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Report of Health and Wellbeing Improvement Manager (East North East Area)

Report to Inner East Area Committee

Date: 2nd February 2012

Subject: Update Report

Are specific electoral Wards affected? If relevant, name(s) of Ward(s):	X☐ Yes	☐ No
Are there implications for equality and diversity and cohesion and integration?	X☐ Yes	☐ No
Is the decision eligible for Call-In?	☐ Yes	X☐ No
Does the report contain confidential or exempt information? If relevant, Access to Information Procedure Rule number: Appendix number:	☐ Yes	X☐ No

Summary of main issues

1. Update of national agenda.
2. Update/progress of work over last year.
3. Future Plans.

Recommendations

4. The Area Committee is asked to note the attached report and provide suggestions for building on and further developing health improvement work in Inner East Area.

1 Purpose of this report

1.1 The purpose of this report is to outline how the national agenda is shaping the work of the East North East Health and Wellbeing partnership and provide a progress report on how key health issues are being addressed in the context of the Inner East Leeds Area Committee.

2 Background information

2.1 New local partnership arrangements for health and wellbeing were established by Healthy Leeds in 2009, following extensive consultation, which proposed the need to focus service delivery at a more local level. The development of the three local Health and Wellbeing Partnerships complements existing themed partnerships. These are based on area committee boundaries and are supported by Health and Wellbeing Improvement Managers, joint funded by the Council and Leeds PCT.

2.2 In the East North East Area, the core Health and Wellbeing team resource consists of Liz Bailey (Health and Wellbeing Improvement Manager) and Janet Smith (Health Improvement Officer). There is no non HR financial support attached to these posts.

2.3 Following political changes at a national level in 2010, Primary Care Trusts will be abolished in 2013 and accountability for the delivery of public health will move to Local Authorities, supported by jointly appointed Directors of Public Health. Dr Ian Cameron took up this position in Leeds during November 2010.

2.4 Clinical Commissioning Groups, which include secondary care clinicians and nurses will commission healthcare services, based on the health needs assessments of their local populations. A new Leeds Health and Wellbeing Board, met in shadow form in October 2011 and it will be involved 'throughout the process' of GPs developing their commissioning plans. The Health and Wellbeing Board may refer plans back to the clinical commissioning group, or the NHS Commissioning Board for further consideration. A key function of the Health and Wellbeing Board is to produce a Joint Strategic Needs Assessment, which will be the primary document for agreeing the Joint Health and Well Being Strategy for the City.

2.5 The terms of reference of the Health and Wellbeing Partnerships, which are chaired by a member of a Clinical Commissioning Group, have recently been amended to take into account the changing health improvement landscape. The partnerships will now become integral for delivery of the work of the Health and Wellbeing Board.

3 Main issues

3.1 The East North East Health and Wellbeing Partnership has been working to progress three main priorities for action across the ENE area: to contribute towards tackling child poverty, primarily around increasing uptake of free and paid school meals, to prevent and reduce the impact of Chronic Obstructive Pulmonary Disease and to increase the levels of physical activity across the area.

3.2 Progress has been made on free school meals. Over the past year, the group has worked with the School Meals Policy Adviser to raise awareness of the issues, train key personnel and ensure schools and parents are more engaged. Increasing free school meal uptake has subsequently become much higher profile and although take up has increased over the past year, this work now has delivery and outcome mechanisms within the financial inclusion strand of the child poverty action plan. Locally and city wide, the 'Be Healthy' Challenge - a lifestyle focused whole school event, now includes school meal based activity and signposting eligible, but non claiming individuals to appropriate assistance is now included in NHS third sector contracts. As a result of the Health and Wellbeing Improvement Manager's contribution to the child poverty needs assessment, which also included a Scrutiny Committee visit to Seacroft in February 2011, this work has recently been expanded towards supporting families with complex needs. An outcomes based accountability session has been held and an action plan/programme of work is now being developed. This work will include delivery across Inner East.

3.3 The Joint Strategic Needs Assessment has now produced MSOA level data, which has identified high level of need across the area. Some of this was previously hidden in larger data sets and more detail is listed in appendix B of accompanying MSOA paper. Whilst Lincoln Green and Ebor Gardens has been identified as the MSOA with most health needs, all of the Inner East, MSOAs have a number of different issues that require attention.

3.4 Issues such as coronary heart disease, cancer and smoking have been highlighted across a number of MSOAs, but there are several new areas of work emerging such as the high prevalence and age standardised rates of admissions to hospital through alcohol use and higher than average accident and emergency admissions to hospital in Cross Green, East End Park, Richmond Hill, Lincoln Green and Ebor Gardens.

