Notice of meeting of
Health Overview & Scrutiny Committee

To: Councillors Funnell (Chair), Boyce, Cuthbertson, Doughty (Vice-Chair), Fitzpatrick, Hodgson and Richardson

Date: Tuesday, 8 May 2012

Time: 5.00 pm

Venue: The Guildhall, York

A G E N D A

1. Declarations of Interest (Pages 3 - 4)
At this point in the meeting Members are asked to declare any personal or prejudicial interests they may have in the business on this agenda. A list of general personal interests previously declared is attached.

2. Minutes (Pages 5 - 12)
To approve and sign the minutes of the meeting held on **Wednesday 14 March 2012**.

3. Public Participation
At this point in the meeting, members of the public who have registered their wish to speak regarding an item on the agenda or an issue within the Committee's remit can do so. The deadline for registering is **Friday 4 May 2012** at **5:00 pm**.

4. Briefing on NHS 111 Service (Pages 13 - 18)
Members of the Committee will receive a briefing paper on the new NHS 111 telephone service. The Commissioning Manager for NHS North Yorkshire and York and Project Lead for NHS 111 will be in attendance to present the briefing paper and to answer Members' questions.

5. Local HealthWatch: Progress Update (Pages 19 - 26)
This report updates the Committee on the progression from LINks (Local Involvement Networks) to Local HealthWatch by April 2013.

6. Transfer of Public Health Responsibilities (Pages 27 - 42)
This report and attached annexes sets out the plan for the transition of public health responsibilities from NHS North Yorkshire and York to City of York Council.

7. York's Joint Strategic Needs Assessment 2012 (Pages 43 - 146)
York's third Joint Strategic Needs Assessment (JSNA) has recently been produced and formally approved by the Shadow Health and Wellbeing Board. This report provides Members with an overview of the process involved in producing the JSNA and the main findings and recommendations.

8. Work Plan 2011-12 (Pages 147 - 148)
Members are asked to consider the Committee's work plan for 2011-2012.

9. Urgent Business
Any other business which the Chair considers urgent under the Local Government Act 1972

Democracy Officer:

Name: Judith Betts
Contact Details:

- Telephone – (01904) 551078
- Email – judith.betts@york.gov.uk

For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting

- Registering to speak
- Business of the meeting
- Any special arrangements
- Copies of reports

Contact details are set out above

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Agenda Annex

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- ensure that what you want to say speak relates to an item of business on the agenda or an issue which the committee has power to consider (speak to the Democracy Officer for advice on this);
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The majority of councillors are not appointed to the Cabinet (39 out of 47). Any 3 non-Cabinet councillors can 'call-in' an item of business from a published Cabinet (or Cabinet Member Decision Session) agenda. The Cabinet will still discuss the 'called in' business on the published date and will set out its views for consideration by a specially convened Scrutiny Management Committee (SMC). That SMC meeting will then make its recommendations to the next scheduled Cabinet meeting in the following week, where a final decision on the 'called-in' business will be made.

Scrutiny Committees

The purpose of all scrutiny and ad-hoc scrutiny committees appointed by the Council is to:

- Monitor the performance and effectiveness of services;
- Review existing policies and assist in the development of new ones, as necessary; and
- Monitor best value continuous service improvement plans

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Agenda Item 1

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Agenda item I: Declarations of interest.

Please state any amendments you have to your declarations of interest:

Councillor Boyce	Mother in receipt of Care Services
Councillor Doughty	Volunteers for York and District Mind and partner also works for this charity.
Councillor Funnell	Member of the General Pharmaceutical Council Member of York LINks Pharmacy Group Trustee of York CVS
Councillor Hodgson	Previously worked at York Hospital
Councillor Wiseman	Public Member of York Hospitals NHS Foundation Trust Member of the Adoption Panel and Consultation Meetings with looked after children “Show Me That I Matter”

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City of York Council	Committee Minutes
MEETING	HEALTH OVERVIEW & SCRUTINY COMMITTEE
DATE	14 MARCH 2012
PRESENT	COUNCILLORS FUNNELL (CHAIR), BOYCE, CUTHBERTSON, DOUGHTY (VICE-CHAIR), HODGSON, RICHARDSON AND JEFFRIES (SUBSTITUTE FOR COUNCILLOR FITZPATRICK)
APOLOGIES	COUNCILLOR FITZPATRICK

51. DECLARATIONS OF INTEREST

Members were invited to declare at this point in the meeting any personal or prejudicial interests, other than those listed on the standing declarations of interests attached to the agenda, that they might have had in the business on the agenda.

Councillor Jeffries declared a personal non prejudicial interest in the remit of the Committee as the co-Chair of the York Independent Living Network.

Councillor Funnell declared a personal non prejudicial interest in Agenda Item 6 (Health Watch Procurement Monitoring Report) as she had worked with North Bank Forum (the host provider for LINKs) when she worked for the Strategic Health Authority.

No other interests were declared.

52. MINUTES

RESOLVED: That the minutes of the meeting of the Health Overview and Scrutiny Committee held on 20 February 2012 be approved and signed by the Chair as a correct record.

The Chair informed Members that she had written to the Vale of York Clinical Commissioning Group inviting them to attend future meetings of the Committee.

53. PUBLIC PARTICIPATION

It was reported that there had been one registration to speak under the Council's Public Participation Scheme.

A representative from York Older People's Assembly (YOPA) spoke on Agenda Item 6 (Health Watch Procurement Monitoring Report).

He posed a series of questions to the Committee which included;

- What criteria for continued patient and public involvement would be specified or defined in the draft tender requirements for the LINks (Local Involvement Networks)/HealthWatch transition?
- What safeguards would be included in the tender specification to retain the group structure of York LINks and the involvement of its current membership?
- If as suggested, various already established Voluntary Groups would act as information providers, how could/would HealthWatch maintain its authority and overall control of the process?

He added that he felt that although York LINks had been a strong proactive organisation working and acting at the behest of its members and the public, Health Watch had been branded primarily as an information provider or router. He felt that this changed the emphasis from a public and patient based organisation to another department of the Council. In his opinion, this would be at odds with the ethos originally stated in the Health and Social Care Bill.

54. UPDATE REPORT ON THE IMPLEMENTATION OF THE RECOMMENDATION ARISING FROM THE CHILDHOOD OBESITY SCRUTINY REVIEW

Members received a report which provided them with an update on progress relating to the recommendation that had arisen from the Childhood Obesity Scrutiny Review. The report asked them to consider whether they wished to sign off the recommendation as complete or if they wished to receive a further update report at a meeting in six months time.

The Committee was informed of the background to the review and the current situation, in particular, that there was not a lead officer who focused on Childhood Obesity. Officers suggested that Members might be minded to invite the new Director of Public Health to a meeting of the Committee in order to raise their priority to him or her.

Discussion between Members and Officers took place on whether data existed on a ward basis and on levels of obesity across age ranges.

It was reported that both types of data were not available, but that anecdotal evidence implied that there was disparity between wards. In response to a question about levels of obesity across all ages of children, it was reported that children were only weighed in Reception and Year 6. Some Members asked whether data existed relating to levels of diabetes in children, and were told that the available data suggested that it was increasing generally.

The Chair suggested that the Committee ask the new Director of Public Health to a future meeting, in order that Members could ask the Director about their priorities on Childhood Obesity.

RESOLVED: (i) That the report be noted.

(ii) That the recommendation arising from the review be signed off as fully completed.

(iii) That the Director of Public Health be invited to attend a meeting of the Committee once they are in post.[1]

REASON: To raise awareness of the recommendation.

Action Required

1. To write to the Interim Director of Public Health inviting them to a future meeting. TW

55. QUARTERLY FINANCIAL & PERFORMANCE MONITORING REPORT

Members received a report which analysed the latest performance for 2011/2 and forecasted the financial outturn position by reference to the service plan and budgets for all of the relevant services falling under the responsibility of the Director of Adults, Children and Education (ACE).

Questions raised by Members in relation to the report included;

- The reason for delays in letting the Homecare reablement contract.
- The reasons for an underspend in Supporting Living Schemes.
- What issues had been encountered in the promotion of Self Directed Support
- The timeliness of social care assessments

It was reported that delays had occurred in the lease of the Homecare reablement contract because a retendering process had to take place, and that the logistics of this process had reduced targets that had been set.

An underspend in Supporting Living Schemes had been attained through vacant posts in the Directorate, additional funding from the Primary Care Trust for the warden call service and contributions towards supported living.

Members were informed about the process used in order to count Self Directed Support. Officers informed the Committee that the resource allocation system for Self Directed Support included several components; an initial assessment of the person's needs, a sample population to set up point scores to an equivalent monetary value, and then an allocation of that value to an individual dependent upon their need. It was reported that problems had been encountered with the calculation in the initial assessment form. Due to these problems the confidence of people using the forms had been detrimentally affected as they felt their care needs were not being evaluated correctly.

In response to a question about the length of waiting lists for social care assessments and whether this had been exacerbated by vacant posts in the Directorate. It was reported

that one of the outcomes of a recent reorganisation had meant that funding for reassessments had been prioritised, and that average waiting time lists would now be available. Members requested that Officers included this data in future Monitoring Reports.

RESOLVED: (i) That the report be noted.

(ii) That data on average waiting list times for the provision of social care be included in future monitoring reports to the Committee.[1]

REASON: To update the Committee on the latest financial and performance position for 2011/12.

Action Required

1. Provide data on average waiting list times for social care assessments. RH

56. HEALTH WATCH PROCUREMENT MONITORING REPORT

Members received a report which updated them on the progression from LINks (Local Involvement Networks) to Local Health Watch by April 2013.

Officers informed the Committee that the current host of LINks, North Bank Forum, had been offered a 12 month contract extension (to March 2013) in order to prepare and manage the transition from LINks to Local Health Watch.

Discussion took place between Members and Officers on the contract extension and how North Bank Forum would manage the transition process.

Members decided that it would be beneficial to North Bank Forum to attend the next meeting in order to discuss how they would continue to provide the LINks service until Health Watch came into being, and how they would continue to support LINks as a Health Watch Pathfinder.

RESOLVED: (i) That the report be noted.

(ii) That North Bank Forum be invited to the next meeting of the Health Overview and Scrutiny Committee.[1]

REASON: To oversee the transition from LINks to HealthWatch is identified as a priority from the Health Overview and Scrutiny Work Plan.

Action Required
1. To write to North Bank Forum TW

57. WORK PLAN

Members considered a report which presented them with the Committee's work plan for 2012.

The Scrutiny Officer informed the Committee that some Member Training had previously taken place on the personalisation agenda in Health and Social Care. She suggested that the Committee might want to choose this theme as a new scrutiny topic to conduct a review on, if they had any particular concerns around it.

She also suggested that if Members were happy, that an extra meeting be added into the workplan to focus solely on an interim report on the End of Life Care Review.

Members agreed that a representative from North Bank Forum be invited to the next meeting in May in order to answer questions that the Committee might have on the transition from LINks to Local Health Watch.

RESOLVED: (i) That the report be noted.

(ii) That the attendance of the new Director of Public Health at a future meeting of the Committee be scheduled into the work plan once they are in post.

(iii) That the attendance of a representative from North Bank Forum be added to the Committee's May meeting.

(iv) That an additional meeting be scheduled in order to discuss an interim report on the End of Life Care Scrutiny Review.[1]

Action Required

1. To update the Committee's Work Plan TW

Councillor C Funnell, Chair

[The meeting started at 5.05 pm and finished at 6.25 pm].

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Agenda Item 4

NHS
North Yorkshire and York

BRIEFING FOR INFORMATION:

TITLE: NHS 111

TO: York Health Overview & Scrutiny Committee

MEETING DATE: 8 May 2011

Background

NHS 111 is a new telephone based service for patients that will be available throughout the country no later than 1st April 2013.

The service is being introduced to support access to urgent and emergency healthcare and ensure patients are seen by a service most appropriate for their needs.

It will replace the existing NHS Direct telephone number.

The service will be accessed by calling a three digit number, 111, which will be staffed by a team of fully trained call handlers who will be supported by experienced clinicians.

Call handlers will carry out an initial assessment which will be directed by the use of a specific assessment tool. Depending on the answers given by the patient, appropriate services will be identified on the system, thus enabling the call handler to direct the patient accordingly.

Services may include, for example, Out of Hours GP Service, Walk in Centre, Urgent Care Centre, In Hours GP, Community Nursing Team, Emergency Dental service or Late Opening Pharmacy.

In the vast majority of cases, calls to 111 will be dealt with without the need for call backs.

If the call is an emergency and the patient requires an ambulance, the call handler has the facility to dispatch an ambulance without delay.

NHS 111 will be available 365 days a year, 7 days a week and calls will be free to the caller.

When should you call NHS 111?

Patients should dial 111 if they urgently need medical help or advice but it's not a life-threatening situation.

Patients should call 111 if it's not a 999 emergency, but they:

- think they may need to go to A&E or another NHS urgent care service
- don't think it can wait for an appointment with their GP
- don't know who to call for medical help.

For less urgent health needs patients should still contact their GP in the usual way.

For immediate, life-threatening emergencies, they should continue to call 999.

Establishing the service

A number of pilot sites for NHS 111 are already in place. Early pilots include:

- Luton
- County Durham and Darlington
- Lincolnshire
- Nottingham City

Locally, NHS North Yorkshire and York, along with all other Yorkshire & Humber NHS Clusters, is part of an ongoing regional procurement for NHS 111.

Launch Date

Plans are in place to ensure that NHS 111 will be available in North Yorkshire and York, along with other areas of the country, no later than 1 April 2013.

Raising awareness of NHS 111

A regional communication campaign will be planned and implemented prior to the launch of the new service.

This will comprise a range of advertising including radio, newspaper and potentially TV.

The project team has already embarked upon a programme of engagement with the voluntary sector, who will be play a key role in disseminating information to their members as we get nearer to the launch of the service.

A national public consultation was conducted with OFCOM as part of the process of having the three digit number allocated. This showed that there was very strong public support for the service.

There have also been a number of research projects with the public and these have consistently found strong public support for NHS 111.

For more information visit www.nhs.uk/111

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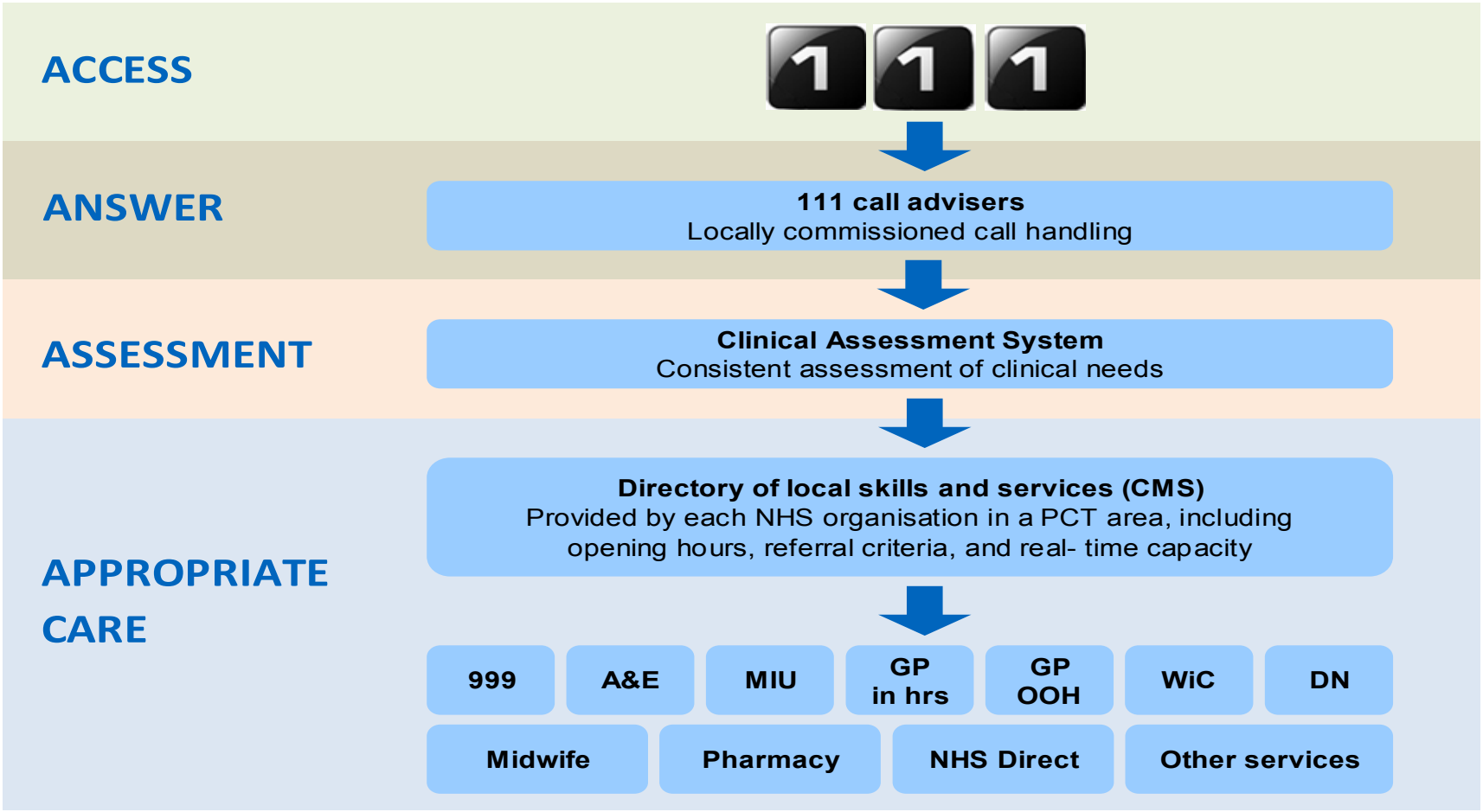
What Does NHS 111 Look Like?

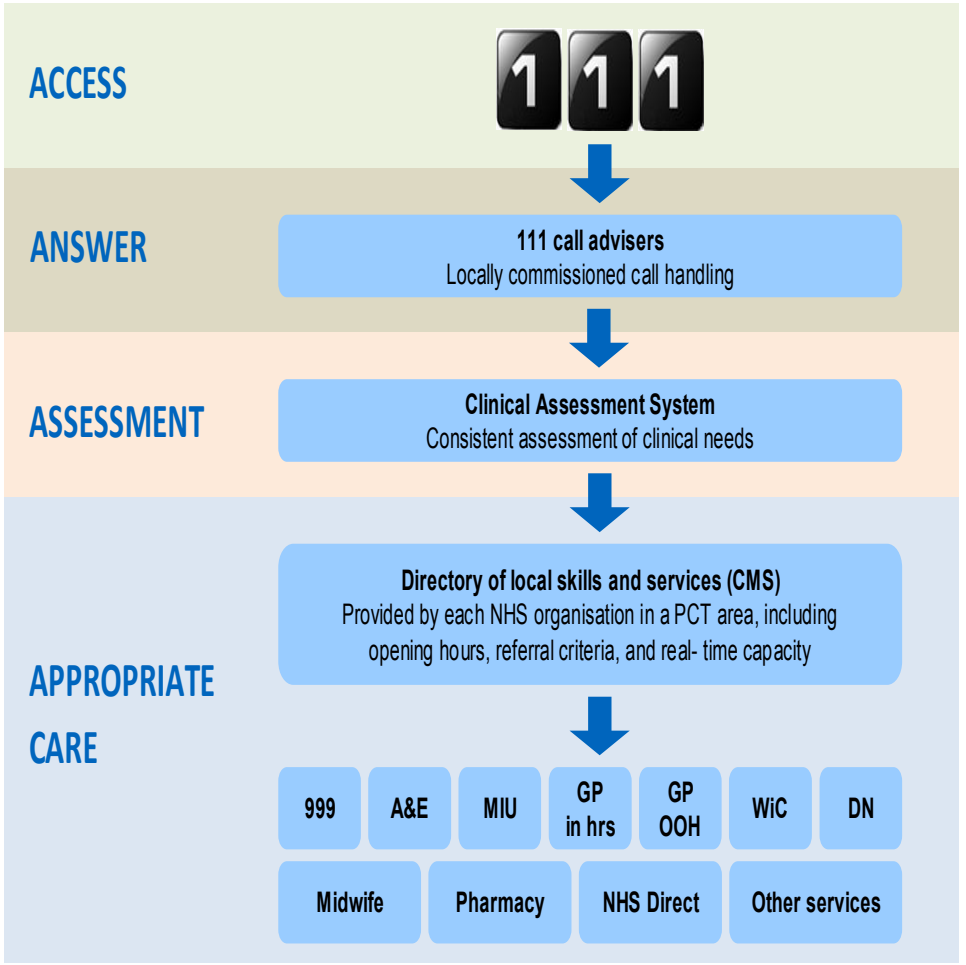
High level '111' Model



How Does NHS 111 Work?

- **Access to Service & Call Handling:**
  - Access via a single point of contact
  - Calls taken by highly trained Call Handlers (non clinical)
  - Calls will includes calls previously handled by GP OOH services
  - No need for call backs
- **Assessment**
  - Call Handler assesses patient using an evidence based assessment tool i.e. NHS Pathways
  - Call Handler accesses clinical advice & support if required
  - Most appropriate course of action determined
- **Appropriate Care**
  - Caller directed to an appropriate service
  - Call Handler can dispatch an ambulance without delay if necessary

High level '111' Model



Health Overview and Scrutiny Committee **8th May 2012**

Report of the Head of Neighbourhood Management

Local HealthWatch York: Progress Update

Summary

1. To update the Health OSC on the progression from LINks (Local Involvement Networks) to Local HealthWatch by April 2013.

Background

2. Subject to parliamentary approval, Local HealthWatch will be the local consumer champion for patients, service users and the public. It will have an important role in championing the local consumer voice, not least through its seat on the Health and Wellbeing board.

3. On 4th January 2012 the Department of Health (DoH) announced that local authorities are now not required to provide Local HealthWatch functions until 1st April 2013, 6 months later than had originally been anticipated.

4. The new date for establishing Local HealthWatch in April 2013 will support the need to align this more closely to the establishment of other new local bodies such as Health and Well Being Boards. The extension will also support preparations for the implementation of HealthWatch England (which will still be established in October 2012) to provide the leadership and support to Local HealthWatch organisations.

Existing York LINk Arrangements in 2012/13

5. North Bank Forum for Voluntary Organisations, the current LINk Host, have accepted a 12-month contract variation agreement (to March 2013), with a specific focus on preparing for, and managing the transition from LINks to Local HealthWatch.

6. Due to CYC budgetary pressures the Host contract for 2012-13 has been reduced by approximately 20% in line with cuts to voluntary sector budgets across CYC. However, it should be emphasised that the LINk Host (North Bank Forum) still have a dedicated staffing complement of three officers to support the LINk during the forthcoming financial year. There level of budget provision for training and support to York LINk members remains at the same level as in previous years.

7. A recent meeting held between LINk Steering Group representatives, the Host organisation and CYC established a series of positive steps moving forwards. LINk representatives emphasised that the work and achievements of the LINk must not be lost in the transition to HealthWatch.

8. There was also a positive discussion at the meeting about the York LINk work programme for the 2012-13 financial year, which is set down in an annex to the contract variation between CYC and North Bank Forum. The Work Programme for 2012-13 is attached as Annex A.

9. As well as the issues Identified within Annex A, York LINk will continue with its "business as usual" approach in relation to matters brought up by members of the public and capturing these within PACE reports. The LINk also agreed to take note of any new Scrutiny topics agreed by Health OSC to see if they could add value to them.

Commissioning Process – Proposed Timescales

10. Although the new deadline gives an additional six months before the launch of Local HealthWatch it is recommended that the procurement process should begin in time to allow a managed handover. It is suggested that the tender process for HealthWatch is launched by July 2012 at the latest, and that a contract is awarded by November 2012. The successor body will have time to work alongside the current LINk in order to manage the handover process, secure premises, recruit / train staff and undertake marketing and promotional activity.

11. At the HWB Board meeting in December 2011 it was suggested that a draft HealthWatch Service specification was produced by February 2012. Given the extended timescales, a revised timetable is suggested as follows.

Feb:	Key themes informing the HealthWatch procurement process produced - following Citywide consultation.
May / June:	Final Service Specification developed
	CYC Portfolio holder to agree final service specification.
	HWB Briefed re Final Service Specification Headlines
June:	Announcement of intent to tender – to stimulate the market and encourage collaborative approaches
June:	Supplier Day Event Held
July:	Tender launched
Nov:	Successful HealthWatch provider announced (The full contract will commence April 2013, but the provider will initiate some transitional work beforehand to ensure a smooth handover)

Further Points to Note

12. It was clear from the York HealthWatch consultation event in December 2011 that there was broad agreement around some aspects of the overall shape / scope of HealthWatch. Feedback from the consultation events will directly inform the content of the Service Specification.

13. It has been agreed by the Health and Wellbeing Board that two lots are procured - Local HealthWatch and NHS Complaints Advocacy. This may result in two separate providers or may allow a single provider to compete for, and hold both contracts. Alternatively, the delivery of NHS Complaints Advocacy services could be more closely connected to the wider advocacy provision in the City through this approach.

14. In respect of Complaints Advocacy, discussions are also underway with other Councils in Yorkshire and the Humber to consider a joint procurement exercise ensure regional co-ordination - i.e. developing similar specifications / timescales to ensure regional synergy. (The current contract is delivered at a regional level).

15. Further guidance is due to be issued imminently by the DoH around the structure / constitution of Local HealthWatches, and the types of delivery models that are permissible. In lieu of this guidance being issued CYC officers are working towards the production of a service specification / tender process which will allow a variety of delivery models to be brought forward.

16. The overarching outcomes and objectives within the service specification will closely align with those contained within York's forthcoming Health and Wellbeing Strategy and the wider community engagement processes of CYC.

Options

17. This report is for information only report, there are no specific options for members to decide upon.

Analysis

18. Please see above.

Council Plan 2011/2015

19. The establishment of Local HealthWatch in York will make a direct contribution to the following specific outcomes listed in the draft City of York Council Plan:
    - Improved volunteering infrastructure in place to support increasing numbers of residents to give up their time for the benefit of the community
    - Increased participation of the voluntary sector, mutuals and not-for-profit organisations in the delivery of service provision

Implications

20. **Financial -** Local HealthWatch will be financed through three separate strands of funding as follows:

    - Existing government funding to Local Authorities to support the current LINks function will be rolled forward into HealthWatch.
    - Monies provided for the current 'signposting element' of PCT PALS teams will be transferred across to local authority budgets from April 2013.
    - Monies for NHS Complaints Advocacy will be transferred to local authorities in April 2013.

21. It should be noted that while an indicative sum of money will be provided to City of York Council under each of the above headings, none of these monies will be ring fenced i.e. they will be paid to City of York Council as part of various Adult Social Care formula grants. The definitive amount of monies transferring from NHS PALS and Complaints Advocacy budgets to local authorities has yet to be confirmed.

22. City of York Council has the discretion allocate all these monies to Local HealthWatch, or allocate some of the funding to other health and social care priorities.

23. **Human Resources (HR)** - There are no human resource implications

24. **Equalities** - Establishing a successful Local HealthWatch in York will enable the targeting of support towards activities which contribute towards all the equality outcomes set out in the draft Council Plan. It will be a requirement of the successful organisation(s) delivering Local HealthWatch to demonstrate and evidence their commitment to equal opportunities in the work of their organisations, in line with the Equalities Act 2010

25. **Legal** - There are no legal implications

26. **Crime and Disorder -** There are no crime and disorder implications

27. **Information Technology (IT) -** There are no information technology implications

28. **Property -** There are no property implications

29. **Other** -There are no other implications

Risk Management

30. There are risks of challenge to the validity of City of York Council's procurement and commissioning process if a HealthWatch contract is let without full and proper consultation with City wide partners. The thorough consultation processes that will be

followed through the HealthWatch Pathfinder process will mitigate this risk.

Recommendations

25. Members are asked to note the report and the latest progress towards establishing HealthWatch. A further update will be provided at the next Health OSC meeting.

    Reason: To oversee the transition from LINKs to HealthWatch is identified as a priority in the Health Overview and Scrutiny Work Plan.

Contact Details

Author:	**Chief Officer Responsible for the report:**
Adam Gray Senior Partnership Support Officer (VCS) Neighbourhood Management Unit Directorate of Communities and Neighbourhoods Tel. 551053	**Kate Bowers** Head of Neighbourhood Management

Report Approved ✓ **Date** 07.04.2012

Specialist Implications Officer(s) n/a

Wards Affected: **All** X

For further information please contact the author of the report

Background Papers:

Annexes

Annex A – LINks Workplan 2012-2013

Annex A

York Local Involvement Network (LINks) Workplan 2012 - 13

Primary Focus: To undertake new activities in the areas of **Information Gathering** and **Community Engagement** in preparation for future health and social care arrangements in the City of York.

1. Work with existing and emerging stakeholders (including both service providers and commissioners) in order to develop a focused piece of work around the development and implementation of local information pathways. **This will be an additional piece of work which add value to the current LINk role and provide a firm foundation for the transition into the new HealthWatch arrangements.**

2. Signposting - Map out all existing signposting services in the City, identify gaps and agree a clear model going forward that does not create additional steps or barriers for individuals.

3. To focus on providing local people with accurate, up to date and accessible information as a means of increasing participation, raising awareness and promoting choice. This will be achieved through a number of new creative and innovative mechanisms including:

    - A Community Atlas
    - Mapping of existing health and social care services across the City.
    - The recruitment, selection and accredited training of Community Health Champions.
    - Scoping the provision of local advocacy and complaints support services.

3.1 **Community Atlas and Service Mapping**

- Build on the current Community Atlas format and develop a comprehensive database of health and social care provision across the City to ensure that users are signposted to the most appropriate and accessible services that best meet their needs.
- Promote the Community Atlas as an information sharing tool to a range of stakeholders including health and social care commissioners, the emerging GP Consortia as well as members of the public and voluntary and community sector groups and organisations.

3.2 Community Engagement

- Enhancing the LINk role of community engagement and information gathering in new and innovative ways.
- Developing a Community Champion model which looks to recruit, train and support active Community Health Champions in the City.
- Using the community engagement and information gathering element of the Community Champion role to work with local communities in order to promote increased access to information to enable them to make informed choices about their health and the treatment options available to them.

3.3 Scoping of Complaints Advocacy

- To begin mapping the current provision of advocacy, complaints and other support services in anticipation of the proposed changes to these services as of April 2013. This will allow existing gaps in service to be identified at an early stage and pro-active work to be undertaken to meet unidentified need.

Health Overview and Scrutiny Committee **8 May 2012**

Report of the
Director of Communities and Neighbourhoods and
Associate Director of Public Health

PUBLIC HEALTH TRANSITION PLAN

1. The attached papers (Annexes A and B refer) set out the plan for the transition of public health responsibilities from NHS North Yorkshire and York to City of York Council.

Background

2. Process

National expectations are that the substantial majority of public health duties will be transferred to local authorities by the end of October 2012 with robust governance in place for the remainder of 2012/13 while the Primary Care Trust (PCT) remains responsible. By the end of December 2012 all remaining duties will be transferred and by the end of March 2013 all PCTs must have completed the formal handover of public health responsibilities to local authorities.

There are a number of interconnected strands for transition which are detailed within the plan (Annex A refers):

a) Developing the CYC public health model
b) Appointing the CYC Director of Public Health
c) Transferring PCT staff
d) Transferring commissioning responsibilities

3. **Consultation**

The plan was developed in collaboration between CYC and NHS North Yorkshire & York, paying particular attention to corresponding plans with North Yorkshire County Council, Public Health England and the NHS Commissioning Board. Initial draft plans were reviewed by the Strategic Health Authority and subsequently updated.

Options

4. There are no specific options associated with this report, however Members can comment on the report.

Analysis

5. Whilst this report is predominantly for information, the Committee can use it to identify potential areas for scrutiny review.

Council Plan

6. This report links to the 'Protecting Vulnerable People' and 'Building Strong Communities' priorities in the Council Plan 2011-15.

Implications

7. **Financial** *The transfer includes budgetary responsibilities. The transition plan includes actions to address this.*

8. **Human Resources (HR)** – *The transfer includes staffing responsibilities. The transition plan includes actions to address this.*

9. **Equalities** *The transfer of public health responsibilities will enhance the local authority role in promoting equalities.*

10. **Legal** – *The transfer includes legal responsibilities. The transition plan includes actions to address this.*

11. **Crime and Disorder** – *Alcohol and Drug Misuse are part of the public health responsibilities.*

12. ***Information Technology (IT)*** – *The transfer includes IT requirements. The transition plan includes actions to address this.*

13. **Property** – *There are no property implications*

14. **Other** – *All other implications have been included within the report.*

15. There are no immediate Financial, Human Resources, Crime and Disorder, IT or Property Implications.

Risk Management

16. The transition plan and associated risks are monitored through the Public Health Transition board and the PCT Public Health Governance Committee.

