Community Committee

Leeds CITY COUNCIL

**Report of:** Tony Cooke (Chief Officer Health Partnerships)

**Report to:** Outer South Community Committee

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**Date:** 27 November 2017 **To note**

# Leeds Health and Care Plan: Inspiring Change through Better Conversations with Citizens

## 1. Purpose of report

1.1 The purpose of this paper is to provide the Outer South Community Committee with an overview of the progress made in shaping the Leeds Health and Care Plan following the previous conversation at each Committee in Spring 2017. It is fundamental to the Plan's approach that it continues to be developed through working 'with' citizens employing better conversations throughout to inspire change. The conversation will ensure open and transparent debate and challenge on the future of health and care, and is based around the content of the updated plan and accompanying narrative. The aim is to consider the proposals made to date and support a shift towards better prevention and a more social model of health.

1.2 The Leeds Health and Care Plan is the Leeds description of what it envisages health and care will look like in the future and how it will contribute to the delivery of the vision and outcomes of the Leeds Health and Wellbeing Strategy 2016-2021. It is a Leeds vision for health and care and moves beyond the limited agenda outlined in national Sustainability and Transformation Plans (STPs).

1.3 The Leeds Plan envisages a significant move towards a more community focused approach which understands that good health is a function of wider factors such as housing, employment, environment, family and community and is integral to good economic growth. There are significant implications for health and care services in communities and how they would change to adopt this way of working. The paper provides further information on these

1.4 For the changes to be effective it is proposed there are significant new responsibilities for communities in how they may adopt a more integrated approach to health and care and work with each other through informal and formal approaches to maximise health

outcomes for citizens. This includes how community and local service leaders (including elected members) may support, steer and challenge this approach.

## 2. Main issues

2.1 The Leeds Health and Care Plan is the Leeds description of what it envisages health and care will look like in the future and how it will contribute to the delivery of the vision and outcomes of the Leeds Health and Wellbeing Strategy 2016-2021. It is a Leeds vision for health and care and moves beyond the limited agenda outlined in national Sustainability and Transformation Plans (STPs).

2.2 The Leeds Health and Care Plan is the city's approach to closing the three gaps that have been nationally identified by health, care and civic leaders. These are gaps in health inequalities, quality of services and financial sustainability. It provides an opportunity for the city to shape the future direction of health and to transition towards a community-focused approach, which understands that good health is a function of wider factors such as housing, employment, environment, family and community.

2.3 Perhaps most importantly, the Leeds Health and Care Plan provides the content for a conversation with citizens to help develop a person-centred approach to delivering the desired health improvements for Leeds to be the Best City in the UK by 2030. It is firmly rooted in the 'strong economy, compassionate city' approach outlined in the Best Council Plan 2017-18.

2.4 The Leeds Health and Care Plan narrative sets out ideas about how we will improve health outcomes, care quality and financial sustainability of the health and care system in the city. The plan recognises the Leeds Health and Wellbeing Strategy 2016-2021, its vision and its outcomes, and begins to set out a plan to achieve its aims.

2.5 The Leeds Health and Wellbeing Board has a strong role as owner and critical friend of the Leeds plan championing an approach of 'working with' citizens throughout. The steer to the shaping of the Leeds Health and Care Plan has been through formal board meetings on 12th January and 21st April 2016 and two workshops held on 21st June and 28th July 2016. The Board has held a further workshop on 20th April 2017 where the previous Community Committee meeting feedback was given and more recently at a formal board meeting on 20th June 2017. The board has further reviewed progress on the 28th of September of the plan in the context of both short-term challenges for winter and wider transformation of primary care health and care services. Further comment on the draft plan and supporting narrative has been incorporated.

2.6 The plan recognises and references the collaborative work done by partners across the region to develop the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP – previously the STP), but is primarily a Leeds based approach to transformation, building on the existing strategies that promote health and inclusive growth in the city. Whilst the financial challenge is a genuine one, the Leeds approach remains one based on long term planning including demand management, behaviour change and transition from acute-based services towards community based approaches that are both popular with residents and financially sustainable.

2.7 A transition towards a community-focused model of health is outlined in the plan. This is the major change locally and will touch the lives of all people in Leeds. This 'new model of care' will bring services together in the community. GP practices, social care,

Third Sector and public health services will be informally integrated in a 'Local Care Partnership'. Our hospitals will work closely with this model and care will be provided closer to home where possible, and as early as possible. New mechanisms, known as 'Population Health Management' will be used to ensure the right people get the right services and that these are offered in a timely fashion. This is designed to prevent illness where possible and manage it in the community.

2.8 The Leeds Health and Care Plan narrative presents information for a public and wider staff audience about the plan in a way that that citizens and staff can relate to and which is accessible and understandable.

2.9 The Leeds Health and Care Plan narrative (when published) will be designed so that the visual style and branding is consistent with that of the Leeds Health and Wellbeing Strategy 2016-2021 and will be part of a suite of material used to engage citizens and staff with.

The narrative contains information about:

- The strengths of our city, including health and care
- The reasons we must change
- How the health and care system in Leeds works now
- How we are working with partners across West Yorkshire
- The role of citizens in Leeds
- What changes we are likely to see
- Next steps and how you can stay informed and involved

2.10 The final version will contain case studies which will be co-produced with citizen and staff groups that will describe their experience now and how this should look in the future.

2.11 It will enable us to engage people in a way that will encourage them to think more holistically about themselves, others and places rather than thinking about NHS or Leeds City Council services. Citizen and stakeholder engagement on the Leeds Health and Care Plan has already begun in the form of discussions with all 10 Community Committees across Leeds in February and March 2017.

2.12 The approach taken in developing the Leeds Plan has embodied the approach of 'working with' people and of using 'better conversations' to develop shared understanding of the outcomes sought from the plan and the role of citizens and services in achieving these.

## 3. Influence of Community Committees and Voice of Citizens

3.1 The Leeds Health and Care Plan has been substantially developed subsequent to the previous conversation in Community Committees in Spring 2017. The previous discussion outlined the key areas of challenge for health and care services both at a city level and within each locality. For this meeting of the Outer South Community Committee, please find attached the latest Community Committee Public Health profile and corresponding profiles for Integrated Neighbourhood Teams (INTs) to inform discussions (Appendix 1).

3.2 The four suggested areas for action in the Plan remain as: better prevention, better self-management and proactive care, better use of our hospitals and a new approach to responding in a crisis. These are supported by improvements to our support for our

workforce, use of digital and technology, financial joint working, use of our estates and making best use of our purchasing power as major institutions in the city to bring better social benefits.

3.3 The Leeds Health and Care Plan (Appendix 2) has been further developed following feedback from Community Committees.

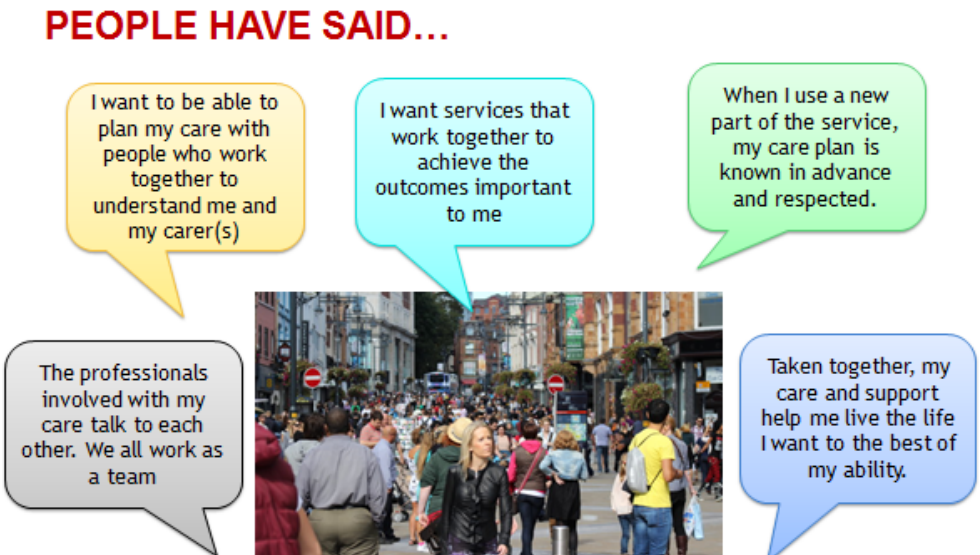
3.4 The Leeds Plan conversation has been supported by partners and stakeholders from across various health and care providers and commissioners, as well as Healthwatch and Youthwatch Leeds, Third Sector in addition to local area Community Committees. Discussion at Leeds City Council Executive Board on July 2017 endorsed the overall approach for further conversation with the public. Refinement of the Leeds Health and Care Plan has continued through the Leeds Health and Wellbeing Board meetings on the 20th June 2017 and 28th of September 2017, and through the Scrutiny Board (Adults and Health) meeting on the 5th of September. Using the feedback received the Leeds Health and Care Plan has been updated as detailed below as Background Information.

## 4. How does the Plan affect local community services?

4.1 The Leeds Plan is an ambitious set of actions to improve health and care in Leeds and to close our three gaps. It requires a new approach to working with people, inspiring change through better conversations and a move towards much more community based care. To achieve this the Plan includes a significant change to the way our health and care services work, particularly those based in the community.

Community Committee and other public feedback has said that health and care is often not working because:

- They have to wait a long time between services and sometimes they get forgotten, or they worry that they might have been forgotten.
- The health and care system is complicated and it can be difficult to know who to go to for what. This causes stress for services users and carers because there is often no-one who can provide everything they need.
- People feel as though they are being 'passed around' and they often end up having to tell their story again and again. No-one seems to ask what's most important to them so they feel as though they have to accept what's on offer and what they are told to do.
- Service users and carers value and respect staff and services highly and are thankful that they have health and care available to them. They don't want to complain or be seen as a nuisance as they know how over-burdened workers are.



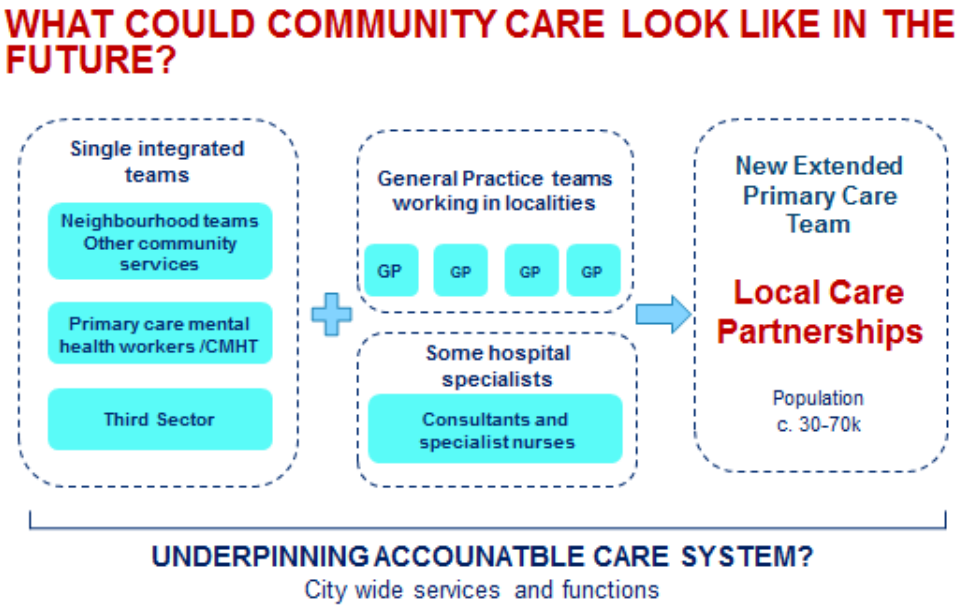
4.2 The starting point to changes in Leeds is the already established pioneering integrated health and social care teams linked to thirteen neighbourhoods (Integrated Neighbourhood Teams). This means that the basis of joint working between community nursing and social workers and other professionals as one team for people in a locality is already in place.

4.3 We have an opportunity to build on this way of working and increase the number of services offered in a neighbourhood team. In order to make this happen we are agreeing with partners what this team may look like and then ensure the organisations that plan and buy health and care services align or join their planning and budgets so that we both create these teams and avoid duplication and gaps in care. This will ensure resources are all focused on making health and care better, simpler and better value.


4.4 The plan is for the number of services based around neighbourhoods to increase and jointly work together as Local Care Partnerships. Building on the current neighbourhood teams Local Care Partnerships will include community based health and care services and possibly some services that are currently provided in hospital such as some outpatient appointments. People will still be registered with their GP practice and the vision is that a much wider range of health and care services will 'wrap-around' in a new way of working that emphasises team working to offer greater capacity than the GP alone. It will mean services no longer operating as entirely separate teams as they often do now.

4.5 Professionals working within Local Care Partnerships will work as one team avoiding the need for traditional referrals between services. The approach will be locally tailored to acknowledge how health and care needs vary significantly across Leeds. Working with local people, professionals within Local Care Partnerships will have more opportunities to respond to the needs of local populations and focus on what matters most for local communities.

4.6 The ambition is for the majority of peoples' needs will be met by a single team in their local area in the future making services easier to access and coordinate. If people do need to go into hospital the services will work together to make sure this happens smoothly.




4.7 These changes will take a number of years to work towards and people are unlikely to start to see any changes until 2019-20 at the earliest. Before this point we will work with local people and stakeholders to make sure the model will deliver what people need.

## 5. A Conversation with Citizens

5.1 In order to progress the thinking and partnership working that has been done to help inform the Leeds Health and Care Plan to date, the next stage is to begin a broader conversation with citizens in communities. The conversation we would like to have will be focussed on the ideas and direction of travel outlined in the Leeds Health and Care Plan and the changes proposed to integrate our system of community services. We wish to ask citizens and communities what community strengths already exist for health and care, what they think about the updated plan and ideas to change community services and how they wish to continue to be involved. We are inviting comment and thoughts on these.

5.2 Our preparation for our conversation with citizens about plans for the future of health and care in Leeds will be reflective of the rich diversity of the city, and mindful of the need to engage with all communities. Any future changes in service provision arising from this work will be subject to equality impact assessments and plans will be developed for formal engagement and/or consultation in line with existing guidance and best practice.

5.3 Over the coming weeks, engagement will occur through a number of local and city mechanisms outlined below in addition to Community Committee meetings. Where engagements occur this will be through a partnership approach involving appropriate representation from across the health and care partnership.

- Staff *engagement- November / December.* Staff will be engaged through briefings, newsletters, team meetings, etc. All staff will have access to a tailored Leeds Plan briefing and online access to the Leeds Plan and Narrative.

- *'Working Voices' engagement - November*
  We will work with Voluntary Action Leeds (VAL) to deliver a programme of engagement with working age adults, via the workplace.

- *Third Sector engagement events - November*
  We will work with Forum Central Leeds to deliver a workshop(s) to encourage and facilitate participation and involvement from the third sector in Leeds in the discussion about the Leeds Plan and the future of health and care in the city.

- *'Engaging Voices' Focus Groups, targeted at Equalities Act 'protected Characteristic Groups - November*
  We will work with VAL to utilise the 'Engaging Voices' programme of Asset Based Engagement to ensure that we encourage participation and discussion from seldom heard communities and to consider views from people across the 'protected characteristic' groups under the Equalities Act.

- *3 public events across city – January / February*
  Working with Leeds Involving People (LIP) we will deliver a series of events in each of the Neighbourhood Team areas for citizens to attend and find out more about the future of health and care in Leeds. These will be in the style of public exhibition events, with representation and information from each of the 'Programmes' within the Leeds Plan and some of the 'Enablers'. To maximise the benefit of these events, they will also promote messages and services linked to winter resilience and other health promotion / healthy living and wellbeing services.

- *'Deliberative' Event – early in the New Year*
  We will use market research techniques to recruit a demographically representative group of the Leeds population to work with us to design how a Local Care Partnership should work in practice and to find out what people's concerns and questions are so we can build this into further plans.

5.4 The plan and narrative will be available through our public website 'Inspiring Change' (www.inspiringchangeleeds.org) where citizens will be able to both read the plan, ask questions and give their views. Collated feedback from the above conversations will provide the basis for amendments to the Plan actions and support our next stages of our Plan development and implementation.

5.5 Through engagement activities we will build up a database of people who wish to remain involved and informed. We will write to these people with updates on progress and feedback to them how their involvement has contributed to plans. We will also provide updates on the website above so that this information can be accessed by members of the public.

## 6. Corporate considerations

### 6.1 Consultation, engagement

6.1.1 A key component of the development and delivery of the Leeds Health and Care Plan is ensuring consultation, engagement and hearing citizen voice. The approach to be taken has been outlined above.

### 6.2 Equality and diversity / cohesion and integration

6.2.1 Any future changes in service provision arising from this work will be subject to an equality impact assessment.

6.2.2 Consultations on the Leeds Health and Care Plan have included diverse localities and user groups including those with a disability.