3.5 Harehills and Harehills Triangle are revealed as particular hotspots for diabetes, this probably reflecting the vulnerability of particular ethnic groups.

3.6 During the next twelve months, the team will build on existing work as detailed below, developing targeted action according to need and where appropriate, look towards rolling out successful aspects of work developed elsewhere. We will also need to further investigate some of the newly emerging issues, before we can respond appropriately.

3.7 Smoking is still the single biggest preventable cause of ill health and mortality, including from COPD, cancer and coronary heart disease. Therefore, action to reduce smoking and managing smoking related conditions has been and will continue to be a high priority.

3.8 Prevalence of smoking, coronary heart disease and chronic obstructive pulmonary disease are high in Seacroft North and work is progressing to address this. However, Gipton South, has the highest prevalence of COPD at 4.3 compared to the Leeds average of 1.7. It also has a high prevalence of coronary heart disease and cancer. Harehills, Compton, Sutherlands and Nowells has the second highest prevalence of COPD, (between 2.9 and 3.1), followed by Seacroft North.

Table 1.

Prevalence of smoking across the East North East Area 2011 (As at Quarter 4, 2011)

MSOA	**Smoking Prevalence %**
Leeds	23.0
Harehills Triangle	**24.1**
Harehills	31.6
Gipton South	32.7
Gipton North	34.0
Cross Green, East End Park & Richmond Hill	34.1
Fearnville, Hollin Park, Beechwood, Brooklands	34.8
Seacroft South	37.3
Seacroft North	**38.3**
Wetherby West	11.3
Alwoodley West	9.7

Source: Leeds JSNA 2011

3.9 The Seacroft community wide programme to tackle Chronic Obstructive Pulmonary Disease will shortly be evaluated, with a view to possible rollout of successful aspects to other neighbourhoods. A partnership between NHS Leeds, Leeds Community Healthcare, the voluntary and community sector, the Local Authority and North and East Leeds Clinical Commissioning Groups is delivering a combination of prevention, self care management and early diagnosis services.

This includes:

- 36 new families have undertaken to have a smoke free home. Ways to encourage follow up of participating individuals to fully quit smoking are now being considered.
- 500 lifestyle packs have been supplied to ENE homes, to distribute to new tenants, and 16 Seacroft Housing Officers attended an information session around COPD/Smoking Cessation/Smoke Free Homes/Got a cough, get a check.
- The 'Breathe' Group which now has ten participants provides lifestyle and self management support for COPD patients to reduce risk of re-admission to hospital. It is funded by the Inner East Area Committee and delivered by Space 2 and the British Lung Foundation. Respiratory Nurses are currently evaluating physiological and psychological changes to assess the health effectiveness of this approach and patients will be completing satisfaction and wellbeing questionnaires to track self assessed improvements
- A pilot programme to screen smokers for COPD in order to identify and manage the disease early is being run in Bellbrooke Health Centre and

Chapeloak Surgery. This is administered by the NHS Stop Smoking Service and if successful, would help individuals to modify lifestyle and enable lower cost interventions to be applied.

- Two awareness raising events have been held:

1 A 'Recipe for Life' July 2011-arts based event run by Space 2. Health messages were woven into a performance attended by 288 local people, 5 schools were involved, 7 community groups and 9 volunteers. A respiratory nurse and the health and well-being team provided stop smoking information, did 20 blood oxygen tests and 16 inhaler technique checks.

2 A World COPD event took place on 16th November 2011 at Tesco, Seacroft and in approximately 4 hours, 80 individuals were advised about lung health as follows:

Table2.

Outputs from Tesco Seacroft event 16th November 2011

Blood Oxygen tests	Number with higher than expected lung age	Number referred to GP	Number referred to pulmonary rehab/respiratory team	Number referred to Seacroft Hospital for chest X ray	Number provided with information
9	5	6	5	1	80

3.10 This opportunistic method of assessing lung health identified at least five individuals who's lung health 'age' was indicative of someone very much older than their chronological age. These individuals were previously unaware of this and were referred on further checks. Five individuals are reported to have contacted the stop smoking service with a view to starting the stop smoking programme.

- A community focused inhaler technique DVD is now being developed to help people with COPD or asthma self manage their condition. Incorrect use of inhalers is a common reason for exacerbation of symptoms and admission to hospital. Once developed (anticipated by March 2012), the DVD will be available for use in Seacroft and more widely across the East North East area.

- A young people's survey is being administered-to find out what type of stop smoking services young people would access and what would likely encourage them to stop smoking. This information will be used to help develop young people friendly stop smoking initiatives.