Recommendations

17. Members are asked to note the contents of this report and identify any concerns that they may have.

    Reason: To keep the Health Overview & Scrutiny Committee updated on the transition of public health responsibilities to City of York Council.

Contact Details

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	Report Approved ✓ **Date** *24 April 2012*
	Sally Burns Director of Communities and Neighbourhoods
	Report Approved ✓ **Date** *24 April 2012*

Wards Affected: *List wards or tick box to indicate all* **All** ✓

For further information please contact the author of the report

Background Papers:
Public Health Transition Plan

Annexes
Annex A Transition Plan
Annex B Transition Action Plan

Annex A

Public Health Transition Plan
Transfer to City of York Council
March 2012

1. Purpose

For NHS North Yorkshire and York the transition of public health has four distinct elements which relate to the transfer of responsibilities to:

- City of York Council
- North Yorkshire County Council
- Public Heath England
- NHS Commissioning Board

This is the public health transition plan for York which covers those functions which will transfer from NHS North Yorkshire and York (NHS NYY) to **City of York Council (CYC)**. The plan has been jointly agreed with CYC and will oversee the safe transfer of public health functions into the LA as identified in recent DH guidance whilst ensuring continuity of delivery of functions through 2012/13 and into 2013/14.

The plan is a reflection of the information available to date and may be subject to revision if additional information becomes available.

As functions are to be split between two local authorities (see section 3) It is designed to work in parallel with the Transition Plan for North Yorkshire to ensure consistency for staff and for transfer of commissioning responsibilities.

It will also have due regard to the transition plans from NHS NYY for Public Health England (PHE) and the NHS Commissioning Board (NHSCB).

2. Future operating model of public health in York

There are a number of local complexities which impact on local public health transition and the future delivery model.

Annex A

i) The current public health function is provided by a team covering both North Yorkshire and York, covering two Local Authorities – CYC (a unitary council) and NYCC (a two tier authority).

At a meeting on 7th December 2011 it was agreed by the CEXs of NHS NYY, NYCC and CYC and the Cluster DPH, that the future public health model for North Yorkshire and York would be based on two separate teams for North Yorkshire and City of York with mutual or shared arrangements to be developed as appropriate.

Both LAs have indicated their intention to have their own Director of Public Health (DPH). City of York Council has initially aligned public health to the Directorate of Communities and Neighbourhoods during a pilot phase, and is currently considering options for the permanent DPH role.

ii) City of York Council has developed a strong relationship with Vale of York Clinical Commissioning Group CCG and is considering a joint approach to public health. The CCG covers the whole of York and parts of North Yorkshire and East Riding which will make public health engagement more complicated but all parties are committed to making this work.

3. Governance and Risk Management

Until 31 March 2013 NHS North Yorkshire and York will remain the accountable body for the delivery of public health and will ensure that all critical public health services and their related clinical governance arrangements are delivered to that date. This means that no service or responsibility will be transferred until NHSNYY has been assured that future arrangements are robust and that appropriate interim governance arrangements have been established between the local authority, PHE or the NHSCB and the PCT. The Interim Director of Public Health will lead this assurance on behalf of the PCT. Work to develop the process for assurance and ongoing governance will progress alongside the development of local authority public health models.

There are a number of mechanisms in place to maintain oversight and assurance of public health transition and ensuring business continuity over the transition year. These are as follows:

Annex A

- The NHS NYY Governance and Quality Committee, informed by the Public Health Governance Committee, will maintain an oversight of the transfer with a focus on clinical, information and organisational governance.
- The York Health and Wellbeing Board will maintain an oversight of the transfer of public health functions.
- A York public health transition group was set up in 2011 to oversee the transfer under the project sponsorship of the Director of Communities and Neighbourhoods. This group includes senior members of the public health team and CYC, along with commissioning leads and HR and finance experts.
- The HR leads for NHS NYY, NYCC and CYC will meet regularly to ensure a consistent process. This meeting will include transition leads from public health where this is appropriate.
- Similar meetings will be held to consider the finance and contracting workstreams.
- As required meetings will be held with the chief executives of NHS NYY, CYC and NYCC and the cluster DPH.

The attached action plan (**appendix 1)** includes a section on governance and risk which uses a detailed checklist to ensure that risks are identified and mitigated for each of the transferring functions. This will be reviewed through the mechanisms set out above.

4. Key Progress to date

4.1 Workforce support

- The first PCT organisational development workshop was delivered for all public health staff in December 2011 to explore impact of change and future public health world. The CYC Chief Executive and Assistant Director of Housing attended and met with staff.

- HR clinics are being held to provide HR advice to support and keep staff updated with the HR implications of transition.

Annex A

4.2 Developing the City of York public health model

- The Associate Director of Public Health for York has been working closely with CYC senior leaders to develop future plans.

- Two well attended workshops have been held for public health staff and CYC staff across all directorates to shape the local public health system and the vision for the future. These workshops considered the widest possible implications of local authority functions on public health, including planning, licensing, education and transport, as well as the more core functions which may sit within or be aligned to public health in the new model. The workshops also allowed teams to consider the similarities and differences between working in the NHS and in local authorities. As these sessions have been well received and have contributed to team building, a further workshop will be held on 27th March to continue to build the local vision.

- A Memorandum of Understanding has been developed covering Public Health Directorate support to CCGs on responsibilities for population health and health care. This covers the transition period 12/13 and will form the basis of the public health 'core offer' from April 13 onwards. Vale of York CCG are happy with the proposed way forward and are keen to establish opportunities to work jointly on public health priorities.

4.3 JSNA and Health and Wellbeing Board

- The City of York JSNA is being produced by CYC and NHSNYY, in conjunction with partners. It is currently in draft form and will be finalised at the Shadow Health and Wellbeing Board on 26th March.
- The York Shadow Health and Wellbeing Board has met a number of times and is in the process of agreeing priorities, which will include consideration of the JSNA and the development of the Health and Wellbeing Strategy.

Annex A

4.4 Communications and Engagement

- The PCT cluster has a transition and reform section on its intranet site which is updated with public health guidance and frequently asked questions. The PCT cluster produces regular team briefs and HR briefings for staff which supplement the HR clinics discussed in 5.1
- All stakeholder partner organisations are briefed on public health through the shadow Health and Wellbeing Board (see section 5.3) which includes Vale of York CCG, York Council for Voluntary Services, York LINk, York Hospitals NHS Foundation Trust and Leeds Partnership Foundation Trust.
- CYC Corporate Management Team, the Portfolio Holder and Cabinet have considered the CYC approach to public health and will continue to be involved at appropriate decision-making points in the transition year.
- CYC staff have been consulted on the plans for aligning public health with Communities and Neighbourhoods and will be updated as further developments progress.

5. Mandated Services or Steps

Within the set of responsibilities transferring to local authorities there will be five mandated services or steps

5.1 Appropriate access to sexual health services

Local authorities will become responsible for commissioning comprehensive open-access accessible and confidential contraception and sexually transmitted infections testing and treatment services. The PCT commissions a range of sexual health services from a number of different providers including GPs, pharmacies, voluntary organisations and acute services. Some contracts are specific to localities and some cover both LA areas.

A sexual health transition group has been established with representation from both NYCC and CYC. All existing contracts have been mapped, which describes existing services, links service specifications, contracts and funding. We are currently working with LA and PCT contracting colleagues to identify risks and shadow governance arrangements from October onwards. A programme of work has been identified jointly with LA colleagues this year around refreshing sexual health needs assessment work to inform the strategic direction of sexual health and the future commissioning of services.

There is designated public health sexual health lead overseeing this work.

5.2 Plans in place to protect the health of the population

Throughout the period of transition through to April 2013, it will be essential for the PCT Cluster, the Local Authorities and other key partners such as the Health Protection Agency to maintain all existing systems, plans and governance arrangements relevant to Emergency Planning, Response and Resilience (EPRR) and all other aspects of health protection, until they are superseded by agreed, resourced and tested new models and ways of working.

The proposed new national model for EPRR was approved centrally in December 2011, and is described in Appendix 3 of the "Public Health England and NHS Commissioning Board" section of the overall Public Health Transition Plan for North Yorkshire and York. Further national clarification is expected soon in respect of arrangements for EPRR, and local implementation in the NHS and through Local Resilience Fora (LRF). Initial discussions have taken place through the existing local NHS whole-system EPRR mechanisms, including the PCT-led Health Emergency Planning Network (HEPN), and an update briefing will be provided to the North Yorkshire and York LRF. As soon as this further national guidance is issued, the local design and preparation for implementation of the new EPRR arrangements will be progressed by the PCT Cluster, working with Local Authorities and other partners. Safe transition from existing to new systems will be a key part of this work.

A range of single-agency and multi-agency plans and groups currently underpin local arrangements to protect the health of the population in its broadest sense (i.e. in addition to EPRR systems and plans). There will be a need to review all of these arrangements, and identify which of them will require updating or re-casting to take account of the overall set of changes expected to be brought about by the Health and Social Care Bill. The Director of Public Health and the Local Authority will need to be assured that (a) the health of the population continues to be protected during the period of transition, and (b) that the proposed new local arrangements are robust and fit for purpose.

5.3 Public health advice to NHS commissioners

The public health team has agreed a memorandum of understanding with the local clinical commissioning group and will continue to develop joint working on public health in line with the core offer. The opportunity for a joint DPH will be considered which could allow enhanced working in this area.

5.4 National Child Measurement Programme

The National Child Measurement Programme is currently commissioned from both Harrogate Foundation Trust and York Foundation Trust school nursing services with a specific service specification and funding stream. There is a designated public health lead who maintains oversight of the programme and ensures providers are delivering against the specification and fulfilling performance requirements. A detailed description has been produced to describe current governance arrangements during transition and work is being undertaken on working through how the arrangements will work from October onwards and risks identified.

5.5 NHS Health Check assessment

NHS Health Checks is currently commissioned as a GP LES across North Yorkshire and York. A pilot in Scarborough, which included community pharmacists as well as GPs, started April 2010 until Sept 2011. During the pilot phase 2049 patients were invited and 1098 were assessed (uptake rate of 53.6%). Between April 2011 and end Sept 2011, 1467 patients were invited and 819 were assessed. It was decided that because of the low uptake of pharmacy assessments that a GP only LES would be developed in line with the Best Practice Guidance.

The Local Enhanced Service (LES) for NHS Health Checks covering the whole of North Yorkshire and York started on the 1st October 2011. A total of 91 GP Practices are signed up to the LES with 7 Practices not yet signed up to the programme.
There is a plan in place to liaise with these Practices in order to understand reasons for non sign up and be in a position to offer the programme to those eligible patients for those Practices. Practices have been incentivised to invite 20% of their eligible population in 2012/13. In Q3 2011/12, 7927 patients were invited (3.2% of eligible population) with an increase expected in Q4. We

plan to invite 20% of the eligible population per year (5% per quarter) in 2012/13.

The programme is led by public health with primary care commissioning support. The programme uses QuestBrowser software which allows practices to invite eligible people with the highest estimated risks first, and also provides the performance and quality data. The FIMS return identified £20k funding in 20010/11. However, the programme has been identified to cost up to £1.2m per year based on 20% invites per year and 75% uptake. This funding mismatch was flagged up at the time with LA finance colleagues. Work is ongoing with local authority and primary care contracting colleagues to fully understand the risks and ensure that there is a safe and effective transition of responsibility to local authorities.

6. Action plan and milestones

There are a number of interconnected strands for transition:

a) Developing the CYC public health model
b) Appointing the CYC Director of Public Health
c) Transferring PCT staff
d) Transferring commissioning responsibilities

Each of these elements have financial, legal, governance and human resources implications and appropriate advice will be sought at each step of the process. The detailed plans appear as a spreadsheet in the attached file. Key milestones are as follows.

a) Developing the CYC public health model

Key milestones (see action plan for details)

March 2012	CYC public health draft vision and local delivery model produced for comment and development with partners
March 2012	York JSNA finalised
April 2012	CYC and PCT staff pilot public health transition arrangements.
May 2012	Briefing to CYC Cabinet

Annex A

July 2012	Complete health and wellbeing strategy Briefing to CYC Cabinet on public health.
August 2012	Following Royal Assent amend CYC standing orders to prepare for October and April transfers
September 2012	NHSNYY Board consider assurance and transition governance arrangements. If assured agree transfer for 31 October.
October 2012	Transfer of responsibilities from 31st October
January 2013	New CYC headquarters – enhanced team working
April 2013	CYC statutory responsibility begins

b) Appointing the CYC Director of Public Health

The DPH will be appointed in line with available guidance. HR colleagues in CYC and NHS NYY are working together to advise on the best way forward.

Key milestones:

April 2012	Begin DPH appointment process
Jun-July 2012	DPH appointment made
September 2012	DPH in post

c) Transferring PCT staff

HR colleagues from NHS NYY, CYC and NYCC will work together to make sure that this runs in parallel with that for NYCC, ensuring that staff have a consistent experience.

Annex A

Key Milestones:

May 2012	Agree CYC Public Health Structure
September - October 2012	HR process to designate PH staff to new roles.
November 2012	PH staff start in designate roles at CYC.
November - March 2013	Consultation on TUPE transfer
April 2013	TUPE transfer on 1st April 2013

d) <u>Transferring commissioning responsibilities</u>

CYC will take on a wide set of health related commissioning responsibilities which are delivered through a range of contractual mechanisms with acute hospitals, general practices, pharmacies, independent providers and the voluntary sector. In many cases these services are commissioned for the whole of North Yorkshire and York or for areas bigger than CYC so a significant amount of work is required to disaggregate these between the local authority areas.

Key Milestones

May 2012	Disaggregation of contracts and recommendations made on sharing or split with NYCC
June - August 2012	Agree mechanisms for CYC-specific and shared contracts
July 2012	Notify providers of change of commissioner
September 2012	NHSNYY Board consider assurance and transition governance arrangements. If assured agree transfer for 31 October.
October 2012	Transfer of responsibilities from 31st October
April 2013	CYC full responsibility transfers

Transition Area	Success Criteria	Action no.	Actions	CYC Lead	PCT Lead	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
1. Developing a public health model in CYC	1.1 Public health vision for York	1.1.1	Events held to develop a vision and model for public health in York	Steve Waddington	Rachel Johns															
		1.1.2	Consultation on vision and partnership arrangements (to include interface with CCGs, LA neighbours PHE, CSS and NHS CB)	Steve Waddington	Rachel Johns															
		1.1.3	Briefing to Cabinet on vision and partnership arrangements	Sally Burns	Rachel Johns															
		1.1.4	CYC standing orders amended (following Royal Assent) to prepare for Oct and April transfers	Andy Docherty																
	1.2 Public health operating model agreed and in place by November 2012	1.2.1	Workshops to develop PH operating model in CYC.	Steve Waddington	Rachel Johns															
		1.2.2	CYC staff and NYYPCT pilot public health arrangements	Sally Burns	Rachel Johns															
		1.2.3	Agree joint working models with NYCC	Sally Burns	Rachel Johns															
		1.2.4	Work with developing Public Health England and NHSCB to clarify health protection, screening, immunisation and intelligence arrangements		Rachel Johns															
		1.2.5	Operating model agreed by Cabinet (structure produced ready for consultation with staff)	Sally Burns	Rachel Johns															
		1.2.6	Implement HR process (see below) to deliver operating model	Sally Burns	Rachel Johns															
		1.2.7	Identify and address any subsequent risks and issues that are identified.	Sally Burns	Rachel Johns															
		1.2.8	PCT Board consider transfer of functions to CYC		Phil Kirby															
		1.2.9	Implement new operating model (including leadership, organisational structure and commissioning arrangements.	Sally Burns	Rachel Johns															
	1.3 Core offer to Clinical Commissioning Groups/NHS agreed and in place.	1.3.1	Memorandum of Understanding developed and operational covering PH core offer to support CCGs during transition year		Martin Hawkings															
		1.3.2	Core offer draft operating model produced		Martin Hawkings															
		1.3.3	Further work on developing core offer to NHS Commissioners		Martin Hawkings / Rachel Johns															
		1.3.4	Finalised core offer operational		Martin Hawkings / Rachel Johns															
	1.4 JSNA launched	1.4.1	Local stakeholder events delivered.	Judy Kent	James Crick															
		1.4.2	Final JSNA presented to H&W Board	Judy Kent	James Crick															
		1.4.3	JSNA launched	Judy Kent	James Crick															
	1.5 Health and Wellbeing Strategy developed	1.5.1	Development of Health and Wellbeing Strategy	Sally Burns	Rachel Johns															
		1.5.2	Health and Wellbeing Strategy published	Sally Burns	Rachel Johns															
2. Appointment of CYC Director of Public Health.	2.1 DPH to be appointed and in post by October 2012.	2.1.1	Agree remit of DPH and agree appointment process that meets LA, PHE and Faculty requirements	Janet Neeve	Amanda Wilcock															
		2.1.2	Begin DPH appointment process	Janet Neeve	Amanda Wilcock															
		2.1.3	DPH process concluded	Janet Neeve	Amanda Wilcock															
		2.1.4	DPH postholder begins.	Janet Neeve	Amanda Wilcock															
3. Transferring PCT staff	3.1 Transfer of staff to LA	3.1.1	Staff aligned to LA identified - letters received		Amanda Wilcock															
		3.1.2	Analysis conducted on implications of CYC public health indicative funding allocation on staffing establishment and risks identified	Patrick Looker	Louise Engledow															
		3.1.3	Negotiate any discrepancies in funding.	Patrick Looker	Louise Engledow															
		3.1.4	Staff to agree job descriptions for substantive roles																	
		3.1.5	Agree with CYC/NYCC split/shared arrangements of staffing.	Sally Burns	Phil Kirby															
		3.1.6	Develop and agree CYC public health team structure.	Sally Burns	Phil Kirby															
		3.1.7	Sender receiver agreement reached on staffing transfers.	Janet Neeve	Amanda Wilcock															
		3.1.8	Consultation with staff and trade unions on structure.	Janet Neeve	Amanda Wilcock															
		3.1.9	HR process so staff are designated to new roles	Janet Neeve	Amanda Wilcock															
		3.1.10	Staff support (CV writing, interview skills) /redeployment/exits		Amanda Wilcock															
		3.1.11	Staff start in designated roles at CYC (shadow new operating model inc governance arrangements assess and address risks.	Janet Neeve	Amanda Wilcock															
		3.1.12	Address any residual part of HR transfer	Janet Neeve	Amanda Wilcock															
		3.1.13	Consultation on TUPE transfer	Janet Neeve	Amanda Wilcock															

Transition Area	Success Criteria	Action no.	Actions	CYC Lead	PCT Lead	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
		3.1.14	Transfer of staff to LA complete	Janet Neeve	Amanda Wilcock															
	3.2 All infrastucture in place to support Public Health staff in LA	3.2.1	Scope infrastructure requirements - including IT, office accommodation,		Philippa Press															
		3.2.2	Address infrastructure requirements.		Philippa Press															
4. Transferring Commissioning functions and resources	4.1 Transfer of LA commissioning functions and resources	4.1.1	Collate information on contracts (including budgets, governance arrangements, performance) relating to all functions transferring and identify risks.	Adele Spencer	Rachel Johns															
		4.1.2	Negotiate any discrepancies in funding.	Patrick Looker	Louise Engledow															
		4.1.3	Disaggregate contracts between North Yorkshire and York (as applicable).	Adele Spencer	Rachel Johns															
		4.1.4	Make recommendations on split and shared contract arrangements with clear details on how the governance will work.	Adele Spencer	Rachel Johns															
		4.1.5	Agreement between LAs on shared contract arrangements - and structures influenced accordingly.	Sally Burns	Phil Kirby															
		4.1.6	Agree and develop mechanisms for CYC-specific and shared contracts.	Adele Spencer	Rachel Johns															
		4.1.7	Clarify future arrangements/mechanisms that allow LA to commission and place future contracts with primary care providers (inc. CCGs, NHS CB)		Rachel Johns															
		4.1.8	Clarify future arrangments/mechanisms around prescribing elements (inc funding) within commissioned services.		Rachel Johns															
		4.1.9	Sender receiver agreement of functions to transfer (health improvement, health protection and healthcare)	Sally Burns	Phil Kirby															
		4.1.10	Notify Providers of change of commissioner	Adele Spencer	PCT contracting															
		4.1.11	Begin transfer and delegation of functions (contracts, budgets and staff).		Phil Kirby															
		4.1.12	Collation of all legacy documentation relating to functions transferring.		Philippa Press															
		4.1.13	Transfer of LA commissioning functions and resources complete	Sally Burns	Phil Kirby															
	4.2 All commissioning/corporate services in place	4.2.1	Scope support service requirements for each function - including finance, IT, contracting (including invoicing system), performance management, HR, communications, admin, and governance		All function leads															
		4.2.2	Implement new structure to support PH functions and staff	Sally Burns																
5. Governance	5.1 Identifying risks and developing mitigation actions	5.1.1	Send out checklist to function leads		Bruce Willoughby															
		5.1.2	Checklist responses shared with NY Public Health Group		Bruce Willoughby															
		5.1.3	CYC to identify arrangements for hosting governance functions	Sally Burns																
		5.1.4	Function leads to identify risks and mitigation actions		all function leads															
	5.2 Ensure Shadow governance arrangements in place	5.2.1	Regular monitoring of action plan, risks and mitigation actions by York Public Health Transition Board	Sally Burns	Rachel Johns															
		5.2.2	Continued Governance monitoring of Public Health function through Public Health Governance Committee, overseen by PCT Governance and Quality Committee		Bruce Willoughby															
		5.2.3	Continued support by PCT Governance staff in dealing with Serious Incidents etc		Dawn Taylor															
	5.3 Developing governance arrangements for post April 2013	5.3.1	Use checklist and risk register to identify or develop new governance arrangements to cover risks identified	Sally Burns	Bruce Willoughby															
		5.3.2	NHS NYY Board to receive assurance that governance arrangements are in place before transfer		Phil Kirby															
		5.3.3	Implement and test new governance arrangements (corporate and clinical).	York PH team	York PH team															
		5.3.4	Formal transfer of responsibility 31st March 2013																	

Health Overview and Scrutiny Committee **8 May 2012**

Report of the Associate Director of Public Health, NHS North Yorkshire & York / City of York Council and Assistant Director, Integrated Commissioning, Adults Children and Education

York's Joint Strategic Needs Assessment 2012

1. York's third Joint Strategic Needs Assessment (JSNA) has recently been produced and formally approved by the Shadow Health and Wellbeing Board. This report provides members with an overview of the process involved in producing the JSNA and the main findings and recommendations.

Background

Process

2. The production of York's JSNA 2012 was commissioned jointly by the Director of Children's & Adults' Services and Associate Director of Public Health / Locality Director in September 2011. All areas are required to produce a JSNA, the legal basis for which is now the Health and Social Care Act 2012 (formerly the Local Government & Public Involvement in Health Act 2007).

3. The Shadow Health and Wellbeing Board, which acquired formal council committee status on 1 April 2012, subsequently received progress updates and draft versions of the report for comment and direction, and formally approved the findings and recommendations in March 2012.

4. Building from previous assessments, the JSNA aims to provide a comprehensive local picture of the health and wellbeing needs of all people who live in York, including vulnerable and geographic groups. It will inform the development of the new Health and Wellbeing and other strategies, local priorities, and commissioning decisions.

5. At nearly 100 pages, the full document is long. A 4 page signposting summary document will be available shortly which will indicate the

contents and key findings and tell people where to find further information. The full document is necessarily quite technical in nature but we have tried to keep it readable and feedback has confirmed that many consider the document to be an interesting and relatively easy read.

6. There are four main sections of the JSNA report: a snapshot of who lives in York; a look at "wellbeing" in its widest sense; our lifestyles; and finally a profile of our health. There are 25 separate recommendations that relate to these sections as well as the JSNA process itself.

7. In summary, the overarching themes emerging from the JSNA process are as follows:

   - For most people, York is a pleasant and enjoyable place to live, with most people living longer than the national average and experiencing a better quality of life. However unhealthy lifestyle choices still have a negative impact on a proportion of the population and there are inequalities present in York in terms of health outcomes and opportunities that are attributable to relative deprivation. Reducing these inequalities will improve health and wellbeing outcomes for people in the City.

   - The population in York is ageing. This changing demographic profile will incorporate an anticipated increase in the prevalence of long-term conditions including dementia and will have implications for health and social care commissioning decisions in the future.

   - The improvements in life expectancy and the reductions in death rates are due to a combination of improving economic, environmental and societal conditions, greater awareness of risk factors in the general population and high quality, effective services which prevent and treat existing illnesses. A continued focus on prevention and early intervention through targeted services and a focus on the wider determinants of health will be important to improve outcomes for individuals.

8. The full JSNA document can be accessed online at http://www.york.gov.uk/health/yorknhs/, it is also attached at Annex A to this report and due to its size, is viewable online only. The full document, 4 page summary and supporting evidence and data will be widely available though the council, health, YorOK and other websites.

9. The recommendations of the JSNA will inform the development of York's first Health and Wellbeing Strategy. The Health and Wellbeing Board has begun work on identifying core strategic priorities, and following planned stakeholder consultation, aims to have the strategy completed by September 2012.

Consultation

10. The process of producing the JSNA involved several stages. A small multi agency working group lead reviewed the most recently available population-level needs related data along with findings from other needs analyses where available. Local experts and groups across a wide range of relevant service and policy areas were also asked to provide information about health and wellbeing needs. This approach enabled the team to build up a health and wellbeing profile and identify known and emerging issues in the process.

11. In December 2011, early messages and emerging issues were shared at a stakeholder event involving partner agencies and young people and attendees were invited to challenge and confirm the early findings. Also in December, a JSNA Lay Person was appointed following an advertisement through York CVS networks. The Lay Person provided challenge and objectivity to the process and all involved are agreed about the value and contribution of this role.

12. Members of the Health and Wellbeing Board were invited to read and comment on a first draft JSNA in February 2012, following which an amended draft version was circulated for comment to all individuals and groups who had been involved earlier in the process. Approximately forty responses were received by email and in person at publicised feedback sessions. During this time, the JSNA drafts were discussed at many single agency and partnership meetings where feedback was also taken. A final, amended draft version was presented to the Health and Wellbeing Board in March where the findings and recommendations were approved.

Options

13. There are no specific options associated with this report, however Members can comment on the report and the JSNA attached at Annex A to this report (online only).

Analysis

14. Whilst this report is predominantly for information, the Committee can use it to identify potential areas for scrutiny review, especially around themes where they have specific concerns. Alternatively the Committee can request that the Associate Director of Public Health prioritise work in specific areas where there are concerns

Council Plan

15. This report links to the 'Protecting Vulnerable People' priority in the Council Plan 2011-15, and specifically to the key outcomes: health inequalities will reduce across York, especially morbidity and obesity; and, setting up a Health and Wellbeing Board which will review and refresh our 'Joint Strategic Needs Assessment' and a new Health & Wellbeing Strategy that flows from it.

Implications

16. There are no immediate Financial, Human Resources, Crime and Disorder, IT or Property Implications.

Equalities

17. The JSNA 2012 report describes what we know about the health and wellbeing needs of different communities of interest at a given point in time. It is acknowledged that more information is needed in relation to some communities, for example LGBT and BME communities. This will be addressed through the updating and ongoing development of the JSNA and through the work of the Neighbourhood Management Service and the development of neighbourhood plans. At the strategic level, the JSNA seeks to enhance our understanding of the needs of vulnerable groups within the city and will inform planning and commissioning initiatives aimed at tackling health and wellbeing inequalities. The new health and wellbeing strategy will be a key mechanism for progressing this work.

Risk Management

18. There are no specific risks associated with this report.

Recommendations

19. Members are asked to note the contents of this report and identify any concerns that they may have.

Reason: To keep the Health Overview & Scrutiny Committee updated on the content of the Joint Strategic Needs Assessment.

Contact Details

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	Report Approved ✓ **Date** *24.4.12* Associate Director of Public Health, NHS North Yorkshire & York / City of York Council
	Report Approved ✓ **Date** *24.4.12* Assistant Director, Integrated Commissioning, Adults Children and Education

Wards Affected: **All** ✓

For further information please contact the author of the report

Background Papers:
York Joint Strategic Needs Assessment 2012

Annexes

Annex A Joint Strategic Needs Assessment (online only)

Health & Wellbeing in York

Joint Strategic Needs Assessment (JSNA) 2012

Full Report

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The 2012 Joint Strategic Needs assessment for the City of York

Introduction

Welcome to our third Joint Strategic Needs Assessment (JSNA) for the City of York.

Building from previous assessments, this document aims to provide a comprehensive local picture of the health and wellbeing needs of all the people who live in York. It will inform the development of future strategies, help us to decide our local priorities, and influence how we spend the money allocated to us.

So who are “we”? We are the Shadow Health and Wellbeing Board, an important new partnership body for York. Membership of the Shadow Board reflects the statutory, voluntary and independent sectors in the city and includes representation from the new Vale of York Clinical Commissioning Consortium as well as people who can speak up for the people who use our services. A full list of Board members can be found at Annex 1.

Following the passage of the Health and Social Care Act 2012, we will become a formal committee of the Council from 1 April 2013. In the meantime, we have been working on a less formal basis, with the production of this needs assessment as our top priority.

We hope that you will find the assessment both interesting and useful. We have tried to keep it readable, although some parts are necessarily quite technical in nature. There are four main sections: a snapshot of who lives in York; a look at “wellbeing” in its widest sense; our lifestyles; and finally a profile of our health.

This document confirms that overall York is a great place to live. Most people who live here have good health and wellbeing. However, this does not apply to everyone: some people in our city experience poorer health and wellbeing outcomes. This may be down to their needs, their circumstances, or simply where they live. Tackling health inequalities is likely to be a top priority for our future work.

So what happens next? The Shadow Health and Wellbeing Board is responsible for developing York's first Health and Wellbeing Strategy, which will take into account the recommendations from this JSNA as well as other relevant recent reports, including *the York Fairness Commission: A Fairer and Better York, 2011*, and *the Independent Review of Health Services in North Yorkshire and York August 2011*. We aim to have our Health and Wellbeing Strategy in place by the summer of 2012.

We hope you find this report both informative and thought provoking.

Pete Dwyer
Director of Adults, Children and Education
City of York Council

Rachel Johns
Associate Director of Public Health and Locality Director - York
NHS North Yorkshire & York / City of York Council

On behalf of the Shadow Health and Wellbeing Board

If you would like more information about any aspect of our JSNA, please email healthandwellbeing@york.gov.uk or telephone the Public Health Team on 01904 601599 or the Children's Trust Unit on 01904 554358.

Health and Wellbeing in York
The Joint Strategic Needs Assessment 2012

Executive Summary and Recommendations

The overarching findings from this process are that:

There are inequalities present in York in terms of health outcomes and opportunities that are attributable to relative deprivation. Reducing these inequalities will improve health and wellbeing outcomes for people in the City.

The population in York is ageing. This changing demographic profile will have implications for commissioning decisions in the future and should be considered in plans and strategies now.

The improvements in life expectancy and the reductions in death rates are due to a combination of improving economic, environmental and societal conditions, greater awareness of risk factors in the general population and high quality, effective services which prevent and treat existing illnesses. It remains important to focus on prevention through targeted services and the wider determinants of health and on early identification of illness to get the best outcome for individuals.

There is much excellent work already under way across the city that impacts on the health and wellbeing of our citizens and the majority of them experience good health and wellbeing outcomes. However, throughout this Joint Strategic Needs Assessment (JSNA) a major theme is the relationship between disadvantage, poor health and wellbeing, and lower life expectancy. Although York is a relatively prosperous city, there is still a gap of nearly ten years in life expectancy for males between the most and least deprived communities and evidence of a gradient across socio-economic groups. Responding to these findings proportionately is important, so as not to disadvantage any parts of the population. The findings of this JSNA place a sharper focus on certain aspects of need and the recommendations seek to

inform the development of the first health and wellbeing strategy, local priorities and commissioning decisions.

Recommendation 1:

We recommend that all activity concerned with planning, strategy, commissioning and service provision incorporates objectives aimed at tackling health inequalities as a matter of course.

Intervening early in order to achieve better outcomes will benefit the individual and the population, and may also reduce costs. This applies as much to health education programmes to encourage people to maintain healthy lifestyles as it does to pathways designed to help people receive support to receive treatment in their own homes rather than being admitted to a hospital when a crisis occurs. These principles are generally well recognised, but they are not always translated into commissioning decisions and the design of services.

Recommendation 2:

We recommend that the principle of early intervention informs every commissioning decision taken within York, and that partnership working to achieve this end is regarded as the norm not the exception.

