Final Draft – 29th April 2009

Health and Wellbeing Partnership Plan

2009 to 2012

Improving health and reducing health inequalities in Leeds

Contents

Foreword

Welcome to the Leeds Health and Wellbeing Partnership Plan for 2009 to 2012.

This Plan is part of the broader Leeds Strategic Plan, based on the outcomes and priorities agreed with our partners and shaped by local people. We are pleased that the priorities which have emerged are closely linked to those of our previous Plan for 2005-8 but we have taken into account feedback that the associated Framework for Action needed more focus.

The new Plan does not attempt to cover all of the wide ranging work which individual partners are doing to improve the health and wellbeing of Leeds residents. Instead it concentrates on the main Healthy Leeds Partnership actions for the agreed strategic priorities and how we are going to help deliver the aspirations for the city set out in the Vision for Leeds 2004 to 2020. Our holistic approach to health and wellbeing for individuals, communities and the city as a whole enables us to link up a wide range of activities happening as a result of related plans and strategies and thus to make them more effective. We attach especial importance to the Children and Young People's Plan developed by Children Leeds. Links to other partnership priorities and plans are listed in the action plans and Appendix I.

We also regard our focus on tackling health inequalities as a cross-cutting theme that needs to be addressed in all the priority areas. This includes inequalities between different neighbourhoods in Leeds as well as between different priority groups and the general population.

The strength and quality of partnership working in Leeds were recognised during 2008 by the national award of Beacon status to Leeds Initiative. Success in building effective partnerships to address the many and varied challenges faced by the city, depends on their structures being clear, fit for purpose and flexible enough to adjust to change. In response to changes in national expectations and local requirements, we have updated the Healthy Leeds partnership structures during 2008 to include stronger joint commissioning arrangements with clearer governance and accountability. This will help us to ensure we are using our resources as effectively as we can and will give us a clearer view of how well we are doing.

This partnership plan is an indication of the real commitment of all sectors to focus our efforts collectively so that we can together bring our resources to

bear on the problems and the opportunities facing Leeds over the next three years. We know that the issues we have to address will take more than three years to change but we intend at the end of this period to have a clear indication that we are on the way.