- The www,wellbeingleeds.com and www.wellbeingleeds.co.uk portals have been designed and set up to enable local people and professionals to identify local healthy living opportunities, including physical activity, healthy eating, stop smoking, alcohol and substance use etc.

- More free physical opportunities for vulnerable groups, including those from the Inner East have been developed. Several volunteer walk leader training sessions have been delivered, 25 walk leaders have been trained and several new walks are being developed/ supported including Touchstone (mental health) which works in Richmond Hill, and Space 2, which works in Gipton and Seacroft.

- A number of events to support the elderly to live independently have been held, including on 2nd July 2011 Seacroft Gala. 19 older people received information around falls prevention, telecare and equipment, Care and Repair falls prevention service, COPD, Fearnville Leisure Centre, Active Life exercise sessions and Extend exercise classes.

- On 28th September 2011 a Falls Prevention Volunteers Education 2 hr Session to build capacity of Seacroft Neighbourhood Networks Group was held.

- On 12th October 2011, a Falls Prevention event, was held at Kentmere Community Centre. This was funded by Wellbeing and POCA and provided the following outputs:

Table 3.

Falls prevention Work-Kentmere Community Centre 12-10-11

Attended	Balance screen	Balance problems	New slippers	Benefits advice	Referred to falls service
63	55	19	55	15	4

3.11 One person was referred on to the pension service, one to the one stop centre and 3 to the community fire service.

- A similar session was held in South Seacroft on 8th November 2011. 14 people attended and were screened for balance and mobility issues. 10 of these reported issues with balance and mobility and were advised to seek further advice from their GP. All were provided with new slippers and advised on falls prevention, foot care, health and choosing appropriate footwear.

- A financial inclusion event run by Burmantofts Health Improvement Group.- included partners from, the NHS, Adult Social Care, Touchstone, Children's Centre and ENE Homes.

- The NHS has extended the 'Got a Cough, Get a Check' campaign to detect early stage lung cancer in the Inner East Area. Between January and July 2011 1238 patients were assessed and X rayed (between St Georges Middleton and Seacroft Hospital). The following outcomes were recorded:

1. Referral rates increased by 55% compared to the same months 2008-2010.

2. The proportional increase has been higher in Inner East and Inner South (61%), where there has been a targeted campaign, whilst the increase for the rest of Leeds is 53%.

3. Since the campaign, the number of patients being diagnosed with lung cancer following emergency hospital admission has fallen from 27.6% in 2010 to 13.7% (January to March 2011).

4 Supporting families with Complex Issues

4.1 This work is at an early stage, but is intended to improve partnership working and communication between agencies, reduce duplication of effort and maximise resources. The child poverty needs assessment identified a need to address wider factors, which can be either a cause, or effect of poverty. These factors, which often co-exist, include alcohol and drug use, domestic violence, and mental health issues within families and need to be tackled, alongside efforts to raise income through employment, training and benefit uptake.

4.2 An outcome based accountability session took place in October 2011 and an action plan is being drawn up with relevant partners. The Health and Wellbeing Partnership will be a key vehicle in driving delivery of this project.

5 Corporate Considerations

5.1 The work of the health and wellbeing partnership corresponds with the published White Paper by the Department of Health "Equity and Excellence: Liberating the NHS" and the move towards localism. There is a greater emphasis on delivering services around local needs, especially for those that have the greatest health and wellbeing inequalities. The newly published MSOA profiles will enable more effective targeting of resources. There will be a new public health function in the council and there is a challenge to ensure that health becomes everyone's business.

6 Consultation and Engagement

6.1 The work has developed on the basis of previous consultations and involvement of stakeholders, including Third Sector organisations, who work with community groups and active involvement from individuals themselves.

7 Equality and Diversity / Cohesion and Integration

7.1 The main thrust of the work is aimed towards reducing health inequalities and as such primary consideration has been to meet the particular needs of especially vulnerable groups.

8 Council policies and City Priorities

8.1 The work is developing in line with the City Priority plan and the forthcoming Health and Wellbeing Strategy.

9 Resources and value for money

9.1 This work has taken place with few additional resources and relies heavily on partnership approaches.

10 Legal Implications, Access to Information and Call In

10.1 None.

11 Risk Management

11.1 None.

12 Conclusions

12.1 There is an opportunity to incrementally build on the current work and the MSOA profiles now afford a better opportunity to target limited resources more effectively.

13 Recommendations

13.1 The Area Committee is asked to note the information in the attached report and provide suggestions for building on and further developing health improvement work in Inner East Area.

14 Background documents

14.1 None attached, but the Committee is referred to Appendix B in the accompanying JSNA paper.