Population

Population estimates forecast an increase in the older population in York, most notably in those aged 85 years and over. An ageing population is likely to have the largest impact on local need. The recent review of health services in York and North Yorkshire also identifies priorities in this area. The prevalence of long-term conditions rises as individuals grow older and therefore it would be reasonable to expect increasing need in this area. In addition, the prevalence of dementia rises with an ageing population, with the associated impact on families, carers and support services.

Recommendation 3:

We recommend that a comprehensive picture of prevalence and need is established in relation to the physical and mental health needs of this group. Some of this work is underway to capture

information beyond those who receive adult social care services and should be built upon.

Recommendation 4:

We recommend that the implications of an increasingly ageing population are systematically considered in planning and commissioning activities including in the areas of mental health, physical and learning disability, maintaining independence, loneliness and carers.

Recommendation 5:

We recommend that there is a particular focus on reducing the impact of ill-health and falls in older people, providing community-based responses in responding to long term conditions and in preventing admissions to hospital.

Recommendation 6:

We recommend that homes and neighbourhoods are designed and adapted to accommodate needs recognised as being associated with ageing and maintaining independence.

Estimates of the size of specific groups and communities and their associated health and wellbeing outcomes within the City have been difficult to identify. Specifically, accurate estimates of the black and minority ethnic (BME) population and estimates of the lesbian, gay, bisexual and transgender (LGBT) population and their associated health and wellbeing outcomes have been particularly challenging.

Recommendation 7:

We recommend that work continues to ensure that groups and communities within the City are appropriately represented and not disadvantaged with regard to health and wellbeing decisions.

Social and Place

Most people living in the city can expect to have a good quality of life and experience positive health and wellbeing outcomes. However, parts of the City are in the 20% most deprived in the country and that people

living in these areas experience higher levels of inequality in health, wellbeing and opportunity.

Recommendation 8:

We recommend that active consideration is given to tackling the many and complex issues faced by people living in the most deprived areas of the city. This will involve communities working alongside statutory, voluntary and independent partners.

Employment provides income and opportunity, and will also increase an individual's self esteem and access to social networks. Employment opportunities are becoming increasingly compromised at this time of economic difficulty, and have remained limited for some groups of people. In York the unemployment rate has risen since 2005, although it is lower than the England rate. However, whilst unemployment in men has risen, unemployment in women has dropped, although the number of women claiming Job Seekers Allowance has increased and is at the highest level for 13 years, mirroring the national trend. Whilst the latest data shows that the number of 16-18 year olds not in education, employment or training (NEET) in York has increased it is comparable to other areas in the North of England

Recommendation 9:

We recommend that action is taken to explore and increase employment opportunities for the following groups of people: people with physical and learning disabilities – both young and older, young people, adults who may be returning to work (including rehabilitation back to work following illness), people with mental health problems and people who have substance use problems.

Having a safe home that is appropriate to a person's need is a central to good health and wellbeing. There is a clear link between poor and inappropriate housing and poor health outcomes. Most dwellings in York are maintained to a relatively good standard in terms of general condition and thermal efficiency. It has been identified that there is pressure on quality housing in York with a growing gap between the demand for quality housing and supply. There were 3466 households registered as looking for a social rented home in York in December 2011 therefore there is an aim to better understand the needs of particular

groups and ensure the availability of appropriate accommodation to meet their specific needs.

Recommendation 10:

We recommend that the housing needs of key groups of people are considered in the context of service planning and high quality provision, including older people, families, people who have mental health needs, young people, Gypsies and Travellers, students, people with physical and learning disabilities, black and minority ethnic households and the ageing population.

Lifestyle

There is a clear link between lifestyles and health and wellbeing outcomes. Aspects of lifestyle are risk factors for a range of conditions and diseases that limit both quality and quantity of life. Individuals can be helped to change lifestyle behaviours and patterns. Smoking is implicated in the development of many long-term conditions and several cancers. The associations between smoking and deprivation are also well recognised and have been identified within the City of York.

Recommendation 11:

We recommend that established programmes aimed at reducing the smoking prevalence in York are maintained and built upon. Consideration needs to be given to targeting specific groups to prevent long term consequences of smoking such as young people, pregnant women and routine and manual occupational groups.

Obesity is also a major risk factor in disease development which has been recognised as an issue nationally. Active and healthy lifestyles are promoted in many ways across the City, including through initiatives aimed at particular groups of people such as the Health, Exercise, Activity and Lifestyle (HEAL) programme, the Healthy Schools programme and schemes such as Cycling City and Intelligent Travel York. Whilst levels obesity and those at risk of obesity amongst children compare well nationally, a robust measure of obesity and risk of obesity in adults is not currently available either locally or nationally. It is expected that levels of obesity across the whole population will continue to rise unless preventative action is taken.

Recommendation 12:

We recommend that a comprehensive local picture of obesity amongst adults and children is established.

Recommendation 13:

We recommend that there is continued support for initiatives aimed at increasing levels of physical activity across the whole population and that priority is given to vulnerable groups and those who are least active.

The misuse of alcohol has been linked to looked after children and young people who leave care, offenders, parents coping with stress and people with mental health needs. A similar picture has emerged in relation to substance misuse where there are links with the same population groups. However, consumption of alcohol above the recommended limits is not necessarily limited to these groups and arguably has wider reaching effects related to physical and mental health, in addition to wider social effects.

Recommendation 14:

We recommend that local data is collected to establish an accurate picture in relation to the prevalence and impact of the use of alcohol and drugs. Work is already underway in this area in terms of an alcohol needs assessment and a needs assessment relating to young people and substance misuse and these should be utilised in service planning and commissioning decisions.

Health Outcomes

Most of premature deaths in York occur as a result of cancer, and circulatory diseases. Action can be taken to minimise the impact of these conditions.

The aim of the National Awareness and Early Diagnosis Initiative (NAEDI) is to coordinate and provide support to activities and research that promote the earlier diagnosis of cancer and therefore improve the outcomes associated with cancer.

Recommendation 15:

We recommend that activities are maintained to reduce the impact of cancer through maintaining and improving the uptake of screening, early diagnosis and appropriate treatment.

Circulatory diseases account for approximately one third of all deaths in England and Wales. Fortunately, the death rates due to circulatory diseases have been dropping in York. Risk factors for circulatory disease are multiple, some of which can be modified through lifestyle changes. There is a marked difference in death due to circulatory diseases between the most deprived and the least deprived in the City.

Recommendation 16:

We recommend that activity is maintained with regard to identifying and treating those diagnosed with, or at risk of circulatory diseases, including heart disease and stroke. A lifestyle modification approach in addition to a pharmacological approach should be maintained.

High blood pressure is an important risk factor for the development of circulatory conditions, which can be modified through lifestyle changes including physical activity, weight loss, stopping smoking and reducing alcohol consumption and the use of medication. However, is estimated that there are a large proportion of individuals with high blood pressure who are undiagnosed. Identifying these individuals and providing the most appropriate advice and treatment should reduce the chance of them developing circulatory diseases.

Recommendation 17:

We recommend that work should be maintained to identify the accurate prevalence of high blood pressure and once diagnosed an evidence-based approach to management of this condition should continue.

The prevalence of diabetes has increased in York, although this could be attributed to greater awareness amongst the general population and case-finding activity by the health service. Diabetes is a leading cause of sight loss before old age and these effects can be mitigated. In addition, diabetes increases the chance of developing circulatory disease. Therefore the management of other risk factors and

appropriate control of an individual's blood sugar is important to reduce the chance of poor health outcomes. In diabetic individuals registered with General Practices that make up the Vale of York Clinical Commissioning Group the proportion of individuals with diabetes with acceptable blood pressure control was lower than the England average, as was the proportion with acceptable long-term blood sugar control.

Recommendation 18:

We recommend that activity is maintained regarding identifying those individuals with diabetes. Once diagnosed, individuals should continue to be managed according to evidence-based guidelines. Work should be undertaken to improve the proportion of individuals with diabetes who are optimally managed to improve health and wellbeing outcomes.

Chronic obstructive pulmonary disease (COPD) is a long term respiratory condition that is associated with smoking and causes disproportionately more deaths amongst the most deprived communities in York compared to the least deprived. Identifying and addressing the potential causes of this inequality would be important in improving the health and wellbeing outcomes for the City.

Recommendation 19:

We recommend that work continues to reduce the impact of respiratory disease in York, including COPD. This will need to include both a preventative approach in addition to maintaining and improving on the management on individuals with respiratory conditions.

Whilst some long-term neurological conditions are present from childhood and adolescence, the prevalence of others increases with increasing age. Neurological conditions can be life threatening, and most of them severely affect an individual's quality of life. Caring for someone with a debilitating illness often means that carers have to give up their own employment, in addition to the person with the condition being unable to continue to be economically active. Identifying the prevalence and impact that these conditions have on individuals, families and the wider community is likely to aide understanding of the challenges that these groups face.

In the process of collecting and collating information for this JSNA, it became evident from many sources that there is a perception that there are unmet levels of mental health need across the city, particularly at the lower levels of complexity and severity. However, it has not been possible to establish a comprehensive picture of mental heath needs across York. It is therefore not possible to objectively asses the adequacy of provision. The perception of practitioners is that there are gaps in provision, particularly with regard to lower level mental health needs. Improving mental health outcomes is a stated priority for the York Fairness Commission and is also a priority emerging from the recent review of health services in York and North Yorkshire. Through the process of compiling this report, one of the most consistently and strongly articulated themes has been to develop a better picture of mental health needs and to improve the ability to meet those needs.

Recommendation 20:

We recommend that work be undertaken to establish a full and holistic picture of mental health needs across the whole population and in relation to specific groups of people (including the Gypsy and Traveller community, looked after children, teenage mothers, people with autism, parents experiencing stress, people misusing substances, people who are unemployed, older adults including those with dementia and carers) in order to inform future planning and commissioning activity.

Recommendation 21:

We recommend that active consideration is given to the provision of a range of comprehensive community based, early intervention support and services for individuals with mental health problems.

Recommendation 22:

We recommend that active consideration is given to joining up more closely the children's and adults' mental health agendas and work streams in order to support a closer focus on early intervention, prevention and transition.

Recommendation 23:

We recommend that service planning takes account of the mental health needs of the ageing population, with particular reference to loneliness and the growing number of people with dementia.

The JSNA Process

It has been difficult to obtain data about the health and wellbeing needs of some population groups. Detailed information is often held at the individual case level, but is not collected at the population level. In some areas there is an absence of local data and there is a reliance on modelled estimates. In these cases it has not been possible to establish an accurate picture of local need and identify improvement or deterioration in outcomes and trends. Some data sets may improve as the activities and priorities of the new Vale of York Clinical Commissioning Group become established and joint working with local partners develops.

Recommendation 24:

We recommend that data collection is improved in agreed priority areas in order to more accurately inform the picture of local health and wellbeing need, ongoing JSNA activity and planning and commissioning activity. The specific groups identified by this JSNA process are looked after children, young people who leave care, carers including young carers, people who have disabilities, people with mental health needs, older people, offenders and people who misuse substances.

An important objective of the JSNA is for it to reflect perspectives about health and wellbeing from across the local community. We acknowledge that our approach to gathering this information has been only partly successful and as a consequence this aspect of the JSNA is underdeveloped. This is an area for development for future JSNA activity and will be of broader interest to the Shadow Health and Wellbeing Board, particularly given plans to establish the local HealthWatch service.

Recommendation 25:

We recommend that further work is undertaken to establish a full picture of community engagement / consultation / feedback activity and to develop clear mechanisms for ensuring that local perspectives inform the JSNA process.

Section 1: Population structure and projections

The Population

The most recent data available suggests that the population of York was 202,447 in 2010, an increase of 11.7% since 2001[1]. Such growth is twice the national average but the rate has now slowed[2]. It masks variations for different age groups, with rises in the numbers aged 20-24 and the 25-29, and a fall in the 30-39 and 50-54 age groups.

Data from 2010 shows that since 2001 there has been a 24% rise in the number of people aged 80 and over (from 8,100 to 10,047 people). This trend is set to continue with an additional increase of 62% (a further rise in numbers to 13,100) by 2021[3]. The independent review of health services in North Yorkshire and York has identified a similar projected increase for the whole County[4]This reflects national trends and has significant implications for the provision of services.

York is estimated[5] to have higher net migration (i.e. more people moving into the city than out) than both the region and the UK. In fact 90% of the population change between 2009 and 2010 is estimated to be due to this. Overall trends in the population of York over the period 2001-2010 are illustrated in Fig. 1.

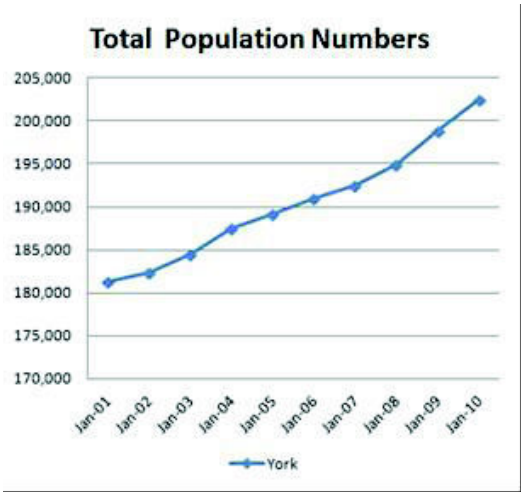
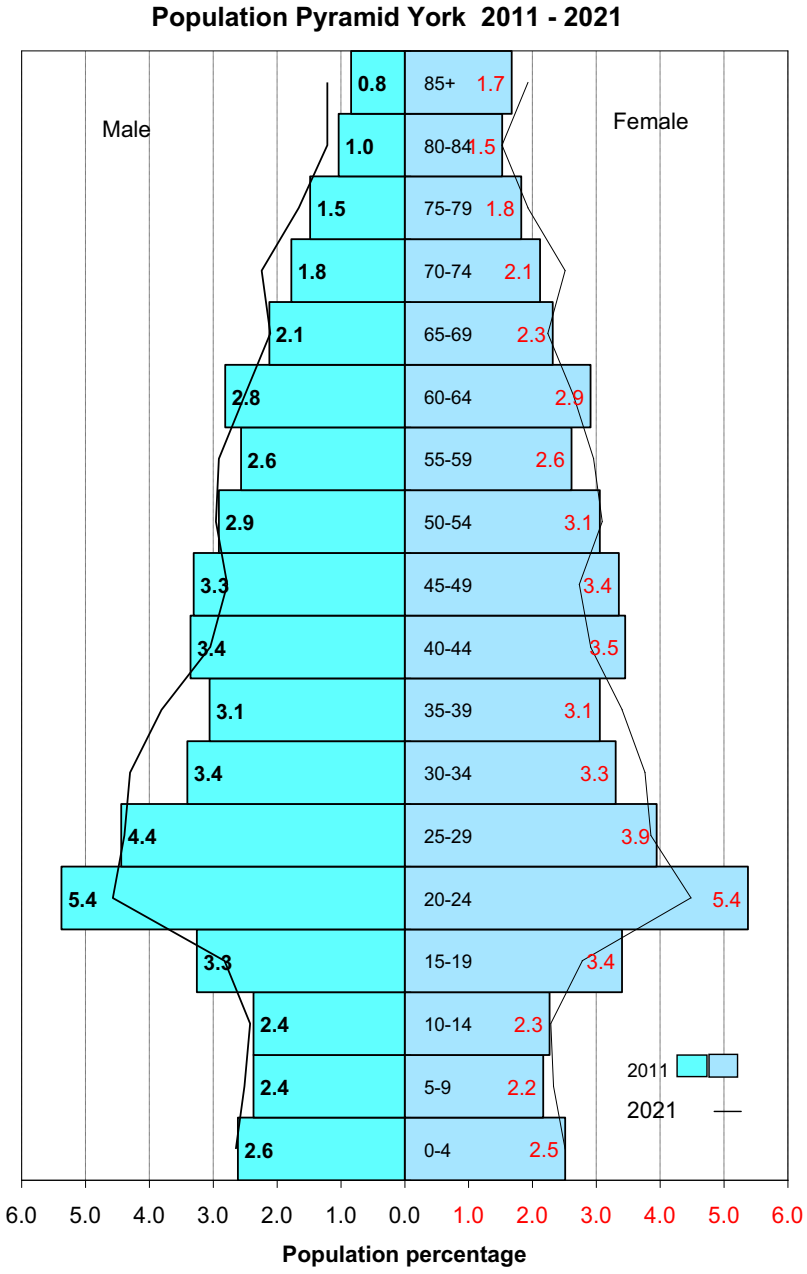


Figure 1: Projected population growth for York

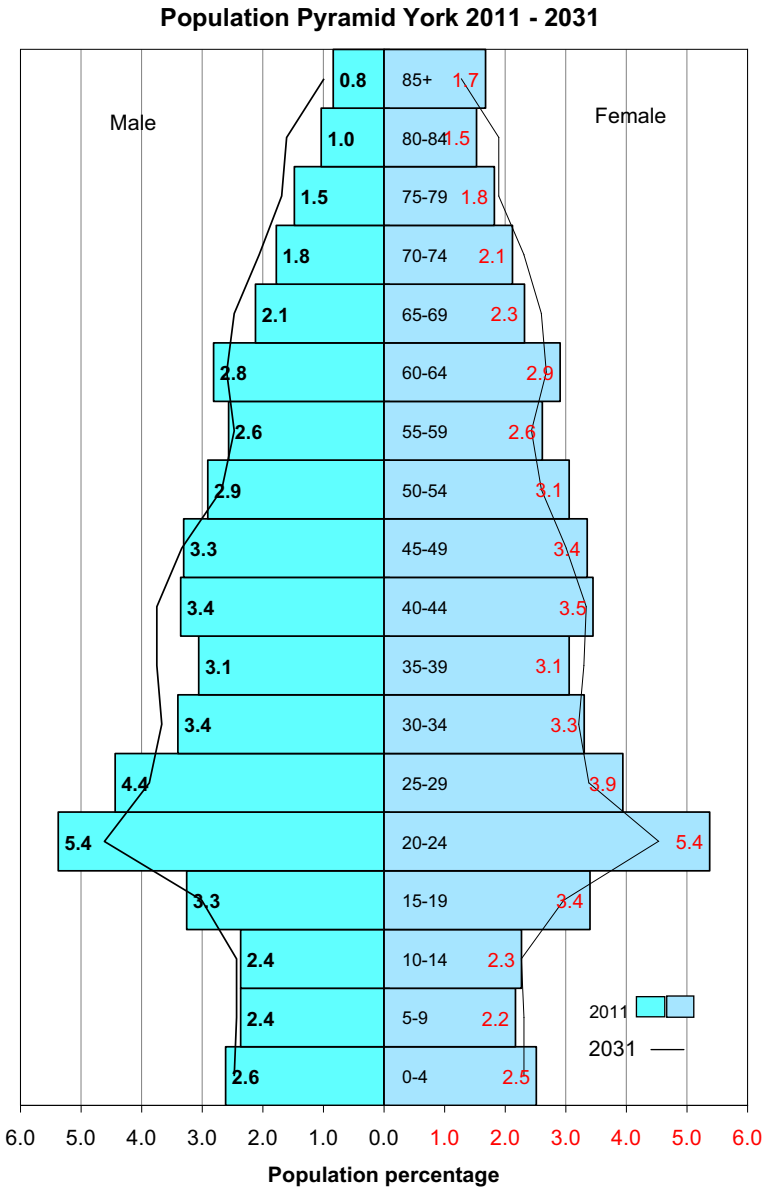
[1] ONS Mid Year 2010 population estimates
[2] Statistics from Yorkshire Forward Chief Economist Unit, August 2011, based on regional.
[3] Local Authority Local Account 2011
[4] Independent Review of Health Services in North Yorkshire and York: Report of the Independent Commission 2 August 201
[5] ONS Mid Year 2010 population estimates

Fig. 2 and 3 show the current population structure and the projected position for 2021 and 2031.



Source: ONS 2008 population projections

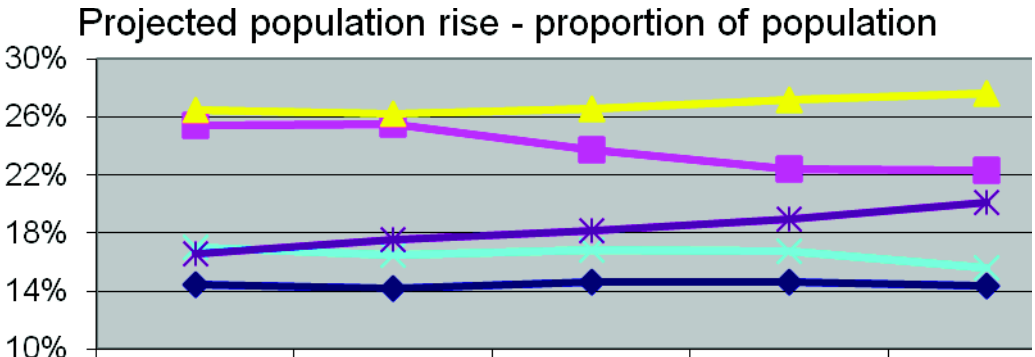
Figure 2: York population pyramid for 2011 and 2021



Source: ONS 2008 population projections

Figure 3: York population pyramid for 2011 and 2031

Fig. 4 shows the population projections for different age groups.



	2009	2014	2019	2024	2029
0-14	14.4%	14.2%	14.6%	14.7%	14.3%
15-29	25.5%	25.5%	23.7%	22.4%	22.3%
30-49	26.5%	26.2%	26.6%	27.2%	27.6%
50-64	17.1%	16.5%	16.9%	16.8%	15.6%
65+	16.6%	17.6%	18.2%	19.0%	20.1%

Figure 4: Projected population change in York by age group

Births and Deaths

In 2010, the number of births to mothers who live in York decreased, the first reduction in the rate since 2002. For 2010 the birth rate was 10.5 per 100,000, compared to 10.8 in 2009. This is also below the birth rate for England in 2010, which was 13.2 per 100,000 people.

Another way of analysing this is to look at the "fertility rate". In 2010 the fertility rate for York women was 1.4 children compared to 2.0[6] for England. This may be because more families in York are choosing to wait to begin a family, reducing the potential size.

The number of deaths of individuals resident in York was 1,757 in 2010. The death rate for York has remained stable over the period 2005-09 with a rate of around 500 deaths per 100,000 people.

[6] ONS, Birth Summary Tables England and Wales – Births by usual area of mother's residence. http://www.ons.gov.uk/ons/rel/vsob1/birth-summary-tables--england-and-wales/2010/birth-summary-tables--england-and-wales-2010--13-07-11.xls

How and where people live

The number of households in York[7] is expected to increase by 37% from 84,000 in 2008 to 115,000 in 2033. York's housing tenure profile[8] is as follows:

- owner occupied, 70%;
- private rented, 15%;
- social rented: 15% (approximately 7,900 City of York and 4,300 registered social landlords).

It is known from local surveys[9] that the private rented sector has grown dramatically since 2001. York has very low levels of homes left empty for a long period, at around 0.5%.

Projected trends in households differ depending on the type of household. For example, one-person households are set to increase by 60.7% by 2033, accounting for 39% of all households. Family size is predicted to decrease because of fewer children being born, or parents separating. Lone parent households are set to increase by 80%, accounting for 8% of all households by 2033. Households with no dependent children are set to increase by 42%, with one dependent child by 26%, with two dependent children by 26% and with three or more dependent children by 3.6%.

Households with a head of household aged 75-84 are projected to increase by 50%, accounting for 4,000 households. However the largest predicted increase of all is in households where the head of household is aged over 85 years: this type of household is set to increase by 200%, accounting for 6,000 households by 2033.

In recent years there has been a significant reduction in the number of people in York who are regarded as homeless or at risk of homelessness. This has come about because of a successful focus on homelessness prevention, family intervention initiatives and other forms of personal support. Agencies across York have been working together to ensure that the level of rough sleeping remains low. The overall number of households placed into emergency temporary accommodation has also been reducing year on year[10].

[7] Based on ONS modelled estimates
[8] Data rounded. Housing Strategy Statistical Appendices 2011; Private Sector Housing Stock Condition Survey 2008
[9] 2008 Private sector stock condition survey
[10] CYC Directorate Quarter 3 Monitoring 2011/12

The Local Development Framework Core Strategy sets out where demand for quality housing is, and how it will be met in the future. The focus for new housing development (around 87%) will be in the main urban area of York. The Council has set a target to build 800 dwellings annually from 2011, including affordable housing[11].

The Council and its partners will continue to address the specialist housing needs of specific population groups such as homeless young people, people with mental health issues, people with learning disabilities and older people. The overall aim is to help people to live successfully in their own homes.

Specific population profiles and their needs

The remainder of this chapter looks at various subsets of the overall population, especially those for whom local intelligence or national research suggests there may be specific health and wellbeing issues. In doing so, it is important to acknowledge that everyone will have health needs at some stage in their lives, and the aim of all the agencies in York will always be to provide outstanding universal services for everyone. However we also need to recognise that we may need to set particular priorities for specific groups if the evidence points that way.

The section starts by analysing three population groups whose needs are recognised in national legislation and into which people may fall for all or most of their lives: by virtue of their ethnicity, disability, or sexuality. The section then analyses groups that are smaller or more transitory in nature, from childhood through to adulthood, before finally looking at the needs of the older population. Needless to say, people may fall into more than one category in this section, and policy-makers should be aware of this.

Black and minority ethnic groups

There is a rapidly growing black and minority ethnic population in York, due in part to the continuing expansion of university and higher

[11] LDF Core Strategy Document

education facilities within the city. Another factor is seasonal work in York's tourism and agricultural industries.

The 2001 census stated that York's black and minority ethnic population[12] was 4.9% of the total. A more recent study commissioned by the Joseph Rowntree Foundation suggested that by 2009 this had grown to 11%[13]. The study identified 92 different ethnic and national origins in the city and 78 different first languages[14].
The most recent socio-economic analysis[15] of black and minority ethnic households in York found that that this population group is mostly made up of younger, settled black and minority ethnic people (aged 25-39), living in rented accommodation (mainly houses) and of whom the largest identified ethnic group is "Asian". There is a significant secondary group of migrant workers who are mostly from Eastern European countries, aged18-39 years old, and living in private rented flats and converted houses.

National research tells us that black and minority ethnic households are four times more likely to be living in private rented sector housing than the population as a whole. Households for this group tend to be larger, with over 12% cent comprising 6 or more members, compared with 1% of the population as a whole, with some suggestions of a greater prevalence of overcrowding[16].

Estimates suggest that there are in the region of 330 Gypsy and Traveller households in York[17], mainly comprising English Gypsy (Romany) households and including a small Irish Traveller Community and a smaller population of Show people[18]. An accommodation needs assessment for the Gypsy and Traveller community in North Yorkshire was undertaken in 2007-08[19]. This identified that the council has 55 individual pitches allocated for the Gypsy and Traveller community[20], the majority of which are sufficiently large to accommodate two caravans and one or two vehicles[21]. There are no private sites allocated in York for this purpose[22]. It may be appropriate to make a distinction between those individuals and families who identify themselves as being part of a Gypsy and Traveller community and being relatively mobile, and those

[12] All groups other than White British
[13] JRF – Mapping rapidly changing population growth. A case study in York 2010
[14] ibid.
[15] Experian Origins Household Profiles mapped against Experian Mosaic Household Types
[16] Based on householders perception as opposed to an objective assessment based on the Government's 'Bedroom Standard'
[17] Gypsy and Traveller accommodation assessment 2007-8.
[18] ibid.
[19] arc[4]. Gypsy and Traveller Accommodation Assessment North Yorkshire Sub-region – 2007/8.
[20] Count of sites provided by Local Authorities http://www.communities.gov.uk/documents/statistics/xls/2030947.xls
[21] CYC website (http://www.york.gov.uk/environment/travellersites/ - accessed on 15th December 2011)
[22] Gypsy and Traveller accommodation assessment 2007/8

individuals and families who identify themselves as being part of the Gypsy and Traveller community but live in houses due to accommodation issues. The former category is likely to be the smaller of the two and this is borne out as most of the Gypsy and Traveller households that do not access the Council pitches live in conventional housing. However, there are still some unauthorised developments, and periodically unauthorised encampments appear in North Yorkshire and York. This often occurs on the way to and from fairs, and there is a high level of homelessness reported by those encamped unofficially[23].

A count of Gypsy and Traveller caravans has been undertaken biannually since 1979, recording the number of caravans on both authorised and unauthorised sites across England. These counts are used to estimate the size of the travelling population nationally, and can assist planning locally. The results of the count since July 2009 suggest that the number of Gypsy and Traveller caravans in York ranged from 86-130 caravans[24]. The local provision of pitches corresponds to 165 caravans[25], which based on this count may be sufficient. However, there are limitations with the methodology used in this approach, and although it has been used for several decades it may not provide an accurate estimate of the Gypsy and Traveller population size.

The number of households estimated in the 2007-08 Accommodation Assessment (330) was based on the number of children known to Traveller Education[26]. Traveller Education have access to the number of children who are recorded as being current attendees for the 12 months prior to January 2012, and the number of children who have had any input in the 12 months prior to January 2012. The latter figure will include children of Showpeople, who may move more frequently than other sections of the Gypsy and Traveller community. Although this may not completely identify the population of Gypsy and Traveller families, it could be used to estimate the proportion of the community who are mobile. Based on this, approximately 40% of the Gypsy and Traveller community are mobile, with around 60% remaining in the City for a sufficiently long period of time for their children to be recorded as currently receiving education, although this will include home schooling as well as state schooling. This will not identify childless families, nor will it identify those families that identify themselves as being part of the

[23] arc[4]. Gypsy and Traveller Accommodation Assessment North Yorkshire Sub-region – 2007/8.
[24] Count of Gypsy and Traveller caravans, July 2009-July 2011.
http://www.communities.gov.uk/documents/statistics/xls/20309401
[25] Count of sites provided by Local Authorities http://www.communities.gov.uk/documents/statistics/xls/2030947.xls
[26] arc[4]. Gypsy and Traveller Accommodation Assessment North Yorkshire Sub-region – 2007/8.

Gypsy and Traveller community, but have not recorded this with the City of York Council.

National research has identified that the health outcomes within the gypsy and traveller community are often worse than in the most deprived communities in the UK[27]. This population group reports[28] relatively high levels of mental health and respiratory problems and higher levels of infant and adult mortality although less inequality is observed regarding diabetes, strokes and cancer.

Educational outcomes at national and local level vary across ethnic groups. When compared to children classed as white English, black and minority ethnic children in York on average out-performed their peers at key stages 2 and 4 in 2011[29]. This may reflect cultural differences and the international nature of our two universities. Conversely, educational outcomes for Gypsy and Traveller children are poor, with national results in 2010 revealing a gap of around 50 percentage points when compared to the national average for pupils achieving 5+ A*-C GCSEs (including English and maths)[30,31]. This group of children has the worst school attendance and highest exclusion rates.

In a recent report[32], Refugee Action York described having regular contact with 27 adults and 46 children, noting that in addition to dealing with the traumas associated with fleeing their host country, refugee families experience isolation and social and economic exclusion. Children and young people from refugee communities often bear a great deal of responsibility within the home and often act as translators for their parents. Refugee Action York state that the young people they work with experience poverty and social exclusion on a daily basis and can feel very isolated from their peers.

Disabled People and those with Learning Disabilities

Clearly, disability can arise at any age and it is important to recognise that younger disabled people may have needs that are different from older people. Learning disability, on the other hand, is more likely to affect people throughout their lives.

[27] Van Cleemput, P & Parry, G. Health Status of Gypsy Travellers. Journal of Public Health Medicine 2001:23:2;129-134
[28] G&T accommodation assessment 2007/8
[29] CYC Analysis of school attainment via EPAS and Nexus 2011
[30] DfE statistical release http://www.education.gov.uk/rsgateway/DB/SFR/s000977/index.shtml
[31] DfE statistical release http://www.education.gov.uk/rsgateway/DB/SFR/s001047/index.shtml
[32] Early Intervention Fund Update, Refugee Action York, 2011

Starting, then, with disabled children: this group has very definite needs. Four in ten disabled children live in poverty nationally[33], and put the other way around, approximately two thirds of children living in poverty will have special educational needs. Locally, we have observed a strong correlation between those with special educational needs and those entitled to free school meals[34]. National research shows an increased prevalence of child disability in lower socio-economic groups.

CHIMAT[35] quote a Thomas Coram Research estimation that between approx 1,000 and 2,000 children experience some form of disability in York. York has register for disabled children, but this is new and depends on parents identifying a disability. It does not yet accurately indicate the actual numbers of disabled children in York.

There are nearly 4000 children and young people in mainstream schools in York who have some form of special educational need, of whom 471 pupils are subject to a formal educational statement. The needs of many of these children continue to be met through provision within mainstream schools. This year saw the first rise in the numbers of children with special educational needs since 2008[36] from 16.4% to 16.8% at January 2011[37].

