

Hull tPCT & Hull City Council

# Summary Joint Strategic Needs Assessment

October 2008

# Table of contents

<b>Table of contents.....</b>	<b>2</b>
<b>Table of figures.....</b>	<b>4</b>
<b>List of Acronyms .....</b>	<b>5</b>
<b>1 Approach to Joint Strategic Needs Assessment.....</b>	<b>6</b>
1.1 What is a Joint Strategic Needs Assessment (JSNA)....	6
<b>2 Key trends and priorities.....</b>	<b>11</b>
2.1 General.....	11
2.2 Specific trends and priorities .....	12
2.3 JSNA Priorities Scorecard.....	21
2.4 Short and Long Term Priorities .....	28
2.5 Knowledge Development .....	31
2.6 Developing Commissioning.....	34
2.7 Outcomes and Reducing Inequalities.....	35
2.8 Developing Community Engagement and Empowerment .....	37
2.9 JSNA findings by population group .....	40
2.10 Key Recommendations.....	46
<b>3 Demography.....</b>	<b>49</b>
3.1 Analysis of JSNA core dataset.....	49
3.2 Priorities identified by Hull’s health and social care assessments and strategies.....	51
3.3 Developing Knowledge .....	51
<b>4 Social and Environmental Context.....</b>	<b>52</b>
4.1 Analysis of core dataset.....	52
4.2 Priorities identified by Hull’s health and social care assessments and strategies.....	54
4.3 Current interventions deployed by Hull CC and PCT to meet key objectives .....	59
4.4 Developing Commissioning.....	62
4.5 Developing Knowledge .....	62
<b>5 Lifestyle and Risk Factors .....</b>	<b>63</b>
5.1 Analysis of JSNA core dataset.....	63
5.2 Priorities identified by Hull’s health and social care assessments and strategies.....	65
5.3 Current interventions commissioned by Hull CC and PCT to meet key objectives .....	66
5.4 Developing Commissioning.....	72
5.5 Developing Knowledge .....	75
<b>6 Ill health and disability .....</b>	<b>76</b>
6.1 Analysis of JSNA core dataset.....	76
6.2 Priorities identified by Hull’s health and social care strategies .....	79

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6.3	Current interventions deployed by Hull CC and PCT to meet key objectives .....	81
6.4	Developing Commissioning.....	82
<b>7</b>	<b>Services.....</b>	<b>84</b>
7.1	Analysis of JSNA core dataset.....	84
7.2	Priorities identified by Hull’s health and social care strategies .....	86
7.3	Current provision .....	87
7.4	Developing Commissioning.....	90
7.5	Developing Knowledge .....	91
<b>8</b>	<b>Conclusion.....</b>	<b>92</b>

## Table of figures

Figure 1 Role of the JSNA .....	7
Figure 2 JSNA as part of the Strategic Commissioning Process .....	8
Figure 3 The JSNA process.....	9
Figure 4 Partnerships in Hull .....	10
Figure 5 Factors influencing outcomes .....	12
Figure 6 JSNA Priorities Scorecard Key .....	21
Figure 7 JSNA Priorities Scorecard .....	22
Figure 8 Focus against time taken for results to reach population.....	29
Figure 9 Transformation Matrix.....	30
Figure 10 Ensuring sustainable impact.....	36
Figure 11 Hull's Social Marketing Approach .....	38
Figure 12 An Open Source Approach to developing the JSNA.....	39
Figure 13 Pathways from community participation, empowerment and control to health & well-being improvement .....	40
Figure 14 Local Government National Indicators mapped against PCT Vital Signs and improvement targets selected for Hull's LAA (highlighted in yellow).....	55
Figure 15 National Indicators relating to 'Social and Environmental context' selected for JSNA dataset by Hull CC (Hull's LAA priority NIs are highlighted in yellow).....	58
Figure 16 List of National Indicators relating to 'Lifestyle/ Risk factors' selected for JSNA scrutiny by Hull CC (Hull's LAA priority NIs are highlighted in yellow) .....	65
Figure 17 List of National Indicators relating to 'Burden of ill health and disability' selected for JSNA scrutiny by Hull CC (Hull's LAA priority NIs are highlighted in yellow).....	80
Figure 18 List of National Indicators relating to 'Services' delivered in Hull selected for JSNA scrutiny by Hull CC.....	86