Signed

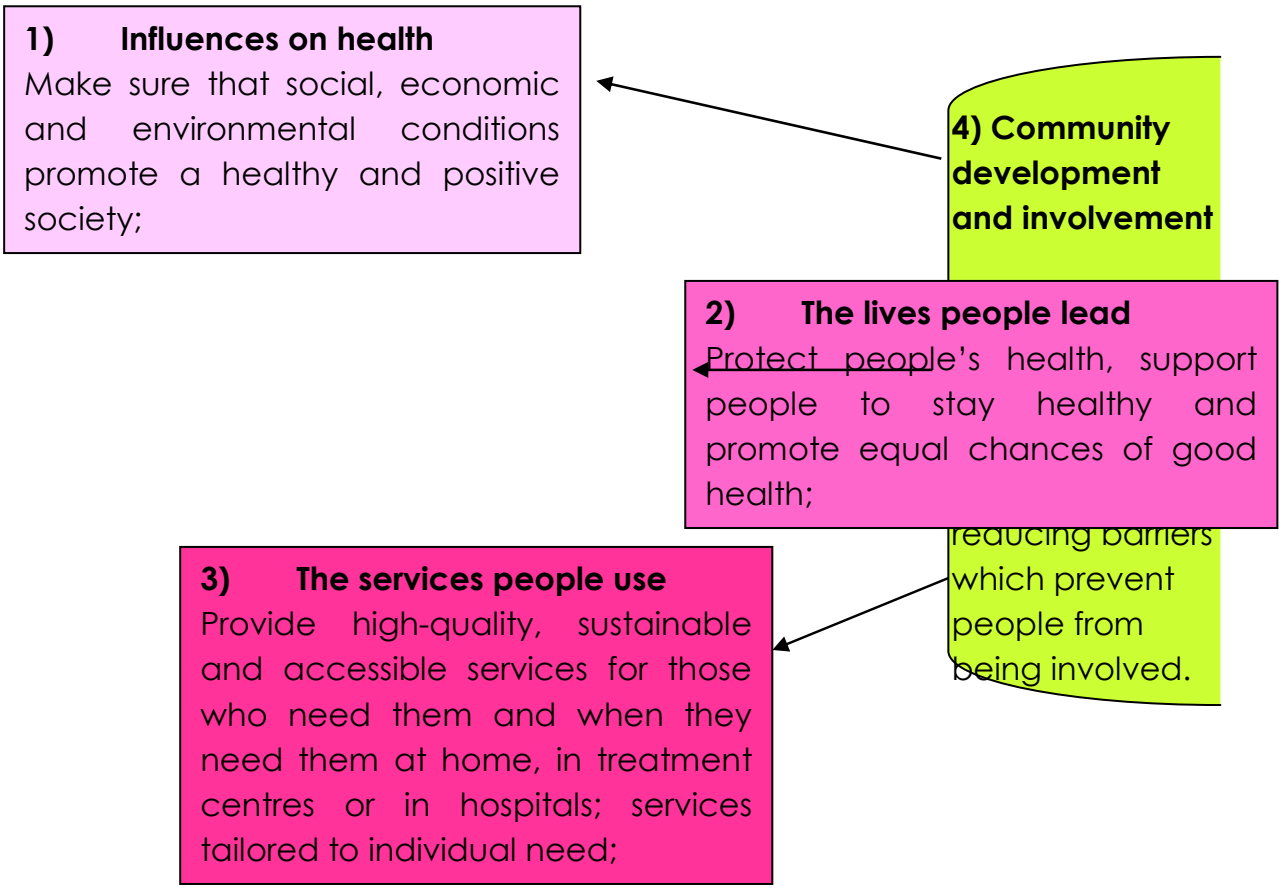
Healthy Leeds partners

Section One

Vision

Leeds will be a healthy city for everyone who lives, visits or works here, promoting fulfilling and productive lives for all. We will reduce inequalities in health between different parts of the city, between different groups of people and between Leeds and the rest of the country.

Aims



Wellbeing

This plan is for the health and wellbeing of the people of Leeds. We propose working to the following statement of wellbeing which has been developed by a government task group to aid common understanding for policy makers:

> "Wellbeing is a positive physical, social and mental state; it is not just the absence of pain, discomfort and incapacity. It arises not only from the action of individuals, but from a host of collective goods and relationships with other people. It requires that basic needs are met, that individuals have a sense of purpose, and that they feel able to achieve important personal goals and participate in society. It is

enhanced by conditions that include supportive personal relationships, involvement in empowered communities, good health, financial security, rewarding employment, and a healthy and attractive environment."

(Whitehall Wellbeing Working Group 2006)

Section Two

Health and Wellbeing in Leeds

Over the last ten years there have been significant improvements in health. Life Expectancy in Leeds has grown by two years for both men and women so that in 2007 a man could expect to live until 76.7 years and a woman to 81.6 years. The All Age All Cause Mortality Rate for people in Leeds fell by over 18% between 1997 and 2007. Although this is slightly less than the fall for England as a whole (20.7%), Leeds health shows up well in relation to the 7 other core cities in England which are used for benchmarking. Underlying this overall trend, there have been important improvements for particular health conditions – both in terms of services and in outcomes for people. We have impressive new hospital facilities such as the Cancer Centre at St James's Hospital; significant changes in primary and social care to improve quality, enable better access, and emphasise prevention; and new networks of community facilities including joint centres for health and social care, Neighbourhood Networks and Healthy Living Centres. More people in Leeds are giving up smoking. Health and Wellbeing are key objectives for Children's services.

The persistence of health inequalities

The overall figures for Leeds are based on its size, stability and relative prosperity as a whole. Previous health reports and the new *Joint Strategic Needs Assessment (JSNA)* show that these positive overall trends mask significant differences within the city.

Infant Mortality in Leeds for the years 2004-6 was 6 per 1000 live births compared to 5 for England. When we factor in disadvantage, Infant Mortality in deprived areas of Leeds was around 8 per 1000 in the same period.

In 2007 the death rate for Leeds men (Standardised Mortality Ratio) was 105, i.e. 5% higher than in England as a whole, compared to only 1% higher for women. Mortality from lung cancer and respiratory diseases is also higher both in Leeds as a whole, and, to an even greater degree in deprived areas. Alcohol related harm is a particular problem.

This dimension of disadvantage continues to have a profound effect on the health both of Leeds and of the country as a whole. Recent reports such as

Measuring the Gap – Tackling Health Inequalities in Leeds and the *JSNA* have shown how persistent it is. The gap in life expectancy between the least and most disadvantaged parts of Leeds has remained at around 10 years since the 1990s.

Both nationally and within Leeds it has been recognised that we must organise our priorities especially to address these inequalities. During the last year we have been developing support and services aimed at securing improvement for the 20% (150,000) of the population who live in the most deprived parts of the city. This Plan continues that work, which is not just about health services, but about all Council services as well as the Voluntary Community and Faith sector, and the private sector. We are determined to continue our improvements for the city as a whole, and to ensure that we are providing the right interventions to lessen the effects of the economic recession on health in Leeds. We know that measures to improve housing and address poverty can be as important to health and wellbeing as NHS services themselves. We intend that our emphasis on skills, capacity, empowerment, choice and control will make our services more effective and easier to use.