### 6.3 Resources and value for money

6.3.1 The Joint Strategic Needs Assessment (JSNA) and the Leeds Health and Wellbeing Strategy 2016-2021 have been used to inform the development of the Leeds Health and Care Plan. The Leeds Health and Wellbeing Strategy 2016-2021 remains the primary document that describes how we improve health in Leeds. It is rooted in an understanding that good health is generated by factors such as economic growth, social mobility, housing, income, parenting, family and community. This paper outlines how the emerging Plan will deliver significant parts of the Leeds Health and Wellbeing Strategy 2016-2021 as they relate to health and care services and access to these services.

6.3.2 There are significant financial challenges for health and social care both locally and nationally. If current services continued unchanged, the gap estimated to exist between forecast growth in the cost of services, growth in demand and future budgets exceeds £700m at the end of the planning period (2021). The Leeds Health and Care Plan is designed to address this gap and is a significant step towards meeting this challenge and ensuring a financially sustainable model of health and care.

6.3.3 The Leeds Health and Care Plan will directly contribute towards achieving the breakthrough projects: ‘Early intervention and reducing health inequalities’ and ‘Making Leeds the best place to grow old in’. The Plan will link to local breakthrough project actions for example in targeting localities for a more ‘Active Leeds’.

6.3.4 The Leeds Health and Care Plan will also contribute to achieving the following Best Council Plan Priorities: ‘Supporting children to have the best start in life’; ‘preventing people dying early’; ‘promoting physical activity’; ‘building capacity for individuals to withstand or recover from illness’, and ‘supporting healthy ageing’.

### 6.4 Legal Implications, access to information and call In

6.4.1 There are no access to information and call-in implications arising from this report.

### 6.5 Risk management

6.5.1 Failure to have robust plans in place to address the gaps identified as part of the Leeds Health and Care Plan development will impact the sustainability of the health and care in the city.

6.5.2 The proposed model of health based on local health and care partnerships requires support both from communities and the complex picture of local and regional health and social care systems and their interdependencies. Each of the partners has their own internal pressures and governance processes they need to follow.

6.5.3 Ability to release expenditure from existing commitments without de-stabilising the system in the short-term will be extremely challenging as well as the risk that any proposals to address the gaps do not deliver the sustainability required over the longer-term.

6.5.4 The effective management of these risks can only be achieved through the full commitment of all system leaders within the city to focus their full energies on developing and delivering a robust Leeds Health and Care Plan within an effective governance framework.

## 7. Conclusion

7.1 The Leeds Health and Care Plan is the Leeds description of what it envisages health and care will look like in the future and how it will contribute to the delivery of the vision and outcomes of the Leeds Health and Wellbeing Strategy 2016-2021. It is a Leeds vision for health and care and moves beyond the limited agenda outlined in national Sustainability and Transformation Plans (STPs).

7.2 The Plan has been developed and improved through working with citizens, third sector groups, a variety of provider forums and through our democratic and partnership governance.

7.3 The Leeds Plan envisages a significant move towards a more community focused approach, which understands that good health is a function of wider factors such as housing, employment, environment, family and community and is integral to good economic growth.

7.4 The Plan includes a significant change to how health care is organised in communities to bring together current resources into cohesive Local Care Partnerships.

## 8. Recommendations

The Outer South Community Committee is recommended to:

- Support the updated Leeds Plan as a basis for conversation with citizens on the future of health and care.
- Actively support widespread conversation and discussion of the Leeds Plan and narrative to encourage feedback and comment.
- Support the emerging model of Local Care Partnerships and actively engage with their development in their communities.

## Background information

| Community Committee Feedback Spring 2017 | Action taken |
|---|---|
| **Committees emphasised these areas for the Plan to address:**<br><br>**Mental health**<br>**Physical activity**<br>**Drug & Alcohol Services**<br>**Diet and nutrition, especially for mothers and children**<br>**Tackling loneliness**<br>**Getting into schools more and promoting healthy lifestyles from a young age**<br>**Better integration**<br>**Relieve pressure on hospitals and GPs by making better use of pharmacies and nurses in communities**<br>**The number of GPs in the city and the consistency of good quality GP and health services across the city.** | The Plan draft promotes holistic inclusive health with mental health needs considered throughout health and care services. There are specific actions for those with a need for mental health care in hospital and actions to promote wellbeing through physical activity. The Plan targets people with frailty for a more integrated approach where loneliness and mental health will be addressed in a more joined up approach locally by health and care services. The Plan links to actions across West Yorkshire to improve mental health.<br><br>Physical activity, Drug and Alcohol, A best start (including nutrition advice and early promotion of health lifestyles) are actions in the Plan.<br><br>The integration approach across the Plan emphasizes better use of all community resources including nurses and pharmacists in a team approach to support GPs and hospital services.<br><br>The workforce plans in the city are to increase the numbers in training of GPs and nurses in line with NHS national strategies. This increase would need to be balanced against the number of trend of more GPs working part time and retiring. Our plan is to increase the skills and numbers of other staff in nursing and primary care team roles to improve access to healthcare. This is being undertaken in a citywide approach to ensure consistent quality of health services accessible by local communities. |
| **Committees felt the following were important to working with citizens in a meaningful, open and honest way:**<br>**Health system is very complex – if we can simplify it this would benefit local people**<br>**Reassurance / education / coaching for people with long-term conditions so they feel more empowered to manage their condition better and reduce the need to go to the hospital or GP**<br>**People recognised the need to do things differently in a landscape of reducing resources, but felt there needed to be greater transparency of the savings needed and their impact on services** | The Plan has tried to keep a simple approach to how the health care system works and contains improvements for greater simplicity. The Plan is for local services to be more joined together with less referrals leading to appointments with different organisations in different places.<br><br>The Plan includes specific approaches to reassurance, education and coaching for long term conditions to increase empowerment and reduce GP and hospital use<br><br>The wider plan document includes information transparently of current estimates of savings that need to be made and the risks to services that may become real. |
| **The following were requests by Committees for further involvement:**<br>**There should be more regular discussions about health locally**<br>**Local Community Health Champions**<br>**Local workshops, including at ward level**<br>**People want to better understand their local health and wellbeing gaps and be empowered to provide local solutions and promote early prevention / intervention** | The Plan has adopted a conversations with Community Committees and other local conversations as key to its approach. Local Health Champions are integral to these and increasing use is being made of local workshops and ongoing meetings to<br>The proposal of a move to Local Care Partnerships is to change the role and model of primary care and integrates local leadership from elected members, health services, local third sector organisations and education to promote early prevention and better early intervention. |

| Leeds Health and Wellbeing Board and Scrutiny Board feedback 2017 | Action taken |
|---|---|
| **Acknowledged and welcomed the opportunity for the Community Committees to have had early discussions on the Leeds Health and Care Plan during the Spring 2017. A request for an update to the community committees was noted.** | The success of these sessions have been held up as a good practice example across the region of the value of working 'with' elected members and our local communities. We recognise that an ongoing conversation with elected members is key to this building on the sessions that took place.<br><br>In addition to local ongoing conversations since Spring 2017, there are a number of engagement opportunities with elected members outlined throughout the report under para 3.6 including a second round of Community Committee discussions taking place during autumn/winter. |
| **The need to emphasise the value of the Leeds Pound to the Health and Care sector and the need to acknowledge that parts of the health economy relied on service users not just as patients but buyers.** | There is a greater emphasis to the Leeds Pound within the narrative document and it is now highlighted within the Leeds Health and Care Plan on a page through "Using our collective buying power to get the best value for our 'Leeds £". |
| **Emphasising the role of feedback in shaping the finished document.** | The narrative in its introduction emphasises the engagement that has taken place to shape the document from conversations with patients, citizens, doctors, health leaders, voluntary groups and local elected members. The narrative also invites staff and citizens to provide feedback through various forums and mechanisms. Further work is needed to make this process easier and this will take place during October/November. |
| **A review of the language and phrasing to ensure a plain English approach and to avoid inadvertently suggesting that areas of change have already been decided.** | The narrative has been amended for plain English and emphasises the importance of ongoing engagement and co-production to shape the future direction of health and care in the city. |
| **The narrative to also clarify who will make decisions in the future** | The narrative makes greater reference to decision making in 'Chapter 10: What happens next?' highlighting that:<br>• The planning of changes will be done in a much more joined up way through greater joint working between all partners involved with health and care partners, staff and citizens.<br>• Significant decisions will be discussed and planned through the Health and Wellbeing Board.<br>• Decision making however will remain in the formal bodies that have legal responsibilities for services in each of the individual health and care organisations. |
| **The Plan to include case studies. Acknowledged the need to broaden the scope of the Plan in order to "if we do this, then this how good our health and care services could be" and to provide more detail on what provision may look like in the future.** | Case studies are being co-produced with citizens and staff groups which will describe their experience now and how this should look in the future. These will be incorporated in the future iteration of the Plan as well as used in engagement sessions with communities. |

| | |
|---|---|
| **References to the role of the Leeds Health and Wellbeing Board and the Leeds Health and Wellbeing Strategy 2016-2021 to be strengthened and appear earlier in the Plan.** | The narrative in its introduction and throughout the document emphasises the role of the Leeds Health and Wellbeing Board. It also articulates that the Leeds Health and Care Plan is a description of what health and care will look like in the future and that it will contribute to the delivery of the vision and outcomes of the Leeds Health and Wellbeing Strategy 2016-2021. |
| **References to taking self-responsibility for health should also include urgent care/out of hospital health** | Narrative has been updated to reflect this. In addition, the engagement through the autumn will be joined up around Leeds Plan, plans for winter and urgent care. |
| **Assurance was sought that the Plan would be co-produced as part of the ongoing conversation** | Plans outlined in this paper for ongoing conversation and co-production during the autumn. |
| **A focus on Leeds figures rather than national** | Work is ongoing with finance and performance colleagues and will feed into the engagement through the autumn. |
| **Requested that a follow up paper with more detail, including the extended primary care model, be brought back in September.** | The narrative has a greater emphasis on the transition towards a community focused model of health and is highlighted on the Leeds Health and Care Plan on a Page. A separate update on the System Integration will be considered by the Board on 28 September 2017. |
| **Request that pharmacy services are included as part of the Leeds Plan conversations** | Pharmacy services will be engaged in the Plan conversation with citizens via their networks. The opportunity has been taken to also include dental and optometry networks. |
| **The need to be clear about the financial challenges faced and the impact on communities.** | The Narrative contains clear information of a financial gap calculated for the city. The narrative contains a list of clear risks to the current system of healthcare posed by the combination of funding, arising need and need for reform.<br><br>The presentation that accompanies the plan has been amended in light of Scrutiny comments to be clearer on the reality of financial challenges. This presentation will be used for future public events. |
| **Clarification sought in the report regarding anticipated future spending on the health and care system in Leeds.** | Scrutiny identified that the previous information in the narrative indicated the balance of expenditure would fund greater volume of community based care but also seemed to portray a significant growth in total expenditure. This diagram has been replaced by a 'Leeds Left Shift' diagram indicating more clearly the shift in healthcare resources without indicating significant growth. |
| **An update on development of a communication strategy and ensuring that the public was aware about how to access information on-line.** | This paper identifies a communication approach for the Leeds Plan and Narrative. |
| **Suggested amendments to patient participation and the role of Healthwatch Leeds.** | The section on participation is being revised to include the opportunities and approach identified by Healthwatch Leeds. |

**Appendix 1 – Outer South Community Committee Public Health Profile and Draft Area overview profiles for Middleton and Morley Integrated Neighbourhood Teams (INTs)**

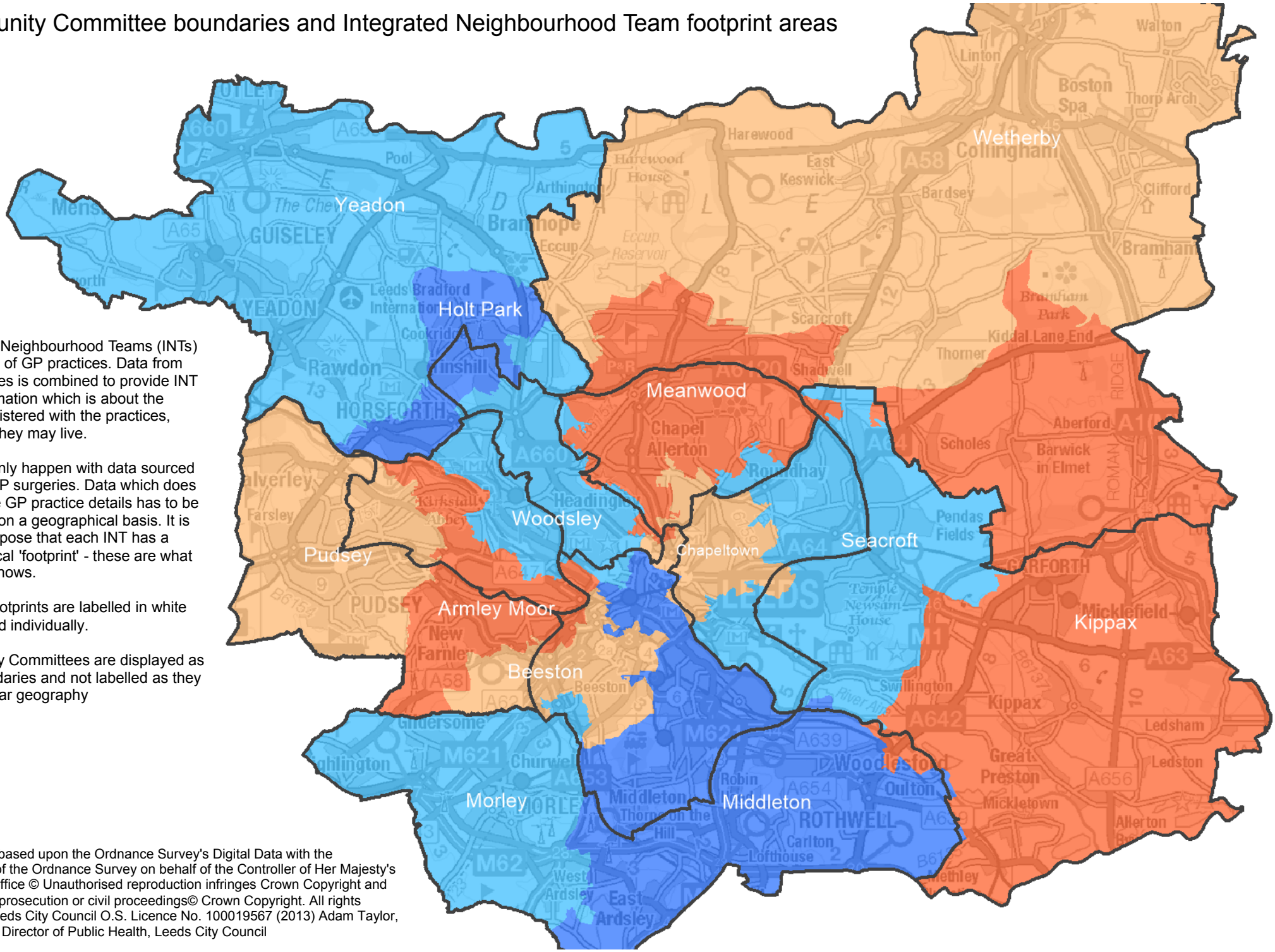
The Leeds public health intelligence team produce public health profiles at various local geographies Middle Layer Super Output Area, Ward and Community Committee.

These are available on the Leeds Observatory (http://observatory.leeds.gov.uk/Leeds_Health/). In addition, the public health intelligence team have developed profiles for Integrated Neighbourhood Teams (INTs). There are 13 in Leeds, each team is a group of health and social care staff built around localities in Leeds to deliver care tailored to the needs of an individual. Further information on services delivered through integrated neighbourhood teams is available here https://www.leedscommunityhealthcare.nhs.uk/our-services-a-z/neighbourhood-teams/. People who need care from these teams are allocated to a team based on their GP practice, we have combined GP practice level information to produce a profile for each of the 13 integrated neighbourhood teams in Leeds.

This appendix includes:

- Map of the Community Committee boundaries and Integrated Neighbourhood Team footprint areas
- Latest Outer South Community Committee Public Health Profile
- Draft Area overview profiles for Middleton and Morley Integrated Neighbourhood Teams (INTs)

# Community Committee boundaries and Integrated Neighbourhood Team footprint areas




Integrated Neighbourhood Teams (INTs) are groups of GP practices. Data from the practices is combined to provide INT level information which is about the people registered with the practices, wherever they may live.

This can only happen with data sourced from the GP surgeries. Data which does not include GP practice details has to be combined on a geographical basis. It is for this purpose that each INT has a geographical 'footprint' - these are what this map shows.

The INT footprints are labelled in white and shaded individually.