## List of Acronyms

Acronym	Definition
BME	Black Minority Ethnic
BMI	Body Mass Index
CAF	Common Assessment Framework
CC	City Council
CHD	Coronary Heart Disease
COPD	Chronic Obstructive Pulmonary Disorder
CSR	Comprehensive Spending Review
DSR	Directly Age-Standardised Ratios
GUM	Genito-Urinary Medicine
IMD	Index of Multiple Deprivation
JSNA	Joint Strategic Needs Assessment
LAA	Local Area Agreement
LLSOAs	Lower Layer Super Output Areas
NDTMS	National Drug Treatment Monitoring Service
NI	National Indicator
NIs	National Indicators
NIS	National Indicator Set
NRF	Neighbourhood Renewal Fund
ONS	Office for National Statistics
PCT	Primary Care Trust
PRUs	Pupil Referral Units
RAP	Referrals, Admissions and Packages of Care
SHA	Strategic Health Authority
SMR	Standardised Mortality Ratio
SMRs	Standardised Mortality Ratios
tPCT	Teaching Primary Care Trust
YHPHO	Yorkshire & Humber Public Health Observatory

# 1 Approach to Joint Strategic Needs Assessment

## 1.1 What is a Joint Strategic Needs Assessment (JSNA)

The JSNA process is a joint duty on Hull City Council and Hull PCT under the Local Government and Public Involvement Health Act.

It is:

*“a process which will identify the current and future wellbeing needs of a local population, informing the priorities and targets set by Local Area Agreements and leading to agreed commissioning priorities that will **improve outcomes and reduce health inequalities**”*

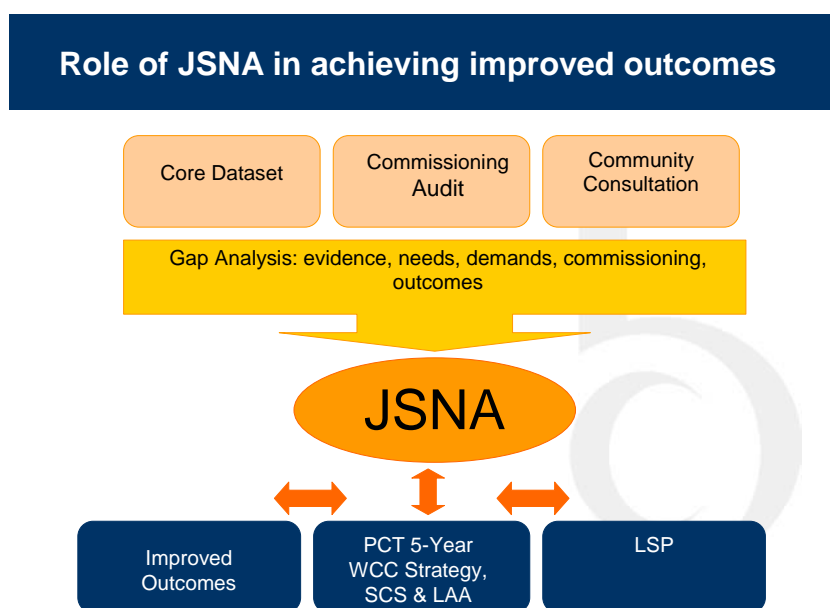
Department of Health, December 2007

The JSNA process is about:

- Understanding the current and future health and well-being needs of the local population over both the short-term (three to five years) to inform Local Area Agreements (LAAs) and the longer-term (five to ten years) to inform strategic planning.
- Commissioning services and interventions that will achieve better health and well-being outcomes and reduce inequalities. In particular, the guidance states that JSNA will address the outcomes contained in the National Indicator Set for local government and the Vital Signs for PCTs.

Figure 1 illustrates the role of JSNA in relation to influencing the LAA and World Class Commissioning in achieving improved outcomes.