The impact of demographic change

The Office of National Statistics predicts that the total number of people in Leeds will have risen by 30% between 2006 and 2031 giving a total projected population of 974,300. On current rates of fertility and the increase in life expectancy, this growth will include significant increases at both ends of the population spectrum with a 24.4% increase in people aged 0-19 years and a 49.4% increase in people aged 75 years and over.

Two aspects of these population changes are highly significant for health in Leeds.

The gradual extension in life expectancy is a result of a broadly healthier population. This has two results. On the one hand the new generations of older people will be more easily able to make positive contributions in all areas of life, from staying longer in work to wider participation in society and culture both through increased mobility and through new technology accessed from home. It is increasingly unacceptable to treat older people as passive recipients of services or second class citizens. Concepts such as the 'silver economy' will have increasing social force. However increased

longevity also leads to a growing number of the very old who will need support

We are also aware that health inequalities often result from population changes (often not showing up in local data collections) within and among local communities. We will strive to be flexible enough to detect, understand and manage new or changed demands which result from local population movements or fluctuations in migration patterns.

Section Three

National context and drivers

This section of the Plan sets out the principal elements of national policy which affect Leeds. A further list of relevant Plans, Policies and other documents is in Appendix I.

Improving Health and Reducing Health Inequalities

Over the last ten years, the government has set out a series or programmes and actions to improve health, improve the quality of health and social care services, and reduce health inequalities. (*Saving Lives: Our Healthier Nation* (1999); *NHS Plan* (2000); *Tackling Health Inequalities: A Programme for Action* (2003); *Choosing Health* (2004); *Our Health Our Care Our Say* (2006); *Putting People First* (2007); *Tackling Health Inequalities: Progress and Next Steps* (2008); *NHS Next Stage Review* (2008))

National Targets

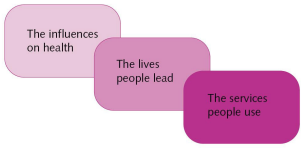
Health targets for England set in 1999 included:

> **Improve the health of the population by 2010.** (Increased life expectancy at birth and reduced infant mortality)
>
> **Substantially reduce mortality rates from coronary heart disease and stroke, from cancer and from suicide by 2010** (from the *Our Healthier Nation* baseline, 1995-97)

Progress across the country means that at a national level these targets are likely to be met. Early deaths from heart disease have halved, while the death rates for stroke and cancer have fallen by 44% and 18% respectively. There is a similar pattern in Leeds.

But these targets as originally framed did not take account of inequalities. In fact the health of those who are better off or who live in better off areas has improved much faster than the health of people who are more disadvantaged, so the inequalities gap was actually increasing. So in 2003 the government identified the 20% of local authority areas with poorest health and classed them as 'spearheads' where the effort to reduce inequalities should be targeted. (Leeds as a whole fell just outside.) A new target was developed to narrow the gap between the health experience of the spearhead areas and the average for England as a whole.

Reduce health inequalities by 2010, by 10% as measured by infant mortality and life expectancy at birth [from a 1995-97 baseline].



The National Targets for England and the three areas of action (see right) highlighted in Tackling Health Inequalities are reflected in the priorities of the Leeds Strategic Plan and this Health and Wellbeing Plan which aim to reduce the gap in mortality between the deprived parts of Leeds and Leeds as a whole.

A further national set of targets aims to tackle some key underlying determinants of ill health and health inequalities by:

Reducing **adult smoking rates** (from 26% in 2002) to 21% or less by 2010, and reducing the prevalence among routine and manual groups (from 31% in 2002) to 26% or less;

Halting the **year-on-year rise in obesity among children under 11** by 2010 (from the 2002-04 baseline) in the context of a broader strategy to tackle obesity in the population as a whole.

Reducing the **under-18 conception rate** by 50% by 2010 (from the 1998 baseline), as part of a broader strategy to improve sexual health.

The importance of the national health inequalities targets for the NHS is reinforced by their inclusion in the top priorities of the *NHS Operating Framework* since 2006. But health is not the responsibility of the NHS alone and health inequalities are also included in priorities for local government, both in its role as 'place shaper' and for the transformation of social care as set out in documents such as *Putting People First* with the key themes of

- prevention
- early intervention and re-enablement
- personalisation
- information, advice and advocacy
- social capital and developing communities

The health and wellbeing objectives of the Leeds Strategic Plan are a joint response to these obligations and also include commitments to developing support for independent living within inclusive communities and safeguarding vulnerable adults and children.

Commissioning for Outcomes

Commissioning is using the available resources to achieve the best **outcomes** by securing the best possible **health** and care services for local people. The main commissioners are NHS Leeds and Leeds City Council, but there is an increase in Practice Based Commissioning by consortia of General Practitioners.