There appears to be a steady rise in the numbers of children with a physical and sensory disability coming into York schools, from 52 in 2009 to 70 in 2011. There has also been a significant rise in the numbers of pupils with speech, language and communications needs since 2009, increasing by 30 children to 207 in 2011[38]. Since 2010 the number of children with a hearing loss as their primary need has risen from 44 to 52, and the number of those with a visual impairment has levelled at 15 . 446 children have social, emotional behavioural needs and the number of children affected by autism spectrum condition has risen from 118 to 131, the biggest rise being recorded for primary school aged children. The most recent local data[39], shows that in 2010 there were 250 deaf people of all ages within City of York and 916 registered as hard of hearing.

[33] Children Society Report, October 2011
[34] CYC SEN Analysis 2011
[35] Child and Maternal Health Observatory http://www.chimat.org.uk/resource/view.aspx?RID=102733
[36] SEN Analysis 2011
[37] PLASC January 2011
[38] ibid.
[39] SSDA910, Deaf & Hard of Hearing Register return (completed every 3 years) dated March 2010

Disabled children also include those with chronic conditions such as epilepsy, diabetes, asthma and anaphylaxis. In July 2010 there were 126 children in year 6 who had such identified health needs of this nature.

In 2010 a consultation with parents said that the lack of high quality childcare for disabled children was a barrier to work and greater income. Over half of the parents responding to the York Transition Survey said they worried a lot about what their young person would be doing after school: 32 % of young people in York who are not in education, employment or training (NEET) are young disabled people, compared to 22% nationally.

The prospect of disadvantage unfortunately continues through into adult life for people with disabilities. According to the document improving the Life Chances of Disabled People[40], disabled people are more likely to live in poverty and their income is, on average, less than half of that earned by their non-disabled peers. Disabled people are less likely to have educational qualifications and are more likely to be economically inactive with only one in two disabled people of working age currently in employment, compared with four out of five non-disabled people. This group is more likely to experience problems with hate crime or harassment, with housing, and with transport - the issue given most often by disabled people as their biggest challenge. On a more positive note, a recent local survey[41] of adults with physical and sensory disabilities showed that most were satisfied with the way they lived their lives.

It is difficult to estimate the number and percentage of disabled people who live in our city as there are numerous definitions of disability and different data sets. The NHS Information Centre has calculated that 16.1% of York residents have a limiting, long-term condition (compared to an estimate of 17.3% for England)[42], and that 3.7% of working age adults are permanently sick and unable to work[43]. According to the 2001 Census, 12,506 people of working age in York considered they had a health problem or limiting long term illness (this figure includes all impairments, not just physical and sensory impairments).

[40] Improving The Life Chances of Disabled People, Prime Minister's Strategy Unit, 2005
[41] City of York Council Survey of people with physical disabilities, 2011
[42] NHS Information Centre. Available at: https://indicators.ic.nhs.uk/download/NCHOD/Data/03A_009VS_01_V2_D.xls accessed 11/01/2012
[43] NHS Information Centre. Available at: https://indicators.ic.nhs.uk/download/NCHOD/Data/03B_010VS_01_V2_D.xls accessed 11/01/2012

Some impairments and illnesses are particularly associated with ageing, some people are born with a physical and sensory disability and some communities display a higher incidence of chronic conditions. Disabilities can also be acquired either as a result of an accident or from disease. The most commonly reported impairments for both men and women are problems of the back, neck and legs or feet, followed by heart or circulation or breathing problems. The wards in York where the levels of self-reporting of health problem or long-term illness were higher than the national average were Fulford, Guildhall, Heworth Without, Huntington and New Earswick, Osbaldwick and Westfield.

At the 31st March 2011, 495 people in York were registered as blind and 525 were registered as partially sighted[44]. Of the individuals who were registered blind, 275 had additional disabilities and 65% were over the age of 65 years[45]. Of the individuals who were registered partially sighted, 295 had additional disabilities and 71% were 65 years or over[46]. 45 individuals were newly registered as blind and 70 as partially sighted during the year to the end of March 2011[47]. We anticipate a doubling of these numbers over the next 25 years due in part to the ageing population, but also to an increase in underlying causes such as diabetes.

Nationally there are an estimated 9 million deaf and hard of hearing people in the UK of which about 688,000 are severely or profoundly deaf. Approximately 41% of all over 50 year olds have some kind of hearing loss, rising to approximately 71% of over 70 year olds. In 2010 there were 250 deaf people of all ages and 916 registered as hard of hearing in York. Nationally there are about 24,000 people in the UK who are dual sensory impaired. These figures do not take into account the large number of older people who are losing both their sight and hearing.

The number of Disability Living Allowance claimants in York rose by 24% between 2002 and 2010, which is above the regional rate of 23%, though less than the national rate of 31%. The number of Incapacity Benefit /Severe Disablement Allowance claimants has decreased by 31% over the same period.

[44] NHS Information Centre. Available at: http://www.ic.nhs.uk/webfiles/publications/009_Social_Care/Regblind11/Registered_Blind_and_Partially_Sighted_Council_level_tables_31_March_2011.xls accessed 11/01/2012
[45] ibid.
[46] ibid.
[47] ibid.

The number of residents of working age in York who have physical and sensory disabilities and who receive long-stay residential or nursing care has fallen from 2.0 per 10,000 people in 2008-09 to 1.7 in 2010. This compares with an England average 2.6 per 10,000.

We know that adults with learning disabilities may be amongst the most vulnerable and marginalised people in society. People with learning disabilities are more likely to be socially excluded, experience worse physical and mental health and have difficulties in accessing healthcare. People with learning disabilities are likely to be at risk from abuse and to be discriminated against and are at greater risk of ending up in prison. This group of people need support to access quality housing, health, employment and independent living.

There were 474 working age adults with learning disabilities known to social services in York in December 2011[48]. This number fluctuates slightly year on year, but has remained stable at just under 500 individuals in recent years. Under present arrangements, the local health check process does not give us information about the specific health needs of this group. We need to consider how the contractual arrangements with General Practitioners can be developed to provide this information.

The most recent Valuing People self assessment report[49] notes that in York, 48.1% of people with a learning disability and who are known to social services have their own tenancies, (compared to the national average of 15%). There are still people with learning disabilities living at home with carers, and whilst this can be through choice, appropriate options will be needed to support moves towards more independent living.

The number of adults with learning disabilities in employment in York fell in 2009/10 to 4.3% from 5.8% which is a higher fall in percentage terms than the regional rate. The number of working age people who have learning disabilities and who were receiving long-stay residential or nursing care at the end of March 2010 was 5.69% compared to an England average of 9.08 per 10,000 population.

[48] NHS IC: Social Care and Mental Health Indicators from the National Indicator Set 2008-09 http://www.ic.nhs.uk/webfiles/publications/009_Social_Care/socmhi09-10/Disaggregated_Social_Care_Indicators_2008-09_v2.0.xls

[49] Valuing people Now, Local Learning Disabilities Partnership Board, Annual Self Assessment Report 2010/11

Lesbian, gay, bisexual and transgender groups

Although the health needs of the lesbian, gay, bisexual and transgender (LGBT) population are in the main universal there are specific needs relating to sexual orientation and homophobia that can have a significant impact on care needs. The York lesbian, gay, bisexual and transgender forum have identified that there are specific needs related to particular stages in an individuals life. In both young people and adults it was recognised that there was a need for frontline medical staff to practice in accordance with the Equalities Act 2010, and that assumptions should not be made with regard to an individual's sexual orientation[50]. Young people may experience difficulties in the education system related to bullying which is likely to have an impact on an individual's mental health. Adults in the LGBT population will have different needs, often related to personal and social support structures[51]. Specific differences are notable within the LGBT population over the age of 55 years[52]. Members of this population are more likely to live alone, are less likely to have children and are less likely to see biological family members than the broader population[53]. With regard to wellbeing, research has identified that as members of the LGBT population are consistently more concerned than the broader population with regard to future care needs, independence, mobility, health and housing[54]. With diminished support networks in comparison to their heterosexual counterparts, they expect they will need to rely on external services, including GPs, health and social care services and paid help. There is a real concern that services in later life are designed for heterosexual people and the needs of lesbian, gay and bisexual people may not be met, particularly in care homes[55].

Smaller and transient population groupings

As suggested earlier, the next part of this chapter looks at smaller population groupings, or those that people may only occupy for a period of their lives. Even a transitory status, however, may have a long term

[50] Hunt R & Fish J 2008. Prescription for Change: Lesbian and bisexual women's health check 2008. Stonewall. Available at: http://www.stonewall.org.uk/documents/prescription_for_change_1.pdf
[51] Stonewall 2011. Lesbian, Gay and Bisexual People in Later Life. Available at: http://www.stonewall.org.uk/documents/lgb_in_later_life_final.pdf
[52] ibid.
[53] ibid.
[54] ibid.
[55] Stonewall, national charity for promoting the interests and needs of the LGB population. Reports: Prescription for Change 2009; Lesbian, gay and Bisexual People in Later Life 2011; Change Champion Programme for Local Authorities and Schools (Ongoing). Consultation and discussion with the York and District LGBT Forum 2012

impact. This sub-section is roughly chronological in structure, ie from childhood through to adulthood.

Looked after children and young people who leave care

The number of "looked after" children in York currently stands at around 250. This number has doubled in the last decade, in line with national trends. The health and wellbeing needs of individual looked after children are assessed and reviewed regularly; however local aggregated data is not currently available, making it difficult to establish how far the needs of this group are improving or deteriorating.
Children and young people entering the care system are statistically more likely[56] to have been exposed to traumatic events such as bereavement, separation, violence and abuse, parental drug addiction and mental health difficulties, all of which can affect their general and psychological development and mental health. Local practitioners are observing increasing health needs within this group, including poor physical and sexual health, a higher prevalence of teenage parenthood, missed immunisations and developmental reviews, undiagnosed and undetected health problems, speech and language delays, a lack of preventative healthcare, and poor oral health.

Looked after children who took part in a national survey[57] said that the greatest threats to their safety and welfare were drugs and alcohol. The same survey reported a need for ongoing care and emotional support. Placement availability and stability are key needs for this group of children and young people. The number of placement moves generally correlates with deteriorating mental health and children who have been in the same placement for six years perform the highest of this group in public exams[58].

For some years national and local educational outcomes for looked after children have been lower than average outcomes for all children. Locally, the attainment gap between looked after pupils and all students is narrowing in three of the four indicators and especially in the headline "5 GCSEs at A*-C English and maths"[59]. Whilst exclusions from school are reducing overall, the total level of absence for looked after young people remains higher than for all pupils, though it is lower than for some

[56] Care Matters: Time for Change, DfE, 2007
[57] Ofsted Children's Care Monitor 2010 /York Looked after Children Strategy 2011-14, City of York Council
[58] Children Looked After National Pupil Database, Department of Education
[59] CYC LAC Educational Analysis 2011

other vulnerable groups such as pupils entitled to free school meals or some pupils with special educational needs.

Young people who have left care often face tremendous challenges in making the transition to living independently. Support and services aim to help young people who leave care build up resilience and strong emotional health to equip them to operate effectively in the adult world.

There are currently approximately 150 young people who leave care who are engaged with the local "leaving care" team. Practitioners find that the general health of young people who leave care is quite poor due to the experience of having being looked after, low income and the consequent links with poor diet, over-reliance on processed food and a lack of physical exercise or leisure activities. Many young people who leave care do not have the confidence to seek medical help and this, combined with poor levels of personal hygiene, means that minor health conditions can become much more serious.
Practitioners estimate that at least 25% of young people who leave care over the age of 18 have mental health needs, often centring on poor relationship attachments, or poor self-esteem. This in turn can impact on the ability to obtain and sustain college, work or benefit claims, increasing the likelihood of getting into abusive relationships and increasing the risk of young people becoming dependent on substances.

Children and young people who have safeguarding needs

In line with national trends, the number of children in York who were subject to formal child protection plans rose from 115 in April 2011 to 157 at the end of 2011[60]. By definition, this group of children have suffered, or are at risk of suffering from, significant harm arising from physical, emotional and sexual abuse and neglect. Neglect continues to be the largest single category of child protection plans, often alongside other forms of maltreatment including domestic abuse, physical abuse, and sexual abuse. Many children who live within neglecting families are disadvantaged from early life and encounter social, emotional, behavioural and educational difficulties as they grow older. Children's health needs can be compromised due to parental failure in seeking appropriate medical and dental attention.

[60] Children's Social Care Database, City of York Council

Whilst overall levels of serious domestic abuse incidents appear to be declining, domestic abuse is a significant factor in approximately 55% of all cases of children subject to child protection plans. Substance and alcohol misuse are linked to domestic violence[61] and these issues represent the largest proportion of risk. Domestic abuse is known to coexist with all other forms of child maltreatment and is linked to poor outcomes for children including, teenage pregnancy, intervening in abuse (injury), substance misuse, running away and child sexual exploitation.

Child sexual exploitation is an emerging issue both nationally and locally[62] however there is a lack of accurate data about its prevalence and nature. York's Safeguarding Children Unit has observed an increasing number of referrals in this area although this is likely to be due to the introduction of a new process for dealing with such cases. A particular feature of this type of abuse is that, often, the young people themselves do not realise they are being sexually exploited. Young people who are being sexually exploited are more likely to be looked after, have low educational attainment and/or have a learning disability, be engaging in risk taking behaviour (including substance and alcohol misuse) and have experienced maltreatment within their families. Significantly these young people will often go missing from home for short and extended periods of time and disengage with services.

Young Carers

The number of young carers in York is not precisely known: the 2001 Census indicated that there were 342 young carers; the Child In Need Census suggested there were approximately 1600. A recent report from the Young Carers Service[63] states that the organisation currently supports 93 young carers. This new service is working to provide emotional support and social opportunities and piloting the Young Carers Card support scheme in school settings. The profile of young cares who are involved with this service is 63 females and 30 males; 19 young carers caring for a sibling and 74 caring for a parent, 91 young carers are white British and 2 are mixed heritage. The report also notes that a high proportion of the families receive benefits. It is clear that we

[61] Management Information Report to City of York Safeguarding Children Board, January 2012

[62] "Tackling Child Sexual Exploitation: action plan" (2011), HM Government; City of York Safeguarding Children Board Business Plan

[63] York Carers Centre, Young Carers Service, Report for the Early Intervention Fund 2011

need to pay special attention to the needs of this group of particularly vulnerable young people.

Young people Not in Education, Employment or Training (NEET)

There are approximately 300 young people aged 16 to 18 in the City who are not in employment, education or training. Provisional data indicates that despite a small rise in the number of NEET compared to last year, York has the second lowest number of NEET in the Yorkshire and Humberside region[64]. The rising numbers of young people who are NEET and who have learning difficulties, disabilities and behavioural difficulties remains a concern. Local employment support and provision is not at present able to meet the needs of this group.

There are more young people who are NEET living in wards associated with poverty and deprivation[65] (Westfield, Clifton and Heworth). A large proportion of these young people experienced family difficulties during their schooling and as a result faced homelessness. Approximately 20% had contact with a social worker and a third of had disrupted education, attending two or more schools (including local specialist education provision outside mainstream schools), prior to becoming NEET[66].

Teenage Parents and their children

At the end of 2009 there were 27 teenage mothers under the age of 18 and 72 under the age of 19 in York[67]. The rate of teenage pregnancy in York has been falling consistently since its high point in 2007, and is now below 1998 levels (the usual baseline date for such analyses).

It is difficult to estimate the number of teenage fathers as no service routinely asks about this. Research undertaken in York in 2009[68] found that the fathers were often not teenagers, older than the mothers, and that their relationships were likely to break up within a short time of pregnancy being discovered. Teenage fathers are supported through Yorbabe, an ante natal group, but there is a gap in post-natal support for teenage fathers. Post natal depression is prevalent amongst teenage

[64] CYC Directorate Quarter 3 Monitoring 2011/12
[65] Local Authorities' Client Caseload Information System
[66] CYC YPS RPA research paper Dec 2011
[67] DfE, March 2011
[68] Being a Teenage Mum in York: Qualitative research on teenage mothers in York, Summary report for participants May 2009, Department of Social Policy and Social Work, University of York

mothers, though it has not been possible to establish a reliable local picture.

The research found that becoming pregnant often resulted in the mother leaving school and stopping education, thereby limiting job and career prospects. In June 2011 there were 27 teenage parents under 18 receiving support with childcare costs through Care to Learn. In January 2011 35% of teenage mothers were in education, employment or training compared to the regional and England average of 29%[69].

Housing issues often become chronic after the birth of a child, with a gap in appropriate and supported accommodation. It is worth noting that Howe Hill Hostel for young people will support up to 6 teenage parents in designated accommodation from early 2012.

Young offenders

York has shown year-on-year improvement in the numbers entering the criminal justice system for the first time. York has a relatively high volume of less serious youth crime and a limited volume of serious youth crime. A survey of 2,500 households in 2009 confirmed that this is the perception of the resident population.

There are currently approximately 100 young people aged between 13 and 18 who are being supervised by York Youth Offending team. Local research[70] has established that first-time offenders are more likely to:

- have special educational needs – 43.5% compared to 15.8% of York LA school children;
- Have been excluded from school – 30.4% compared to 4.5% of York LA school children;
- Be eligible for free school meals, an indicator of poverty – 25.1% compared to 9.7% of York LA school children
- Live in certain areas of York, also linked with multiple risk factors – 16% in Westfield, 11% in Clifton;
- Be looked after, currently or historically.

They are less likely to achieve the ‘average’ levels of attainment at key stages 2, 3 and 4.

[69] Local Authorities’ Client Caseload Information System
[70] CYC report Still Spotting Them and Stopping Them

The student community

York has two Universities and a Further Education College. This attracts young people to the City, and explains in part the bulge in the population pyramid in the 15-24 age range.

York College notes[71] that there are a growing number of students presenting with a range of issues with which they need support. College data and the Connexions database show an increase in referrals for support, 78 referrals being made in September 2010 - July 2011 compared with 39 at the same point in 2008-09. Student needs are seen to be becoming more complex, with homelessness and housing matters, and mental health being the most prominent.

Students can be chaotic in their approach to seeking help with their problems, often making initial appointments and only getting back in touch again when they are at a point of crisis. College counsellors dealt with 25 referrals during the 2011-12 enrolment period, of which more than 50% involved suicidal thoughts. There were 741 attendances at the sexual health drop-in clinic (mostly female) where emergency contraception, pregnancy tests, condoms and treatment for Chlamydia infection were provided.

We are still seeking information from the city's two Universities in order to understand better the health needs of their student populations.

Adult parents

Clearly, this is a large subset of the overall population, but it is still worth analysing particular issues that may affect it. For most families in York, parenting will be a very positive experience, with excellent schools and other facilities such as nine children's centres. However, we are receiving increasing numbers of referrals for parenting support services with 670 parents attending a range of parenting support courses during 2009-10 to 2010-11. Many parents who seek help have mental health needs ranging through low mood to severe depression. Some parents lack resilience and have no close support networks such as extended family and close friends. Separated parents face coping with their own emotional and psychological needs following the breakdown of their relationship.

[71] York College Strategic Plan (2011-2014)

Local data suggests that drug and alcohol misuse are used as coping mechanisms by some parents to combat low mood, depression and anxiety, often triggered as a response to specific events and traumas such as bereavement, relationship breakdown, debt and domestic abuse.

A particular sub-group whose needs deserve consideration are the approximately 300 service families living in York. Their needs include dealing with temporary separation periods at times of military deployment and postings. The parents and children who remain in York are faced with feelings of loss and anxiety and may fear the death of the absent parent especially if posted to a war zone. Service parents also face difficulties in providing consistent parenting during times of separation and on the return of serving parent.

Adult Carers

The 2001 Census found that there were 17000 adult carers in York, i.e. 9% of the adult population. A more recent profile of this group found that in 2009-10 over 3000 people identified themselves as providing at least fifty hours of care a week and that nearly 1500 carers of all ages were assessed as carrying out substantial and regular care. In the first national survey of carers, 49% who responded were aged 65 or over. With the expected rise in the local elderly population, more older people are expected to become carers, often in a mutual caring role.

Assessing the needs of carers is critical to help support their physical and emotional health, to enable their caring role and to maintain employment. There are also specific challenges as a result of caring for a person who has dementia. The provision of breaks for carers is critical. The York Mental Health Partnership Board endorses this perspective and confirms that the effects of mental ill health (particularly at the severe end of the spectrum) on carers and families can be devastating. This Board is currently looking at reported gaps in support for carers, for example when a person cared for is discharged from secondary care.

People who are victims of domestic violence

There were nearly 3,000 reports of domestic violence made to the police during 2010-11 in York[72] with the highest level of reporting from the Westfield, Heworth and Clifton Wards. The York Independent Domestic

[72] York Joint Strategic Intelligence Assessment 2011

Abuse Service (IDAS) supported over 400 families living in the community and accommodated 41 families in the local refuge. IDAS report that about 85% of the people they work with are considered 'high risk' victims having experienced repeated physical assaults, the emotional and physical effects of which can be enduring, affecting mental health, parenting ability and adversely impacting upon children's development. The York Children's Advocacy Project states that children living within domestic abuse situations need protection, reassurance, help with managing their thoughts, feelings and relationships and support to avoid engaging in behaviours that may present a risk to their health and wellbeing[73].

Figures from national studies show[74] that one-third of women attending emergency departments for self-harm were survivors of domestic violence; abused women are five times more likely to attempt suicide and one third of all female suicide attempts can be attributed to current or past experience of domestic violence. Between 50% and 60% of female mental health service users have experienced domestic violence, and up to 20% will be experiencing current abuse. 70% of female psychiatric in-patients and 80% of those in secure settings have histories of physical or sexual abuse.

Adult offenders

The York and North Yorkshire Probation Trust currently work with approximately 690 adult offenders. There is extensive research[75] to indicate a high incidence of health-related issues amongst adult offenders, including poor mental health, substance misuse (alcohol and drugs) and physical health problems. This remains, though, an under-researched area within the York adult offender population.

A snapshot[76] of the prevalence of mental health problems amongst the York probation community caseload showed that 86% were identified as having a significant mental health problem (compared with 16.5% general population, DoH 1999). Of those, 25% had been diagnosed with a serious mental health condition.

[73] Report of the Children's Advocacy Project for the Early Intervention Fund, 2011.
[74] Women's Aid Federation of England
[75] Bradley Report 2009; Yorkshire & Humberside Improvement Partnership
[76] March-April 2011, (excluding cases in custody) , North Yorkshire Forensic Psychiatric Team, using Health of the Nation Outcome

A screening of the full current caseload for the Probation Trust[77] indicates that mental health problems are linked to offending behaviour for 49% of the caseload and are linked to serious risk of harm for almost 49%. The caseload screening indicates that alcohol misuse is linked to the offending behaviour of 46% of offenders and is linked to serious risk of harm for 30% of offenders. Almost half of the offenders identified as having a mental health problem are also identified as having a problem with alcohol misuse. Whilst the incidence of drugs misuse is slightly lower, almost 30% of the caseload indicates that there is clear need for intervention.

HMP Askham Grange

Askham Grange is a women's open prison situated in a rural setting, south of the City of York. It receives offenders from all over the country. It can accommodate up to 150 residents and the prison ethos is one of resettlement and preparation for release. A health needs assessment was undertaken for HMP Askham Grange in 2010-11[78] and identified little evidence of a cohort of residents with undiagnosed, ongoing mental health problems. However, alcohol was identified as a potential problem nationally and locally, and services have been put in place to address this need.

An ageing population

The final section in this chapter considers the needs of older people. The number of older people is expected to increase by over 30% in the next 20 years, but with by far the biggest rise predicted in those aged 85 and over[79]. The over-65 population is expected to increase by approximately 40% by 2020, accounting for almost 25% of the total population. Even more significantly, by 2020 the number of people aged over 85 years is expected to increase by 60%. This changing demography will have major implications for the future provision of adult social care services as more older people, many with increasingly complex needs, are living longer and choosing to live independently.

An overriding aspiration of older people is to remain independent within their own home for as long as possible. However, many homes in York were not designed around the needs of older people and without some form of adaptation can become hazardous to health and wellbeing, often

[77] Offender Assessment System (OASys)

[78] HMP Askham Grange Health Needs Assessment, 2010-11. http://www.nyypct.nhs.uk/AboutUs/Publications/PHAnnualReport/2011/docs/c5_Askham_Grange_HNA.pdf

[79] There is forecast to be a 90% increase in the number of over 85s between 2009 and 2029

resulting in a call on health services. A recent survey of older peoples' housing and support needs in York found significant unmet need for home adaptations such as improved insulation and heating, security alarms, bathroom alterations and internal handrails. Support needs were also identified for help with everyday tasks such as gardening, cleaning and repairs and maintenance. As the older population grows, so too will demand for 'stay at home' and telecare[80] services.

The rate at which older people in York have been helped to live at home (in 2009-10, 96 per 1,000 head of population) exceeds the national average and that of York's statistical neighbours (78 people per 1,000 head of population).

On the other hand, York has the second highest proportion of patients discharged to residential homes and the highest rate of delayed transfers of care in the region[81]. The rate at which York residents aged 65and over received long term residential care per 1,000 population was 10.76 per 1,000 head of population (compared to the England average of 13.78 per 1,000 for England), and the rate of long stay supported residents aged 65 and over who received nursing care was 7.14 per 1,000 head of population (compared to an England average of 6.23.)
A particular (and preventable) health issue for older people is hip fractures arising from falls. As an indicator it will underestimate the total prevalence of falls, however as data has been collected for several years we can identify a trend which is illustrated in Fig. 5. The most recent figures show the hip fracture rate is 406 per 100,000 which is lower than the England rate and also considerably lower than the previous rate of 479 per 100,000[82].

[80] Telecare is a service which provides people who are usually elderly or vulnerable with the support to help them lead independent lifestyles. Telecare equipment makes it possible for them to call for help and assistance when needed.
[81] Independent Review of Health Services in North Yorkshire and York August 2011
[82] Department of Health. York Health Profile 2011. Available at: http://www.apho.org.uk/default.aspx?RID=49802 accessed 11/01/2012

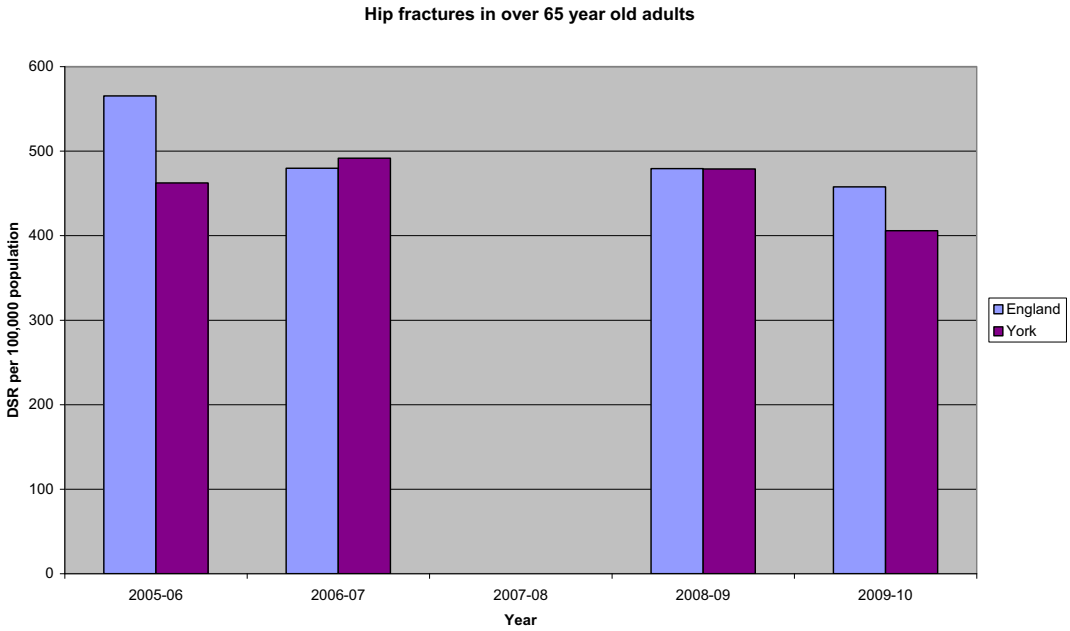


Figure 5: Hip fractures in over 65 year adults

In York, a relatively large proportion of the older adult population is in a position to self-fund their care, thus bypassing local authority social care services. We have not therefore been able to provide a completely accurate picture of all the health and wellbeing needs in relation to this group. Work is ongoing to improve the quality of information about the needs of all older people as opposed to those supported by the council. We do however have good information about those who receive the Council's support. The York Adult Social Care Survey asked 655 older people who were receiving services funded by social services how they would best describe their social situation. 77.8% of respondents said they had adequate or as much social contact as they wanted, and 22.2% said they did not get enough or were feeling socially isolated. When asked how they spent their time 62% of respondents said they spent their time in ways they valued and enjoyed, with 31% of people saying they did some, but not enough, valuable and enjoyable things[83].
The survey also asked about home life, independence and how well older people were able to undertake certain activities by themselves. The three areas of most difficulty were dealing with paperwork and finances, washing oneself, and getting dressed and undressed. Fig. 6 shows responses by people aged over 65 in relation to the question: 'Do you manage to...?':

[83] Adults Social Care survey

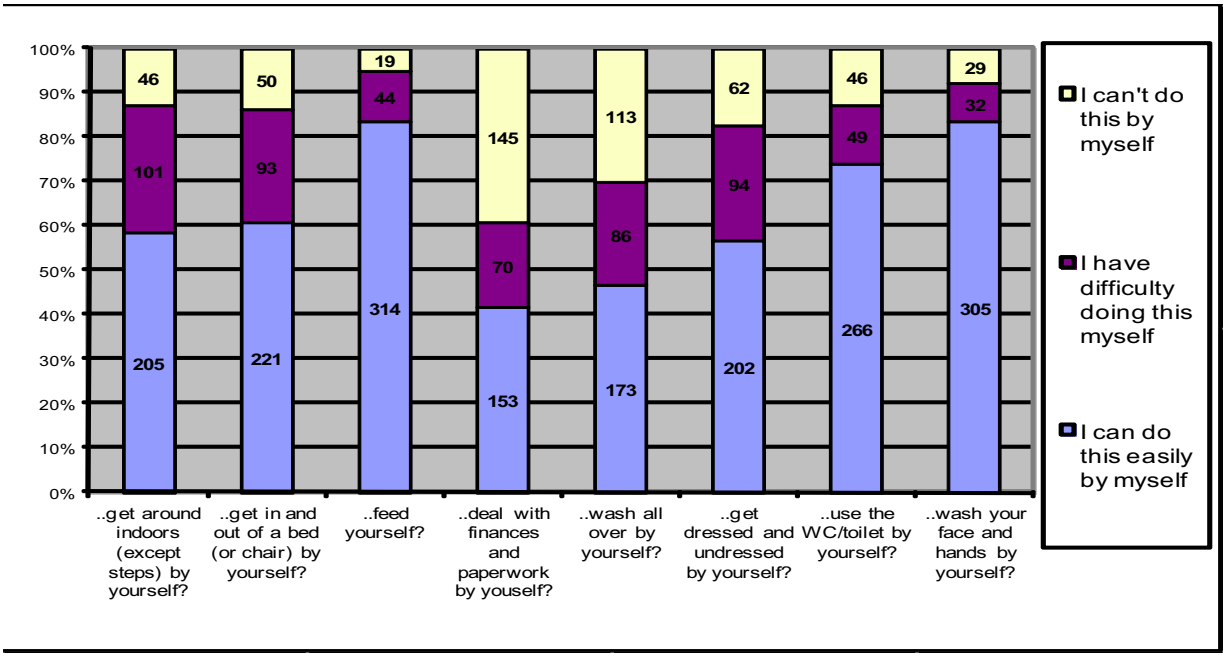


Figure 6: Responses to the York Adult Social Care survey concerning activities of daily living

There is growing evidence that the characteristics of home and neighbourhood affect both social interaction and physical activity of older people, improved levels of which can have beneficial effects on health. Studies show that participation in activities and having fulfilling roles in the community and family can lead to better social support in times of need, in turn promoting better health and wellbeing among older people. Conversely, social isolation, or the lack of access to social support is related to poorer health and wellbeing. The Adult Social Care survey confirmed that most respondents felt safe in their environment (60%), with a further 33% feeling adequately safe, and 6% not feeling safe.

Research has shown that people who are active in their communities are less likely to experience mental illness, such as depression[84], less likely to develop health problems, more likely to practice good health habits and appropriate self-care during recovery[85], and are less likely to die early than those who are less actively engaged. 74 older people replied to a question in the Adult Social Care Survey about depression and anxiety with nearly half saying they did not feel anxious or depressed, 24 reporting moderate anxiety and depression and 4 reporting extreme anxiety and depression. The mental health needs of older people, and dementia in particular, are covered in the Health Profile section of this report.