Figure 1 Role of the JSNA



### Policy Context

Both the NHS and Social Care are undergoing significant changes both from a commissioning and provider perspective. Some of these changes are listed below:

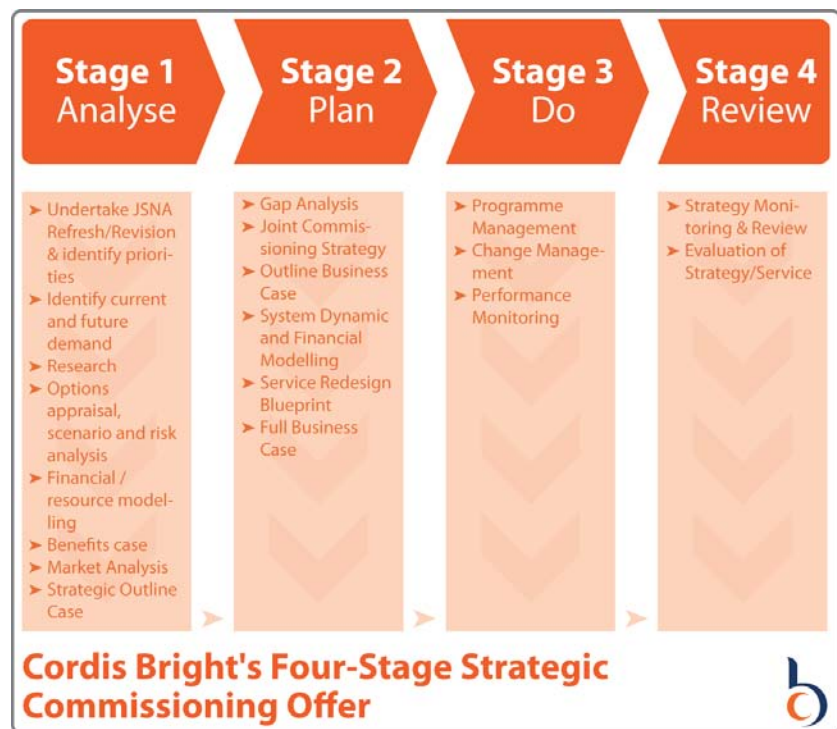
- Personalisation of services
- Enablement and self directed support
- Individual Budgets
- Practice-based commissioning
- Competition amongst service providers
- A growing market
- Greater emphasis upon the quality of services
- Greater accountability for effective commissioning
- Development of out of hospital care
- Integrated working
- Expectation that PCTs become world class commissioners
- Commissioning for outcomes
- Commissioning across pathways of care
- Programme budgeting
- Greater emphasis on value for money

JSNA does not cover the whole commissioning process nor is it the plan to deliver changes in service delivery. It is the information and evidence to support other parts of the commissioning process, for instance, World Class Commissioning as well as feeding into the development of the

Sustainable Community Strategy and locally agreed improvement targets in new Local Area Agreements.

We view commissioning as a four stage process: Analyse – Plan – Do – Review, with JSNA forming a key part of the Analyse Stage as illustrated in Figure 2 below.

Figure 2 JSNA as part of the Strategic Commissioning Process



Preparing the JSNA has involved producing the following key outputs:

#### JSNA Core Dataset

This data-set presents a comprehensive array of secondary data from Hull tPCT and Hull City Council. For the first time this data is presented in one place allowing more holistic analysis to be conducted. This approach should feed into more robust evidence-led decision-making and commissioning.

#### Summary JSNA

This summary JSNA provides an objective and independent view of Hull. It is based on:

- Analysis of data provided by Hull tPCT and Hull City Council (i.e. the core data-set)
- Analysis of strategies and plans provided by Hull tPCT and Hull City Council



- Recommendations concerning future areas of development around:
  - JSNA going forward
  - Commissioning
  - Addressing knowledge and data gaps
  - Priorities for Hull going forward

### Stakeholder event

We have conducted a stakeholder event on 25<sup>th</sup> September 2008 with 38 key Stakeholders from across Hull whose input has been fed back into this JSNA. Some of the key points raised at the stakeholder event included prioritising mental health, support for informal carers and linking the JSNA to strategies on crime and disorder.