Community Committees are displayed as grey boundaries and not labelled as they are a familar geography

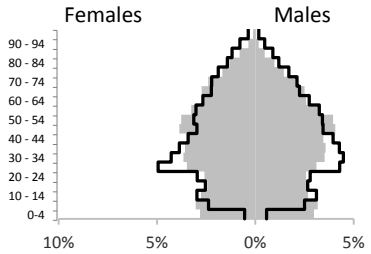
# Area overview profile for Outer South Community Committee

This profile presents a high level summary of data sets for the Outer South Community Committee, using closest match Middle Super Output Areas (MSOAs) to calculate the area.

All ten Community Committees are ranked to display variation across Leeds and this one is outlined in red.

If a Community Committee is significantly above or below the Leeds rate then it is coloured as a red or green bar, otherwise it is shown as white. Leeds overall is shown as a horizontal black line, Deprived Leeds* (or the deprived fifth**) is a dashed horizontal. The MSOAs that make up this area are shown as red circles and often range widely.

**Population: 91,203** 46,256 44,947



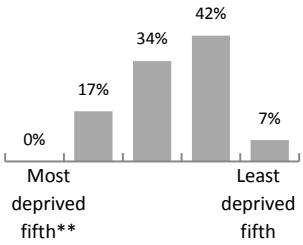

Comparison of Community Committee and Leeds age structures in April 2017. Leeds is outlined in black, Community Committee populations are shown as orange if inside the most deprived fifth of Leeds, or grey if elsewhere.

| Pupil ethnicity, top 5 | Area | % Area | % Leeds |
|---|---|---|---|
| White - British | 12,340 | 95% | 71% |
| Any other white background | 244 | 2% | 5% |
| Indian | 131 | 1% | 2% |
| White and Black Caribbean | 106 | 1% | 1% |
| Any other mixed background | 75 | 1% | 2% |

(January 2017, top 5 in Community committee, corresponding Leeds value)

**Deprivation distribution**

Proportions of this population within each deprivation 'quintile' or fifth of Leeds (Leeds therefore has equal proportions of 20%), April 2017.




| Pupil language, top 5 | Area | % Area | % Leeds |
|---|---|---|---|
| English | 13,303 | 99% | 87% |
| Polish | 56 | 0% | 1% |
| Panjabi | 5 | 0% | 1% |
| Other than English | 5 | 0% | 1% |
| Czech | 5 | 0% | 0% |

(January 2017, top 5 in Community committee, corresponding Leeds value)

| GP recorded ethnicity, top 5 | % Area | % Leeds |
|---|---|---|
| White British | 66% | 62% |
| Other White Background | 13% | 9% |
| Not Recorded | 10% | 6% |
| (blank) | 4% | 4% |
| Not Stated | 2% | 2% |

(April 2017, top 5 in Community committee, and corresponding Leeds values)

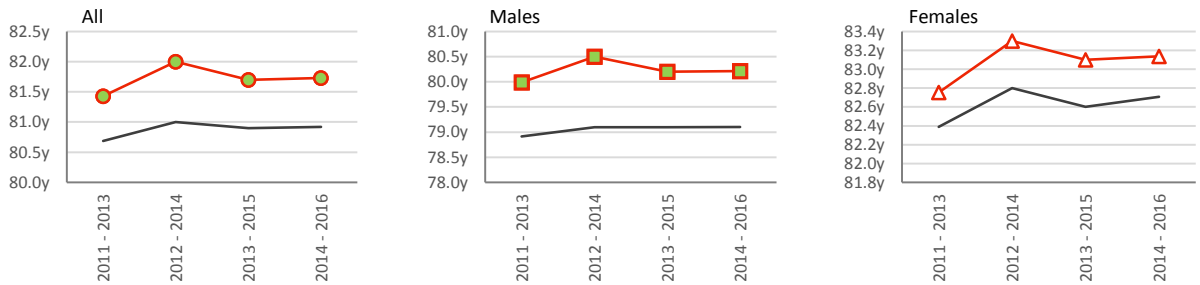
**Life expectancy at birth, 2014-16 ranked Community Committees** *ONS and GP registered populations*


| (years) | All | Males | Females |
|---|---|---|---|
| Outer South CC | 81.7 | 80.2 | 83.1 |
| Leeds resident | 80.9 | 79.1 | 82.7 |
| Deprived Leeds* | 76.6 | 74.4 | 79.0 |

*"How different is the life expectancy here to Leeds?"*

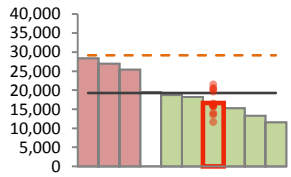
The three charts below show life expectancy for people, men, and women in this Community Committee in red against Leeds. The Community Committee points are coloured red if the it is significantly worse than Leeds, green if better than Leeds, and white if not significantly different.

Life expectancy overall, and for men is significantly better than that of Leeds and it has been this way since 2011-13. Female life expectancy is also higher than Leeds.



## GP recorded conditions, persons (DSR per 100,000)

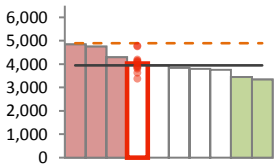
*GP data*




**Smoking (16y+)**

| | |
|---|---|
| Outer South CC | 16,616 |
| Leeds | 19,265 |
| Deprived fifth** | 29,163 |

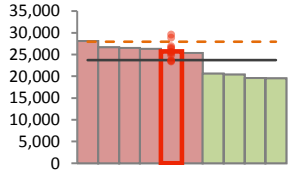
(April 2017)




**CHD**

| | |
|---|---|
| Outer South CC | 4,024 |
| Leeds | 3,947 |
| Deprived fifth | 4,894 |

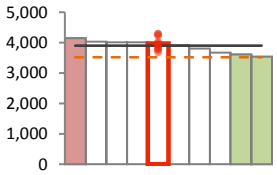
(January 2017)




**Obesity (16y+ and BMI>30)**

| | |
|---|---|
| Outer South CC | 25,735 |
| Leeds | 23,722 |
| Deprived fifth | 27,951 |

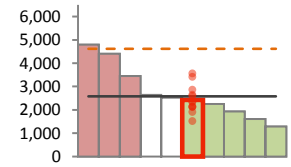
(April 2017)




**Cancer**

| | |
|---|---|
| Outer South CC | 3,972 |
| Leeds | 3,899 |
| Deprived fifth | 3,519 |

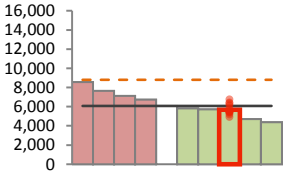
(January 2017)




**COPD**

| | |
|---|---|
| Outer South CC | 2,426 |
| Leeds | 2,580 |
| Deprived fifth | 4,617 |

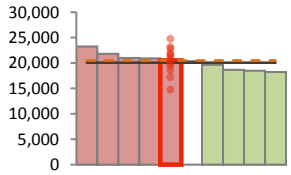
(April 2017)




**Diabetes**

| | |
|---|---|
| Outer South CC | 5,689 |
| Leeds | 6,076 |
| Deprived fifth | 8,802 |

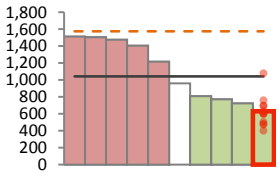
(April 2017)




**Common mental health**

| | |
|---|---|
| Outer South CC | 20,496 |
| Leeds | 20,060 |
| Deprived fifth | 20,496 |

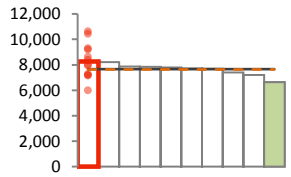
*(January 2017)*




**Severe mental health**

| | |
|---|---|
| Outer South CC | 628 |
| Leeds | 1,042 |
| Deprived fifth | 1,574 |

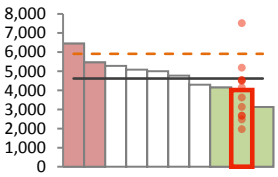
*(January 2017)*




**Asthma in children**

| | |
|---|---|
| Outer South CC | 8,267 |
| Leeds | 7,659 |
| Deprived fifth | 7,633 |

*(October 2016)*




**Dementia (over 65s)**

| | |
|---|---|
| Outer South CC | 4,011 |
| Leeds | 4,618 |
| Deprived fifth | 5,911 |

*(January 2017)*

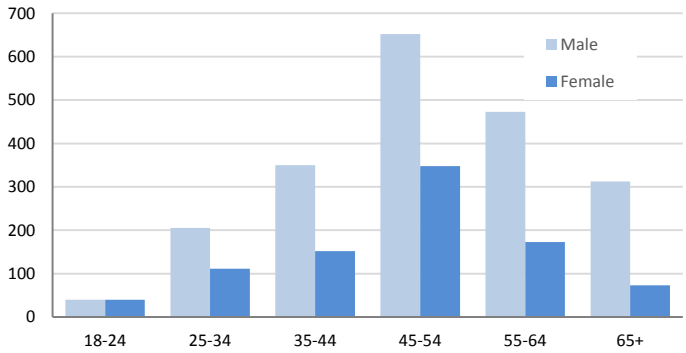
The GP data charts show all ten Community Committees in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. GP data can only reflect those patients who visit their doctor. Certain groups within the population are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture. This data includes all Leeds GP registered patients who live within the Community Committee. Obesity here is the rate within the population who have a recorded BMI.

## Alcohol dependency - the Audit-C test

*GP data, April 2017*

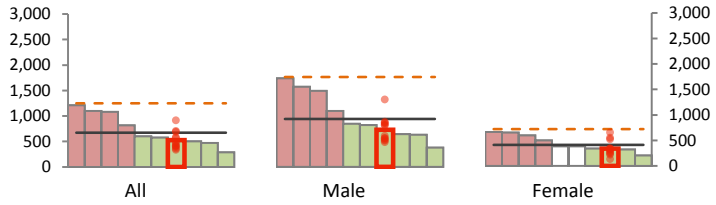
The Audit-C test assesses a patients drinking habits, assigning them a score. Patients scoring 8 or higher are considered to be at 'increasing risk' due to their alcohol consumption.

In Leeds, almost half of the adult population have an Audit-C score recorded by a GP. This chart displays the *number* of patients living inside the Community Committee boundary who have a score of 8 or higher.



## Alcohol specific hospital admissions, 2012-14 ranked

*HES*




| (DSR per 100,000) | All | Males | Females |
|---|---|---|---|
| Outer South | 524 | 723 | 338 |
| Leeds resident | 673 | 934 | 412 |
| Deprived Leeds* | 1,249 | 1,752 | 722 |

## Mortality - under 75s, age Standardised Rates per 100,000

*ONS and GP registered populations*

*"How different are the sexes in this area?"*

Males
Females
Persons

Shaded if significantly > persons
Shaded if significantly < persons

*"How different is this area to Leeds?"*

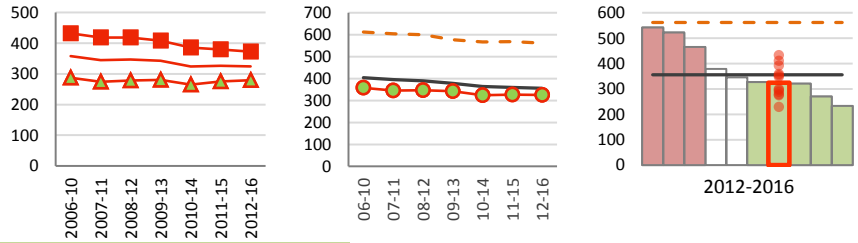
Persons
Leeds
Deprived fifth**

Shaded if significantly > Leeds
Shaded if significantly < Leeds

*"Where is this Community Committee in relation to the others and Leeds?"*

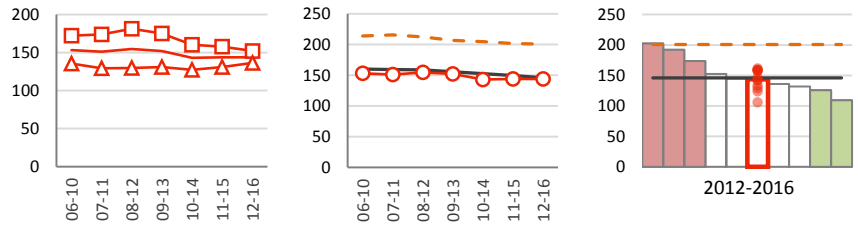
Community Committees are ranked by their most recent rates and coloured as red or green if their rate is significantly above or below that of Leeds. Rates for small areas within this Community Committee are shown as red dots. This Community Committee is highlighted with a red border.

### All cause mortality - under 75s



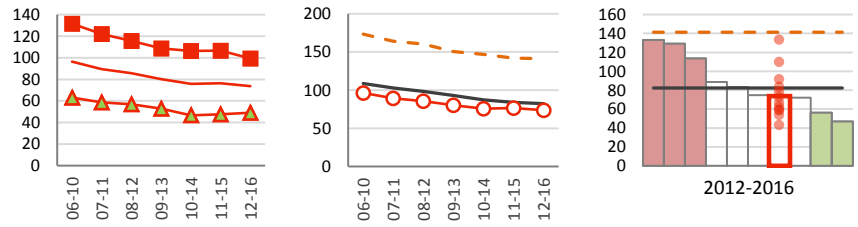

| Persons (DSR per 100,000) | |
|---|---|
| Community Committee | 325 |
| *Count of deaths in 2012-16* | *1,230* |
| Leeds resident | 356 |
| Deprived fifth** | 562 |

### Cancer mortality - under 75s



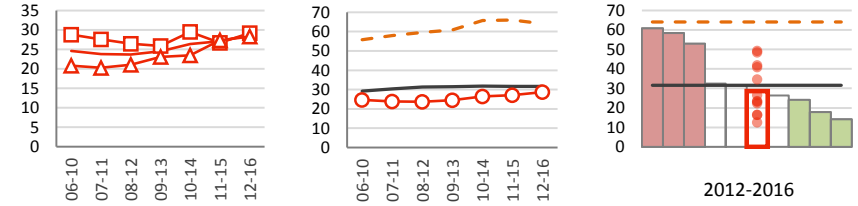

| Persons (DSR per 100,000) | |
|---|---|
| Community Committee | 144 |
| *Count of deaths in 2012-16* | *541* |
| Leeds resident | 146 |
| Deprived fifth | 201 |

### Circulatory disease mortality - under 75s




| Persons (DSR per 100,000) | |
|---|---|
| Community Committee | 74 |
| *Count of deaths in 2012-16* | *274* |
| Leeds resident | 82 |
| Deprived fifth | 141 |

### Respiratory disease mortality - under 75s




| Persons (DSR per 100,000) | |
|---|---|
| Community Committee | 29 |
| *Count of deaths in 2012-16* | *105* |
| Leeds resident | 32 |
| Deprived fifth | 64 |

DSR - Directly Standardised Rate removes the effect that differing age structures have on data, allows comparison of 'young' and 'old' areas.

**Outer South Community Committee**

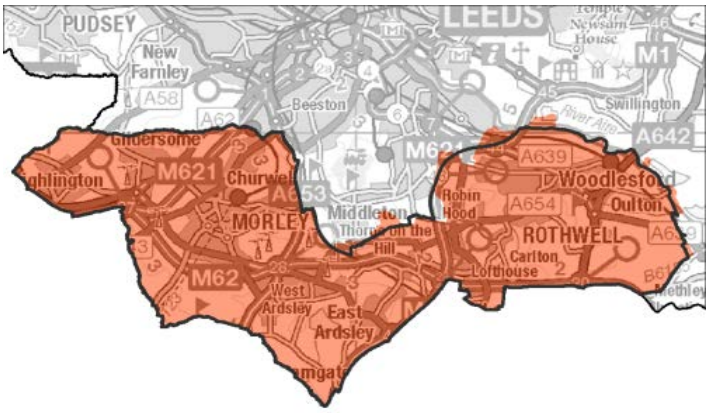
The health and wellbeing of the Outer South Community Committee contains relatively wide variation across the range of Leeds, excluding some extremes, and is overall within the mid range for the city. It is the fourth largest Community Committee in the city and none of the population live in the most deprived fifth of Leeds**. Life expectancy for the Community Committee population has for some time been significantly higher than Leeds overall. Male life expectancy is also much higher than the city. Female life expectancy though follows a similar pattern but is not significantly higher.

The age structure bears little resemblance to that of Leeds overall with fewer young adults, more young children, and very slightly greater proportions of those aged between 40 and 74. GP recorded ethnicity shows the Community Committee to have larger proportions of "White background" than Leeds. However 12% of the GP population in Leeds have no recorded ethnicity which needs to be taken into account here. The pupil survey shows a clearer but similar picture.