[84] Antonucci, T.C., H. Akiyama, and P.K. Adelmann, Health behaviors and social roles among mature men and women. Journal of Health and Aging, 1990. 2(1): p. 3-14; Bowling, A. and M. Farquhar, Associations with social networks, social support, health status and psychiatric morbidity in three samples of elderly people. Social Psychiatry and Psychiatric Epidemiology, 1991. 26(3): p. 115-126.

[85] Mutran, E.J., et al., Social support, depression, and recovery of walking ability following hip fracture surgery. Journals of Gerontology: Series B: Psychological and Social Sciences, 1995. 50B(6): p. S354-S361.

Fears about the future were confirmed in a survey of people aged 50 and over, undertaken by the York Older People's Assembly[86]. The survey noted expressed anxieties about care, health and finance and loneliness. Many respondents said they recognised and feared the implications of the rise in numbers of older people and the longer period of dependency in later years which could be associated with this.
We consider social isolation, and the loneliness that results from it, to be a highly significant issue for older people in York, and a serious challenge for policy-makers and providers.

[86] York Older People's Assembly Questionnaire, Autumn 2010 (100 respondents aged 50+)

Section 2: Social and Place Wellbeing in York

The findings of the Marmot Review in February 2010[87] highlighted a link between health and social inequalities, confirming that where people are born, live and work can have a profound affect on their health and wellbeing. It also confirmed that individuals in the poorest areas in England are likely to die earlier than individuals living in the richest areas.

The interim report of the York Fairness Commission reiterated this, stating that there is compelling evidence of a link between reduced inequalities and stronger societies and that greater equality is of benefit to all[88].

Economy and income

York is a distinctive city and attracts around 7 million visitors each year. The city has a strongly performing economy[89] and continues to attract investment. The City has successfully adapted from being a railway and confectionery-manufacturing city into an international destination and hub for science and technology, and a national centre for financial and business services. The City is home to internationally competitive industry; research expertise in the biosciences; the environment; and digital and creative technologies.

The City currently supports more than 80,000 jobs and contributes £3bn of value to the national economy[90]. Average incomes are just below the national average although the gap between local and national average incomes narrowed between 2010 and 2011. Currently the average earnings for York residents is £25,524 compared with the national average of £26,357. Economic growth has slowed in recent years following the global economic crisis, therefore in the UK the public, private and voluntary sectors have all been affected. The economic climate is uncertain and volatile, with increasing national and international competition for investment, talent and jobs. Individuals face

[87] Marmot Review: Fair Society, Healthy Lives, Strategic Review of health Inequalities, 2010 http://www.instituteofhealthequity.org/Content/FileManager/pdf/fairsocietyhealthylives.pdf
[88] The York Fairness Commission: A Fairer and Better York, 2011, Interim report to the City of York Council
[89] York Council Plan 2001-2015
[90] York Council Plan 2011 to 2015

increasing challenges in finding and maintaining employment and managing personal finances in this context.

There is an inverse association between deprivation and education and skills attainment, thereby limiting access for some people to the opportunities brought about by investment. The provision of debt services and advice about 'in work benefits' can support efforts to reduce financial exclusion.

Employment

York has a higher proportion of employees in public administration, health and education (34%) compared to the region and nationally[91]. 15% of all jobs in York are in Health. Increasing pressures on public funding are likely to impact on local employment opportunities.

Fig. 7 shows the profile of where people work in York.

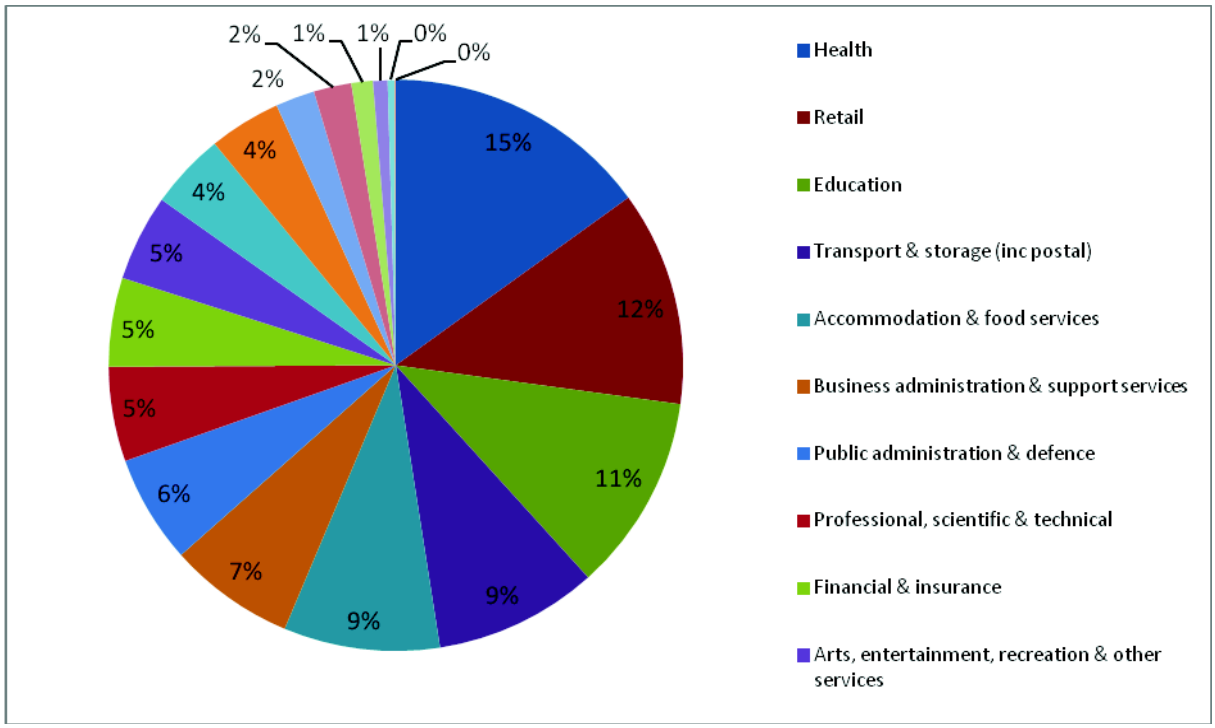


Figure 7: Employment profile of York
Source: Business Register and Employment Survey 2010

Overall unemployment has increased since 2005 but is lower than the national rate, as illustrated in Fig. 8. Within this trend, male unemployment has risen and female unemployment has reduced,

[91] Nomisweb

however the number of women claiming Job Seekers Allowance has increased and is at the highest level for 13 years, mirroring the national trend.[92] Youth unemployment, as recorded in November 2011, is lower than national levels and whilst the latest data for 2011-12[93] shows that the number of 16-18 year olds not in education, employment or training (NEET) in York has increased[94] to 5.6% (approximately 300 young people), York is comparable to other areas in the North of England.

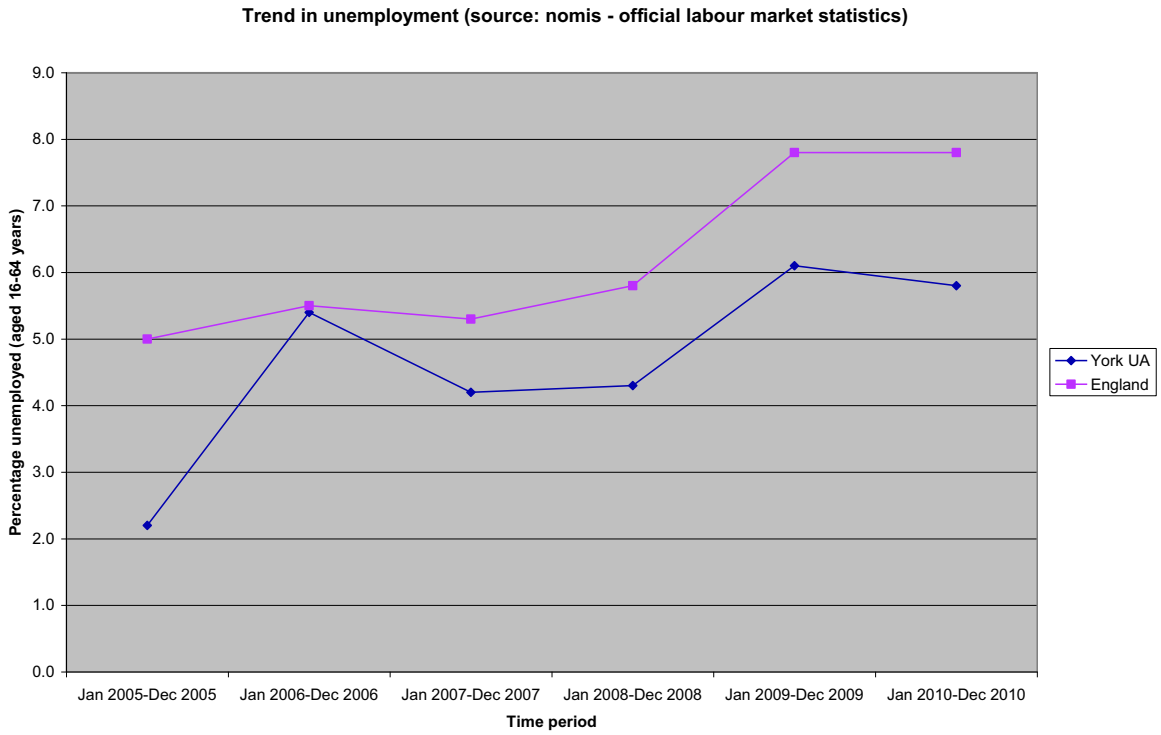


Figure 8: Trend in unemployment figures for York

Generally the level of qualifications and skills gained by York citizens is high. However differences exist between the most and least deprived areas in the city[95].

Between 2008 and 2009, the number of workless households had increased from 13,000 to 19,000. The number of workless households with children in York has increased by 50% from 2,000 in 2008 to 3,000 in 2009[96]. York has the second lowest proportion of workless households in the region and compares very well nationally[97].

[92] Nomisweb
[93] CYC Caseload Client Information System (CCIC)
[94] This increase should be considered with caution as the way the data is calculated changed at the beginning of 2011-12 to only cover NEETs who are York residents. Previously, it included anyone coming to university and college institutions.
[95] Employment - Indices of Multiple Deprivation
[96] DWP
[97] ONS Annual Population Survey 2011

Claims for Landlord and Mortgage possessions reached a peak nationally in 2008. Fig. 9 illustrates the trend for York, which has consistently remained below the England rate since 2000. Despite this, there were 565 claims lodged with the courts between 2008 and 2010, representing 565 households facing uncertainty as to whether they would be expected to leave their homes.

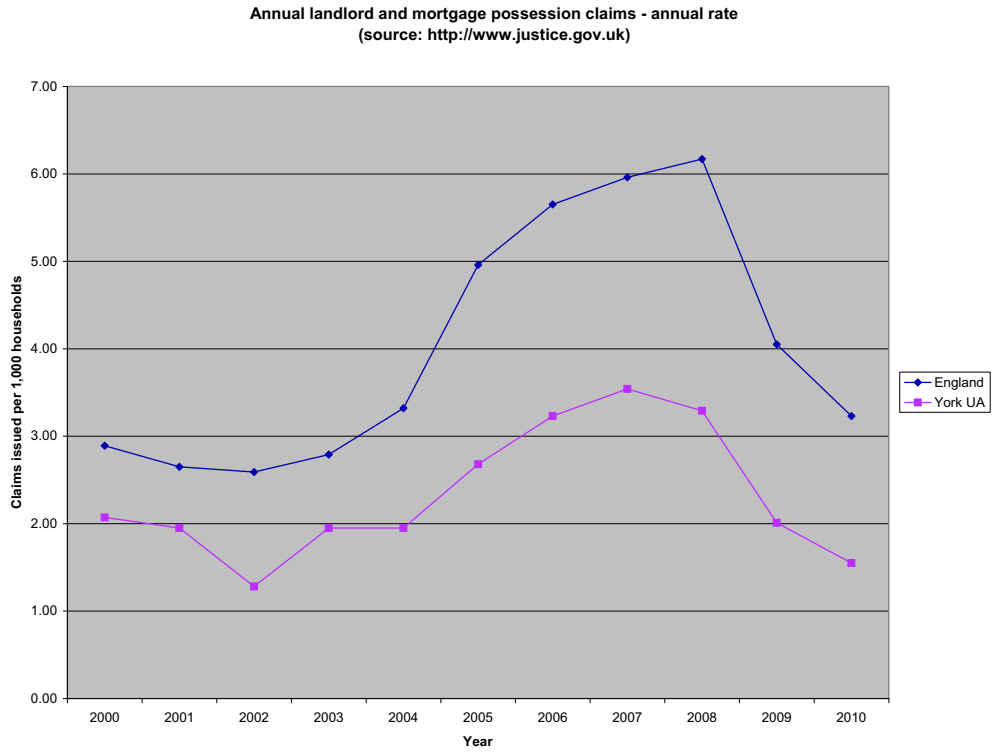


Figure 9: Trend in annual landlord and mortgage possession claims for York

Feedback from York Citizen's Advice Bureau and the York Credit Union[98] note that a practical challenge often faced by people on low incomes is accessing free, reputable bank accounts, this being difficult due to problems with an individual's credit history or access to identification. This can limit access to fuel discounts, affordable credit or insurance and other general goods. There has been a rise in payday lenders within York, who offer quick credit to customers often at high interest rates.

Community wellbeing

Research has shown that individuals who live in less supportive communities are more likely to die from all causes than people with close family, friendship, and community ties[99]. Individuals who perceive

[98] Feedback from York CAB and Credit Union for York JSNA 2011-12
[99] Putnam R. Bowling Alone The Collapse and Revival of American Community 2000

that they are socially excluded can experience poorer health and wellbeing in comparison to the rest of the community[100].

In contrast, strong communities can provide support to those who act as carers and those for whom they care. In addition, there are benefits for the individual as it has been identified that undertaking voluntary work can reduce the impact of depression[101] and forming and maintaining social connections reduces the chance of suffering with psychological stress[102].

The results of the last Place Survey, undertaken in 2008, were very positive[103] and were reported in the 2010 JSNA for York. Whilst this survey has now ceased and has not yet been replaced, the findings confirmed a strong sense of civic pride, high levels of satisfaction and the perception of opportunities to influence decisions[104]. The 2008 Place Survey identified three wards where low levels of community cohesion was reported. These were the Acomb, Guildhall and Westfield wards which also have relatively high levels of deprivation and reflect some of the poorest outcomes for many vulnerable groups.

The Cities Outlook 2011 report ranked York in the top 10 cities with the lowest level of inequality between residents[105]. There are many examples of local communities working together and the city has a large number of cultural events run and local projects delivered in partnership.

The York Council for Voluntary Service has reported that York is comparatively robust city in terms of maintaining levels of volunteering[106]. The local volunteer profile is varied and includes individuals who do not consider themselves to be volunteers, despite giving up much of their time to do what would be considered voluntary work. There are currently 22 international, 108 national and 627 local charities based in York and 4,164 trustees of registered charities live in the city. These charities provide opportunities, support, advice and services in response to the differing needs of local people.

York Council for Voluntary Service has identified an increase in the demand for volunteering opportunities that are linked to the development

[100] Spicker P, An introduction to Social Policy Available at: http://www2.rgu.ac.uk/publicpolicy/introduction/needf.htm
[101] (Rushey Green Timebank Evaluation Report April 1999 – 2001)
[102] (Neighbouring in Contemporary Britain JRT 2006)
[103] Place Survey 2008: The Place Survey provides information on people's perceptions of their local area and the local services they receive.
[104] Place Survey 2008
[105] Centre for Cities – Cities Outlook 2011
[106] Correspondance from York Council for Voluntary Service

of skills which will help to increase employment opportunities. This is unsurprising in a time of relatively high unemployment. Some organizations are finding it more difficult to find funding and as a consequence are reducing the number of volunteering opportunities that they are able to offer. There are insufficient volunteering opportunities available for people who have additional support needs, for example people with learning difficulties.

The 2008 Place survey also found that that there were high levels of satisfaction from black and minority ethnic (BME) communities with their home and community. A large proportion (85%) of BME households felt their home met their cultural needs whilst 7% cited dissatisfaction with their local area. 94% of BME households reported feeling safe going outside during the day, and 77% after dark.

Deprivation and inequality

York is ranked the fourth least deprived city in England[107]. Most people living in the city can expect to have a good quality of life and experience positive health and other outcomes. However, there are groups of people who, by virtue of their particular needs or where they live in the city, are more likely than the general York population to experience less positive outcomes in relation to their health and other aspects of their lives. The York Fairness Commission interim report[108] notes that that while two fifths of York's population live in areas that are in the least deprived 20% in England, 7% of York's population (around 13,000 people) live in areas classified as being the 20% most deprived areas in the country[109].

According to the Indices of Multiple Deprivation,[110] the most deprived areas of York are Westfield, Guildhall, Clifton, Heworth and Hull Road. The least deprived wards are: Derwent, Haxby and Wigginton, Heslington, Heworth Without and Rural West York.

Fig. 10 shows the lower super output areas[111] in York that rank amongst the 30% most deprived areas in England.

[107] Median score, Government's Indices of Multiple Deprivation (IMD) – see below
[108] The York Fairness Commission: A Fairer and Better York, 2011, Interim report to the City of York Council
[109] Index of Multiple Deprivation and ONS Population Estimates
[110] Index of Multiple Deprivation: national data provided at ward and super output area level. Domains include income deprivation, employment deprivation, health deprivation and disability, education, skills and training (children / young people) barriers to housing and services, crime and the living environment.
[111] Lower Super Output Areas (LSOAs) are geographically designed areas used for the collection and publication of small area statistics. There are 118 LSOAs in York

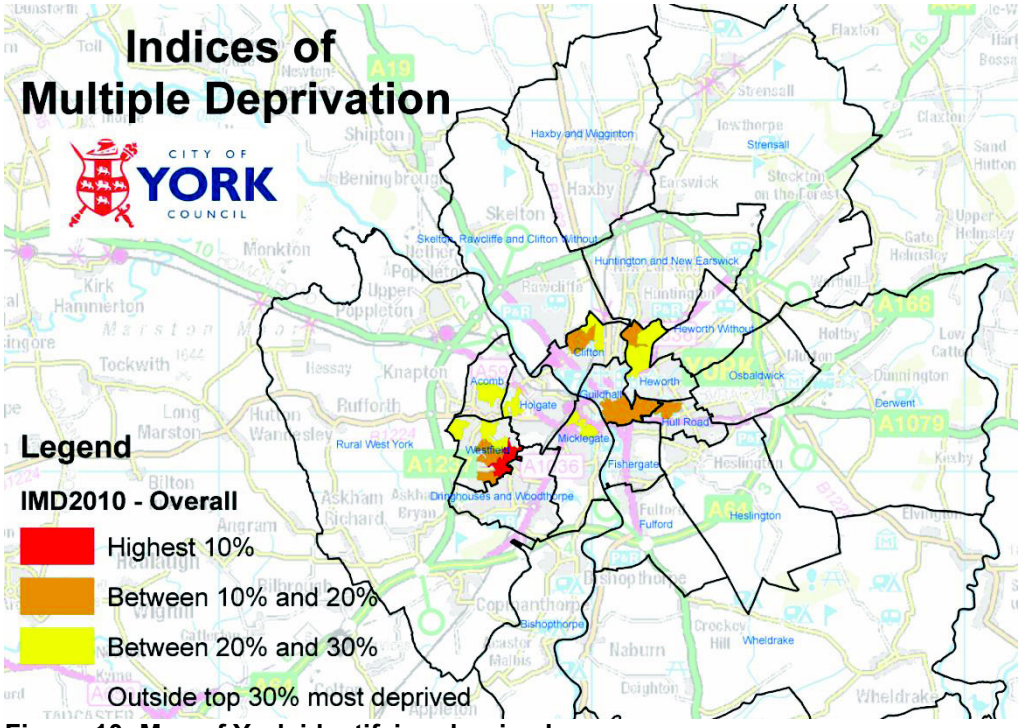


Figure 10: Map of York identifying deprived areas

The difference in life expectancy between the most and least deprived areas in York is 6.6 years (3.6 years difference for women; 9.9 years difference for men). In North Yorkshire and York, inequalities in health lead to approximately 76 additional deaths in the most deprived 10% of the population each year[112]. The effects of deprivation are well recognised[113] and manifest as a reduction in life expectancy, higher crime, less material wealth and often a poverty of aspiration and opportunity.

The Fairness Commission noted the differences in terms of deprivation between "affluent York" and "excluded York" were more marked than the absolute level of deprivation itself[114]. Therefore the greatest challenge and opportunity facing the city is to tackle these differences, without disadvantaging the less deprived communities in the city.

Children are said to be living in relative income poverty if their household's income is less than 60% of the median national income. An estimated 4705 children were living in poverty in York during 2009[115]. The proportion of children living in poverty in York (13.3%) was substantially lower than the regional (21.9%) and England (21.3%)

[112] Annual Report of the Director of Public Health 2011, North Yorkshire and York
[113] Fair Society, Healthy Lives. Strategic Review of Health Inequalities in England post-2010. The Marmot Review 2011.
[114] The York Fairness Commission: A Fairer and Better York, 2011, Interim report to the City of York Council
[115] APHO Local Profiles (http://www.apho.org.uk/resource/view.aspx?RID=105247 – accessed 15th December 2011)

proportions however this is predicted to rise[116]. Child poverty is prevalent in all wards but is heavily concentrated in the Westfield, Clifton, Heworth, Hull Road and Acomb wards[117].

There is a considerable attainment gap between pupils in receipt of free school meals and other pupils. In 2011, 10% of York pupils were claiming free school meals, compared to the national average of 18%[118]. The school absence rate amongst pupils eligible to receive free school meals in York was approximately double the rate of those pupils who were not[119]. We know that education is essential in improving life chances and opportunity.

Whilst the comparatively lower levels of child poverty in York help to ensure that the health of York children is generally good, children who live in the more disadvantaged communities have a poorer level of health. In the most deprived areas of the city, teenage pregnancy rates are higher and the obesity levels for Year 6 pupils are higher.

These areas are discussed in more detail later in the report.

Environment

Living in a safe and pleasant environment can have a positive impact in terms of health and wellbeing. Access to green spaces, well equipped play areas and strategies that encourage active travel by cycling or walking can increase an individuals' healthy life expectancy. Conversely high population density, poor urban design, lack of green space, noise and traffic have a negative impact on healthy life expectancy[120]. Locally, excesses of nitrogen dioxide are predicted in the areas served by the inner ring road and Fulford Road.

The Committee for the Medical Effects of Air Pollution (COMEAP) undertakes research into the links between poor air quality and health[121]. Most research carried out in this area relates to the health impact of particulate matter which, in addition to nitrogen dioxide is another air pollutant of interest to the City. Small area data on the impact of

[116] City of York Child Poverty Needs Assessment (4/10/2011). Available at: http://www.yor-ok.org.uk/Downloads/Child-Poverty/Child%20Poverty%20Summary%202006-2009.pdf accessed on 13/02/2012.
[117] CYC Child Poverty Strategy 2011-2020
[118] DfE Statistical release http://www.education.gov.uk/rsgateway/DB/SFR/s001012/index.shtml
[119] CYC Absence analysis for 2010-11
[120] The Center for Analysis of Social Exclusion http://sticerd.lse.ac.uk/case/
[121] http://comeap.org.uk/documents/reports.html

particulate matter on health is not readily available. National level data can be applied to the local population to provide an estimate of the impact on the health of the City. Applying the national data to the population of York would suggest that air pollution is responsible for 87 premature deaths in York per year. However this is an estimate which needs to be considered with caution.

Local climate studies indicate that by 2050 York may experience more extreme weather conditions, including more rainfall, drier summers and wetter winters. There are potential implications for public health around extreme weather conditions, specifically heat waves, and fuel poverty during cold or prolonged winters and for the wider community in terms of disruption to services, transport and logistics and business continuity.

Transport

The Local Transport Plan for York 2011-31 notes a clear link between transport, health and wellbeing. As a relatively compact city, accessibility to services is better in York than in many other areas. The consultation for the Transport Plan identified that access to out of town shopping centres and the hospital were areas of concern for non-car users. Car ownership (one of the indicators used to calculate deprivation) is lowest in some of the more deprived areas to the East (Heworth) and the West (Acomb, Clifton, Westfield) of the City.

We know that there are many health benefits from leading a physically activity lifestyle. York acquired a Local Sustainable Transport Fund award for 2011-15 and has more recently been promoting Intelligent Travel York which promotes both cycling and walking and reduced motor vehicle use. The 'Cycling City Programme' has resulted in a significant increase in the numbers of people cycling in the city.

Accident levels across the city are reducing, having halved over the period 2000-10. However, there are still more than 60 individuals killed or seriously injured on York's roads each year[122] although the numbers of road injuries and deaths are significantly lower than the England average[123]. Most accidents are experienced by people who live in York, with young males being over-represented in accident statistics, along with older drivers and pedestrians. Approximately 10% of the accidents are on roads within the main residential areas.

[122] City of York Council's Local Transport Plan 2011-2031
[123] APHO Local Health Profiles. Available at http://www.apho.org.uk/resource/view.aspx?RID=105247 accessed 27/02/2012.

Education

York is home the University of York and York St John University and two higher education colleges, York College and Askham Bryan College. More than 20,000 students attend these higher education establishments. The University of York was ranked 121st in the Times Higher Education 2011-12 World University Rankings and 43rd overall in Europe[124].

Educational attainment is a key factor in maximising opportunity. York is one of the best performing cities in the UK for primary and secondary education, with 83% of all secondary school pupils attaining five A*-C grades at GCSE. If considering those pupils who achieved five A*-C grades to include English and mathematics, this drops to 62%, although compares favourably with the national average of 58%[125]. A recent survey of primary and secondary school pupils[126] confirmed that the vast majority of pupils (over 90%) feel safe in school and that most pupils liked school.

There is an attainment gap between children in York who are eligible to receive free school meals and those children who are not eligible. In 2011 the difference in percentage points of pupils who achieved level four at key stage two between those children eligible for free school meals and those who were not was 30%[127].

Using free school meals as a proxy for disadvantage, there is consistently a smaller proportion of those pupils eligible for free school meals who achieve five or more GCSEs A*-C (including English and mathematics) than in the group of pupils who are not eligible for free school meals. The gap has narrowed for the City of York in 2010-11 to a difference of 33 percentage points[128].

The numbers of children and young people being excluded from school remain very low in York and the numbers of fixed term exclusions continues to fall year on year[129]. The level of persistent absenteeism in

[124] Time Higher Education World University Rankings 2011-12. Available at http://www.timeshighereducation.co.uk/world-university-rankings/2011-2012/europe.html Accessed 13th February 2012
[125] www.education.gov.uk/rsgateway/DB/SFR/s001034/index.shtml
[126] Stand Up For Us 2011: Bullying Survey in York Schools, York St John University
[127] www.education.gov.uk/rsgateway/DB/SFR/s001047/index.shtml
[128] www.education.gov.uk/rsgateway/DB/SFR/s000995/index.shtml
[129] Qrt 3 2011/12 – School Planning and Organisation PI Monitor for ACE, CYC

York (5.9%) is substantially lower than the national (7.2%) and regional averages (7.9%)[130].

Housing

Housing is a key social determinant of health and has the potential to impact on physical and mental health and wellbeing[131]. Unsuitable or poor quality housing can affect health and wellbeing through, for example, overcrowding, risk of falls, excess cold and the stress associated with homelessness. There is strong evidence linking improved housing conditions to improved health outcomes[132].

There is significant pressure on quality housing in York with a growing gap between the demand for quality housing and supply. House prices and rents are often above that which those on lower incomes can comfortably afford, creating growing demand for affordable homes. In December 2011 there were 3466 households registered as looking for a social rented home in York. There is an aim to deliver many more new homes and to continue to ensure the best use of homes that already exist. Within this, we aim to better understand the needs of particular groups and ensure the availability of appropriate accommodation to meet their specific needs.

Most dwellings in York are maintained to a relatively good standard in terms of general condition and thermal efficiency. All 7,900 council owned homes meet the Decent Homes Standard[133], as do most of the 4,500 homes owned by housing associations. Less than 20% of private sector homes in York fail the Decent Homes Standard against an average of 37% nationally. Less than 10% contain hazards detrimental to health or pose a serious risk to safety. These hazards most commonly include excess cold, risk of falls on stairs and electrical issues. Where problems do exist they tend to be in dwellings that are privately rented, especially poorly converted flats, in inner city areas or are occupied by vulnerable households or the elderly. We will continue to tackle poor standards to ensure that existing homes meet the city's housing needs for the future.

[130] www.education.gov.uk/rsgateway/DB/SFR/s001030/index.shtml
[131] The World Health Organisation Commission on the Social Determinants of Health 2005-8. Available at: http://www.who.int/social_determinants/final_report/key_concepts_en.pdf Accessed on 14/02/2012.
[132] Davidson M, Roys M, Nicol S, Ormandy D and Ambrose P. The real cost of poor housing. IHS - BRE Press 2010
[133] The "Decent Homes Standard": a standard whereby a house meets the current statutory minimum standard for housing, it is in a reasonable state of repair, has reasonably modern facilities and services and it provides a reasonable degree of thermal comfort.

The incidence of fuel poverty was last measured in 2008 and discussed in York's 2010 Joint Strategic Needs Assessment. At that time it was estimated that around 8% of private sector households were fuel poor, representing around 7,000 households across the city. Given recent steep rises in energy costs it would be reasonable to assume an increase in this figure. In 2008 the highest rates of fuel poverty were found in the Fishergate, Acomb, Westfield and Guildhall wards and more generally in the private rented sector.

Around one third of households in York incorporate an adult over pensionable age, which is similar to both the regional and national rates. Most homes in York were not designed with the needs of an ageing population in mind. A growing aspiration of older people is to remain independent within their own home, but this can be difficult without some form of home adaptation or practical help. A recent survey of older peoples' housing and support needs in York identified significant unmet need for home adaptations and handyperson services. Timely and relatively low cost interventions can make a huge contribution to a person's health and wellbeing and result in financial savings in other service areas.

Crime & Disorder

Levels of crime and fear of crime are key components of community safety and cohesion and impact on the health and wellbeing of victims, offenders and wider communities in different ways. Crime has fallen by 5% in York from 14579 recorded offences to 14073 between 2009-10 and 2010-11. There are predicted to be 1200 fewer crimes committed during 2011-12 compared to 2010-11.

There was a small decrease in the proportion of serious acquisitive crime[134] in 2011 compared to 2010, although there was an increase of 11% in serious sexual crime over the same period. Whilst serious sexual crime accounted for only 1% of the crimes committed in York, the longer term consequences to the victims and their families are extensive[135]. Local analysis shows that these offences were mostly committed by males aged between 20 and 29[136] and that alcohol featured prominently in these crimes. More than 40% of these crimes were committed in the Guildhall and Micklegate wards. However, York

[134] Acquisitive crimes include burglary, attempted burglary, robbery, and theft and handling offences
[135] Koss M P et al. Deleterious Effects of Criminal Victimization on Women's Health and Medical Utilization. Arch Intern Med. 1991;151(2):342-347
[136] York and North Yorkshire Joint Strategic Intelligence Assessment, December 2011

has lower levels of more general alcohol related crime than the national average, and alcohol related crimes have fallen over the period 2005-09[137].

Levels of hate crime in York are comparatively low[138] and have remained consistent, although predictions suggest that there may be12 fewer cases during 2011-12. The majority of the hate crime is racially related, although there have been a small number of hate crimes that relate to religion, sexual orientation and disability.

Domestic violence accounts for between 16% and 25% of all recorded violent crime[139]. During 2010-11 there was an 8% increase in reported incidents of domestic violence[140]. The majority of offenders were male (84%) and the majority of victims were female (79%). There was a high prevalence of incidents in the Westfield ward with Clifton and Heworth wards also being represented. Levels of violence increased significantly during the two weeks leading up to and including New Year's Eve and notably on the occasion during the 2010 World Cup football match when England lost to Germany and left the tournament, when reported levels of violence on this day were the highest in 2010 with almost twice as many incidents reported as compared to any other day[141].

The number of people convicted of sex offences against children in England and Wales has increased by nearly 60% in six years[142]. In York, one fifth of victims of sexual offences are aged under 16 years and two thirds of these offences involved a child under 13 years. 71% of victims are female and the highest numbers of offences were committed in the Westfield Ward.

A probation survey identified that approximately 4% of respondents in York admitted to having behaved violently due to drug use[143]. The survey also identified high levels of risky behaviour involving alcohol consumption and higher levels of mental health problems than in the non-offending population.