One of the most important ways to achieve change is by switching from service planning (top-down) to service commissioning which is more locally based and takes better account of local needs. Commissioning should be people-centred with the needs of NHS patients, the users of social care services and local people at the centre of Commissioners' work.

The ***Commissioning Framework for Health and Wellbeing*** (2007) made it clear that commissioners should involve local communities to provide services that meet their needs, not just treating people when they are ill, but also keeping them healthy and independent. There should be detailed attention to social inclusion and a focus on reducing inequalities

The outcomes may be

- Health gains for specific or general communities
- Different ways of delivering clinical & care services outcomes – e.g. clinically effective care pathways
- Outcomes for local communities, developing links, skills opportunities and capacity.

Choosing Health

Choosing Health (2004) was the first ever White Paper on Public Health. It set out a wide range of proposed actions to address major public health problems, placing population health and health inequalities at the centre of the Government's health policy agenda. The White Paper identified the following six priorities for action:

- Reducing smoking rates
- Reducing obesity and improving diet and nutrition
- Increasing exercise
- Encouraging and supporting sensible drinking
- Improving sexual health
- Improving mental health

Next Stage Review

During 2008 the Department of Health published national and regional reports of the NHS Next Stage Review led by Lord Darzi. The review aims to secure high quality care for patients and the public by:

- helping people to stay healthy by working in partnership to promote health, and ensure easier access to prevention services;
- empowering patients, giving them more rights and control over their own health and care;
- providing the most effective treatments;
- keeping patients as safe as possible.

Partnerships and joint working should be embedded across health and local government, working to shared plans and priorities and where appropriate through pooled budgets informed by the Joint Strategic Needs Assessment. A framework for funding community and mental health services will also be developed.

NHS Leeds, in common with every other PCT is expected to commission comprehensive wellbeing and prevention services with local authorities with the services personalised to meet the specific needs of their local populations. The Review supports the priorities identified by *Choosing Health* with the addition of treatment for substance misuse. Other significant issues for partnerships include:

- The offer of a care plan for everyone with a long term condition

- Service for children and families and a new Children's and Young Persons strategy
- Planned care closer to home
- Extending mental health services in the community
- Reducing unnecessary hospital admissions

Next Stage Review Vision for Primary and Community Care

The Darzi Next Stage Review also includes a vision for primary and community care built around three main themes and a number of supporting policies and programmes.

The three key themes are

People shaping Services

Promoting Healthy Lives

Continuously improving quality

Local change will be delivered through maximising patient power and choice, ensuring clinical leadership and engagement, and the world class commissioning process.

For both health and social care services the stated intention is to "move away from a one-size-fits-all service to one that is tailored around the needs of patients, focusing on quality and prevention while ensuring equitable access".

This focus on continuing quality improvement will depend not just on formal performance management but the genuine involvement of patients, service users and local people, actively using all available levers to improve performance, and work with everyone concerned, including staff, to continuously drive up standards.

Putting People First

Putting People First (Dept of Health, Dec. 2007) developed the programme for enabling people to have the best possible quality of life irrespective of illness or disability. This applies to both social care and health, leading to a system where adults are increasingly involved in commissioning their own services. Care services need to be transformed so that they consistently promote independence and choice for the delivery of services whilst ensuring people's safety. Services are also required to work actively for prevention, including early intervention and developing community approaches to meeting wellbeing needs. This approach complements the integrated and person-centred approach of Every Child Matters.

For adults, the first changes are being delivered by Leeds Adult Social Care, which will play a championing role, especially in supporting a wide range of services to develop a needs-based approach. Changes in workforce practice will be needed to ensure that commissioners and providers become genuine enablers so that people remain in control of their lives as far as possible. A Putting People First Change Programme, supported by an experts by experience reference group, has been set up with a focus on ensuring that services are person-centred.

Development of locality working and integrated provision (Section 6) is key to implementing all these plans

Section Four

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; together with social, environmental and community interventions which promote and prolong the possibility of independent living but we need to develop wider discussion and engagement around how we do this.

- **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 key focus of intervention will be on reducing inequalities in infant mortality across the city through implementation of the Leeds IM Action Plan. The overall infant mortality rate for Leeds is significantly higher than the national rate, and local analysis shows that rates within Leeds are significantly higher in areas of high deprivation.

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 but there is little difference for men. 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 the prevalence of smoking is falling, there will continue to be a sizeable proportion of smokers. Currently the highest rates (46%) are found in inner east, inner south and inner west Leeds. The take up of smoking among young people and particularly among women remains an issue, reinforcing the need to continue 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 a few areas have moved 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.