GP recorded smoking, COPD, diabetes, severe mental health, and dementia rates are all significantly lower than Leeds and showing relatively little variation at MSOA level. Obesity and common mental health issues though are both significantly higher than Leeds rates. The Community Committee has the highest rate of 'Asthma in children' in the city, but it is not significantly different to the Leeds rate or any other of the committees, it is worth further investigation but rates for all Community Committees are actually very similar.

Alcohol specific admissions are mostly concentrated around the mid range and almost all areas are significantly below Leeds rates – 'Morley East' MSOA stands out as the MSOA with highest rate in the Committee area. All-cause mortality for under 75s for the Community Committee is significantly below the Leeds rate but may be flattening off while the city continues to slowly drop. This is due to female rates beginning to increase in recent years. The same increase in female mortality rates can be seen in the three main causes of death. The 'Morley West' MSOA has the highest rates in the Community Committee for most causes of death.

The ***Map*** *shows this Community Committee as a black outline. Health data is available at MSOA level and must be aggregated to best-fit the committee boundary. The MSOAs used in this report are shaded orange.*




** **Deprived Leeds:** areas of Leeds within the 10% most deprived in England, using the Index of Multiple Deprivation.*
****Most deprived fifth of Leeds** - Leeds split into five areas from most to least deprived.*

# Area overview profile for Middleton Integrated Neighbourhood Team

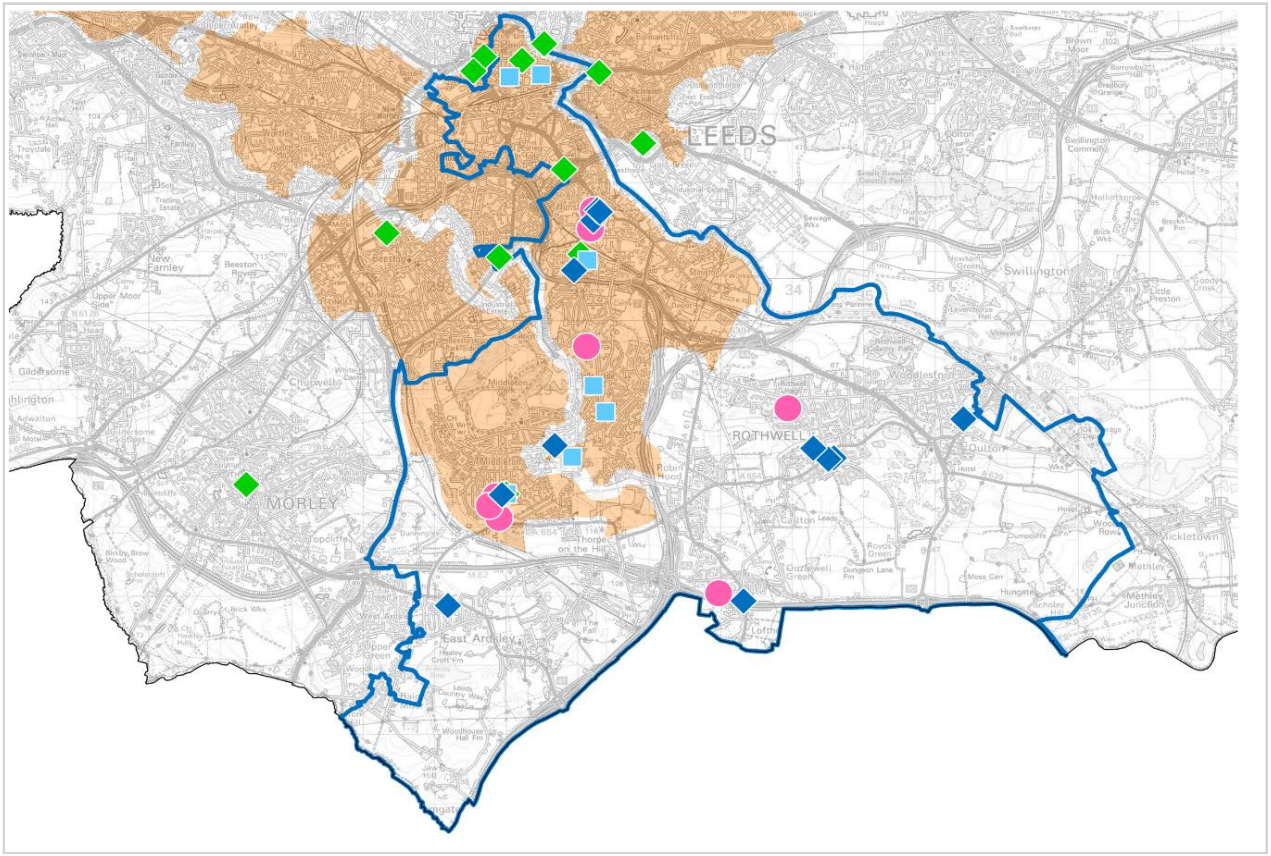
November 2017

This profile presents a high level summary using practice membership data. When not available at practice level data is aggregated to INT footprint on a geographical basis.

The INT has a similar population age structure to Leeds but with slightly larger proportions of children and fewer students and young adults. Deprivation skews to the more deprived end of the scale with over 40% of the population living in the most deprived two fifths of the city. The "White British" ethnic group is slightly more represented in the INT than Leeds as a whole.

This INT has the 3rd largest number of elderly patients in the city. Child obesity in the reception year is second highest in the city. Year 6 rates are mid-range. Two of the 5 most deprived children's clusters overlap this INT footprint, and show low primary school achievement, large numbers of looked after children, and high numbers of NEET. Smoking, obesity, diabetes, CHD, COPD and common mental health rates are all significantly higher than Leeds. Dementia rates are second highest in the city.

The social isolation index shows one small area in the INT footprint with high scores but generally widely ranging scores for the rest of the area. Male and female mortality rates show large differences with male rates being higher. General INT rates are now closer to Leeds but in the past have been significantly higher. Respiratory disease mortality though is still significantly above Leeds.




Practices with more than one branch in this INT are listed once here and appear multiple times in the map: Oulton Medical Centre & Marsh Street Surgery. Church Farm Close Medical Practice. The Whitfield Practice. Lingwell Croft Surgery. Leigh View Medical Practice. Grange Medicare. Arthington Medical Centre. Dr Khan And Partner. Church Street Surgery. Middleton Park Surgery.

Note: A small number of practices have branches that are far enough apart to fall into different INTs. These practices are not listed here or shown in the map. The original INT boundaries do not relate to statistical geographies and so this footprint which is a nearest match LSOA area is used when aggregating geographical data.

INT footprint boundary
Most deprived 5 Children's Clusters
GP practice - member of INT
Children's centre within INT footprint
Community Health Development venue
Voluntary Community Sector venue

# Area overview profile for Middleton Integrated Neighbourhood Team

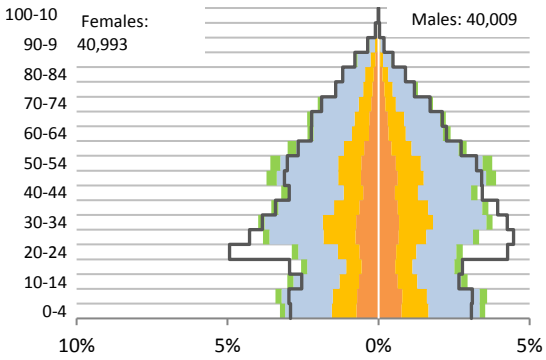
This profile presents a high level summary of data for the Middleton Integrated Neighbourhood Team (INT), using practice membership data. In a small number of cases, practices and branches are members of different INTs, to account for this, their patient data is allocated to the INT their nearest branch belongs to. Where data is not available at practice level it is aggregated to INT footprint on a purely geographical basis ⚡.

All INTs are ranked to display variation across Leeds and this one is outlined in blue. Practices belonging to this INT are shown as individual blue dots. Actual counts are shown in blue text. Leeds overall is shown as dark grey, the most deprived fifth of Leeds** is shown in orange.

Where possible, INTs are colour coded red or green if rates are significantly worse or better than Leeds.

## Population: 81,002 in April 2017 *GP data*

Comparison of INT and Leeds age structures. Leeds is outlined in black, INT populations are shown as dark and light orange if resident inside the 1st or 2nd most deprived fifth of Leeds, and green if in the least deprived.

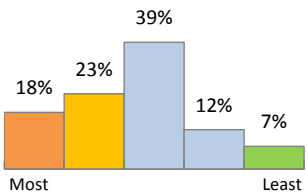



| GP recorded ethnicity, top 5 | % INT | % Leeds |
|---|---|---|
| White British | 75% | 62% |
| Other White Background | 7% | 9% |
| Not Recorded | 7% | 6% |
| Not Stated | 2% | 2% |
| Black African | 2% | 3% |

*(April 2017)*

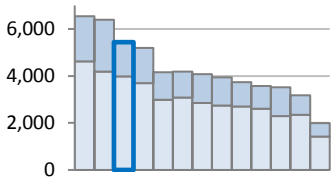
## Deprivation distribution

Proportions of INT within each deprivation fifth of Leeds April 2017. Leeds has equal proportions. **




## Aged 74+ *(April 2017)*

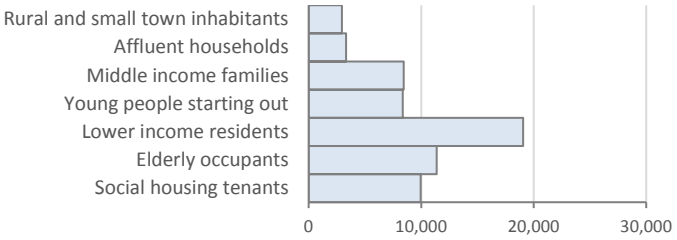
INTs ranked by number of patients aged over 74. 74y-84y in dark green, 85y and older in light green.




## Mosaic Groups in this INT population *(October 2017)*

The INT population as it falls into Mosaic population segment groups. These are counts of INT registered patients who have been allocated a Mosaic type using location data in October 2017.

http://www.segmentationportal.com




## Population counts in ten year age bands for each INT *(April 2017)*

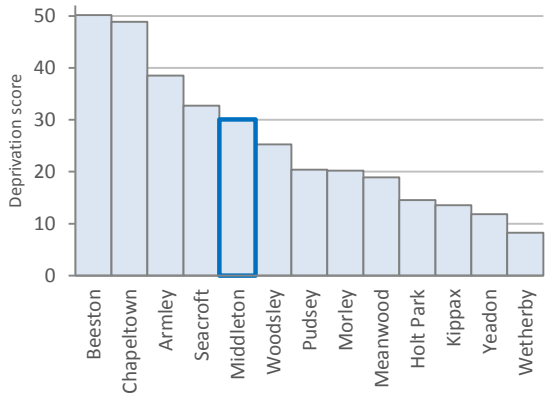
| | Woodsley | Chapeltown | Meanwood | Middleton | Seacroft | Armley | Yeadon | Pudsey | Beeston | Morley | Holt Park | Kippax | Wetherby |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 80+ | 2,266 | 2,103 | 4,224 | 3,185 | 3,976 | 2,521 | 3,119 | 2,465 | 1,198 | 1,804 | 2,455 | 2,392 | 2,220 |
| 70-79 | 3,066 | 3,249 | 5,265 | 5,341 | 5,933 | 3,907 | 5,111 | 3,778 | 1,830 | 3,438 | 3,431 | 4,320 | 3,754 |
| 60-69 | 5,028 | 5,569 | 8,194 | 7,550 | 8,094 | 6,016 | 7,053 | 5,489 | 3,023 | 4,713 | 4,591 | 4,986 | 4,128 |
| 50-59 | 6,802 | 9,376 | 10,627 | 10,747 | 10,471 | 8,843 | 8,182 | 6,979 | 4,799 | 6,151 | 5,431 | 5,728 | 4,469 |
| 40-49 | 8,717 | 13,132 | 12,437 | 11,412 | 10,251 | 9,257 | 8,319 | 7,734 | 6,123 | 6,499 | 5,692 | 5,656 | 4,141 |
| 30-39 | 17,473 | 20,275 | 14,961 | 12,099 | 10,462 | 11,065 | 7,156 | 8,386 | 8,130 | 6,610 | 6,307 | 4,886 | 3,099 |
| 20-29 | 53,913 | 20,411 | 10,616 | 10,372 | 10,107 | 10,101 | 5,665 | 6,427 | 6,945 | 5,286 | 5,116 | 4,474 | 2,448 |
| 10-19 | 13,339 | 11,955 | 8,778 | 9,119 | 9,000 | 7,281 | 6,128 | 5,406 | 5,244 | 4,418 | 4,408 | 4,274 | 3,050 |
| 00-09 | 7,297 | 15,190 | 11,384 | 11,179 | 9,970 | 9,021 | 6,358 | 6,995 | 6,800 | 5,130 | 5,313 | 4,322 | 3,067 |
| Total | 117,901 | 101,260 | 86,486 | 81,004 | 78,264 | 68,012 | 57,091 | 53,659 | 44,092 | 44,049 | 42,744 | 41,038 | 30,376 |

## Deprivation and the population of Middleton INT

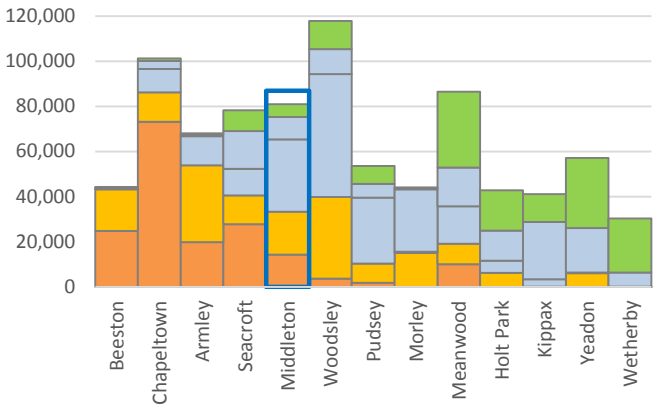
*IMD2015 and GP data*

The INT deprivation score is calculated using the count and locations of patients registered with member practices in April 2017, and the Index of Multiple Deprivation 2015 (IMD). The larger the deprivation score, the more prominent the deprivation within the INT population. This INT deprivation score is 30.1, ranked number 5 in Leeds.

### INTs ranked by deprivation *score*




### INT population *sizes* ranked by deprivation score

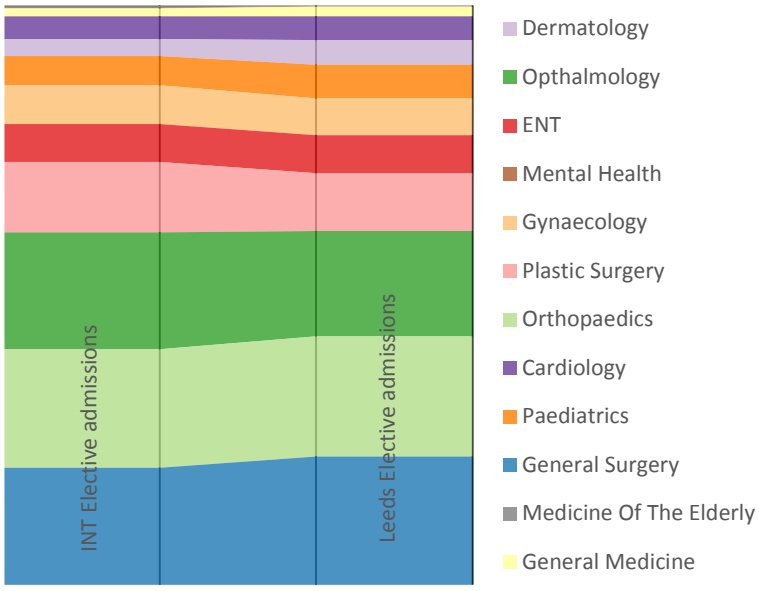



## Hospital admissions for this INT by specialty (2016/17)

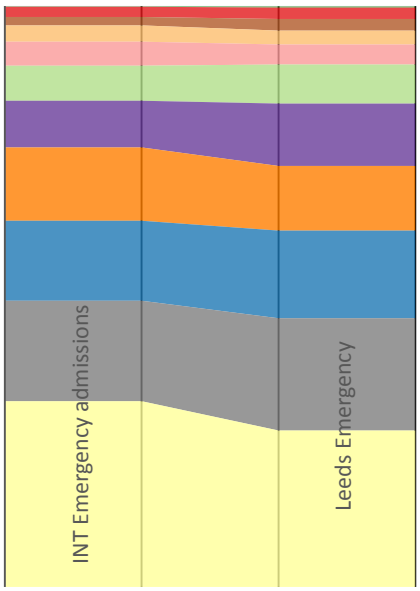
Elective (non-emergency) and emergency admission proportions for this INT are compared to Leeds below. Admissions data is divided between twelve hospital specialties and the additional group of 'others' which is where an admission does not have a recognised specialty assigned to it.