[137] York and North Yorkshire Joint Strategic Intelligence Assessment, December 2011
[138] IQuanta, Racially Aggravated Offences, 31.1.11 – 31.1.12
[139] British Crime Survey 2008/09
[140] Approximately 25% of domestic violence incidents resulted in being classified as crime in 2010/11. York and North Yorkshire Joint Strategic Intelligence Assessment, December 2011
[141] Domestic Violence Problem Profile, cited in the York and North Yorkshire Joint Strategic Intelligence Assessment, December 2011
[142] York and North Yorkshire Joint Strategic Intelligence Assessment, December 2011
[143] OASYS Probation survey. OASYS is a national system for assessing the risk and needs of an offender, designed jointly by the Probation and Prison Services

Section 3: Lifestyles in York

This section looks at what we know about the lifestyles of people who live in the City of York and the associated risk factors that could impact on their health. It should be borne in mind that whilst this chapter discusses risk factors separately the same individual can experience multiple risk factors.

Smoking

Smoking is a primary cause of preventable illness and early death in England[144]. Trading Standards officers work with health services on tobacco control activities to reduce smoking prevalence and to stop young people starting smoking. Approximately 12% of test purchases made by young volunteers aged 14-16 who were working with Trading Standards resulted in an illegal sale. There is evidence that strong enforcement reduces underage sales, however is not clear whether this approach would lead to a reduction in consumption[145].

The majority of adult smokers began smoking as young people; therefore working to prevent young people from taking up smoking in the first place is important in seeking to reduce overall smoking prevalence over time. In addition, whilst there is little robust data regarding the prevalence of smoking amongst young people in York, this group has been identified at a national level as having the highest smoking rates[146].

In York, the adult smoking prevalence is estimated at 18.5%, which equates to approximately 37,400 individuals. It has been calculated that half of all people who smoke through their lives will die from smoking related illness[147]. In addition, parental smoking has a detrimental effect on the health and wellbeing of children.

Smoking whilst pregnant can harm both the mother and the baby, increasing the risk of infant mortality by 40%[148] and the national ambition

[144] Department of Health 2010. Healthy lives, healthy people: a tobacco control plan for England. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917 accessed 24/01/2012
[145] Stead LF, Lancaster T. Interventions for preventing tobacco sales to minors. Cochrane Database of Systematic Reviews 2005, Issue 1. Art. No.: CD001497. DOI: 10.1002/14651858.CD001497.pub2.
[146] Department of Health 2010. Healthy lives, healthy people: a tobacco control plan for England. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917 accessed 24/01/2012
[147] ibid.
[148] Department of Health 2007. Review of health inequalities infant mortality PSA target. Available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_065545.pdf

for smoking in pregnancy is to reduce the prevalence to 11% or lower by the end of 2015[149]. In addition, smoking is associated with the risk of delivering a low birth-weight baby which has further implications which are considered in the neonatal health section.

Younger women and women from routine and manual[150] occupational backgrounds are more likely to smoke during pregnancy than older women and women from less deprived backgrounds[151]. 16.7% of women giving birth at York Hospital in 2010-11 admitted to smoking during their pregnancy. Although this prevalence had dropped steadily from 18.9% in 2006-07 it is significantly higher than the national prevalence and indicates a major area of concern.

Nationally, smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups[152]. Smoking in the routine and manual occupation group is 30.2% which is why this population is a priority for interventions. In addition, individuals with long-term health conditions (such as coronary heart disease, stroke, high blood pressure, diabetes and chest conditions such as chronic obstructive pulmonary disease and asthma) who continue to smoke may experience exacerbations of their condition which is likely to impact on their quality of life and may result in a hospital admission. Whilst data obtained from local GPs may not be sufficiently robust to provide a complete picture, there does appear to be a strong social gradient illustrated in Fig. 11.

[149] Department of Health 2010. Healthy lives, healthy people: a tobacco control plan for England. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917 accessed 24/01/2012

[150] Occupations as defined in The National Statistics Socio-Economic Classification User Manual, ONS 2005

[151] NHS Information Centre. Infant Feeding Survey 2010: Early Results. Available at http://www.ic.nhs.uk/cmsincludes/_process_document.asp?sPublicationID=1308571083822&sDocID=6828

[152] Marmot, M. et al. (2010). *Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010*. Marmot review secretariat, London.

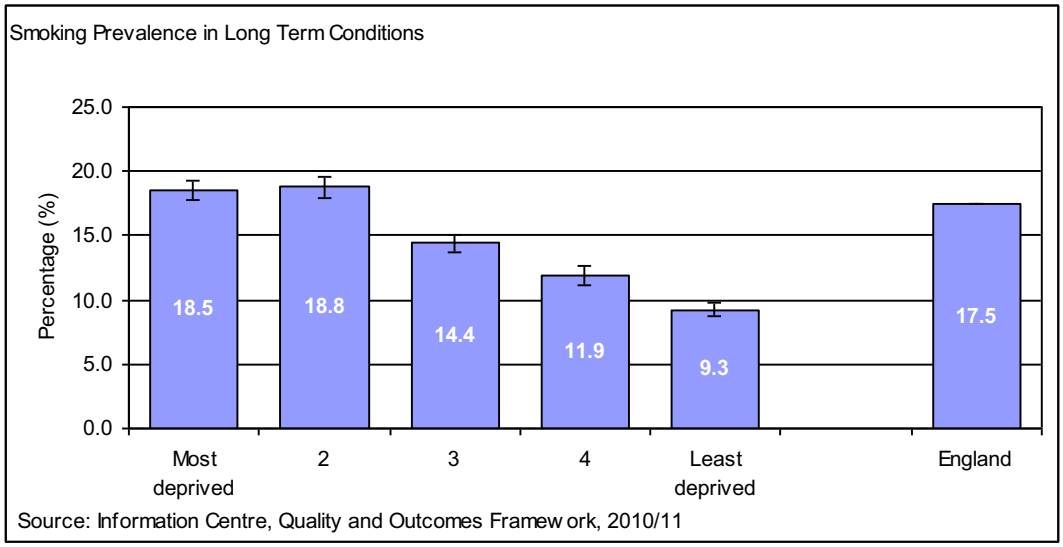


Figure 11: Smoking prevalence in long term conditions by deprivation quintile

Physical activity

Physical activity contributes positively to the prevention and management of over twenty chronic diseases and conditions including coronary heart disease, diabetes, cancer, mental health and obesity. Two approaches have been taken to estimate participation in physical activity, the 2010 Talkabout survey[153] and the national Active People survey[154]. The Talkabout survey suggests that 58% of York residents are participating in 30 minutes of activity five times a week, whereas the Active People survey suggests that 24% of York residents were participating in 30 minutes of moderate intensity physical activity three times a week during 2008-09 to 2009-10. These two surveys provide dramatically different estimates of participation in physical activity in York, illustrating the challenge of sample based monitoring.

The initial Active People survey (2006-07) identified a marked difference in participation rates between the average population of the city and those in the lower socio-economic groups. Subsequent surveys identified an increase in the proportion of this group participating in physical activity, however the most recent survey suggests that this has returned to the 2006-07 baseline. Targeting this group to improve participation in physical activity is likely to improve outcomes. In

[153] York's Citizens' Panel, 'talkabout', random selection of 2,300 panellists from York's electoral register, who are broadly representative of the city's population

[154] Active People Survey, Sport England. Available at: http://www.sportengland.org/research/active_people_survey.aspx (accessed 09/11/2011)

addition, whilst the Active People survey places York in the top 25% of local authorities in England, the participation rate was only 24% for the most recent data collection. Given the links between physical activity and physical and mental health and wellbeing, this is also an area that could be improved further.

Participation in at least three hours of high quality physical education or sports amongst 5-16 year-olds in York was significantly lower than the England average in 2009-10 at 49.7%[155]. However it had improved over the 2008-09 proportion of 43%. Previous measurements had identified York as performing particularly well against a similar indicator. Whilst a change in the definition of this indicator to increase the required length of time from two to three hours will have had an impact on the result, encouraging a greater proportion of young people to participate in sport will have an effect on lifestyle, the risk of obesity and subsequent risk of some long term conditions.

However, physical education is not the only method of encouraging participation in physical activity and in York, 63.2% of state primary school pupils and 47.6% of state secondary school pupils walk to school, which is above the England averages of 59.5% and 42.0% respectively[156]. York was designated a Cycling City from 2008 – 2011and is regarded as one of the country's premier cycling cities. It has an extensive network of off-road cycle paths and on-road cycle lanes for cyclists of all ages and abilities to enjoy. More recently Intelligent Travel York promotes both cycling and walking and reduced motor vehicle use. Relative to the England average, a higher proportion of York pupils cycle to school with 4.6% of primary school pupils and 10.1% of secondary school pupils travelling to school by bicycle (England averages 0.8% and 2.9% respectively)[157]. Maintaining and improving on these levels of active transport may encourage healthier behaviours as young people become adults.

Future measures of Physical activity will monitor the proportion of the population meeting the recommended activity level of 150 minutes of moderate intensity physical activity each week, and the proportion of the population doing less than 30minutes physical activity per week. Much

[155] York Health Profiles, APHO. Available at: http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES (accessed 09/11/2011)
[156] DfE: Schools, Pupils and their Characteristics, January 2011 Available at http://www.education.gov.uk/rsgateway/DB/SFR/s001012/index.shtml accessed on 13/03/2012
[157] Schools, Pupils and their Characteristics, Department for Education. Available at: http://www.education.gov.uk/rsgateway/DB/SFR/s001012/index.shtml (accessed 09/11/2011)

emphasis will be placed on initiatives to reduce the number of people undertaking zero to 30 minutes.

Healthy Eating

In adults, healthy eating can help to manage weight and improve overall wellbeing; it can also reduce the risk of developing illness and serious disease. Breast milk is the best form of nutrition for infants, and exclusive breastfeeding is recommended for the first 26 weeks of an infant's life. Thereafter, breastfeeding should continue for as long as the mother and baby wish, while gradually introducing the baby to a more varied diet. For children the right balance of foods will provide all the nutrients they need for healthy growth and development.

There is a clear case for investing in services to support breastfeeding as part of a local child health strategy. This is particularly important for mothers from low income groups, as it is known that they are less likely to breastfeed. Breastfeeding protects the health of babies and mothers, and reduces the risk of illness[158]. Breastfeeding rates at the time of delivery provide an indication of how common the practice is. The proportion of women known to be breastfeeding at the time of delivery in York Hospital has been relatively stable at approximately 68% of births since 2006-07. However, there was a marked rise in breastfeeding at birth for York Hospital in 2010-11 which was statistically significant. Prior to this York Hospital took part in the Baby Friendly Initiative supported by UNICEF, and a social marketing campaign was initiated in York, both having the aim of increasing breast feeding rates. The most recent data regarding breast feeding at delivery covers the first three quarters of 2011-12, and the emerging results suggest that the 2010-11 rise has not been sustained and at present there is a statistically significant reduction in breast feeding initiation back to the baseline figure of 68%. To improve the initiation of breast feeding it may be appropriate to identify the factors that influenced the marked increase in 2010-11. Whilst this data relates to breast feeding at birth, there is currently no data regarding the duration of breast feeding available at a local level however this data is anticipated as being available for future iterations of the JSNA.

There are few measures of eating habits available at a local level. Modelled estimates (which should be treated with caution) suggest that

[158] National Institute for Health and Clinical Excellence (NICE), Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households, London: NICE, 2008

28% of adults eat the recommended five portions of fruit and vegetables per day, which is not significantly different to the England average[159]. However, given the potential health benefits of increasing fruit and vegetable consumption further improvements in this area would seem appropriate.

Breastfeeding is a key component of healthy eating for children. 73.7% of mothers began to breastfeed in 2010-11 for North Yorkshire and York PCT, the same as the national average[160]. Figures for York Hospital alone (based on North Yorkshire and York PCT Vital Signs Monitoring data) are generally lower than the national average: 69.7% in 2006-07 though increasing to 72.1% in 2010-11.

Obesity

Overweight and obesity increase the risk of a wide range of diseases and illnesses, including coronary heart disease and stroke, type 2 diabetes, high blood pressure, metabolic syndrome, osteoarthritis and cancer[161].

Obesity levels are rising nationally and represent one of the biggest threats to the future health of our population. Modelled estimates (which should be treated with caution) suggest that 23.0% of adults in York are obese, not significantly different to the national average of 24.2%[162]. The prevalence of obese adults known to all GPs in the Vale of York Clinical Commissioning Group during 2010-11 was 9.9%, much lower than expected levels suggesting that there may be obese individuals who are not accessing preventative or support in the community[163].

York had a significantly lower prevalence of children (Reception and Year 6) who are overweight or obese compared to the national average in 2010-11[164]. For reception children there has been a decrease from the baseline position in 2006-07 of 8.4% at risk of obesity to 7.5% in 2010-11. For Year 6 pupils, there was an increase in prevalence during 2010-11 from the previous year to 14.7%, though this remained lower

[159] York Health Profiles, Department of Health. Available at: http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES (accessed 09/11/2011)
[160] Statistical releases on breastfeeding, smoking and obesity, Department of Health. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Statistics/StatisticalWorkAreas/Statisticalpublichealth/DH_124185 (accessed 09/11/2011)
[161] Department of Health. (2008). Healthy Weight, Healthy Lives: A Toolkit for Developing Local Strategies. London. Department of Health & National Heart Forum.
[162] York Health Profiles, Department of Health. Available at: http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES (accessed 09/11/2011)
[163] Quality and Outcomes Framework, Information Centre. Available at: http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework (accessed 09/11/2011)
[164] National Child Measurement Programme, Information Centre. Available at: http://www.ic.nhs.uk/ncmp (accessed 09/01/2012)

than the baseline position of 15.6% in 2006-07. Local analysis of this data[165] reported in the 2010 JSNA highlighted a difference between year 6 boys and girls where the prevalence amongst boys was increasing. The latest data (2009-10) show that prevalence fell for boys contributing to the overall lower rate, though prevalence remains higher for boys than for girls (15.9% compared to 12.0%).

Local analysis of child obesity data by deprivation illustrated in Fig. 12 shows that for both reception and year 6 children, prevalence is higher amongst the most deprived 20% of the population compared to the remaining 80% (more markedly for year 6 children where the difference is statistically significant).

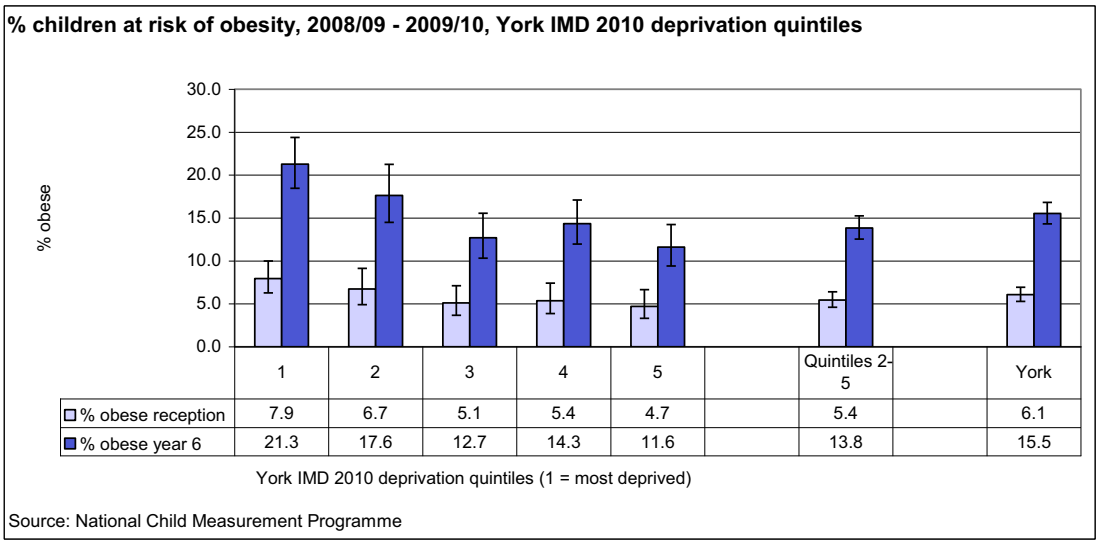


Figure 12: Proportion of children at risk of obesity by deprivation quintile

Alcohol

Alcohol consumption is a significant health concern, both for the short term impact of excessive drinking on any one occasion and the longer term impact on conditions such as heart disease, stroke and some cancers. Alcohol consumption is also shown to play a part in crime and disorder, hospital admissions and coping with stress.

Trading Standards officers carry out “test purchasing” visits involving 14-16 year old volunteers and have noted that illegal sales of alcohol from these “test purchases” have been falling annually. Many retailers have been implementing “Challenge 21” or “Challenge 25” policies[166]

[165] National Child Measurement Programme, Local Cleaned Dataset (subset of national dataset), North Yorkshire and York PCT

[166] Challenge 21 and Challenge 25 policies involve asking for identification in situations where a vendor considers that the purchaser is under 21 or 25 years

regarding alcohol sales, and these have been strictly enforced by local and national Trading Standards officers. However, it is recognised that this is unlikely to reduce adults purchasing on behalf of children, and this may require novel investigative practices.

The North West Public Health Observatory's 'Local Alcohol Profile for England'[167] showed that for the majority of indicators relating to alcohol harm, York compared favourably to the national average.

Despite this, there remains more to be done to reduce the impact of alcohol on health. During 2009-10, the alcohol related admission rate per 100,000 population resident in York was 1,405, the same as the previous year. This is encouraging, comparing well to the national increasing trend yet remains much higher than the rate observed in 2002-03 (912 per 100,0000). A survey conducted by York Hospital[168] between March 2010 and March 2011 focussed on people attending this hospital ten or more times in a year and found that 51% of these attendances were due to alcohol and substance misuse.

Although locally the hospital admission rate due to alcohol-specific conditions amongst under 18 year olds is not significantly different to the national average, it has not followed the regional and national trend over the last few years and instead has increased from 61 per 100,000 during 2003-04 to 2005-06 to 65 during 2007-08 to 2009-10.

Alcohol specific mortality rose between 2003-05 and 2006-08 for both males and females, but appears to have reduced based on the 2007-09 data and is not significantly different to the national average. Information provided by the Yorkshire and Humber Public Health Observatory on "Alcohol-related hospital admissions 2009-10 and their associated costs" show that patients registered with York General Practices cost £5.9 million in alcohol related admissions in 2009-10[169].

Alcohol related recorded crime rates per 1,000 of the population have fallen over the last five years. During 2009-10 the rate was 6.2 in York, similar to the previous year, remaining significantly lower than the national average of 7.2 per 1,000.

In the absence of a reliable measure of drinking behaviour amongst the residents of York, modelled estimates can be used but should be treated

[167] Local Alcohol Profiles for England (LAPE), North West Public Health Observatory, Available at: http://www.lape.org.uk/index.html (accessed 22/11/2011)
[168] York and North Yorkshire Joint Strategic Intelligence Assessment, December 2011
[169] Based on national tariff and adjusted for method of admission (elective/ non-elective) and spell duration.

with caution. These suggest that 26.3% of York residents may consume at least twice the daily recommended amount of alcohol in a single drinking session (8 or more units for men and 6 or more units for women) which is significantly higher than the national average[170]. Estimates defining the level of risk amongst the drinking population show no significant differences in the proportion of increasing risk (22-50 units a week for males and 15-35 units for females) or high risk drinking (>50 units for males and >35 units for females) in York relative to the England average[171].

Substance Misuse

The information regarding the number of individuals who are misusing drugs is based on research evidence, as the prevalence is difficult to capture accurately. The prevalence estimate for York is that there were 933 individuals misusing drugs, specifically opiates or crack in 2009-10[172]. During the same period there were a total of 809 opiate and/or crack cocaine users in structured treatment in York which suggests that more than 80% of the estimated substance misusing population are accessing treatment services.

A key measure of the health and well being of drug users is whether they achieve a drug free status upon leaving treatment (a 'successful completion'). York is in the top national quartile for successful completions for non opiate and crack users (e.g. stimulant users) but in the bottom quartile for opiate and crack users (e.g. heroin).

The health and wellbeing needs of this group can be significant and complex. They suffer from physical and psychological illnesses and social problems as a consequence and possible cause of their substance misuse, Intravenous drug users are at increased risk of contracting blood-borne viruses, and therefore will also be at risk of further transmission once infected. Therefore screening for Hepatitis C and vaccination for Hepatitis B are important for this population. Locally, 70% of those engaged in services will have been tested for Hepatitis C[173], which is above the national average; however uptake of vaccination for Hepatitis B is low in York[174].

[170] York Health Profiles, Department of Health. Available at: http://www.apho.org.uk/default.aspx?QN=P_HEALTH_PROFILES (accessed 09/11/2011)
[171] Local Alcohol Profiles for England (LAPE), North West Public Health Observatory, Available at: http://www.lape.org.uk/index.html (accessed 22/11/2011)
[172] Hay G, et al. Estimates of the Prevalence of Opiate Use and/or Crack Cocaine Use, 2009/10: Sweep 6 report. National Drug Evidence Centre, University of Manchester. Available at: http://www.nta.nhs.uk/uploads/prevalencestats2009-10fullreport.pdf
[173] Correspondence from the City of YorK Drug and Alcohol Action Team 2012
[174] ibid.

Injecting substances can result in wounds, abscesses, blood poisoning, circulatory problems, deep vein thrombosis and HIV/AIDS. The effect of drugs on mental health can include paranoia, psychosis related to amphetamine use, anxiety, depression. Over the past three years the average number of deaths in York related to drug use was 6.3.

The social effects of misusing substances include living in poor housing and homelessness, debt, poor diet, fuel poverty, isolation, domestic violence, family breakdown and child safeguarding issues. In keeping with the national statistics, 15% of those in structured treatment locally are in paid employment, and most drug-related offences occur in the more deprived areas.

Information about young people's substance misuse is collected through National Drug Treatment Management Systems. 60 young people in York accessed specialist substance interventions during 2010-11 with alcohol and cannabis remaining the most commonly misused substances[175]. Many young people receiving an intervention have a range of vulnerabilities. They are more likely to be NEET, half as likely to be in full-time employment, more likely to have contracted a sexually transmitted disease, have a child, be in contact with the youth justice system and be receiving benefits by the time they are 18. A local consultation with young people is planned for 2012-13 to establish their knowledge about and use of drugs and alcohol and the findings will inform future planning and commissioning.

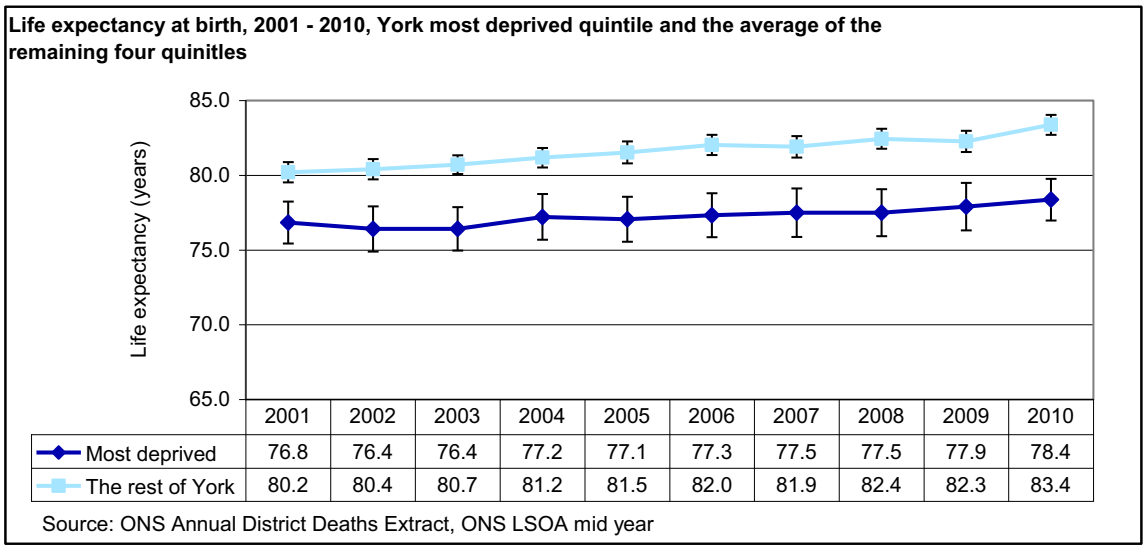
[175] JSNA Support Pack for Strategic Partners: National Treatment Agency for Substance Misuse. York Profile

Section 4: A Profile of Health in York

This section seeks to describe the health and well being issues experienced by the residents of our city. Generally, the health of most of the residents of York is very good, but some sections of the community are relatively disadvantaged.

Life Expectancy

The average life expectancy for York citizens has been steadily climbing over time[176]. Life expectancy for men and women living in the City of York has increased during the period 2007-09 to 79.6 years for men and 83.2 years. This is significantly higher than the England averages of 78.3 years for men, and 82.3 years for women[177]. However, when comparing the life expectancy of the most deprived members of the community to the least deprived there is a clear inequality. Men who live in York's most deprived communities will die, on average 9.9 years earlier than their least deprived counterparts. Similarly, women in the most deprived communities in York will die, on average 3.6 years earlier than those in the least deprived communities in York[178]. These trends are illustrated in Fig. 13.



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Most deprived	76.8	76.4	76.4	77.2	77.1	77.3	77.5	77.5	77.9	78.4
The rest of York	80.2	80.4	80.7	81.2	81.5	82.0	81.9	82.4	82.3	83.4

Source: ONS Annual District Deaths Extract, ONS LSOA mid year

Figure 13: Trend in life expectancy at birth in the most deprived quintile and the average of the remaing four quintiles in York

[176] City of York JSNA 2010.
[177] York Health Profile 2011. Department of Health.
[178] Health Inequalities Indicators for Local Authorities, Slope Index of Inequality for Life Expectancy by Deprivation Deciles, 2005-9. Association of Public Health Observatories.

Fig. 14 shows the life expectancy that would be gained if the most deprived quintile[179] of York had the same mortality rate as the average for the four other quintiles in the local authority for each cause of death[180]. The implications of this analysis are that men and women in the most deprived communities are having their lives cut short by potentially preventable conditions, compared to their more affluent counterparts.

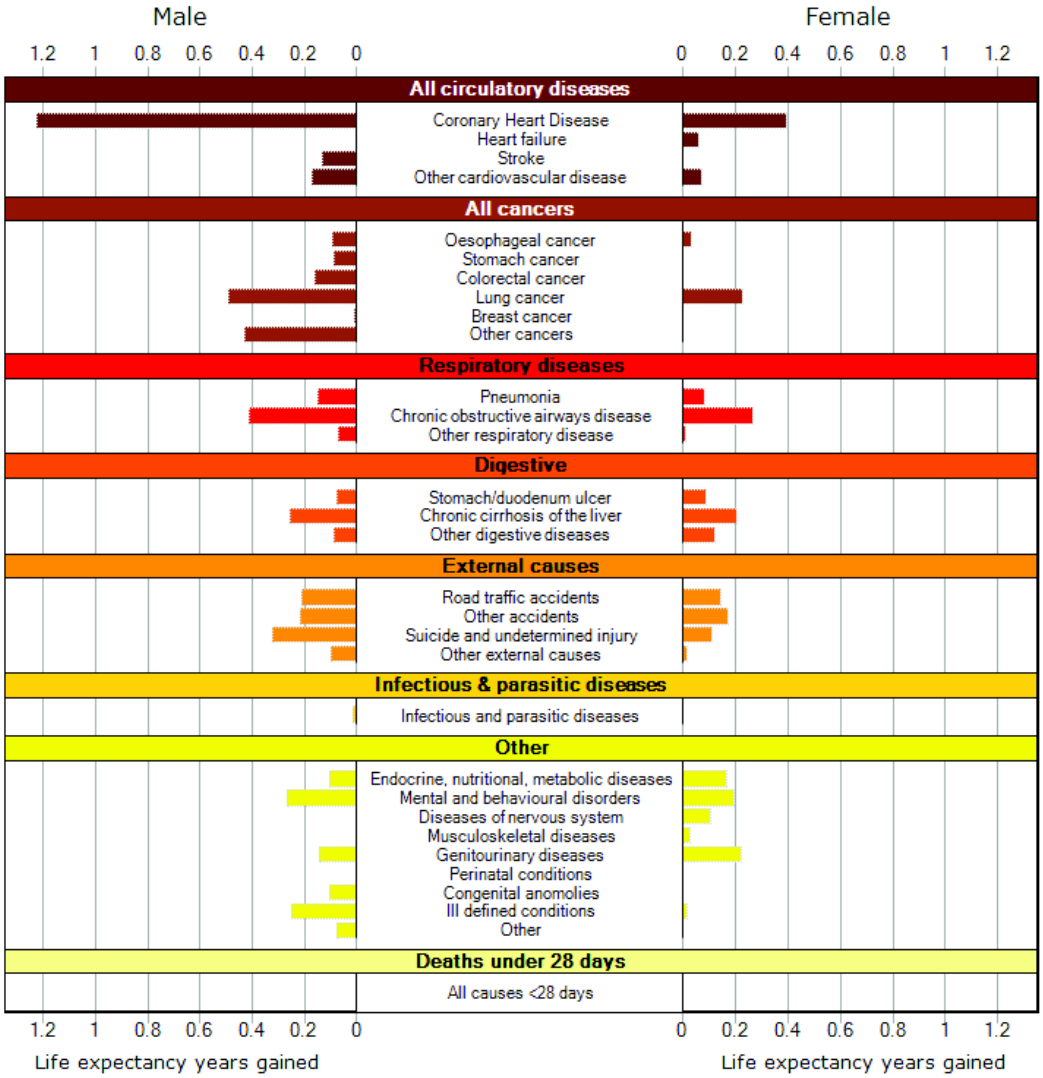


Figure 14: Life expectancy gained if the most deprived quintile experienced the same health outcomes as the remaining four quintiles in York[181]

[179] A quintile is one of five equal groups into which a population can be divided according to a particular variable. In this case the variable used to define the groups is deprivation.
[180] LHO. Health Inequalities Intervention Tool. Available at: http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx accessed 11/01/2012
[181] LHO: Health Inequalities Intervention. Available at: http://www.lho.org.uk/NHII/LEYearsGained.aspx?la=00FF&comp=2 accessed 02/12/2011

Disability-free life expectancy is an estimate of the number of expected years in good health or without a disability for a population. York men have a disability-free life expectancy of 63.5 years from birth, and women 66.1 years. This is significantly higher than the England average of 61.7 years for men and 64.2 years for women[182]; however locally there is still a difference of 10.1 years for men and 7.6 years for women between the most deprived and the least deprived quintiles[183].

Mortality

All age, all cause mortality for the population of York has remained fairly constant over the period 2005-09 with a rate of approximately 500 per 100,000 population. However, over the last ten years, the gap between the most deprived fifth of the population and the average of the remaining four quintiles has increased, and in 2010 mortality amongst the most deprived was 55% higher than the rest of York[184] [185]. As demonstrated in the previous chart the majority of these differences are due to cardiovascular diseases and cancers, mainly lung cancer[186]. Fig. 15 illustrates the all-age all-cause death rate over the period 2001-10, showing the difference in death rate between the most deprived communities in York and the rest of the city[187].

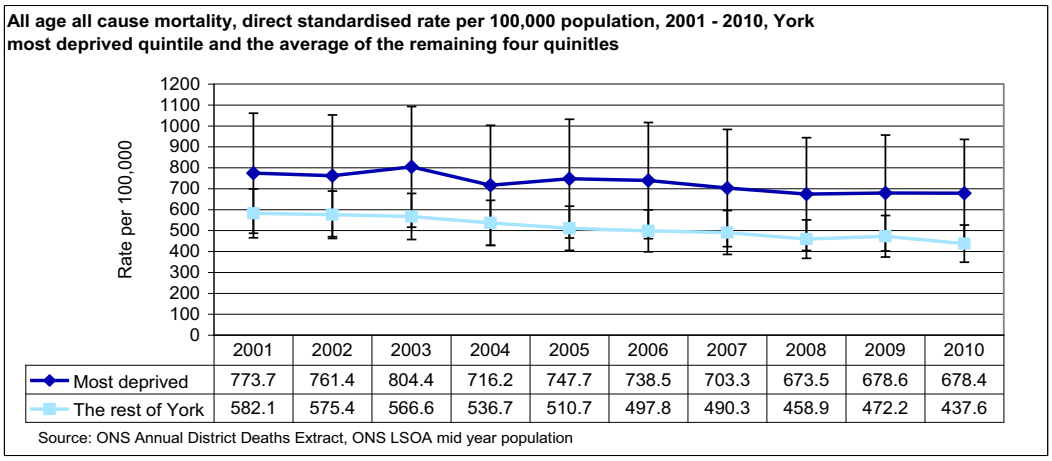


Figure 15: All age all cause mortality in the most deprived quintile and the average of the remaining four quintiles in York

[182] WMPHO Healthy Life expectancy. Available at: http://www.ons.gov.uk/ons/rel/disability-and-health-measurement/health-expectancies-at-birth-and-age-65-in-the-united-kingdom/2001---revised/health-expectancies-for-local-authorities-in-england-and-wales--2001---revised.xls accessed 26th January 2012

[183] LHO. Marmot Indicators for Local Authorities in England. Available at: http://www.lho.org.uk/LHO_Topics/national_lead_areas/marmot/marmotindicators.aspx accessed 11/01/2012

[184] ONS Annual District Deaths Extract held by NHS North Yorkshire and York.