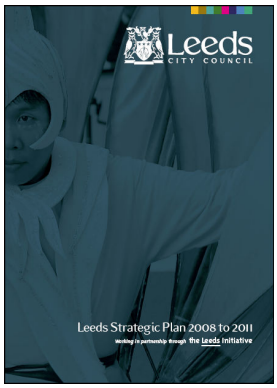
- To meet changing patterns of need (particularly in relation to the effects of economic downturn) it is likely that NHS Leeds, as a partner, would have to consider whether and how it could use its commissioning process to assist Leeds City Council in meeting wider social, economic and infrastructural challenges which impact on health inequalities and affect the overall health and wellbeing of the whole Leeds population.

The Health of Black and Minority Ethnic Groups

In undertaking the JSNA the need to work more closely together was clearly established and one key area for this is the health of Black and Minority Ethnic groups. The lack of effective routine monitoring of the use of health services by people from BME communities means that we have less information about BME health than we would like. However national and local studies reveal how particular groups (both long settle and recent arrivals) each have their own health issues and different experience of being able to access services. Perhaps the best known is the prevalence of Coronary Heart Disease and Diabetes. Work is being undertaken within and with BME communities to identify these issues better and tackle them.

Section Five Health Priorities for Leeds

We are not starting from a clean sheet. We are following on closely from our previous Framework for Action (2005-2008) and the consultations which prefaced local and government agreement to the following strategic outcomes in the ***Leeds Strategic Plan 2008 to 2011***:



Strategic Outcomes

- Reduced health inequalities through the promotion of healthy life choices and improved access to services.
- Improved quality of life through maximising the potential of vulnerable people by promoting independence, dignity and respect.
- Enhanced safety and support for vulnerable people through preventative and protective action to minimise risks and maximise wellbeing.
- Communities which are inclusive, vibrant and

Ten Improvement Priorities for the Health and Wellbeing Partnership have been agreed between the partners. Further Health and Wellbeing Improvement Priorities in the Leeds Strategic Plan are the responsibility of other Partnership groups and are listed overleaf.

Improvement priorities

The agreed improvement priorities for health and wellbeing are:

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

Each priority has a separate plan summarising actions, identifying outcomes, targets and indicators, and related strategies and plans. (See Section 8)
The details of the health and wellbeing partnership structures are in Appendix II and these will provide the mechanisms for taking forward the action in this plan.

The new Children and Young People's Plan (CYPP) for Leeds will run for the next five years and make a crucial contribution to wellbeing in Leeds. Children Leeds has statutory responsibility for strategic development, planning, and commissioning services for children and young people aged 0-19, extending to the age of 25 for those with additional needs

Another key document is the strategy for Leeds Primary Care Trust (now NHS Leeds) which sets out a number of local priorities for delivering health improvement including those selected for the World Class Commissioning programme.

Wider Partnership Contributions

Health and wellbeing is owned by all the Leeds Strategic Partnerships. There are a number of important priorities in other themes of the Leeds Strategic Plan which have a significant impact on health. Achievement of these priorities will depend on the contributions of all services (for instance all Local Authority Directorates) as well those concerned with health in the first

Culture

- Enable more people to become involved in sport and culture by providing better quality and wider ranging activities and facilities

Learning

- Increase the proportion of vulnerable groups engaged in education, training or employment

Transport

- Deliver and facilitate a range of transport proposals for an enhanced transport system including cycling and walking

Environment

- Reduce emissions from public sector buildings, operations and service delivery
- Undertake actions to improve our resilience to current and future climate change

Thriving places

- Reduce the number of people who are not able to adequately heat their homes
- Improve lives by reducing the harm caused by substance misuse

Harmonious communities

- Increase the number of local people engaged in activities to meet community needs and improve the quality of life for local residents
- Increase the number of local people that are empowered to have a greater

instance. The Healthy Leeds Partnership will aim to support and influence the key partners and partnerships responsible for the delivery of these priorities.
Other contributing initiatives include the *Valuing People* programme, the revised *Housing Strategy for Leeds* and the *Financial Inclusion Project*. These are referenced in Section 8.

Section Six How we will deliver these priorities

Making our partnerships more effective

We are building on our previously successful partnerships by adapting them to the new requirements and priorities. We will be working together to commission and deliver appropriate services and interventions and we will ensure that we get feedback about how well these are working. The new partnerships are listed in Appendix I1.

Putting People First: developing people-centred services

The most important way of judging success will be looking at the direct effects for people in Leeds. These are not always easy to measure but the impact of our actions will be as far as possible judged through outcomes rather than just listing activities. We will involve users of services in the development of our plans, paying especial attention to those who find it hard to access appropriate services and recognising that different population groups will need different types of support to take advantage of these changes. Both health and social care services will maximise the opportunities for people to design services which suit them as individuals and families, for example by increasing the provision of direct payments. We will work towards a system of commissioning care planning which is focused around individual needs and enables choices to achieve as good a level of health and wellbeing as is possible.