Non-emergency and emergency admission patterns obviously differ significantly, but of interest here is how the INT might differ to Leeds overall. The two charts us the same colour coding and both rank specialties by their contribution to Leeds overall, (the 'others' group is not charted or included in top 5 lists)

### Proportions of Elective admissions. INT vs Leeds




### Proportions of Emergency admissions. INT vs Leeds

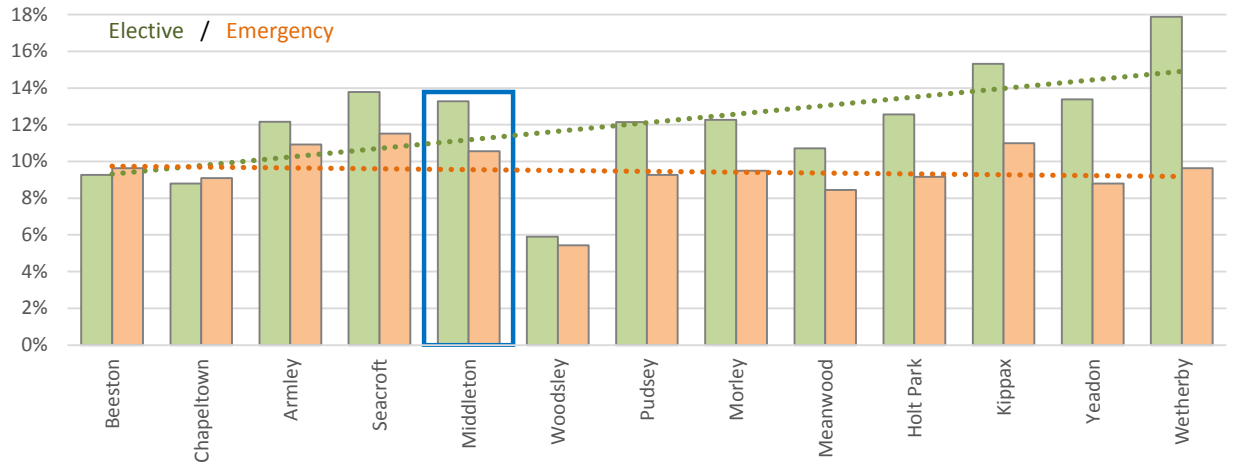



| INT Elective admissions top 5 | | *% of INT admissions* | *Leeds proportion* |
|---|---|---|---|
| 1st | Orthopaedics | *11%* | 11% |
| 2nd | General Surgery | *10%* | 12% |
| 3rd | Opthalmology | *10%* | 10% |
| 4th | Plastic Surgery | *6%* | 5% |
| 5th | Gynaecology | *3%* | 3% |

| INT Emergency admissions top 5 | | *% of INT admissions* | *Leeds proportion* |
|---|---|---|---|
| 1st | General Medicine | *22%* | *16%* |
| 2nd | Medicine Of The Elderly | *12%* | *12%* |
| 3rd | General Surgery | *9%* | *9%* |
| 4th | Paediatrics | *8%* | *7%* |
| 5th | Cardiology | *5%* | *7%* |

## Elective and emergency admission *rates* and deprivation

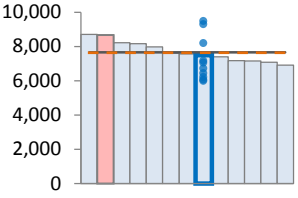
Hospital admission rates as percentage of whole INT populations. The INTs are *ordered by deprivation score* and there is a clear increase in proportion of elective admissions (green) as INTs become less deprived. Emergency admissions show a slightly inverted relationship with deprivation at INT level.




*Numerator: Count of all admissions. Denominator: Oct 2016 Leeds resident and registered population*

# Healthy children

## Asthma in children October 2016 (DSR per 100,000) — *GP data*

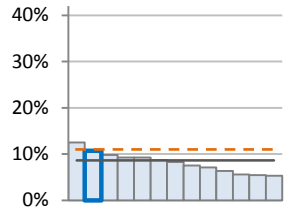



**Asthma - under 16s**

| | |
|---|---|
| INT | 7,498 |
| Leeds registered | 7,659 |
| Deprived fifth** | 7,633 |
| *INT count* | *991* |

*GP recorded* asthma in the under 16s, age standardised rates (DSR) per 100,000. Only the Seacroft INT asthma rate is significantly different to the Leeds rate.

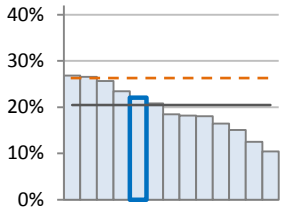
## Child obesity 2015-16 ⚡ — *NCMP, aggregated from LSOA to INT boundary*




**Obesity in Reception year**

| | |
|---|---|
| INT | 10.7% |
| Leeds registered | 8.6% |
| Deprived fifth** | 11.0% |

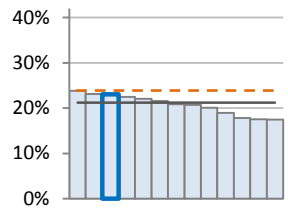
91 of 851 children in INT




**Obesity in Year 6**

| | |
|---|---|
| INT | 22.1% |
| Leeds registered | 20.5% |
| Deprived fifth** | 26.3% |

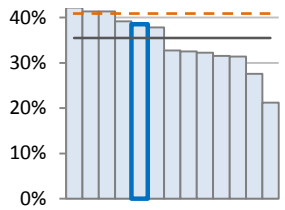
*157 of 711 children in INT*




**Obese *or* overweight, Reception year**

| | |
|---|---|
| INT | 23.0% |
| Leeds registered | 21.2% |
| Deprived fifth** | 23.9% |

*196 of 851 children*



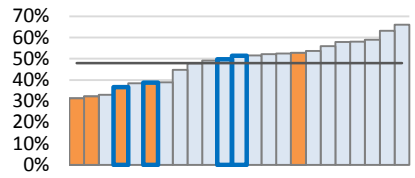

**Obese *or* overweight, Year 6**

| | |
|---|---|
| INT | 38.5% |
| Leeds registered | 35.5% |
| Deprived fifth** | 40.9% |

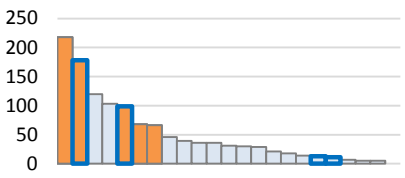
*274 of 711 children*

## Children's cluster data ⚡ — *Children and Young People's Plan Key Indicator Dashboard July 2017*

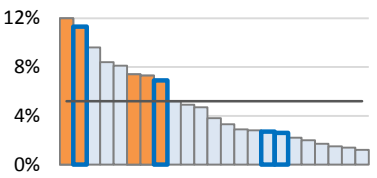
All 23 **Children's clusters** in Leeds, ranked below. Each INT footprint may be *overlapped* by one or more clusters and those having significant overlap with this INT are outlined in blue below. The five most deprived clusters in the city are shown in orange.




% with good achievement at the end of primary school (schools)



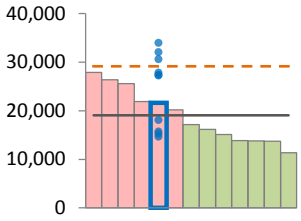

Looked after children




NEET - 'Not in education, employment or training'

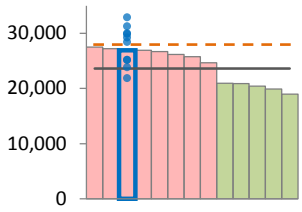
## Healthy adults

*GP data (April 2017)*




**Smoking (16y+)**

| | |
|---|---|
| INT | 21,612 |
| Leeds registered | 19,045 |
| Deprived fifth** | 29,163 |
| *INT count* | *14,311* |




**Obesity (BMI>30)**

| | |
|---|---|
| INT | 26,924 |
| Leeds registered | 23,606 |
| Deprived fifth** | 27,951 |
| *INT count* | *15,997* |

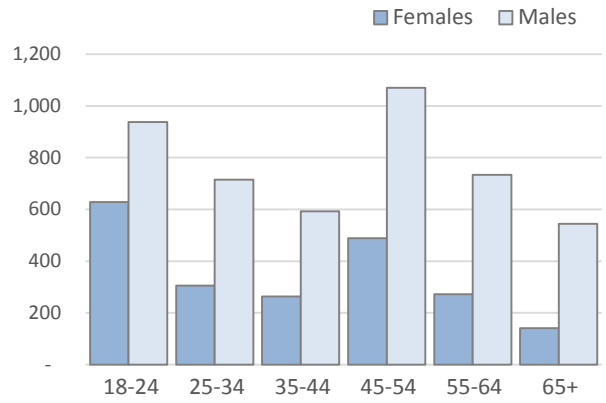
(Within the population who have a recorded BMI)

## Audit-C alcohol dependency

*GP data. Quarterly data collection, April 2017*

The Audit-C test assesses a patients drinking habits, assigning them a score. Patients scoring 8 or higher are considered to be at 'increasing risk' due to their alcohol consumption. In Leeds, almost half of the adult population have an Audit-C score recorded by a GP. Rates for age bands and females in Leeds are applied here to the INT registered population to form a picture of the alcohol risk in the whole INT adult population.

The table and chart below show the **predicted numbers of adults in this INT** registered population who would score 8 or higher.

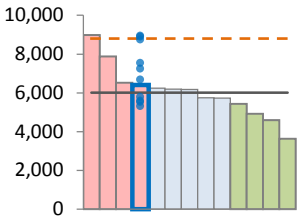



| | 18-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65+ |
|---|---|---|---|---|---|---|
| Females | 628 | 305 | 263 | 488 | 272 | 141 |
| Males | 937 | 715 | 593 | 1,070 | 733 | 544 |
| Persons | 1,501 | 1,022 | 863 | 1,557 | 1,014 | 704 |

## Long term conditions, adults and older people

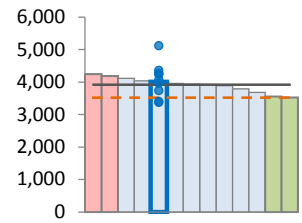
*GP data*

GP data. Quarterly data collection, April 2017 (DSR per 100,000)



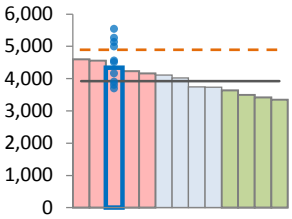

**Diabetes**

| | |
|---|---|
| INT | 6,409 |
| Leeds registered | 6,021 |
| Deprived fifth** | 8,802 |
| *INT count* | *4,391* |



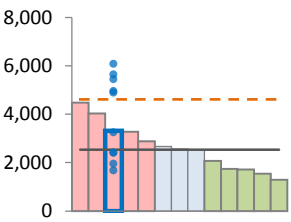

**Cancer**

| | |
|---|---|
| INT | 4,004 |
| Leeds registered | 3,915 |
| Deprived fifth** | 3,519 |
| *INT count* | *2,646* |




**CHD**

| | |
|---|---|
| INT | 4,338 |
| Leeds registered | 3,926 |
| Deprived fifth** | 4,894 |
| *INT count* | *2,774* |




**COPD**

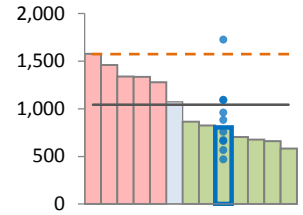
| | |
|---|---|
| INT | 3,319 |
| Leeds registered | 2,537 |
| Deprived fifth** | 4,617 |
| *INT count* | *2,187* |

*Diabetes and COPD - April 2017. CHD and cancer - January 2017*

## Long term conditions, adults and older people continued

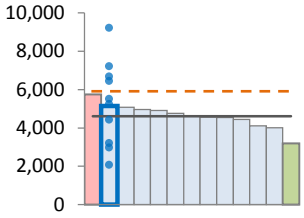
*GP data (January 2017)*

GP data. Quarterly data collection, (DSR per 100,000)



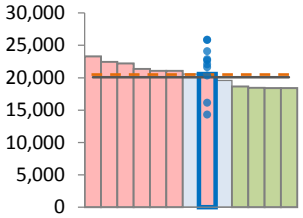

**Severe mental heath**

| | |
|---|---|
| INT | 806 |
| Leeds registered | 1,042 |
| Deprived fifth** | 1,574 |
| *INT count* | *589* |




**Dementia (65+)**

| | |
|---|---|
| INT | 5,138 |
| Leeds registered | 4,618 |
| Deprived fifth** | 5,911 |
| *INT count* | *601* |




**Common mental health**

| | |
|---|---|
| INT | 20,558 |
| Leeds registered | 20,060 |
| Deprived fifth** | 20,496 |
| *INT count* | *15,549* |

The GP data charts show all 13 INTs in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. Where the INT is significantly above or below Leeds is it shaded red or green, if there is no significant difference then it is shown in blue. Blue circle indicators show rates for practices which are a member of the INT, in some instances scales are set which mean practices with extreme values are not seen.

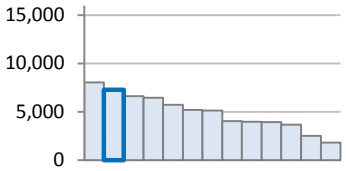
***Most deprived fifth, or quintile of Leeds - divides Leeds into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSOA2011 areas. GP data only reflects those patients who visit their doctor, certain groups are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture.*

## Life limiting illness ⊁

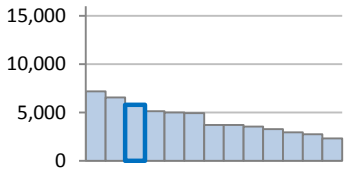
*Census 2011, aggregated from MSOA to INT boundary*

INTs ranked by *number* of people reporting life limiting illness

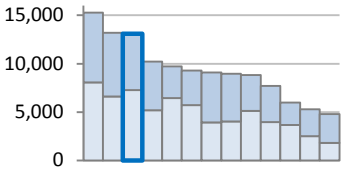
Life limiting illness, under 65



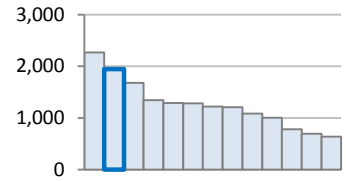

Life limiting illness, over 65




Life limiting illness all ages.
Under 65 years old in dark green. 65y and older in light green



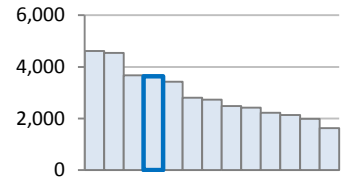

## Carers providing 50+ hours care/week ⊁




The number of people within the INT *area* in these categories are shown in the table below, the INT ranking position in Leeds is also shown.

⊁ This data is not related to INT practice membership so cannot be related back to practice membership of the INT. However each INT has a crude boundary allowing geographical data such as this to be allocated on that basis instead.

## One person households aged 65+ ⊁



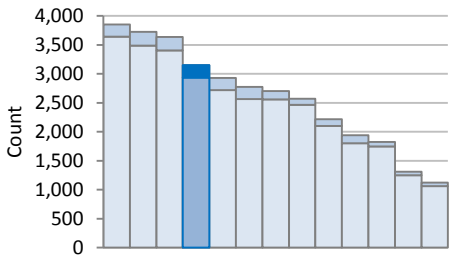

| | number | rank |
|---|---|---|
| Limiting Long Term Illness - All Ages | *13,078* | 3 |
| Limiting Long Term Illness - under 65 | *7,274* | 2 |
| Limiting Long Term Illness - 65+ | *5,804* | 3 |
| Providing 50+ hours care/week | *1,949* | 2 |
| One person households aged 65+ | *3,641* | 4 |

## People living with frailty and 'end of life'

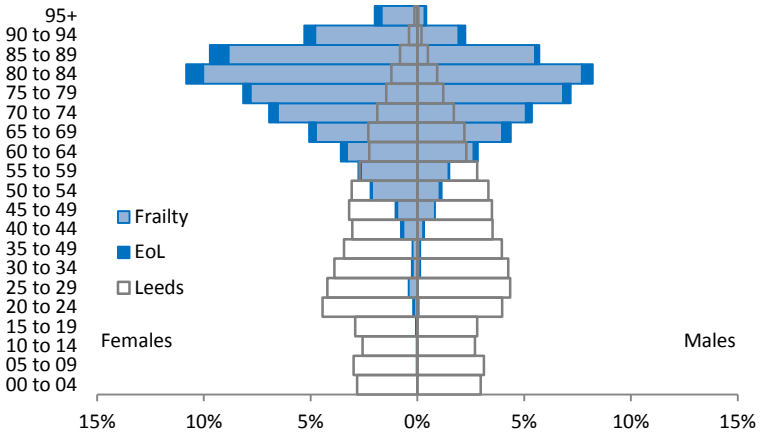
*Leeds data model September 2016 cohort*

Leeds Integrated Neighbourhood Teams ranked by combined count of End of Life and Frailty populations.