[185] ONS LSOA mid-year population estimates.

[186] LHO. Health Inequalities Intervention Tool. Available at: http://www.lho.org.uk/LHO_Topics/Analytic_Tools/HealthInequalitiesInterventionToolkit.aspx accessed 11/01/2012

[187] This analysis is not comparable to the Local Area Agreement targets included in previous JSNA's.

Neonatal Health

The infant mortality rate is defined as the number of deaths that occur between birth and exactly one year of age, per 1,000 live births. Fortunately there are few infant deaths in York. The current crude infant mortality rate for the York is 5.0 per 1,000 live births and is based on 2007-09 data. This is not dissimilar to the previous rate and is not significantly different to the England average of 4.7 for the same period[188].

The percentage of births in York that were considered to be of low birth weight (less than 2,500g) during 2009 was 6.6% which was not significantly different to the England average of 7.5% for the same period.

There appears to have been a small increase in the number of low birth weight babies born in York from 5.8 in 2008. This finding may be due to chance, however as there are recognised links between deprivation, infant mortality and low birth weight babies this may be an area to monitor[189]. Fig. 16 illustrates that a significantly larger proportion of babies born in the most deprived quintile are of low birth weight compared to those born in the rest of the City.

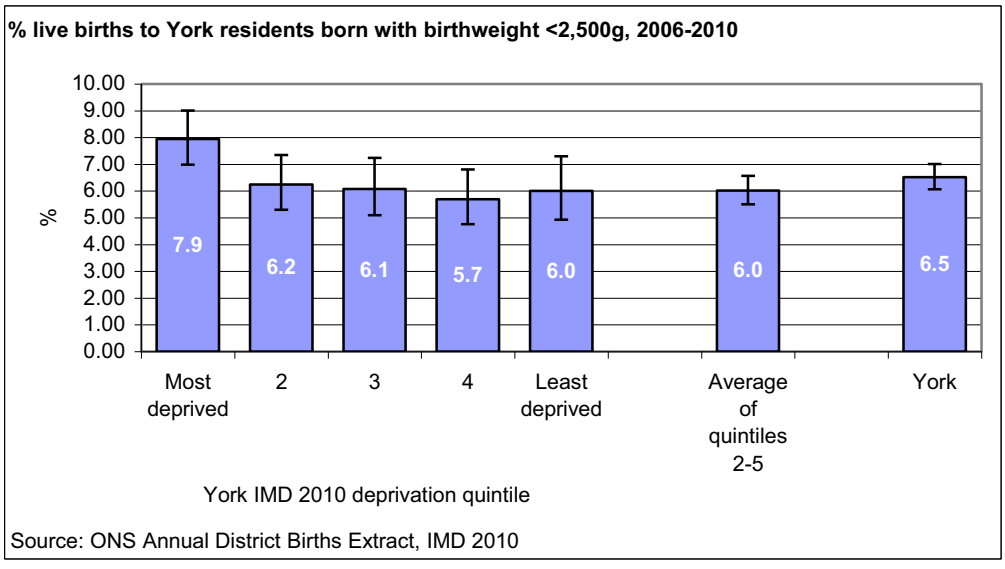


Figure 16: Proportion of births in York with a birth weight of less than 2,500g

The risks associated with low birth weight at delivery persist through into adult life and it is suggested that those individuals who were low birth

[188] NHS Information Centre. Available at: http://www.indicators.ic.nhs.uk/webview/ accessed 11/01/2012
[189] Kogan, M. D. Social causes of low birth weight. J R Soc Med 1995: 88; 611-615

weight at delivery have an increased risk of developing cardiovascular disease in adulthood[190]. As maternal nutrition in pregnancy and smoking in pregnancy and alcohol consumption in pregnancy are individually associated with low birth weight babies, and there are longer term consequences for low birth weight individuals, targeting at-risk populations in this area will be important.

One specific cause of low birth weight babies is foetal alcohol syndrome, where the consumption of more than one or two units of alcohol each week whilst pregnant has a deleterious effect on the health and cognitive functioning of the baby. Estimates of the number of new cases of foetal alcohol syndrome vary and are difficult to reconcile. Although foetal alcohol syndrome is not a common condition, it is regarded as the leading known cause of non-genetic intellectual disability in the Western world[191].

National estimates of alcohol consumption in pregnancy based on the Infant Feeding Survey 2005 show that in the UK, of the women who drank before pregnancy, 34% gave up while they were pregnant and 61% said they drank less during their pregnancy. There is a paucity of local data in this area, both in terms of the local incidence of foetal alcohol syndrome and information regarding alcohol consumption in pregnancy. Therefore no specific recommendations can be made.

Teenage Pregnancy

Research studies show that while young people can be competent parents, children born to teenagers are more likely to experience a range of negative outcomes in later life and are more likely to become teenage parents themselves. Teenage mothers have three times the rate of post-natal depression of older mothers and a higher risk of poor mental health for three years after the birth. In addition, the infant mortality rate for babies born to teenage mothers is 60% higher than for babies born to older mothers. At age 30, teenage mothers are 22% more likely to be living in poverty than mothers giving birth aged 24 or over, and are much less likely to be employed or living with a partner. They are also 20% more likely to have no qualifications at 30 years-old than mothers giving birth aged 24+ years. Rates of teenage pregnancy are far higher among deprived communities, so the negative consequences of teenage pregnancy are disproportionately

[190] Leon, D. A. et al, 1998. Reduced fetal growth rate and increased risk of death from ischaemic heart disease: cohort study of 15 000 Swedish men and women born 1915-29. BMJ 1998:314; 241-5

[191] Abel, E. L. & Sokol, R. J. Incidence of fetal alcohol syndrome and economic impact of FAS-related anomalies. Drug Alcohol Depend 1987 Jan; 19(1):51-70

concentrated among those that are already disadvantaged. The poorer outcomes associated with teenage motherhood also mean the effects of deprivation and social exclusion can be passed from one generation to the next.

The national target to reduce under 18 conceptions by 50% by 2010 was set in 1999 using the 1998 data as a baseline. The 2010 York JSNA identified that whilst the teenage pregnancy rate in 2008 was slightly higher than the 1998 baseline of 34 per 1000 females aged 15-17 years, it was a 20% reduction on the previous year. The data for 2009 identified a further reduction in the conception rate in females aged 15 - 17 years to 26.6 per 1000, which was significantly lower than the England rate for the same period. The trend for York over the period 1998-09 was a 21.7% reduction overall, compared to an 18.7% reduction in the England rate[192]. However, there is marked variation between electoral wards in terms of under-18 conception rates, with more deprived wards having a higher rate than the less deprived. This is illustrated in Fig. 17, confirming a local social gradient that would be appropriate to target.

National data on teenage conception rates is between 15 and 24 months old, and therefore there is a need to generate more up to date local data. This could be achieved by collating data from local organisations such as maternity and abortion services. This would inform commissioning decisions in a timelier manner and allow services to react more quickly to changes in demand.

[192] ONS. Available at: http://www.education.gov.uk/childrenandyoungpeople/healthandwellbeing/teenagepregnancy accessed 09/01/2012

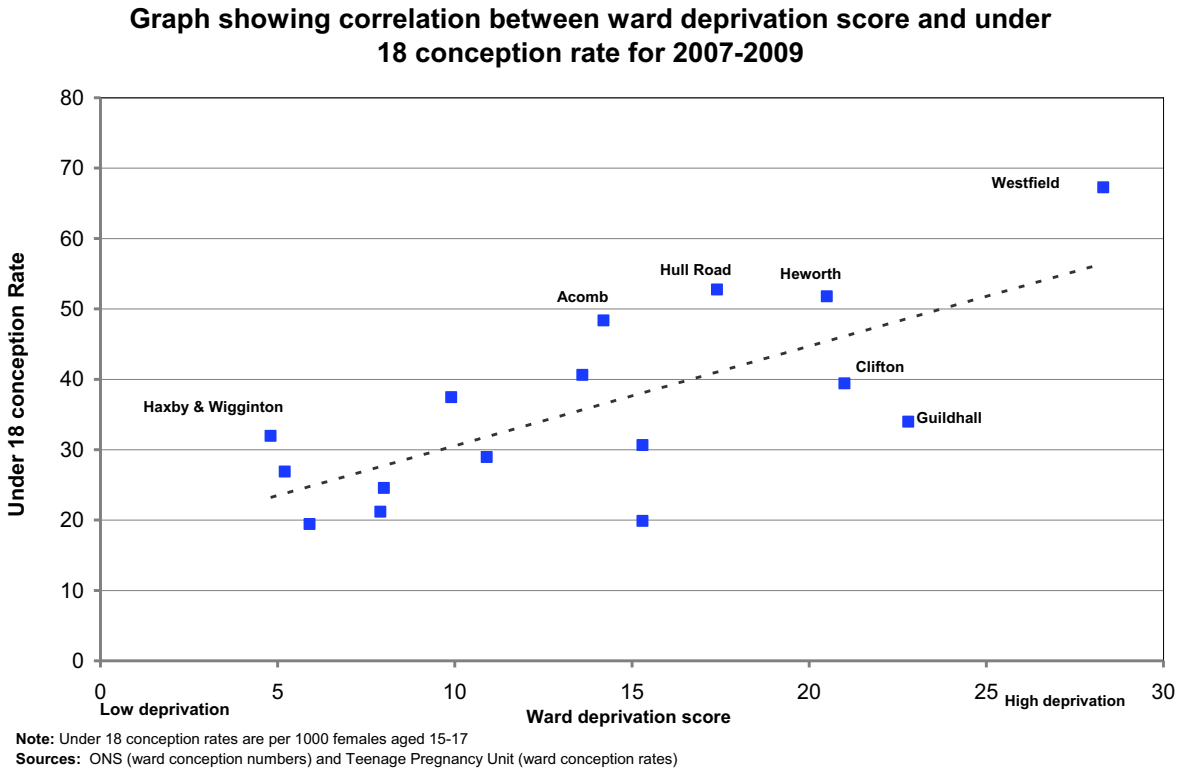


Figure 17: Correlation between ward deprivation score & under-18 conception rate for 2007-09

Dental Health

The National Oral Health Survey is conducted biennially and the adult dental health survey has not been repeated since the 2010 JSNA. On 1st July 2011 there were 7,010 patients on the NHS Dentistry waiting list from the Selby and York area. Of these people, 43% had been waiting for over 7 months and NHS North Yorkshire and York is commissioning services to address this identified gap. At March 2011 more than half of the North Yorkshire and York population had seen an NHS dentist in the previous 24 month period. This was lower than the national average of 55.8% in England. Amongst adults alone, 49% saw an NHS dentist (52.3% in England) and for children 68.1% (70.6% in England)[193].

[193] NHS Information Centre, http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/dentistry Published 2011.

Eye Health

Research estimates suggest that approximately 19% of the population over the age of 75 years are blind or partially sighted194. As the population is projected to increase, with a larger proportion over the age of 65 years this will mean that a greater number of York residents will experience these conditions. In the UK there are five leading causes of blindness and partial sight. These are age-related macular degeneration, diabetic retinopathy, glaucoma, cataracts and refractive error[195]. Many of these conditions are associated with existing risk factors for poor health which can be improved including smoking, obesity and physical exercise; however some of the conditions are associated with a family history of the condition, or environmental factors. Given the projections with regard to our ageing population, and the increase in prevalence of these conditions with increasing age, it is important that individuals attend for regular eye examinations to identify these conditions early enough for potential interventions to be initiated.

Long-term Conditions

High Blood Pressure

High blood pressure (hypertension) is one of the causes of premature mortality and morbidity that is most amenable to treatment. It is a major risk factor for stroke, heart disease, heart attacks, kidney disease and premature death[196]. Risk factors for hypertension include being overweight or obese, physical inactivity, having a family history of high blood pressure or diabetes, and being diabetic[197]. The prevalence of high blood pressure in the registered population of York had been steadily rising to a level of 12.4% in 2008-09. This value remained static through 2009-10 and increased to 12.5% in 2010-11, but has always been significantly below the England average of 13.5%[198]. However, the Association of Public Health Observatories has produced modelled estimates for the prevalence of high blood pressure, suggesting that there may be an undiagnosed prevalence of approximately 11.5%[199].

[194] Evans JR, Fletcher AE, Wormald RPL et al. (2002), 'Prevalence of partial sight and blindness in people aged 75 years and older in Britain: results from the MRC trial of assessment and management of older people in the community', British Journal of Ophthalmology, Vol. 86, pp. 795-800
[195] RNIB 2009. Future sight loss UK (1): The economic impact of partial sight and blindness in the UK adult population.
[196] NICE CG127. Hypertension: The clinical management of primary hypertension in adults. August 2011.
[197] ibid.
[198] Information Centre, Quality and Outcomes Framework. Available at: http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework accessed 11/01/2012
[199] APHO Prevalence Models. Available at: http://www.apho.org.uk/resource/view.aspx?RID=48308 accessed 11/01/2012

Whilst this is a modelled estimate and needs to be treated with caution, increased awareness and identification of individuals with high blood pressure could account for the steady rise in recorded prevalence.

Using Quality and Outcomes Framework targets for the Vale of York Clinical Commissioning group, 80% of those diagnosed with high blood pressure are treated to target in 2010-11[200]. This is similar to the England average of 79%. Whilst this achievement needs to be acknowledged, the target blood pressure is higher than the evidence-based clinical standard and therefore there is potential room for improvement. In addition, 85% of those individuals who were diagnosed as having high blood pressure in 2010-11 were assessed with regard to their risk of developing cardiovascular disease and received advice regarding healthy lifestyle choices[201]. Given that high blood pressure is associated with the development of cardiovascular disease and is amenable to lifestyle modification in terms of physical activity, stopping smoking and weight loss it would be welcome to see even further improvements in these indicators.

Diabetes

The recorded prevalence of diabetes has increased slightly since 2008 to 4.4% of the registered population of York over the age of 17 years during 2010-11[202]. The England average was 5.5%. The crude admission rate attributed to diabetes York in 2009-10 was 1.2 per 1000 registered population, which was similar to the England average of 1.1[203]. During 2010-11, 51.0% of those individuals diagnosed with diabetes had good long-term blood sugar control (as measured by Hb_{A1c}) though this was below the England average of 54.2%. The monitoring and control of an individual with diabetes' blood pressure is also important for preventing long-term complications. Locally, the proportion of diabetic patients who experienced good blood pressure control (78.2%) was lower than the England average (81.2%).

Diabetes is the leading cause of blindness before old age and the effects can be mitigated by early intervention[204]. The Royal National Institute for the Blind estimate that 40% of people with type 1 diabetes and 20% of

[200] Information Centre, Quality and Outcomes Framework. Available at: http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework accessed 11/01/2012
[201] ibid.
[202] ibid.
[203] NHS comparators, 2009/10 published in APHO GP Practice profiles. Available at: http://www.apho.org.uk/PRACPROF/ accessed 11/01/2012
[204] National Collaborating Centre for Chronic Conditions. *Type 2 diabetes: national clinical guideline for management in primary and secondary care (update)*. London: Royal College of Physicians, 2008.

people with type 2 diabetes will develop diabetic eye disease during their lives. A national diabetic eye screening programme is in place to identify early changes which may be amenable to treatment. In patients registered with GP's in the Vale of York Clinical Commissioning Group, 94.3% had undergone diabetic eye screening in the 15 months prior to 31st March 2011. This compares well to the England rate of 91.6% and has increased from the 2010 rate for the commissioning group of 94.0%[205].

The prevalence of diabetes appears to have increased slightly, which could be attributed to a true increase in the prevalence, or may be due to increased awareness of the condition amongst the general population and case-finding activities within the NHS. It would appear that improvements could be made with regard to blood sugar and blood pressure control amongst those patients diagnosed with diabetes.

Circulatory Diseases

Circulatory diseases include heart disease, stroke and diseases of the heart valves or the heart rhythm which accounted for approximately one third of all deaths in England and Wales in 2010[206]. Since 1995, death rates due to circulatory diseases have been dropping in York, and were below the England average in the York JSNA for 2008[207]. Risk factors for circulatory disease are multiple, and include age, gender, family history, high blood pressure, high cholesterol, obesity, smoking and diabetes amongst others. There is a clear gradient across the deprivation quintiles for mortality from circulatory diseases with a rate of 213 per 100,000 population in the most deprived quintile, and 131 per 100,000 population in the least deprived. This is illustrated in Fig. 18.

[205] APHO National General Practice Profiles. http://www.apho.org.uk/PracProf/Profile.aspx#s=mod,1,sha,Q32,pyr,2011,pat,19,par,CCG_323,are,-,sid1,2000002,ind1,241-4,sid2,-,ind2,- Accessed 24th January 2012.
[206] Births and Deaths in England and Wales, 2010. ONS Statistical Bulletin.
[207] City of York JSNA 2008. Available at: http://www.yorkwow.org.uk/healthy-wow accessed 11/01/2012

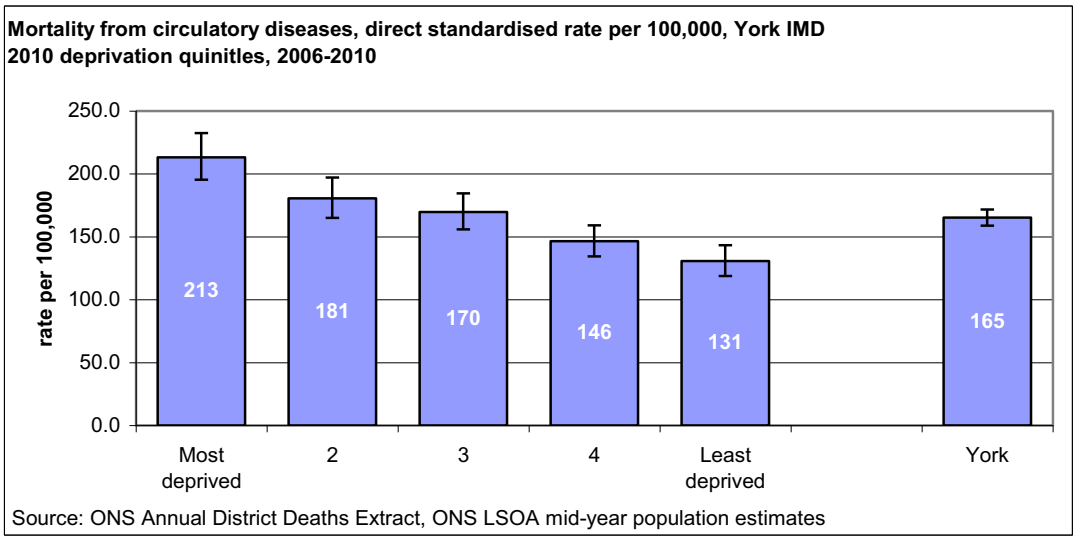


Figure 18: Mortality from circulatory diseases by deprivation quintile in York

For the 2007-09 period, the overall mortality rate for men was significantly lower than the England average for the same period, but there was no significant difference for women[208].

Coronary Heart Disease

Modelled estimates suggests that coronary heart disease prevalence for York in 2011 should be in the region of 4.72%[209]; however the recorded prevalence for 2010-11 based on data routinely collected by GPs gives a figure of 3.5% compared to the England average of 3.4%[210]. Both of these figures should be used with caution as the modelled prevalence is an estimate of the actual prevalence, and the prevalence based on GP data is a crude rate and does not take into consideration the age or gender structure of the population.

Stroke

Modelled estimates of stroke prevalence for York in 2011 suggest that the prevalence should be in the region of 2.25%[211], with GP data suggesting that the recorded prevalence during 2010-11 was 1.9% compared to an England rate of 1.7%[212]. This data should be viewed

[208] NHS Information Centre. Available at: https://indicators.ic.nhs.uk accessed 11/01/2012
[209] APHO Prevalence Models. Available at: http://www.apho.org.uk/resource/item.aspx?RID=111120 accessed 27/02/2012
[210] APHO General Practice Profiles. Accessed at http://www.apho.org.uk/PracProf/ on26th January 2012
[211] APHO disease prevalence estimates for stroke. Available at http://www.apho.org.uk/resource/item.aspx?RID=111124 accessed 27/02/1012
[212] NHS Information Centre, Quality and Outcomes Framework. Available at: http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework accessed 11/01/2012

with similar cautions as the coronary heart disease data. The standardised mortality ratios for stroke for men and women are not significantly different to the England average[213].

Respiratory Disease

Respiratory disease includes relatively common long-term conditions such as chronic obstructive pulmonary disease (COPD) and asthma, and more acute but rarer conditions like tuberculosis.

Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) is a respiratory condition associated with smoking which is more common in deprived communities than affluent ones. The recorded prevalence of COPD has been steadily rising in York from 1.3% of the registered population in 2006-07, to 1.4% in 2010-11[214]. The England rate is 1.57%. This is based on GP data which is not standardised for age or sex, and therefore should be considered to be an approximation of the true prevalence. The modelled estimate for York suggests that 2.8% of the population may have COPD, but this should be used with caution[215].

The mortality rate in 2007-09 for COPD in York men is significantly lower than the England average. The rate for women was higher than the England average, albeit not significantly so[216].

Looking at the prevalence of COPD across deprivation quintiles, there appears to be no discernible pattern based on GP data. However when considering the COPD mortality rate, there is a striking gradient with the most deprived quintile having a mortality rate of 47.7 per 100,000 population, compared to the least deprived quintile having a rate of 10.9 per 100,000 population, which is illustrated in Fig. 19[217].

[213] NHS Information Centre https://indicators.ic.nhs.uk accessed 11/01/2012
[214] NHS Information Centre, Quality and Outcomes Framework. Available at: http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework
[215] APHO Prevalence Models. Available at: http://www.apho.org.uk/resource/view.aspx?RID=48308 accessed 11/01/2012
[216] NHS Information Centre. Available at: https://indicators.ic.nhs.uk accessed 11/01/2012
[217] ONS Annual District Deaths Extract, ONS LSOA mid-year population estimates

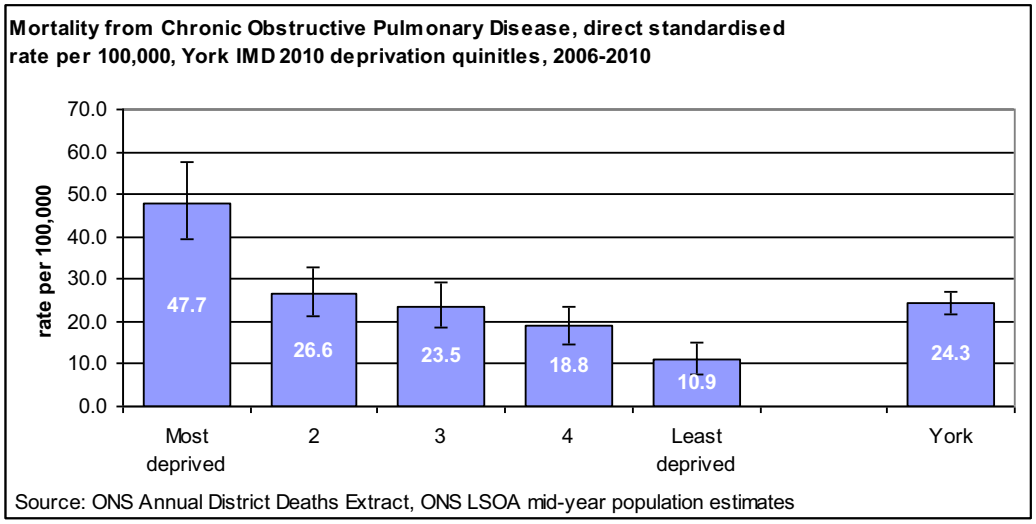


Figure 19: Mortality from Chronic Obstructive Pulmonary Disease by deprivation quintile in York

Asthma

The recorded prevalence of asthma for 2010-11 was significantly lower than the England average (5.6% compared to 5.9%)[218]. Asthma-related admissions in York were 127 per 100,000 population which represents 238 admissions[219]. There appears to be no particular trend across the deprivation quintiles regarding asthma admissions.

Tuberculosis (TB)

The incidence of tuberculosis for 2007-09 remains stable at 6 per 100,000 population, and is significantly lower than the England incidence for the same period of 16 per 100 000 population[220]. Treatment for TB often lasts for six months or more, so ensuring compliance with treatment is essential. Recent data identified that nationally, 83.6% of individuals complete their treatment[221]. Local figures for completion of treatment are not available.

Long-term neurological conditions

Neurological conditions can be life threatening, and most of them severely affect people's quality of life. Caring for someone with a

[218] Information Centre, Quality and Outcomes Framework. Available at: http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework accessed 11/01/2012
[219] NHS North Yorkshire and York. Secondary User Service Inpatient Dataset.
[220] Health Protection Agency. Available at: http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/TBUKSurveillanceData/ accessed 11/01/2012
[221] Tuberculosis in the UK: 2011 report. London: Health Protection Agency, December 2011

debilitating illness often means that carers have to give up their own employment, in addition to the person with the condition being unable to continue to be economically active. This will have a devastating impact on the family's economic situation. Long term neurological conditions include epilepsy, Parkinson's disease and Multiple Sclerosis (MS), but also includes genetic conditions which can be inherited such as Huntington's disease.

Some neurological conditions can present at any time in life and remain, such as epilepsy. Epilepsy can impact on an individual's independence and ability to work as poorly controlled epilepsy can preclude an individual from driving or undertaking some forms of employment. The prevalence of epilepsy in the 18+ age group in practices forming the Vale of York Clinical Commissioning Group for 2010-11 was unchanged from the 2009-10 prevalence of 0.7%. This would correspond to approximately 1,400 individuals, 77.8% of whom had been free of seizures for 12 or more months[222]. This has dropped slightly compared to the 2009-10 value of 78.8% but not significantly so[223].

Multiple Sclerosis is generally diagnosed between the ages of 20 and 40 years, although can present at other ages. MS affects individuals in different ways and limits activities to varying degrees leading to varying health and social care requirements. It is estimated that 120 per 100,000 of the population of England and Wales are diagnosed with MS[224]. Applying this estimate to the population of York would suggest that there are approximately 243 individuals living with MS in the City.

Given the projected increase in the proportion of the population over the age of 65 years, neurological conditions that increase in prevalence with increasing age are of interest. Individuals with these conditions are likely to have increased social care requirements compared to similarly aged disease-free individuals. Parkinson's disease is one of the conditions that would fall into this category, although there are others. The prevalence of Parkinson's disease in the City of York is not known, although Parkinson's UK have undertaken some research and have estimated the national prevalence to be between 269 and 280 per 100,000 of the population[225]. This would correspond to approximately

[222] National General Practice Profiles. Produced by the Association of Public Health Observatories. Accessed at http://www.apho.org.uk/PracProf/Profile.aspx#s=mod,1,sha,Q32,pyr,2011,pat,19,par,CCG_323,are,-,sid1,2000004,ind1,276-4,sid2,-,ind2,- on 02/03/2012.
[223] ibid.
[224] The national audit of services for people with multiple sclerosis 2011. The MS Trust and The Royal College of Physicians September 2011. Available at http://www.rcplondon.ac.uk/sites/default/files/ms_audit_national_report_2011_0.pdf accessed on 02/03/2012
[225] Parkinson's UK. Parkinson's prevalence in the United Kingdom (2009) Available at http://www.parkinsons.org.uk/pdf/parkinsonsprevalenceuk.pdf accessed on 02/03/2012

545 to 567 individuals in the City of York, and if population projections are accurate this estimate would be expected to increase with associated increases in health and social care requirements. Therefore this is an area that needs further consideration both with regard to identifying the true local prevalence and with regard to future strategies.

Cancer

Cancer is one of the contributors to the inequalities in life expectancy experienced by the residents of York (see Fig. 14) and the incidence (new cases) is rising in line with that across England, associated with an ageing population. Cancer is the most significant cause of premature death (death under the age of 75 years) in York. The cancer incidence rate for the period 2006-08 for York in the under 75 years age group was 303 per 100,000 population. This is higher than the England rate, but not significantly so[226], although the incidence for York was significantly lower than the incidence for the Yorkshire Cancer Network for 2004-08. When analysed by gender there is no significant difference between the incidence rates of cancer in men and women in York for the period 2006-08.

The 2010 York JSNA identified that the age-standardised death rates for cancer in the under 75 years age group had decreased substantially and remained below the national comparator rates. This trend has continued and the age-standardised death rate for cancer in the under 75 years age group was 102 per 100,000 population for the rolling period 2008-10[227] which would account for approximately 205 deaths in York for that period. This was similar to the PCT rate and lower than the England rate of 110 per 100,000 population, but not significantly so. There is no significant difference between the death rate for cancer in men and women in York based on the 2008-10 data[228].

Considering the burden of all cancers on the population of York, the directly standardised rate of years of life lost due to mortality was 139 years per 10,000 of the population under the age of 75 years[229] which is not significantly different to the England rate, and there was no significant difference between York women and York men identified.

[226] NHS Information Centre. Available at: https://indicators.ic.nhs.uk/download/NCHOD/Data/11A_077DR0074_08_V1_D.xls accessed 11/01/2012
[227] NHS Information Centre. Available at https://indicators.ic.nhs.uk/download/NCHOD/Data/11B_075DR0074_10_V1_D.xls accessed 05/03/2012
[228] ibid.
[229] NHS Information Centre. Available at: https://indicators.ic.nhs.uk/download/NCHOD/Data/11D_072DR_09_V1_D.xls accessed 11/01/2012

Although the figures are not statistically significant, overall, York appears to have a higher incidence of cancer than the England average, but the death rate for cancer is lower. The implication is that services locally are identifying cancers and treating those with cancer appropriately. Cancers for which there is a national screening programme are considered under those sections.

There is concern nationally that cancer survival in England is not as good as a number of other developed countries particularly in older people, minority ethnic and vulnerable groups and those with multiple long term conditions. The national awareness and early diagnosis initiative is being actively taken forward locally in York including cancer awareness campaigns and closer working with GPs to improve early diagnosis.

Lung Cancer

Of the cancers, lung cancer accounts for the largest gap in life expectancy between the most deprived communities and the remainder of the local population in both men and women. The major risk factor for lung cancer is smoking. Smoking is associated with deprivation and is estimated to account for 85% of lung cancers in the UK[230]. The all-age mortality rate for lung cancer in the City of York is 33.0 per 100,000 population for 2006-10. For the same period, the most deprived quintile experienced an all-age mortality rate of 60.4 per 100,000 which is significantly higher than both the York rate and the rate in the least deprived quintile. In addition, mortality from lung cancer shows a marked trend across the deprivation quintiles which is illustrated in Fig. 20.

[230] Allender S et al. The burden of smoking-related ill health in the UK. Tobacco Control 2009 18:262-267

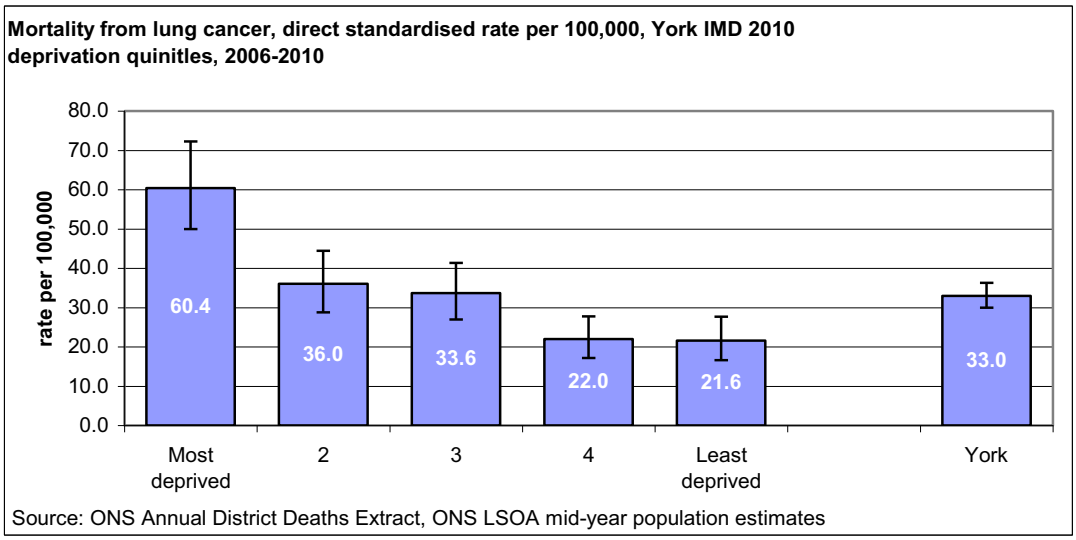


Figure 20: Mortality from lung cancer by deprivation quintile in York

Mental Health

The White Paper Healthy Lives, Healthy People[231], affirms the importance of good mental health throughout life. The annual report of the Director of Public Health[232] states that many key public health issues have a mental health aspect, so for example in order to tackle obesity and alcohol related illness, the psychological, social and other factors that influence behaviour need to be understood. It is also evident that poor mental health can affects a person's life experience and outcomes in many ways. People recovering from mental ill health need support to help them address both the mental health condition alongside help to overcome barriers to social inclusion including schemes to help them into paid or voluntary employment.