Developing integrated services

Many NHS and Social Care services still operate independently of each other partly because their funding streams and accountabilities are very different. However the structure of services is changing. Through Children Leeds, we are moving towards the final stages of integrated planning and provision for children and young people. Some services for adults are already integrated and we are actively examining what more can be done to ensure that people have easier access to exactly what they need and to improve effectiveness. This will include single gateways for finding out what is available as well as much greater flexibility in care planning and service provision. Our performance management systems will also join up.

Promoting health, preventing ill-health and intervening early

We know that there are many factors which influence people's health, wellbeing and need for services. These include social, economic and

environmental factors which produce disadvantage and create barriers to recognising needs and being able to access facilities and services. We need to strengthen the overall skills and resources of individuals, families and communities and remove the barriers which are the result of how facilities and services are designed and provided. It is no longer enough to try and cure problems when they arise. All organisations, including the NHS, are now seeking to find ways of working to prevent, delay or mitigate the onset of health problems as this is not just beneficial but also cost-effective.

Community development and capacity building

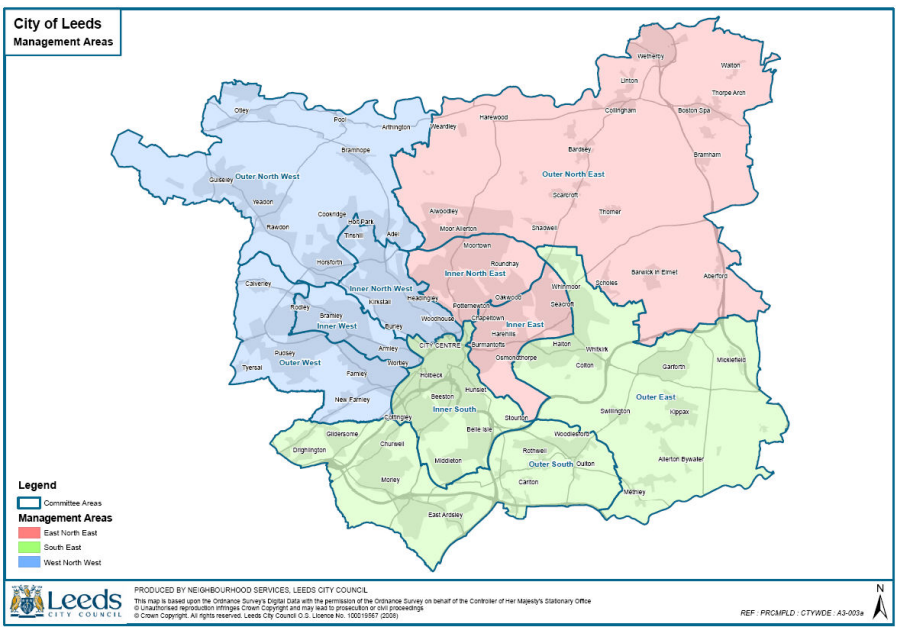
By seeking to embed a community development approach throughout our work (the fourth aim of this plan), we will try to ensure that we not only promote engagement and involvement but also make best use of all the resources available. We will continue to support and promote models of community organisation such as the Neighbourhood Networks and will actively promote the development of community based healthy living programmes and activities, especially in the most disadvantaged parts of Leeds, to enhance healthy living services and support positive changes in lifestyle.

Developing our Locality Approach

Although our priorities are for the whole city, our actions are based around narrowing the gap in health experience between those people who live in the most deprived areas (20% of the population) and the city as a whole. Because of this we need to ensure that our actions deliver improvements at a local level and this requires active engagement with locality services and with communities. This must not ignore the population groups whose needs have been picked out through the Joint Strategic Needs Assessment and who do not live just within those deprived areas.

During 2009 this theme plan will be taken through a process of workshops in the three localities of the city and then discussed a still more local level in order to ensure that the city wide priorities are tailored to local and specific needs and to explore how they can be integrated into area plans.

Leeds City Council Management Areas and Area Committees



Improving our information and analysis systems

Following the JSNA a Joint Information Group has been set up to act as a clearing house for health-related data. The group will look at data (quantitative and qualitative) across the whole system in order to develop a shared picture of progress across the different sectors. The group will review gaps and recommend improvements in data collection and analysis. This work will include investigating how to improve our knowledge of the health needs and experiences of different communities within Leeds, both new and longer established.

