertaken is robust and will support commissioning decisions, there are a number of areas for improvement that both NHS Leeds and City Council wish to make in the short, medium and longer term.

The key actions identified have been summarised within table C overleaf. A more detailed, supporting Action Plan setting out specific activities, milestones and accountability for delivery has also been developed and will provide the basis for tracking progress.

Appendix C High Level Plan to improve joint planning and commissioning through JSNA

	Short Term [In readiness for JSNA 2009]	Medium Term [2-3 Years]	Longer Term [3 Years +]
General Governance	• Put in place effective structures and governance arrangements to maintain oversight of the JSNA process		
Joint Planning and Commissioning	• Feed themes and key issues for action into forward work programmes of Healthy Leeds JSCB sub-groups and Children Leeds • Undertake the bespoke piece of work mapping world class commissioning competencies with the one council approach to commissioning framework and locality commissioning. • Maintain regular meetings of officers from the LCC and NHS Leeds to refresh priority/target discussions and identify further opportunities for planning alignment. • Develop longer term projections/trajectory information for a wider range of communities of interest, localities and city wide targets • Develop a parallel focus alongside the needs of communities on the available human resources to meet those needs • Develop a partnership with higher education to address identified needs in relation to further research and predictive	• Determine key areas to undertake analysis of cost-effectiveness / VFM – spend against performance • Make disaggregated data available for all localities in Leeds • Launch the real-time on-line data base with associated training to create self-sufficient partner users. • Develop review, evaluation and learning methodologies	→

	modelling and analytical techniques • Explore how the JSNA can be extended to support all strategic outcomes in the eight themes of the Leeds Strategic Plan 2008-11		
Data Gathering and Analysis	• Develop and implement the shared data repository approach • Complete data pack • Identify areas where we have not included data from the core data set and actions/reasons • Agree way forward to collect ethnicity data in primary care • Joint data group to meet quarterly-agree Terms of Reference (linked to JSCG) • Place data pack on intranet • Strengthen evidence base across all equalities strands e.g. address ethnicity and disability data gaps across all public services	• Produce 'Vitality index' for localities • Complete detailed programme needs assessments for: mental health; older people and alcohol • Start forecasting work	• Develop comprehensive system for forecasting and future modelling • Joint working with YPHO to ensure updates of JSNA and measuring the gap are timely for commissioners
Stakeholder Engagement	• Consolidate learning developed through JSNA process • Set up Joint involvement and consultation working group with terms of reference, work plan and reporting arrangements etc. • Formalise process for future partnership working and collation of qualitative information • Feed into the shared information database	• Explore potential for shared surveys and joint use of methods such as citizens panel • Communicate best practice and learning across organisations. • Consider new ways of joint working	-