In the process of collating information and data about the health and wellbeing needs of people in York for this JSNA, it became evident from many and varied sources that there are significant and unmet levels of mental health need across the city, particularly at the lower levels of complexity and severity. Whilst information is available in respect of severe mental health needs, it has not been possible at this time to establish a robust picture of the full extent of mental heath needs in York. Developing a better picture of mental health needs and improving the ability to meet need has been one of the most strongly articulated areas for action in the JSNA.

[231] Healthy Lives, Healthy People, Department of health, 2010
[232] The Annual report of the Director of Public Health 2011, NHS North Yorkshire and York

People with mental health needs

It is estimated that at any one time there are approximately 170 individuals suffering with a mental illness for every 1,000 people aged 16 to 74 years in York. This equates to around 25,000 people experience various kinds of mental health problems ranging from anxiety and depression to severe and enduring conditions including dementia and schizophrenia[233]. This is an estimate and therefore may under or over estimate of the true scale of the prevalence.

York has a barracks sited within the City walls, and the UK has been and is still involved in military action in Afghanistan and has been involved in military action in Iraq in recent years. Research has indicated that the most frequently reported mental disorders amongst the UK armed forces personnel are of common mental illnesses and alcohol misuse disorders, and that probable post-traumatic stress disorder was relatively low[234]. The national rates appear to be stable however there is no robust data available to identify whether the national results can be applied locally or whether there is a need in this area in York.

Severe and Enduring Mental Illness

This category includes schizophrenia, bipolar affective disorder and other illnesses which have psychosis as a feature. Synthetic estimates suggest that there are likely to be in the region of 304 individuals with a severe and enduring mental illness requiring an unplanned admission in York. However, many of these potential admissions would now be intensively supported and managed in a community setting by Crisis Teams or Community Teams. Whilst this estimate takes into account known predictors of mental illness, basing assumptions solely on this data would be unwise. Therefore other sources were identified.

Data obtained from the Quality and Outcomes Framework identified a recorded prevalence of 0.7% in York residents in 2010-11 which would correspond to approximately 1,400 individuals, compared to the England prevalence for the same period of 0.8%. However, Quality and Outcomes Framework data is not standardised for age or gender, and in terms of mental illness may under estimate the true prevalence due to a reluctance to disclose the information on the part of the patient.

[233] North East Public Health Observatory – estimates based on 2000 data. Available at: http://www.nepho.org.uk/qsf.php5?f=704&fv=704 Accessed on 14/02/2012.
[234] Fear N T et al. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. The Lancet 2010 DOI:10.1016/S0140-6736(10)60672-1

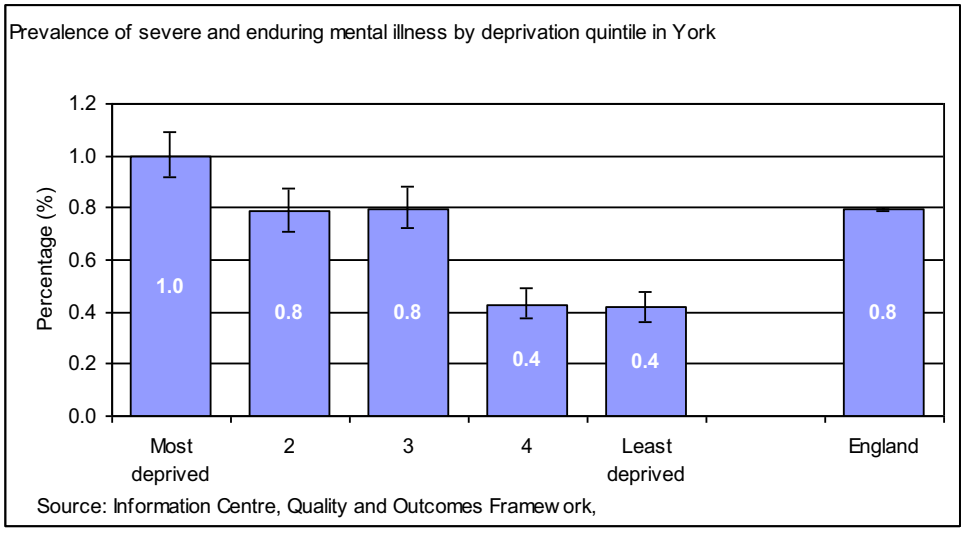


Figure 21: Prevalence of severe and enduring mental illness by deprivation quintile in York

Research has identified poorer outcomes in groups of individuals diagnosed with psychotic disorders, notably increased risks of cardiovascular disease[235]. Fig. 21 illustrates the multifactorial nature of psychotic disorders, in that those who are diagnosed with them are more likely to live in deprived communities. It is not possible to identify whether living in a deprived community increases the risk of developing a severe and enduring mental illness, or whether suffering with a severe and enduring mental illness reduces opportunities and increases the risk of living in a more deprived area. Recognising the risk factors for developing a severe and enduring mental illness and the consequences for those with the diagnosis are essential in tackling the longer term issues.

Disability Living Allowance (DLA) figures suggest that the rate of individuals claiming with mental or behavioural problems as a diagnosis has reduced slightly over the period 2005-08[236].

Older Adults

A local North Yorkshire and York Dementia Strategy was produced in 2011. This highlighted two main priorities: early assessment and diagnosis, and care for people with a dementia in general hospitals. The Operating Framework for the NHS in England 2012 - 13 also highlights Dementia and Care for the Elderly as an area that needs particular attention.

[235] McCreadie, R. G. Diet, smoking and cardiovascular risk in people with schizophrenia: Descriptive study. BJP 2003, 183:534-539.
[236] NHS Information Centre. Available at: www.ic.nhs.uk accessed 12/12/2011.

An increase in dementia of 68% is forecast in York and North Yorkshire between 2008 and 2025[237]. Half of all cases of dementia have a vascular component that can be significantly reduced by improving diet and lifestyle in earlier life[238].

It is estimated that dementia will affect an additional 700 people in York within the next 15 years and that if current service provision continues at same level this means that an additional 105 people could require services.

Table 1 shows the projected number of people in York aged 65 and over predicted to have dementia by 2030.

Dementia – All People	2009	2015	2020	2025	2030
People aged 65-69 predicted to have dementia	105	138	123	132	149
People aged 70-74 predicted to have dementia	212	224	284	257	276
People aged 75-79 predicted to have dementia	382	417	433	561	508
People aged 80-84 predicted to have dementia	603	647	714	761	986
People aged 85 and over predicted to have dementia	1002	1282	1481	1750	2045
Total people 65 and over predicted to have dementia	2304	2708	3035	3461	3964

Table 1: Projections of the number of individuals with dementia over the period 2009-2030
Source: Institute of Public Care 2008[239]

The prevalence of dementia recorded by GPs can be identified from Quality and Outcomes Framework data and is 0.4%, compared to 0.5% for England. However, this may not represent the total prevalence of dementia due to families and carers coping without needing to access

[237] Independent Review of Health Services in North Yorkshire and York August 2011
[238] Healthy Lives, Healthy People, Department of health, 2010
[239] Implementing the National Dementia Strategy in York: York Mental Health Partnership and Modernisation Board, 2011

services. There appears to be no discernible gradient in the recorded prevalence of dementia across the deprivation quintiles.

Given the population projections, and the increased incidence of dementia with increasing age, planning for potential need would be an appropriate strategy.

Mild-moderate mental health problems

Identifying evidence for mild-moderate mental health problems has been more challenging as individuals rarely attend health appointments stating that they are depressed. Modelled estimates for mild to moderate mental illness that take into consideration risk factors including deprivation, housing and benefits suggests that the prevalence of these conditions in York would be predicted to be above the England average. Quality and Outcomes Framework data suggests that the diagnosed prevalence of depression in York residents (12.7%) is significantly higher than the England prevalence of 11.2%[240]. However this may underestimate the true prevalence of mild to moderate mental illness as individuals may not always access support and services. One in four older people in the UK have symptoms of depression requiring professional intervention[241]. There does not appear to be a discernible gradient across the deprivation quintiles in York, illustrated in Fig. 22.

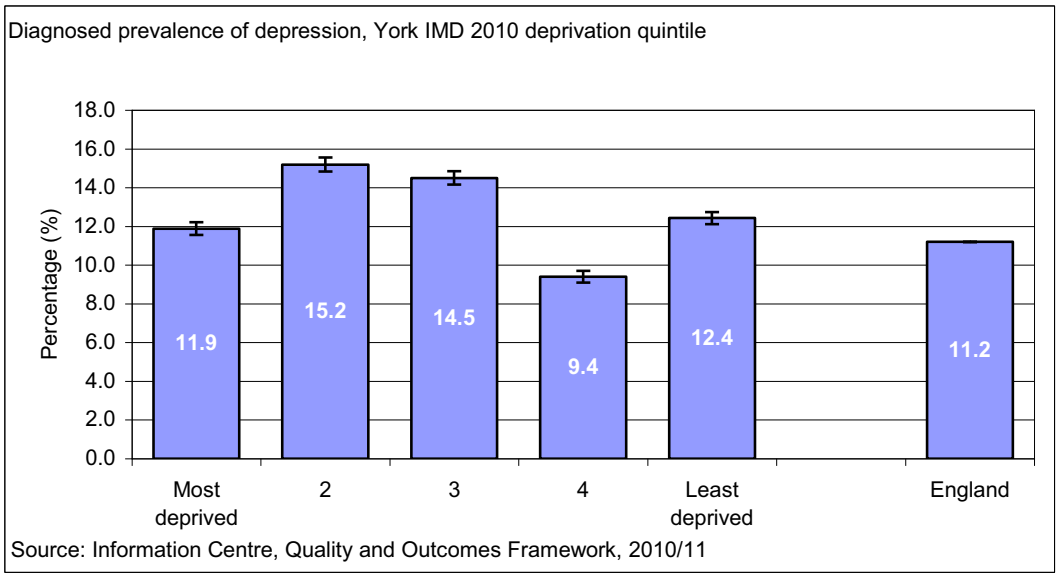


Figure 22: Diagnosed prevalence of depression by deprivation quintile in York

[240] Information Centre, Quality and Outcomes Framework. Available at: http://www.ic.nhs.uk/statistics-and-data-collections/audits-and-performance/the-quality-and-outcomes-framework accessed 11/01/2012
[241] Healthy Lives, Healthy People, Department of health, 2010

The prescribing of antidepressant medication has risen steadily over the period 2007-11 for England and also for the Vale of York Clinical Commissioning Group. However, the prescribing data for the Vale of York Clinical Commissioning Group was consistently below the rate for England for the whole of the period[242]. Using the prescribing of these drugs as a proxy for the number of cases of depression in the population, it could be inferred that there has been a steady rise in the number of individuals suffering with the condition. However, this is not a robust assumption as prescribing decisions are often complex and related to other issues. In addition, the rise may represent a greater awareness of the condition, improvements in access to services or diagnostic tools or a case-finding strategy.

Loneliness

Estimates suggest that around 1 in 10 older people experience chronic loneliness, with people living in deprived areas experiencing much higher rates[243]. The Joseph Rowntree Foundation highlights that loneliness can affect people at any time, and for some it can become an overwhelming problem. There has been a recent surge of interest in loneliness, due in part to the link being made between feeling lonely and physical and mental health. Adverse affects on health can include increasing self destructive habits (such as over eating, greater alcohol consumption, smoking), increased exposure to stress and an increased likelihood of people withdrawing and not seeking emotional support. Loneliness affects the immune and cardiovascular systems and can result in sleeping difficulties which in turn have negative effects on metabolic, neural and hormonal regulations.

Loneliness can also severely affect people's mental health. It can be a factor in depression and is a factor in suicide. In addition, the paper refers to evidence that suggests the risk of late-life alzheimer's disease more than doubles in lonely compared to non-lonely people, and is associated with a more rapid cognitive decline.

Loneliness and isolation were cited as concerns by respondents to the York Older People's Assembly. Many social activities require mobility of one kind or another and can be inaccessible to many, whether disabled or not. Some respondents to the assembly also suggested that the use

[242] Ad-hoc analysis of prescribing data provided by NHS North Yorkshire and York, SSRI prescribing (ADQ/STAR PU) April 2007- September 2011.
[243] Ad-hoc analysis of prescribing data provided by NHS North Yorkshire and York, SSRI prescribing (ADQ/STAR PU) April 2007- September 2011.

of computers and electronic communication can provide restricted social involvement. [244] York Age UK suggest that in addition to providing nutritious food, 'meals on wheels' services are vital in terms of tackling social isolation and monitoring health and welfare[245].

Children and young people's mental health

Lime Trees, the child and adolescent mental health service (CAMHS) has identified the following needs: to improve awareness of (and access to) mental health services in schools; to continue with efforts to counter stigma in mental health; and to ensure privacy when young people contact services. Work is also needed to ensure that the transition from CAMHS to adult services is made as trouble free as possible.

Within school settings it is estimated that 10% of 5 to 15 year olds have a diagnosable mental health disorder[246] and that this figure has remained stable during the last few years. It is estimated that 40% of children and young people with mental health problems do not receive any specialist services[247]. In terms of responding to the mental health needs of children, a wide range of local practitioners confirm the value of investing in psychological therapies, such as cognitive behavioural therapies and in building capacity within schools to identify mental health needs and deliver good quality interventions. This has been the rationale for introducing a comprehensive training course for Teaching Assistants called ELSA (Emotional Literacy Support Assistants) to support children with emotional - mental heath needs.

Community based mental health workers act as the primary referral source for children and young people with possible mental ill health in the Vale of York Clinical Commissioning Group area. This team receives referrals from a variety of sources including but not limited to schools, Health Visitors, GPs and Paediatricians. There have been inaccuracies in the recording of referrals to this team in the past, however these have now been rectified. The most recent data suggests that the team received 61 referrals in the month of January 2012, the majority of which were received from GP surgeries.

The specialist child and adolescent mental health service (CAMHS) in York received over 1,000 referrals for 2011. These are likely to be

[244] York Older People's Assembly Questionnaire, Autumn 2010 (100 respondents aged 50+)
[245] York AGE UK report for York's JSNA 2011-12
[246] No Health Without Mental Health, Department of Health, 2011
[247] The NHS Framework Standard 9: The Mental Health and Psychological Well-being of Children and Young People, DCSF/DH, 2004

individuals who have been seen by community based mental health workers but require more a more specialist service.

Although the majority of children with mental health problems are treated in community services, a comprehensive child and adolescent mental health service (CAMHS) needs access to highly specialised provision including in-patient facilities[248]. In York, this inpatient service is provided by Lime Trees which accepts admissions from other areas in addition to York. In 2011, Lime Trees admitted 48 young people for in-patient treatment, 23 of whom were from the York and Selby area.

Suicide and deaths due to undetermined injury

Mortality due to suicide and undetermined injury is not a good proxy for the burden of mental health problems, but is included for completeness. Due to the fortunately small numbers rates vary considerably in York. Female rates were below the England rate in 2007 to 2009, and male rates were above for the same period. However, neither of these values were significantly different to the England rates.

Health Protection Activities Screening

Screening is the process of identifying and testing individuals who are at high risk of developing a disease, or have the early stages of a disease but have no symptoms. The aim is to intervene early and improve the longer-term outcomes for individuals and communities. Screening programmes running in North Yorkshire and York are both cancer and non-cancer screening programmes. The cancer screening programmes commissioned by NHS North Yorkshire and York achieve universally high Quality Assurance performance monitoring.

Non-cancer screening

Antenatal screening

All pregnant women should be offered information to help them decide whether or not they wish to participate in the antenatal screening programme. The tests included in the programme include a screening

[248] Gowers S G and Cotgrove A J. The future of in-patient child and adolescent mental health services. BJP 2003, 183:479-480.

test for Down's syndrome that meets agreed national standard and an ultrasound scan between 18 weeks and 20 weeks and 6 days gestation to check for physical abnormalities in the unborn baby.

Newborn screening

All parents of newborns should receive information about the newborn screening programme. The programme includes a bloodspot test (also known as a heel prick) for several genetic disorders, congenital hypothyroidism and sickle cell disease. This test is taken between five and eight days after birth[249]. In addition, all parents of newborn children should be offered a hearing screen for their child within 2 weeks of birth.

Abdominal Aortic Aneurysm screening

An abdominal aortic aneurysm is a swelling of the large blood vessel at the back of the stomach. This swelling can cause the wall of the blood vessel to become stretched an in some cases the swelling can burst requiring emergency surgery and in some cases leading to death. This condition is more common in men and if identified early enough surgery can be performed to reduce the risk of rupture.

The programme will invite all men for screening during the year they turn 65, although men aged over 65 years will be able to self-refer for screening. Men who have an aneurysm detected through screening will be offered treatment or monitoring depending on the size of the aneurysm. The programme has not yet been fully implemented across North Yorkshire and York, but will be completed by March 2013.

[249] UK Newborn Screening Programme Centre. http://newbornbloodspot.screening.nhs.uk/professionals

Cancer screening

Breast screening

The plot in Fig. 23 illustrates the trend in uptake of breast screening by eligible women aged 50-70 years within the PCT and in England. The plot shows that NHS North Yorkshire and York have consistently screened a greater proportion of the eligible population than the England rate. However the general trend appears to be downwards with fewer screened in 2009-10 than in 2002-03, although the trend for England is similar[250].

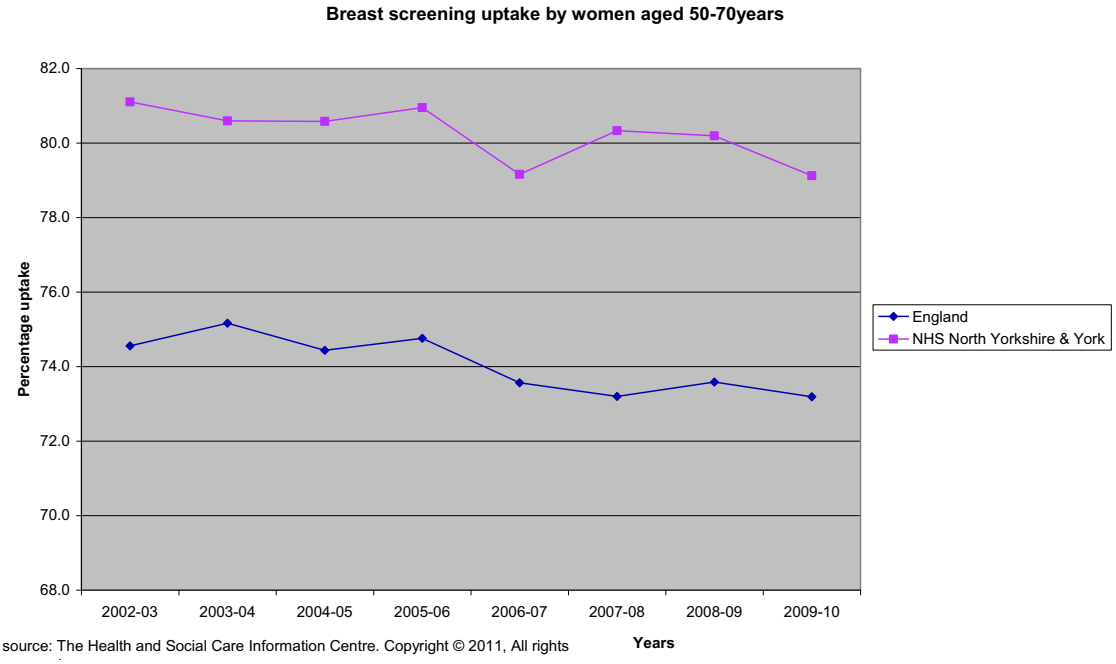


Figure 23: Breast screening uptake by women aged 50-70 years in NHS North Yorkshire and York

The incidence of breast cancer in York for 2007-09 was not significantly different to the England rate at 120 breast cancers per 100,000 of the population aged under 75 years[251]. Similarly the death rate associated with breast cancer in York for 2008-10 was not significantly different to the England rate at 17 deaths per 100,000 of the population aged under 75 years[252]. In spite of these rates being similar to the England rate, the downward trend in the uptake of breast screening should be a cause for caution.

[250] NHS Information Centre. Available at http://www.ic.nhs.uk/cmsincludes/_process_document.asp?sPublicationID=1298286145290&sDocID=6647 accessed on 27/02/2012
[251] NHS Information Centre. Available at https://indicators.ic.nhs.uk/download/NCHOD/Data/16A_033DR0074_09_V1_D.xls accessed on 07/03/2012
[252] NHS Information Centre. Available at https://indicators.ic.nhs.uk/download/NCHOD/Data/16B_034DR0074_10_V1_D.xls accessed on 07/03/2012

Cervical Screening

25-49 years

For the period 2010-11, 77.4% of the eligible population in NHS North Yorkshire and York were screened, which was significantly higher than the England rate for the same period (73.7%). The NHS North Yorkshire and York result for 2010-11 was significantly lower than the 2009-10 result of 78%[253]. However, prior to 2009-10 the coverage had been steadily rising from 76.3% in 2007-08. The increase over the period 2007-08 to 2009-10 may represent the effect on screening uptake of high profile cases of cervical cancer in addition to awareness raising within the NHS.

50-64 years

A significantly higher proportion of eligible women in NHS North Yorkshire and York compared to England in the 50-64 years age group underwent screening in 2009-10 (80.5% vs. 78.9%) and in 2010-11 (78.9% vs. 78.0%). However, the trend appears to be downward with a significantly smaller proportion of women undertaking screening in 2010-11 compared to the coverage for the years since 2007-08 of 83.5%. This follows the England trend but uptake in York is significantly higher[254].

The incidence of cervical cancers in York for the period 2007-09 was significantly lower than the England rate for the same period at 5.44 cervical cancers per 100,000 of the population aged under 75 years[255]. However, the death rate for cervical cancer for 2008-10 was not significantly different to the England rate for the same period at 1.7 deaths per 100,000 women aged under 75 years[256]. Whilst the death rate for cervical cancer was not significantly different to the England rate, the downward trends in cervical screening uptake may be a cause for caution.

[253] NHS Information Centre. Available at http://www.ic.nhs.uk/cmsincludes/_process_document.asp?sPublicationID=1322038333522&sDocID=7190 accessed 27/02/2012
[254] NHS Information Centre. Available at http://www.ic.nhs.uk/cmsincludes/_process_document.asp?sPublicationID=1322038333522&sDocID=7190 accessed 27/02/2012
[255] NHS Information Centre. Available at https://indicators.ic.nhs.uk/download/NCHOD/Data/17A_039DR0074_09_V1_D.xls accessed on 07/03/2012
[256] NHS Information Centre. Available at https://indicators.ic.nhs.uk/download/NCHOD/Data/17B_040DR0074_10_V1_D.xls accessed on 07/03/2012

Bowel Cancer Screening

Colorectal cancers are the third most common cancers in the UK after breast and lung and in the region of 100 new cases of colorectal cancer are diagnosed each day. Almost three-quarters of colorectal cancer cases occur in people aged 65 and over[257] and given the projected population changes for the City of York this is likely to have an impact on future planning. The NHS bowel cancer screening programme is being implemented locally and offers screening every two years to all men and women aged 60 to 69 years. Local data on the performance of the screening programme is not currently available, but it is envisaged that it will inform future iterations of the JSNA.

The incidence rate for the rolling period 2007-09 was 32 new colorectal cancers per 100,000 of the population. This was not significantly different to the rate for the period 2006-08, nor was it significantly different to the England rate for the same period[258]. The death rate attributed to colorectal cancer of 10 deaths per 100,000 of the population for the period 2008-10 was also not significantly different to the England rate for the same period. However, the incidence rate presented here relates to clinically apparent cancers in the majority of cases. When the results of the first cycle of the bowel screening programme are available it would be expected that the incidence rate would rise.

[257] Colorectal cancer: the diagnosis and management of colorectal cancer. NICE November 2011
[258] NHS Information Centre. Available at https://indicators.ic.nhs.uk/download/NCHOD/Data/13A_046DR0074_09_V1_D.xls accessed on 6th March 2012

Vaccinations

The national immunisation programme aims to improve the control of infectious diseases through vaccination[259]. The aim is usually to achieve a vaccine coverage of 95% to make sure communities benefit from 'herd immunity', where the indirect protection from infection of susceptible members of the population, and the protection of the population as a whole is brought about by the presence of immune individuals[260].

Childhood Vaccinations

For the period 2009-10 the childhood vaccine coverage for York practices in 1 year-olds has dropped from 96% to 95%, however this is still above the recommended level to afford herd immunity. The measles mumps and rubella (MMR) coverage for 2 year-olds for the same period has remained stable at 91%[261]. The Health Protection Agency produced a regional report and noted that 85% of children had received two doses of MMR by the age of five years in Yorkshire and The Humber in 2009-10[262].

The coverage of childhood vaccines for children at 5 years-old in York practices was 85% for 2009-10. This is not comparable to previous figures as it relates to the full rather than primary course.

Seasonal Influenza Vaccination

The annual seasonal influenza vaccination is offered to targeted groups within the population, including those with specific long-term conditions and those over the age of 65 years.

In 2008-09, the influenza vaccination rate in people over the age of 65 years in York was 79%, which compared well with the PCT rate of 76% and the England rate of 74%[263].

[259] Salisbury, D, Ramsay, M, Noakes, K Eds. Immunisation against infectious disease. Department of Health, 2006 (Updated 2011). Available at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131000.pdf accessed 11/01/2012

[260] Health Protection Agency. Available at: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1279889319696 accessed 11/01/2012

[261] NHS North Yorkshire and York. COVER data.

[262] Coole L, Wensley A, *Measles, Mumps and Rubella Annual Report 2010*. Health Protection Agency Yorkshire and the Humber, October 2011

[263] Health Protection Agency. ImmForm.

During the 2010-11 vaccination period, the uptake rate for York was 74.0% compared to the England rate of 72.8%. This seems to be a small drop in the uptake of the seasonal influenza vaccine, which will need monitoring in the future.

Sexual Health

The Yorkshire and Humber regional office of the Health Protection Agency produced a sexual health needs assessment for the region in 2010[264]. The needs assessment identified that young people, BME communities, and men who have sex with men are key target groups for any work on sexually transmitted infection prevention.

Chlamydia

Currently, an accurate estimate of the population prevalence of chlamydia is unavailable and the degree to which the prevalence of chlamydia varies between areas is unknown. The National Chlamydia Screening Programme (NCSP) commenced in 2003 with the objective of controlling chlamydia through the early detection and treatment of asymptomatic infection. The programme targets young people in the 15-24 years age group. Over the period 2009-10 the proportion of young people screened has risen from 16.2% to 27.7% of the population aged 15-24 years, which was significantly lower than the England averages of 25.9% and 32.6% for the same period[265]. However, the focus of the programme has shifted to considering both the proportion screened and the proportion of those screened that tested positive.

The annual diagnosis rate of chlamydial infection has increased between 2009 and 2010 from 1611 to 1900 per 100,000 young people aged 15-24 years[266]. The aim of the NCSP is to raise the annual diagnosis rate to between 2,400 and 3,000 per 100,000 young people, which should reduce the overall prevalence. Therefore, this increase in the annual diagnosis rate should be seen as a positive indicator.

[264] Yorkshire and Humber Health Protection Agency. Yorkshire and the Humber sexual health needs assessment 2010
[265] National Chlamydia Screening Programme. Available at: http://www.chlamydiascreening.nhs.uk/ps/data/data_tables.html accessed 09/01/2012
[266] HPA Sexual Health profiles. Accessed at: http://profiles.hpa.org.uk/IAS/dataviews/report/fullpage?viewId=40&reportId=38&indicator=i357&date=2010 on 26th January 2012.

Other sexually transmitted infections

The prevalence of gonorrhoea in York has risen from 3 to 5 per 100,000 from 2009 to 2010, but this rise is not significant[267]. Similarly, the prevalence of syphilis in York is stable at 3 cases per 100,000 population[268]. However, there has been a significant rise in the prevalence of genital warts in York between 2009 and 2010, from 110 to 141 per 100,000 of the population[269].

HIV/AIDS

HIV has the potential to affect all of society, and early diagnosis of HIV infection will be one of the national Public Health outcome indicators for 2013-16. HIV testing is predominantly offered through genitourinary medicine (GUM) clinics and a HIV prevention service. In 2010, 64% of women who attended GUM clinics in York accepted the offer of a HIV test, with 68% of heterosexual men and 94% of men who have sex with men taking up the offer of HIV testing[270]. Regional data suggests that new diagnoses of HIV remain relatively low and that 48% of new cases were in the black African community, with the infection being acquired heterosexually. In spite of this, 25% of new cases were in men who have sex with men. In 2008, 35% of those diagnosed in the region presented as late diagnoses[271], in York this was more than 50% of new diagnoses for the period 2008-10 and therefore more works needs to be done to diagnose HIV infections earlier.

Over the period 2002 to 2010 there has been a significant rise in the prevalence of HIV in York[272]. This is in line with national trends. Improvements in the management of HIV have dramatically improved peoples chances of survival and therefore the number of individuals with HIV/AIDS has increased. Currently there are 133 patients accessing treatment and care from the York service.

[267] HPA Sexual Health profiles. Accessed at: http://profiles.hpa.org.uk/IAS/dataviews/report/fullpage?viewId=40&reportId=38&indicator=i357&date=2010 on 26th January 2012.
[268] Ibid.
[269] Ibid.
[270] ibid.
[271] Defined as an individual with HIV and a CD4 count of less than 350cells/mm^3
[272] HPA Sexual Health profiles. Accessed at: http://profiles.hpa.org.uk/IAS/dataviews/report/fullpage?viewId=40&reportId=38&indicator=i357&date=2010 on 26th January 2012.

Annex 1

Membership of York's Shadow Health and Wellbeing Board

Cllr. Tracey Simpson-Laing, Deputy Leader of City of York Council (CYC)

Cllr. Janet Looker, Cabinet Member for Education, Children and Young People's Services, City of York Council

Cllr. Sian Wiseman, City of York Council

Kersten England, Chief Executive of City of York Council

Pete Dwyer, Director Adults, Children & Education, City of York Council

Jayne Brown, Chief Executive of NHS York and North Yorkshire PCT

Dr. Mark Hayes, Chair of Vale of York Commissioning Consortium

Rachel Potts, York Locality Director, NHS North Yorkshire and York PCT

Rachel Johns, Associate Director of Public Health and Locality Director for York, NHS North Yorkshire and York PCT

Jane Perger, York Local Involvement Network (LINk) Representative

Patrick Crowley, Chief Executive of York Hospital

Chris Butler, Chief Executive of Leeds and York Mental health Trust

Mike Padgham, Chair Independent Care Group

Angela Harrison, Chief Executive of York Council for Voluntary Services

Please Note: Membership details correct as of April 2012

Health Overview & Scrutiny Committee Work Plan 2011/2012

Meeting Date	Work Programme
8th May 2012	1. Briefing/presentation on NHS 111 Service 2. Health Watch Procurement Monitoring Report 3. Public Health – Changing Responsibilities for the Local Authority 4. Report on Joint Strategic Needs Assessment 5. Work Plan

Items to add to the 2012/2013 Work Plan

Date TBC:

Update report on the recently established urgent care centre at York Hospital

Changing Role of the Health Overview & Scrutiny Committee (Autumn)

June 2012

Update on Quality Indicators (Carer's Review)

Update from Yorkshire Ambulance Service on Complaints Received

Safeguarding Assurance report

'Review of Services for Homeless Patients at Monkgate Health Centre' (to be presented by: Medical Director & Director of Primary Care)

July 2012

Update Report – Establishing York's Health & Wellbeing Board

September 2012

Update on the implementation of outstanding recommendations arising from the Carer's Scrutiny Review

Progress Report on the Major Trauma Network

Update on changes to the Urgent Care Unit at York Hospital

December 2012

Update on the Carer's Strategy