Ensuring that we meet our commitments to equality

In developing our interventions to reduce health inequalities overall, we fully recognise the need to ensure that we take account of inequalities which may arise from race, gender, age, disability, sexual orientation and religion or faith. Our objectives and improvement priorities are part of the Leeds Strategic Plan which was developed through wide ranging consultation. Both the Strategic Plan and many of the associated plans from which the action plan is compiled have included an assessment of equality impact. However we need to ensure that the actions, as they develop, do not either directly or indirectly overlook specific equality issues. This will be especially important as the recession will have significant effects on both needs and services. We expect that the JSNA process will help to develop data and provide better definitions of diverse needs. We will also check progress of each improvement priority against equality standards as well as basic performance. Any necessary changes will be included in the annual refresh of the Action Plan.

Recognising emerging and new priorities

Our society is changing in many ways which affect needs, expectations and resources. Some of these changes, such as the balance of population, will have increasing effect over time, while others, like the economy, technological development or climate change are more unpredictable. The recession which developed in late 2008 will have a definite impact which our work will need to take account of. Our plans will need to be able to adapt to changes which affect health and wellbeing and the 2008 JSNA has already pointed to gaps in our knowledge and provision. Our planning

processes need to take all this into account during the period covered by this plan and to ensure that its successor in 2012 will be fully appropriate for its time.

Section Seven

Measuring progress

Leeds Strategic Plan

Progress on the Leeds Health and Wellbeing Partnership Plan will be included as part of the performance monitoring of the Leeds Strategic Plan. Partners will be required to collect information on activities that contribute to each improvement priority. Six monthly performance reports will be produced on the indicators within the Leeds Strategic Plan (including the Local Area Agreement) co-ordinated by Leeds City Council and will be reported to the Local Strategic Partnership's Strategy Group. If there are specific issues or problems that need to be addressed by the partnership, these will be brought to the relevant group – Healthy Leeds Partnership, Joint Strategic Commissioning Board or locality partnerships – to discuss and find possible solutions.

Comprehensive Area Assessment (CAA)

Starting in April 2009, the CAA will provide collective accountability to local people for the use of public money. It brings together 7 inspectorates to provide an overview of how successfully the local organisations are working together, and with local communities, to improve services and quality of life in their area. For health and social care, the three existing separate inspectorates will be replaced by the Care Quality Commission.

It will be focused on outcomes in the LAA and include statutory and non-statutory partners. The CAA will pay particular attention to those most at risk of disadvantage or inequality including those whose circumstances make them vulnerable. It will look for innovative approaches to the commissioning and delivery services.

Views of local people will be a key source of evidence: service users, residents, community groups and third sector organisations. The first CAA report is due in November 2009 and should influence commissioning for future years

Healthy Leeds

An annual report will be produced which will describe where progress has been made and celebrate successes.

Joint Strategic Needs Assessment (JSNA)

The JSNA will start and continue to support the process to measure our overall progress on health inequalities and on health and social care needs. This work will include a focus on vulnerable groups and deprived neighbourhoods. It will help measure trends over time and show if our activities are having an impact on people's health and wellbeing.

Section Eight Action Plans

The agreed improvement priorities for health and wellbeing are:

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

There are 10 templates: one for each Improvement Priority.

Under each Priority

- The first table lists the lead partnerships and contributing strategies.
- The second table lists the national indicators and targets, together with the broad outcomes which are expected. Not all of these are SMART at this stage.
- The third table lists high level actions (delivery activities) and is intended as an overview of the range of work. . Further information and more detail about the actions will be found in the separate strategies and plans to which they relate.

These action templates are not in themselves performance management tools but are a source from which these tools are derived. Joint work between partners is developing more unified performance monitoring systems

and agreeing established baselines. As the plan progresses outcomes will be refined to associate them with measurements to show the difference we are making, particularly in relation to narrowing the gap. The actions will be associated with accountable leads.

Appendix I

Leeds Health - Key Facts and Figures

(Leeds Joint Strategic Needs Assessment)

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);

Circulatory Disease Mortality

Within Leeds the mortality rate for people under 75 from circulatory diseases ranged from 50 per 100,000 in Adel and Wharfedale to 224 per 100,000 in City and Hunslet wards. Between 2001 and 2005 mortality rates from circulatory diseases among people aged under 75 in the deprived areas of Leeds were consistently and significantly higher than the average rates for Leeds as a whole as well as the average rates for Yorkshire and Humber Spearhead areas and the national averages.

Cancer Mortality

Mortality rates under 75 years from cancer in the deprived areas of Leeds have been 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.

Main Causes of Death and Admission Rates

Coronary Heart Disease 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.

Limiting Long Term Illness (LLTL) and Learning Disability

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 a Limiting Long Term Illness are concentrated in particular geographic areas of the city. There are approximately 2,500 people with learning disabilities in Leeds who receive statutorily funded accommodation and support services arranged by the Council.