Total: 3,151. Frailty 2,937. End of life 214




INT (in blue) compared to Leeds by gender and age band.

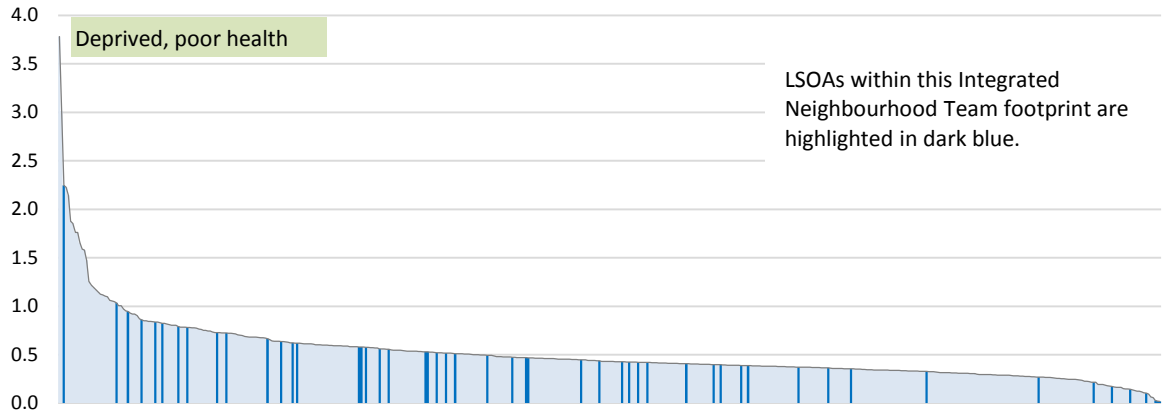


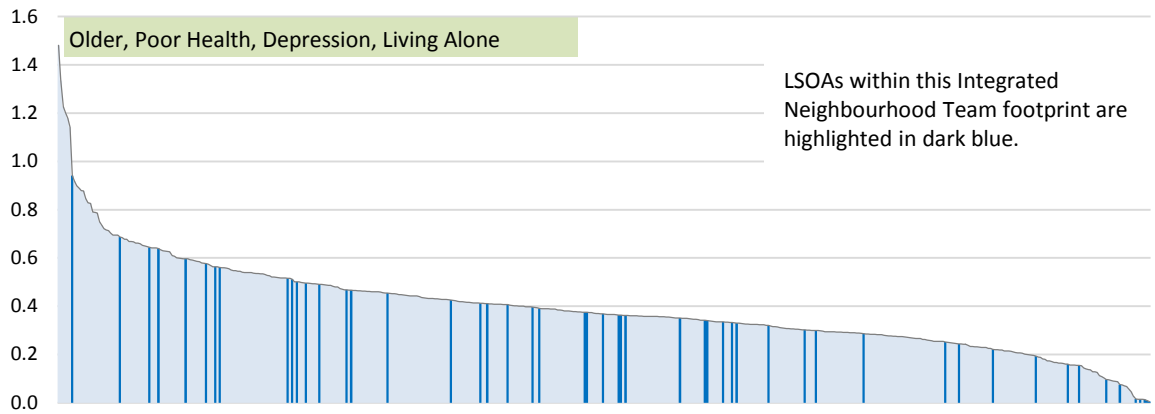

## Social Isolation Index ⊀

*LSOAs in INT footprint*

The Social Isolation Index visualises some of the broader determinants of health and social isolation as experienced by the older population. It brings together a range of indicators pulled from clinical, census and police sources. A shortlist was then used to generate population indexes, for two demographic groups across Leeds; 'Deprived, Poor Health' and 'Older, Poor Health, Depression, Living Alone'.

Each demographic group has a separate combination of indicators in order to better target the group characteristics, and variations in population sizes are removed during the index creation. The index levels show the likelihood a small area has of containing the demographic group in question. The higher the index score, the greater the probability that "at risk" demographics will be present, an area ranking 1st in Leeds is the most isolated in terms of that index. These charts show all Lower Super Output Areas (LSOAs) in Leeds, ranked by the indexes.



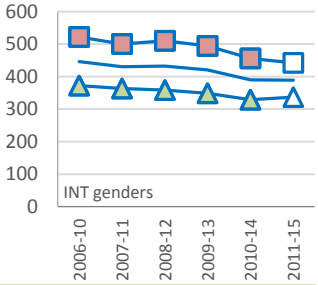

To find out more about the construction of the index, please contact James.Lodge@leeds.gov.uk

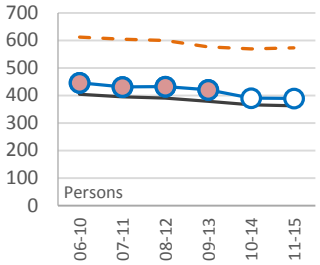
## Mortality, under 75s, age standardised rates per 100,000

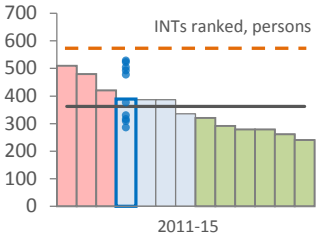
*ONS and GP registered populations*

| *"How different are the sexes in this INT"* | *"How different is this INT to Leeds"* | *"Where is this INT in relation to the others, and Leeds"* |
|---|---|---|
| INT Males | INT persons | INTs are ranked by the most recent rates and coloured as red or green if their rate is significantly above or below that of Leeds. Practice rates for those within this INT are shown as blue dots. This INT is highlighted with a blue border. |
| INT Females | Leeds | |
| INT Persons | Deprived fifth of Leeds** | |
| Shaded if significantly above Persons | Shaded if significantly above Leeds | |
| Shaded if significantly below Persons | Shaded if significantly below Leeds | |

### All cause mortality

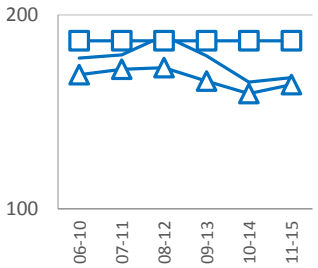


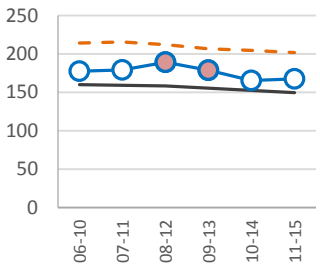



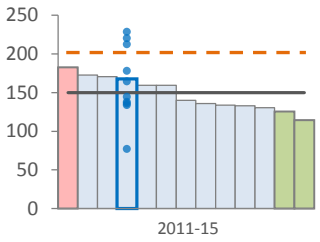




| Persons (DSR per 100,000) | |
|---|---|
| INT | 389 |
| Leeds resident | 363 |
| Deprived fifth** | 573 |
| *INT count* | *1,125* |

### Cancer mortality

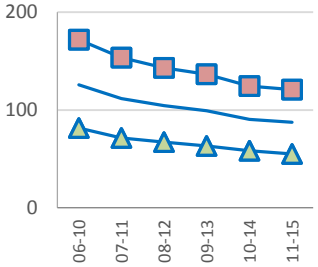


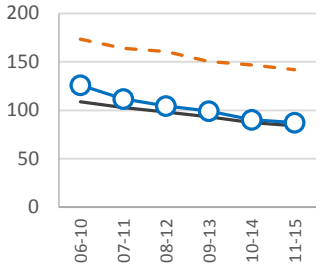



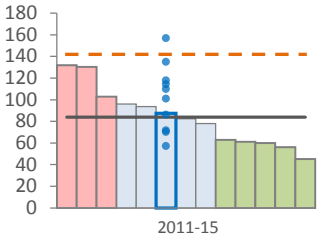




| Persons (DSR per 100,000) | |
|---|---|
| INT | 168 |
| Leeds resident | 150 |
| Deprived fifth** | 202 |
| *INT count* | *476* |

### Circulatory disease mortality

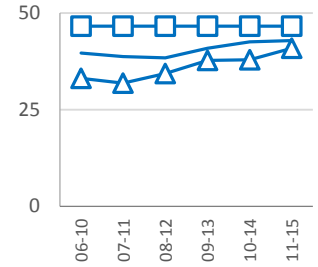


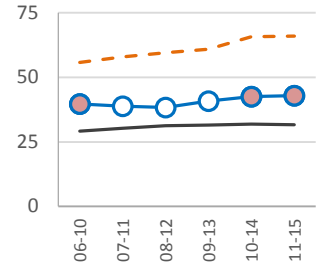



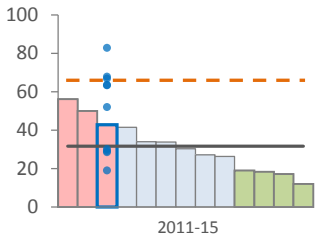




| Persons (DSR per 100,000) | |
|---|---|
| INT | 87 |
| Leeds resident | 84 |
| Deprived fifth** | 142 |
| *INT count* | *248* |

### Respiratory disease mortality




| Persons (DSR per 100,000) | |
|---|---|
| INT | 43 |
| Leeds resident | 32 |
| Deprived fifth** | 66 |
| *INT count* | *117* |

*GP data courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city.*

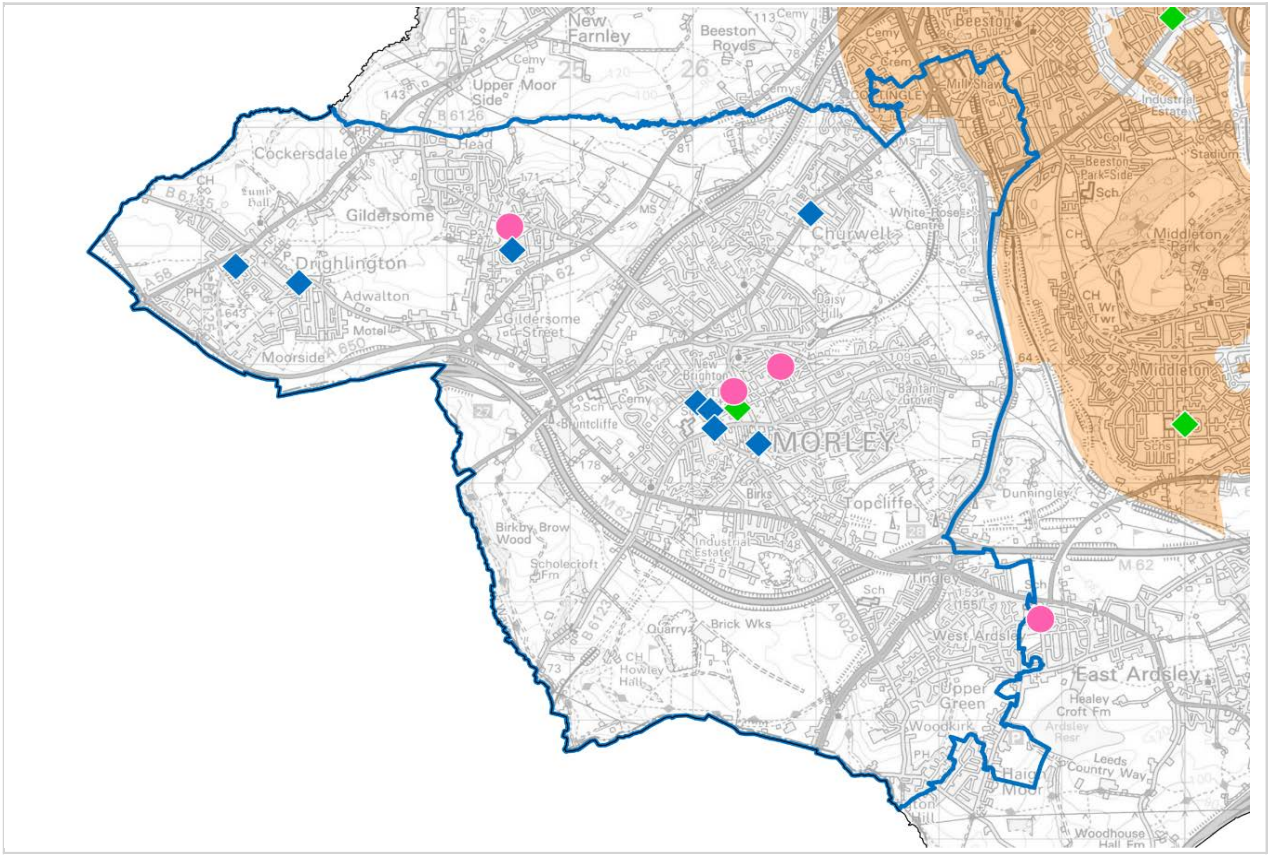
# Area overview profile for Morley Integrated Neighbourhood Team

November 2017

This profile presents a high level summary using practice membership data. When not available at practice level data is aggregated to INT footprint on a geographical basis.

The INT has a similar population structure to Leeds but without the student and young adult ageband bulge. It also has a very large proportion of "Other white background" ethnicity compared to Leeds. 1 in 3 of the population are living in the second most deprived fifth of the city.

Obesity, and Common mental health rates are significantly above Leeds but all other GP recorded conditions are at or below Leeds rates. Some small areas in the INT footprint show high Social Isolation index scores. Mortality rates show the usual male / female differences but overall rates are below Leeds and for all cause mortality they are significantly below the Leeds rate.




Practices with more than one branch in this INT are listed once here and appear multiple times in the map: Morley Health Centre Surgery. South Queen Street Medical Centre. Windsor House Group Practice. The Fountain Medical Centre. Gildersome Health Centre. Drighlington Medical Centre.

Note: A small number of practices have branches that are far enough apart to fall into different INTs. These practices are not listed here or shown in the map. The original INT boundaries do not relate to statistical geographies and so this footprint which is a nearest match LSOA area is used when aggregating geographical data.

INT footprint boundary
Most deprived 5 Children's Clusters
GP practice - member of INT
Children's centre within INT footprint
Community Health Development venue
Voluntary Community Sector venue

# Area overview profile for Morley Integrated Neighbourhood Team

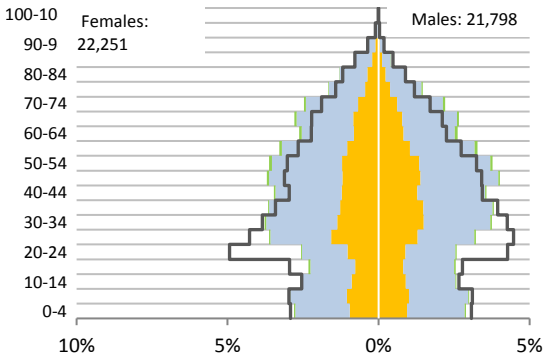
This profile presents a high level summary of data for the Morley Integrated Neighbourhood Team (INT), using practice membership data. In a small number of cases, practices and branches are members of different INTs, to account for this, their patient data is allocated to the INT their nearest branch belongs to. Where data is not available at practice level it is aggregated to INT footprint on a purely geographical basis ⚡.

All INTs are ranked to display variation across Leeds and this one is outlined in blue. Practices belonging to this INT are shown as individual blue dots. Actual counts are shown in blue text. Leeds overall is shown as dark grey, the most deprived fifth of Leeds** is shown in orange.

Where possible, INTs are colour coded red or green if rates are significantly worse or better than Leeds.

## Population: 44,049 in April 2017 *GP data*

Comparison of INT and Leeds age structures. Leeds is outlined in black, INT populations are shown as dark and light orange if resident inside the 1st or 2nd most deprived fifth of Leeds, and green if in the least deprived.

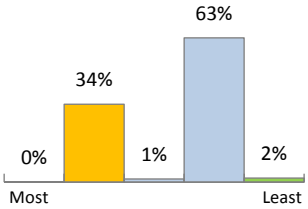



| GP recorded ethnicity, top 5 | % INT | % Leeds |
|---|---|---|
| White British | 58% | 62% |
| Other White Background | 23% | 9% |
| Not Recorded | 11% | 6% |
| Not Stated | 2% | 2% |
| Indian or British Indian | 2% | 2% |

*(April 2017)*

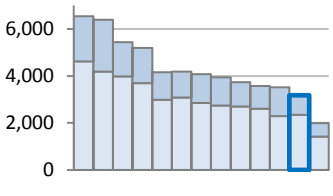
## Deprivation distribution

Proportions of INT within each deprivation fifth of Leeds April 2017. Leeds has equal proportions. **




## Aged 74+ *(April 2017)*

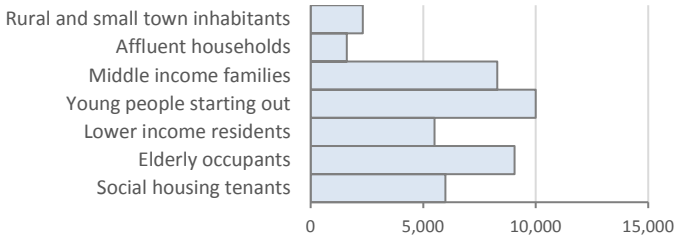
INTs ranked by number of patients aged over 74. 74y-84y in dark green, 85y and older in light green.




## Mosaic Groups in this INT population *(October 2017)*

The INT population as it falls into Mosaic population segment groups. These are counts of INT registered patients who have been allocated a Mosaic type using location data in October 2017.

http://www.segmentationportal.com




## Population counts in ten year age bands for each INT *(April 2017)*

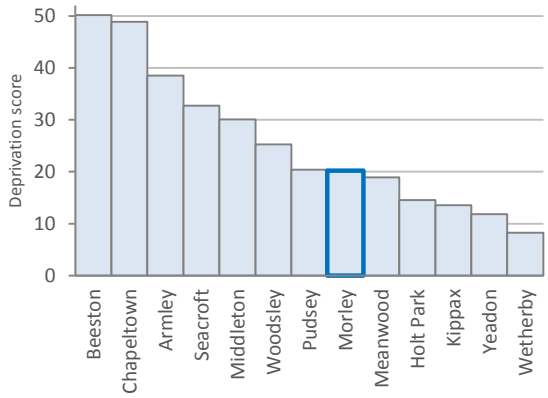
| | Woodsley | Chapeltown | Meanwood | Middleton | Seacroft | Armley | Yeadon | Pudsey | Beeston | Morley | Holt Park | Kippax | Wetherby |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 80+ | 2,266 | 2,103 | 4,224 | 3,185 | 3,976 | 2,521 | 3,119 | 2,465 | 1,198 | 1,804 | 2,455 | 2,392 | 2,220 |
| 70-79 | 3,066 | 3,249 | 5,265 | 5,341 | 5,933 | 3,907 | 5,111 | 3,778 | 1,830 | 3,438 | 3,431 | 4,320 | 3,754 |
| 60-69 | 5,028 | 5,569 | 8,194 | 7,550 | 8,094 | 6,016 | 7,053 | 5,489 | 3,023 | 4,713 | 4,591 | 4,986 | 4,128 |
| 50-59 | 6,802 | 9,376 | 10,627 | 10,747 | 10,471 | 8,843 | 8,182 | 6,979 | 4,799 | 6,151 | 5,431 | 5,728 | 4,469 |
| 40-49 | 8,717 | 13,132 | 12,437 | 11,412 | 10,251 | 9,257 | 8,319 | 7,734 | 6,123 | 6,499 | 5,692 | 5,656 | 4,141 |
| 30-39 | 17,473 | 20,275 | 14,961 | 12,099 | 10,462 | 11,065 | 7,156 | 8,386 | 8,130 | 6,610 | 6,307 | 4,886 | 3,099 |
| 20-29 | 53,913 | 20,411 | 10,616 | 10,372 | 10,107 | 10,101 | 5,665 | 6,427 | 6,945 | 5,286 | 5,116 | 4,474 | 2,448 |
| 10-19 | 13,339 | 11,955 | 8,778 | 9,119 | 9,000 | 7,281 | 6,128 | 5,406 | 5,244 | 4,418 | 4,408 | 4,274 | 3,050 |
| 00-09 | 7,297 | 15,190 | 11,384 | 11,179 | 9,970 | 9,021 | 6,358 | 6,995 | 6,800 | 5,130 | 5,313 | 4,322 | 3,067 |
| Total | 117,901 | 101,260 | 86,486 | 81,004 | 78,264 | 68,012 | 57,091 | 53,659 | 44,092 | 44,049 | 42,744 | 41,038 | 30,376 |

## Deprivation and the population of Morley INT

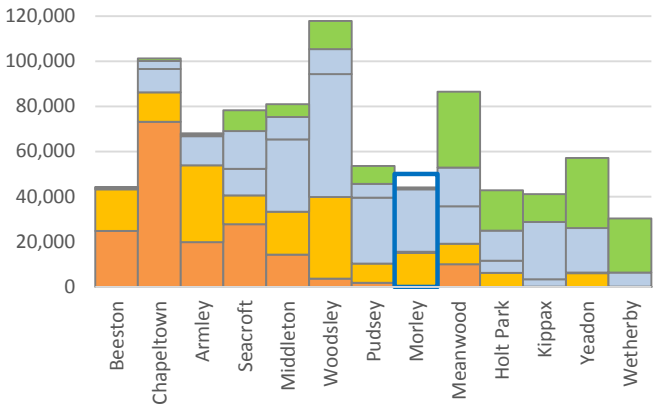
*IMD2015 and GP data*

The INT deprivation score is calculated using the count and locations of patients registered with member practices in April 2017, and the Index of Multiple Deprivation 2015 (IMD). The larger the deprivation score, the more prominent the deprivation within the INT population. This INT deprivation score is 20.2, ranked number 8 in Leeds.

INTs ranked by deprivation *score*




INT population *sizes* ranked by deprivation score

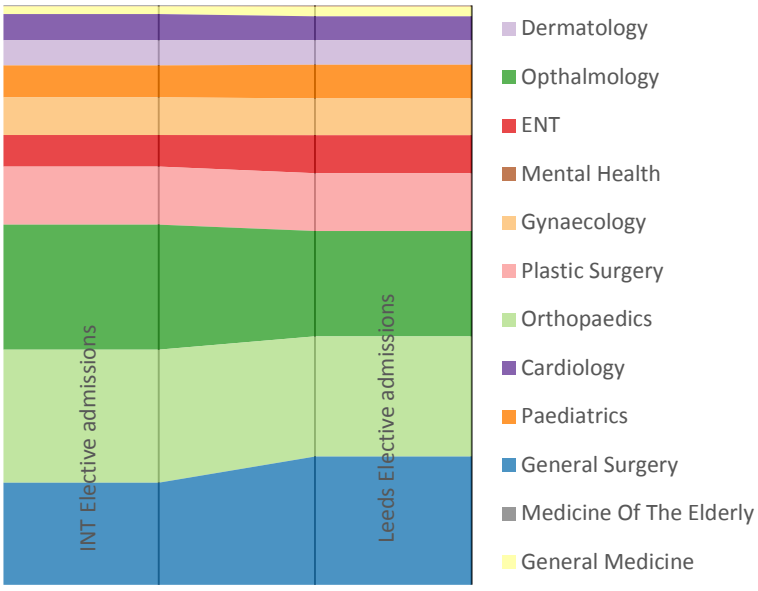



## Hospital admissions for this INT by specialty (2016/17)

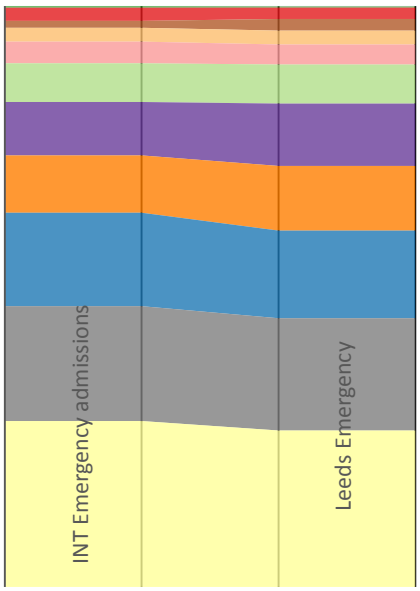
Elective (non-emergency) and emergency admission proportions for this INT are compared to Leeds below. Admissions data is divided between twelve hospital specialties and the additional group of 'others' which is where an admission does not have a recognised specialty assigned to it.

Non-emergency and emergency admission patterns obviously differ significantly, but of interest here is how the INT might differ to Leeds overall. The two charts us the same colour coding and both rank specialties by their contribution to Leeds overall, (the 'others' group is not charted or included in top 5 lists)

Proportions of Elective admissions. INT vs Leeds




Proportions of Emergency admissions. INT vs Leeds

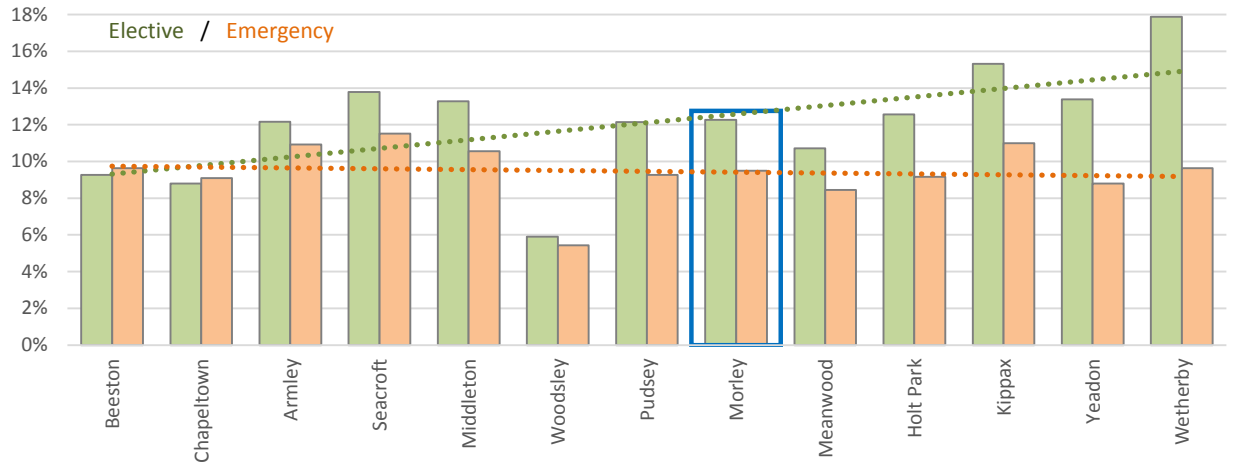



| INT Elective admissions top 5 | | *% of INT admissions* | *Leeds proportion* |
|---|---|---|---|
| 1st | Orthopaedics | *13%* | 11% |
| 2nd | Opthalmology | *12%* | 10% |
| 3rd | General Surgery | *10%* | 12% |
| 4th | Plastic Surgery | *6%* | 5% |
| 5th | Gynaecology | *4%* | 3% |

| INT Emergency admissions top 5 | | *% of INT admissions* | *Leeds proportion* |
|---|---|---|---|
| 1st | General Medicine | *18%* | *16%* |
| 2nd | Medicine Of The Elderly | *13%* | *12%* |
| 3rd | General Surgery | *10%* | *9%* |
| 4th | Paediatrics | *6%* | *7%* |
| 5th | Cardiology | *6%* | *7%* |

## Elective and emergency admission *rates* and deprivation

Hospital admission rates as percentage of whole INT populations. The INTs are *ordered by deprivation score* and there is a clear increase in proportion of elective admissions (green) as INTs become less deprived. Emergency admissions show a slightly inverted relationship with deprivation at INT level.

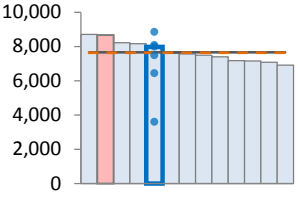



*Numerator: Count of all admissions. Denominator: Oct 2016 Leeds resident and registered population*

# Healthy children

## Asthma in children October 2016 (DSR per 100,000)

*GP data*



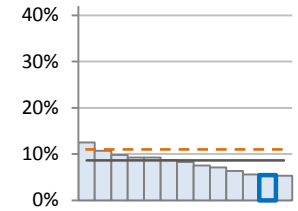

**Asthma - under 16s**

| | |
|---|---|
| INT | 7,980 |
| Leeds registered | 7,659 |
| Deprived fifth** | 7,633 |
| *INT count* | *537* |

*GP recorded* asthma in the under 16s, age standardised rates (DSR) per 100,000. Only the Seacroft INT asthma rate is significantly different to the Leeds rate.

## Child obesity 2015-16 ⚡

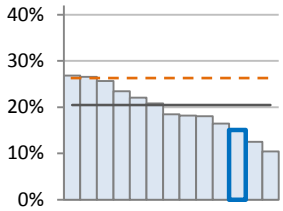
*NCMP, aggregated from LSOA to INT boundary*




**Obesity in Reception year**

| | |
|---|---|
| INT | 5.5% |
| Leeds registered | 8.6% |
| Deprived fifth** | 11.0% |

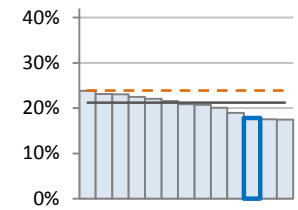
26 of 476 children in INT




**Obesity in Year 6**

| | |
|---|---|
| INT | 15.0% |
| Leeds registered | 20.5% |
| Deprived fifth** | 26.3% |

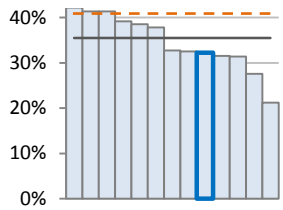
*62 of 412 children in INT*




**Obese *or* overweight, Reception year**

| | |
|---|---|
| INT | 17.9% |
| Leeds registered | 21.2% |
| Deprived fifth** | 23.9% |

*85 of 476 children*




**Obese *or* overweight, Year 6**

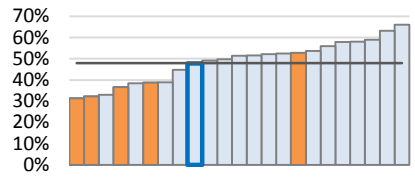
| | |
|---|---|
| INT | 32.3% |
| Leeds registered | 35.5% |
| Deprived fifth** | 40.9% |

*133 of 412 children*

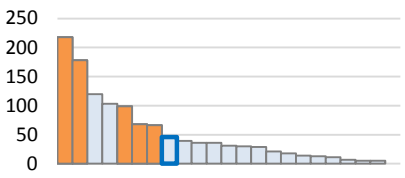
## Children's cluster data ⚡

*Children and Young People's Plan Key Indicator Dashboard July 2017*

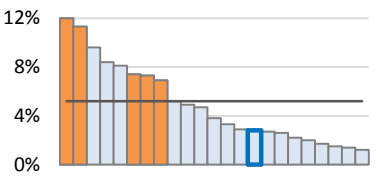
All 23 **Children's clusters** in Leeds, ranked below. Each INT footprint may be *overlapped* by one or more clusters and those having significant overlap with this INT are outlined in blue below. The five most deprived clusters in the city are shown in orange.




% with good achievement at the end of primary school (schools)



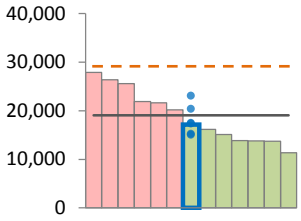

Looked after children




NEET - 'Not in education, employment or training'

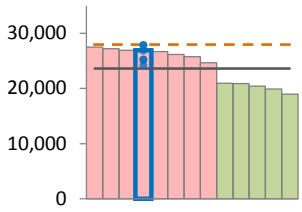
## Healthy adults

*GP data (April 2017)*




**Smoking (16y+)**

| | |
|---|---|
| INT | 17,137 |
| Leeds registered | 19,045 |
| Deprived fifth** | 29,163 |
| *INT count* | *6,376* |




**Obesity (BMI>30)**

| | |
|---|---|
| INT | 26,902 |
| Leeds registered | 23,606 |
| Deprived fifth** | 27,951 |
| *INT count* | *9,132* |

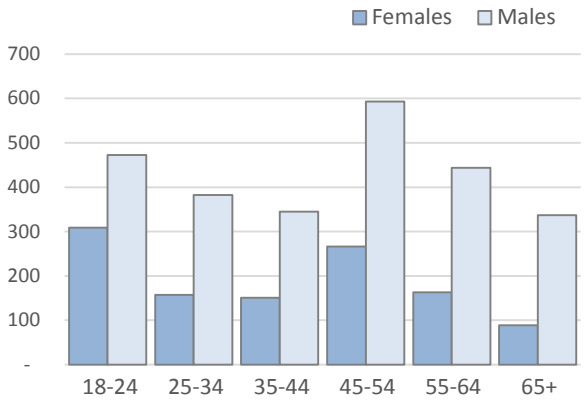
(Within the population who have a recorded BMI)

## Audit-C alcohol dependency

*GP data. Quarterly data collection, April 2017*

The Audit-C test assesses a patients drinking habits, assigning them a score. Patients scoring 8 or higher are considered to be at 'increasing risk' due to their alcohol consumption. In Leeds, almost half of the adult population have an Audit-C score recorded by a GP. Rates for age bands and females in Leeds are applied here to the INT registered population to form a picture of the alcohol risk in the whole INT adult population.

The table and chart below show the **predicted numbers of adults in this INT** registered population who would score 8 or higher.