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 JSNA data sets highlight certain important features of health-related behaviour in Leeds:-

Smoking
The link between deprivation and smoking is clearly seen across Leeds. Local lifestyle surveys have shown how the distribution of smokers varies across the city, with the highest rates in inner east, inner south and inner west Leeds and the lowest in north east Leeds. Separately published estimates suggest even greater variations at ward level where Wetherby has the lowest estimated smoking level at 18% contrasted with the highest level of 46% 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%.

Carers

There are approximately 52,800 carers of working age in Leeds. Of these, 66% are combining caring with paid employment.

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). Of the carers who were offered a service, only 401 (17%) lived in these areas.

Older People

In general people are living longer and there are as many people over 60 as under 16. Although the rate of increase in the proportion of older citizens in Leeds is not likely to be as great as in some neighbouring authorities, it is predicted that the number of people in Leeds aged 65 and over will rise by almost 40% to 153,600 in 2031.

This new older population will be healthier than equivalent cohorts of older people in the past and with the right support will be able to increase the positive role they already play within communities: through caring and grand-parenting, intergenerational work, volunteering, participating in local community activity and also, more and more, by continuing to stay in employment.

However as time passes, there will inevitably also be a higher incidence of physical disabilities and mental health problems which are age-related. 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. Many people as they get older also experience increased deprivation, isolation and loneliness. For example, the 2001 Census showed 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. It is estimated that the number and proportion of people living alone will increase with time.

In 2006 the Office of National Statistics 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

Appendix II

National context and drivers

The NHS Plan (July 2000)

Tackling Health Inequalities: A programme for Action (July 2003)

Health Inequalities: progress and next steps (2008)

Choosing Health: making healthier choices easier (November 2004)

Health Challenge England – next steps for choosing health (October 2006)

Our health, our care, our say: a new direction for community services (2006)

Our health, our care, our say: making it happen (2006)

High Quality Care for All (NHS Next Stage Review) July 2008

Healthy Ambitions – Yorkshire and Humber Strategic Health Authority (2008)

Valuing People: A new strategy for learning disability for the 21st century (November 2007)

Valuing People Now: from progress to transformation

NHS Next Stage Review: Our Vision for Primary and Community Care (July 2008)

Every Child Matters: Change for Children (November 2004)

Strong and Prosperous Communities - The Local Government White Paper (2006)

Putting People First: a shared vision and commitment to the transformation of adult social care (December 2007) and associated documents

Working for a healthier tomorrow (March 2008)

Secretary of State Report on disability equality: health and care services December 08

Local documents referenced on the templates

Leeds Children and Young People's Plan (Forthcoming)

Leeds Alcohol Strategy

Older Better

Leeds Housing Strategy (Forthcoming)

Supporting People (Housing and health)

Safer Leeds Partnership Strategy

Active Leeds: a Healthy City

Leeds Food Matters

Leeds Tobacco Control Strategy

Appendix III

Partnership structures

The partnership arrangements for health and wellbeing in Leeds include:

- **Healthy Leeds Partnership**
  One of the nine strategy and development groups within the Leeds Initiative structure. Responsible for developing and driving forward the health and wellbeing theme of the Vision for Leeds and overseeing the Local Area Agreement.

- **Healthy Leeds Joint Strategic Commissioning Board**
  Responsible for strategic leadership and coordination of commissioning for health and wellbeing. Focus on delivery of strategy, agree priorities, align resources and hold to account (via commissioning sub-groups) programme teams responsible for delivery.

- **Commissioning Sub-Groups**
  The breadth of the health and wellbeing agenda is too large for the Joint Strategic Commissioning Board to have a detailed understanding of each area together with the capacity to performance manage delivery. It has three commissioning sub-groups on: Promoting Health and Wellbeing, Priority Groups and Planned and Urgent Care.

- **Cross-cutting groups**
  Some key issues go across a number of partners and partnerships, for example: Information, Estates, Workforce and Transport. These are covered by specific joint cross-cutting groups.

- **Programme Teams and Networks**
  Responsible for delivery of the strategy for specific client groups or health and wellbeing issues. Programme teams will also influence overall strategy and develop detailed implementation plans. Enable effective involvement to inform and support the planning and delivery of improvements in health and wellbeing, including high quality health and social care services.

- **Locality health and wellbeing partnerships**
  These will be developed as part of the co-ordination groups facilitated by the Council's Area Managers. They will link to area committees and

their delivery plans, Practice Based Commissioning consortia and the developing Children's and Young People's partnerships.

Diagram 1 below shows how the different parts of the partnership arrangements will link together, set in the wider context of the people of Leeds.

Diagram 1

West North West Local Partnership

East North East Local Partnership

South East Local Partnership