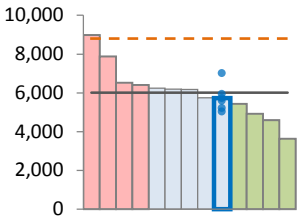



| | 18-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65+ |
|---|---|---|---|---|---|---|
| Females | 309 | 157 | 151 | 266 | 163 | 89 |
| Males | 472 | 383 | 345 | 593 | 443 | 337 |
| Persons | 748 | 536 | 498 | 857 | 611 | 440 |

## Long term conditions, adults and older people

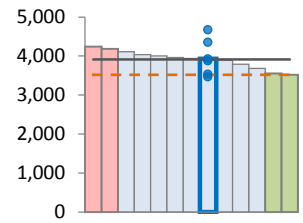
*GP data*

GP data. Quarterly data collection, April 2017 (DSR per 100,000)



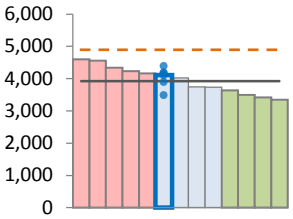

**Diabetes**

| | |
|---|---|
| INT | 5,726 |
| Leeds registered | 6,021 |
| Deprived fifth** | 8,802 |
| *INT count* | *2,339* |



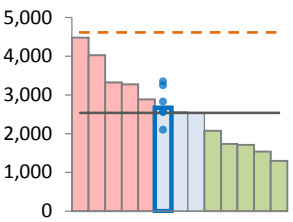

**Cancer**

| | |
|---|---|
| INT | 3,926 |
| Leeds registered | 3,915 |
| Deprived fifth** | 3,519 |
| *INT count* | *1,573* |




**CHD**

| | |
|---|---|
| INT | 4,111 |
| Leeds registered | 3,926 |
| Deprived fifth** | 4,894 |
| *INT count* | *1,600* |




**COPD**

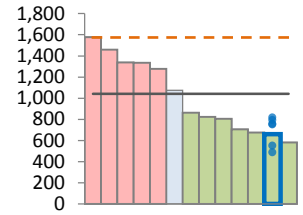
| | |
|---|---|
| INT | 2,672 |
| Leeds registered | 2,537 |
| Deprived fifth** | 4,617 |
| *INT count* | *1,060* |

*Diabetes and COPD - April 2017. CHD and cancer - January 2017*

## Long term conditions, adults and older people continued

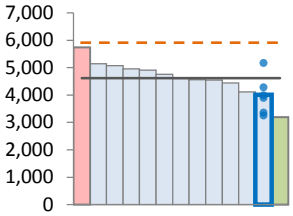
*GP data (January 2017)*

GP data. Quarterly data collection, (DSR per 100,000)



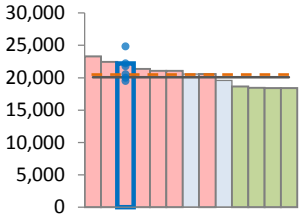

**Severe mental heath**

| | |
|---|---|
| INT | 661 |
| Leeds registered | 1,042 |
| Deprived fifth** | 1,574 |
| *INT count* | *287* |




**Dementia (65+)**

| | |
|---|---|
| INT | 4,006 |
| Leeds registered | 4,618 |
| Deprived fifth** | 5,911 |
| *INT count* | *283* |




**Common mental health**

| | |
|---|---|
| INT | 22,185 |
| Leeds registered | 20,060 |
| Deprived fifth** | 20,496 |
| *INT count* | *9,697* |

The GP data charts show all 13 INTs in rank order by directly standardised rate (DSR). DSR removes the effect that differing age structures have on data, and allow comparison of 'young' and 'old' areas. Where the INT is significantly above or below Leeds is it shaded red or green, if there is no significant difference then it is shown in blue. Blue circle indicators show rates for practices which are a member of the INT, in some instances scales are set which mean practices with extreme values are not seen.

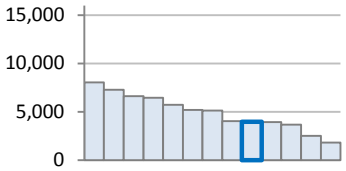
***Most deprived fifth, or quintile of Leeds - divides Leeds into five areas from most to least deprived, using IMD2015 LSOA scores adjusted to MSOA2011 areas. GP data only reflects those patients who visit their doctor, certain groups are known to present late, or not at all, therefore it is important to remember that GP data is not the whole of the picture.*

## Life limiting illness ⊁

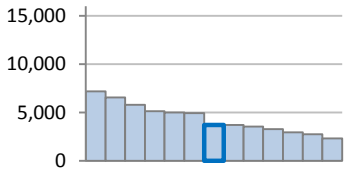
*Census 2011, aggregated from MSOA to INT boundary*

INTs ranked by *number* of people reporting life limiting illness

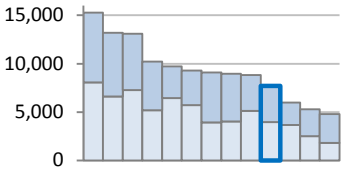
Life limiting illness, under 65



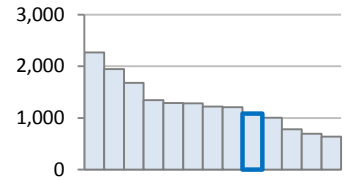

Life limiting illness, over 65



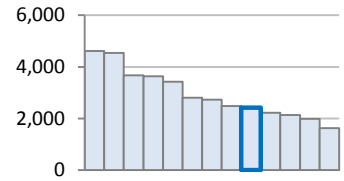

Life limiting illness all ages.
Under 65 years old in dark green. 65y and older in light green




## Carers providing 50+ hours care/week ⊁




## One person households aged 65+ ⊁




The number of people within the INT *area* in these categories are shown in the table below, the INT ranking position in Leeds is also shown.

⊁ This data is not related to INT practice membership so cannot be related back to practice membership of the INT. However each INT has a crude boundary allowing geographical data such as this to be allocated on that basis instead.

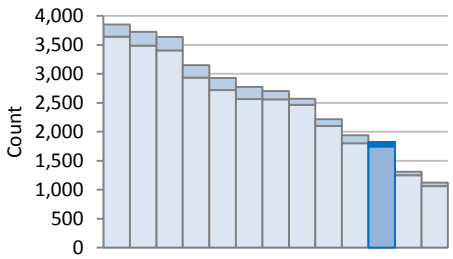
| | number | rank |
|---|---|---|
| Limiting Long Term Illness - All Ages | *7,695* | 10 |
| Limiting Long Term Illness - under 65 | *3,966* | 9 |
| Limiting Long Term Illness - 65+ | *3,729* | 7 |
| Providing 50+ hours care/week | *1,082* | 9 |
| One person households aged 65+ | *2,422* | 9 |

## People living with frailty and 'end of life'

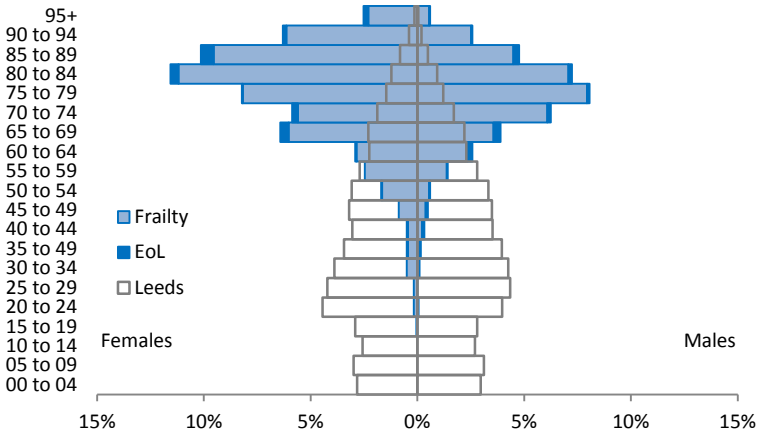
*Leeds data model September 2016 cohort*

Leeds Integrated Neighbourhood Teams ranked by combined count of End of Life and Frailty populations.

Total: 1,824. Frailty 1,750. End of life 74




INT (in blue) compared to Leeds by gender and age band.

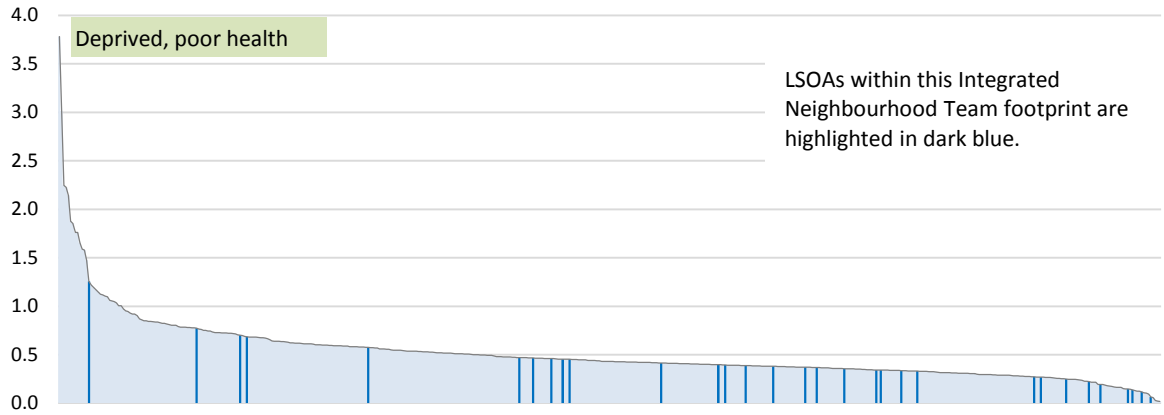


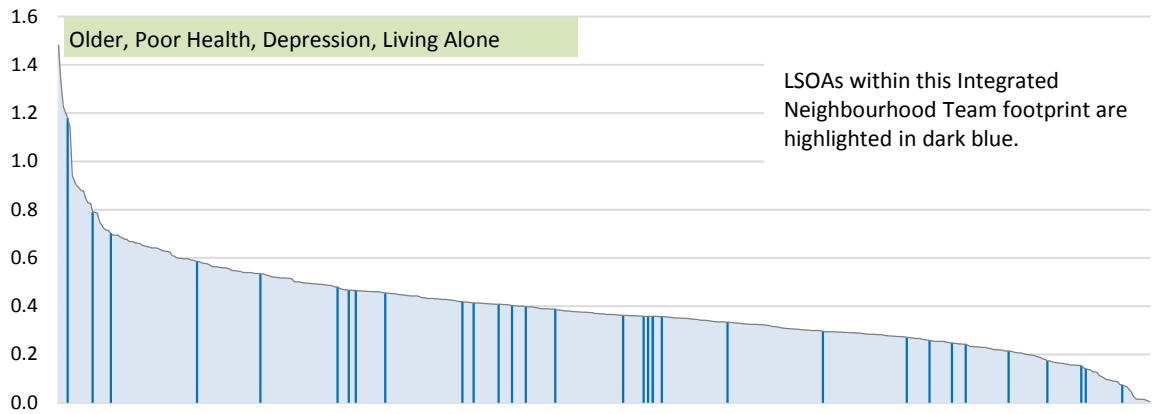

## Social Isolation Index ⊀

*LSOAs in INT footprint*

The Social Isolation Index visualises some of the broader determinants of health and social isolation as experienced by the older population. It brings together a range of indicators pulled from clinical, census and police sources. A shortlist was then used to generate population indexes, for two demographic groups across Leeds; 'Deprived, Poor Health' and 'Older, Poor Health, Depression, Living Alone'.

Each demographic group has a separate combination of indicators in order to better target the group characteristics, and variations in population sizes are removed during the index creation. The index levels show the likelihood a small area has of containing the demographic group in question. The higher the index score, the greater the probability that "at risk" demographics will be present, an area ranking 1st in Leeds is the most isolated in terms of that index. These charts show all Lower Super Output Areas (LSOAs) in Leeds, ranked by the indexes.




To find out more about the construction of the index, please contact James.Lodge@leeds.gov.uk

## Mortality, under 75s, age standardised rates per 100,000

*ONS and GP registered populations*

*"How different are the sexes in this INT"*

- INT Males
- INT Females
- INT Persons

Shaded if significantly above Persons

Shaded if significantly below Persons

*"How different is this INT to Leeds"*

- INT persons
- Leeds
- Deprived fifth of Leeds**

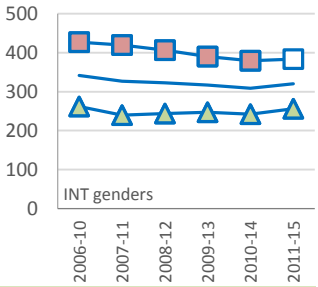
Shaded if significantly above Leeds

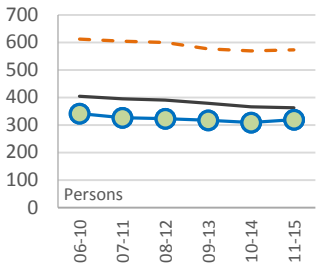
Shaded if significantly below Leeds

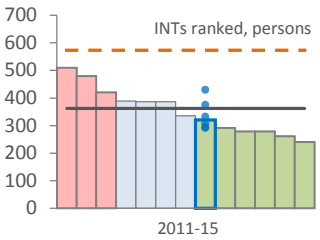
*"Where is this INT in relation to the others, and Leeds"*

INTs are ranked by the most recent rates and coloured as red or green if their rate is significantly above or below that of Leeds. Practice rates for those within this INT are shown as blue dots. This INT is highlighted with a blue border.

### All cause mortality

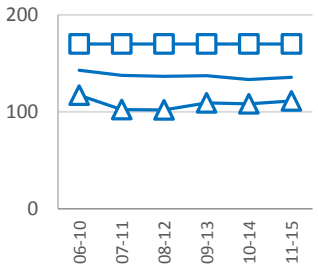


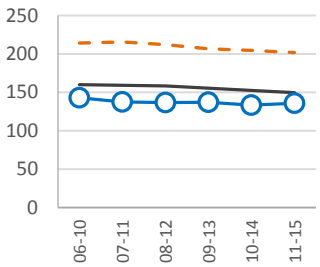



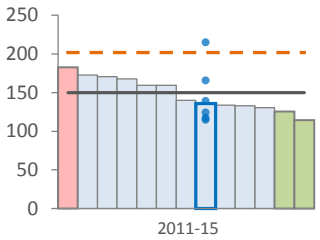




| Persons (DSR per 100,000) | |
|---|---|
| INT | 320 |
| Leeds resident | 363 |
| Deprived fifth** | 573 |
| *INT count* | *570* |

### Cancer mortality

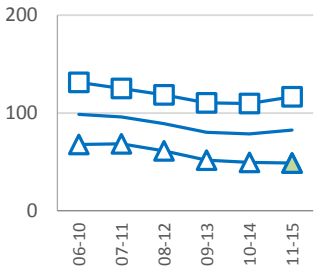


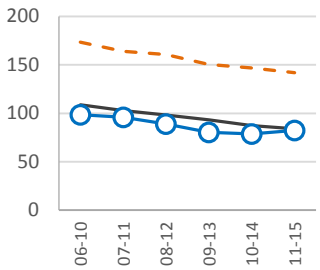



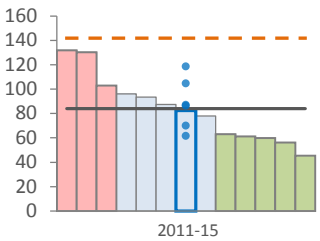




| Persons (DSR per 100,000) | |
|---|---|
| INT | 136 |
| Leeds resident | 150 |
| Deprived fifth** | 202 |
| *INT count* | *242* |

### Circulatory disease mortality

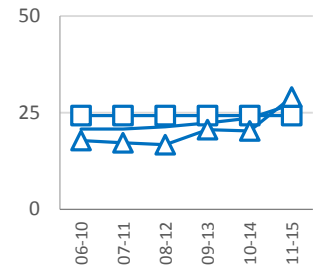


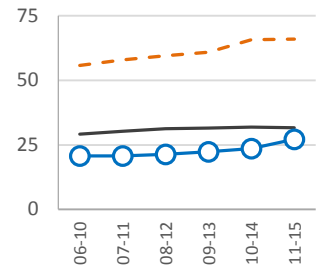



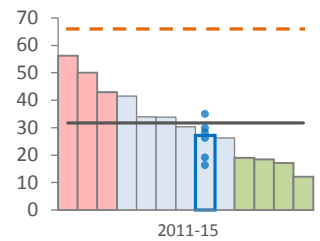




| Persons (DSR per 100,000) | |
|---|---|
| INT | 82 |
| Leeds resident | 84 |
| Deprived fifth** | 142 |
| *INT count* | *143* |

### Respiratory disease mortality




| Persons (DSR per 100,000) | |
|---|---|
| INT | 27 |
| Leeds resident | 32 |
| Deprived fifth** | 66 |
| *INT count* | *47* |

*GP data courtesy of Leeds GPs, only includes Leeds registered patients who are resident in the city.*