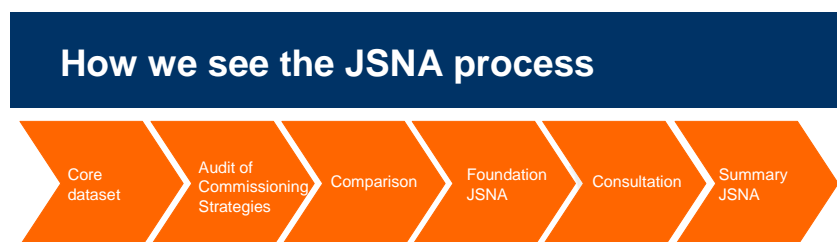
### Public consultation

We have conducted a consultation via an online questionnaire at <http://www.jsnaonline.org/> which has allowed the public to feed into the JSNA process which was concluded on 24<sup>th</sup> October 2008. Feedback from this process included that future JSNA refreshes would benefit from including evidence and data from the criminal justice system.

The intention is that a final version of the JSNA will be published by 31<sup>st</sup> October 2008.

A summary of our approach is illustrated in Figure 3 below:

Figure 3 The JSNA process



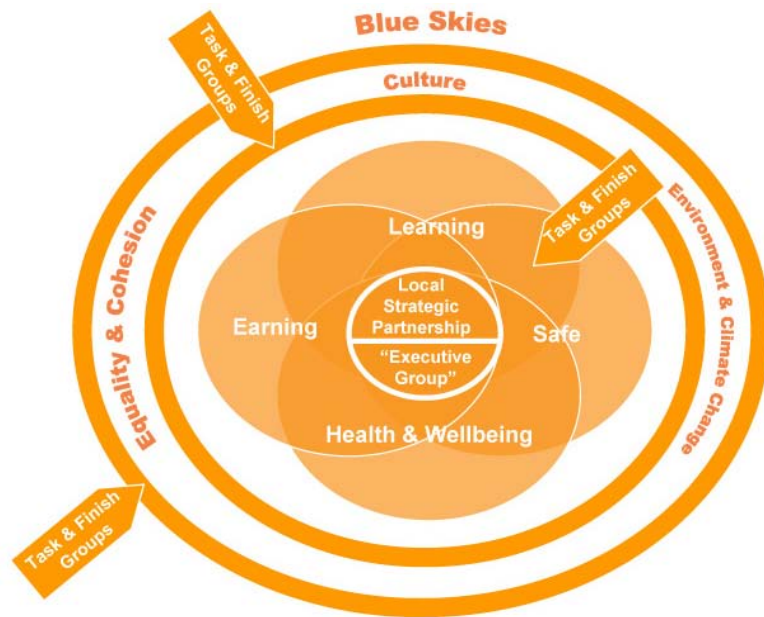
#### Six Stage Process undertaken in sequence

- Core Dataset
- Audit of Commissioning Strategies
- Comparison of evidence and current commissioning strategies
- Produce “Foundation JSNA” and publish Draft Summary JSNA
- Consultation events with key stakeholders
  - From Local Authority, PCT and key partners
  - Public, community groups
- Produce Summary JSNA
  - Including data gaps
  - Inequalities
  - Commissioning gaps
  - Priorities going forward (taking account of the LAA, World Class Commissioning etc.) to achieve **improved health & well-being outcomes**

## Governance

Developing Hull's JSNA has been overseen by a JSNA Working Group which contained representatives from Hull tPCT and Hull City Council which reports into the Hull Local Strategic Partnership (One Hull) Health and Well-being Group as illustrated in Figure 4 below.

Figure 4 Partnerships in Hull



The Director of Public Health Report for 2007 identifies that a systematic approach is necessary in order to make a difference to health outcomes in Hull.

The report identifies the need to:

- Target the right people.
- Change risky behaviour.
- Take individual and collective responsibility for change.
- Support individuals and communities to effect change.

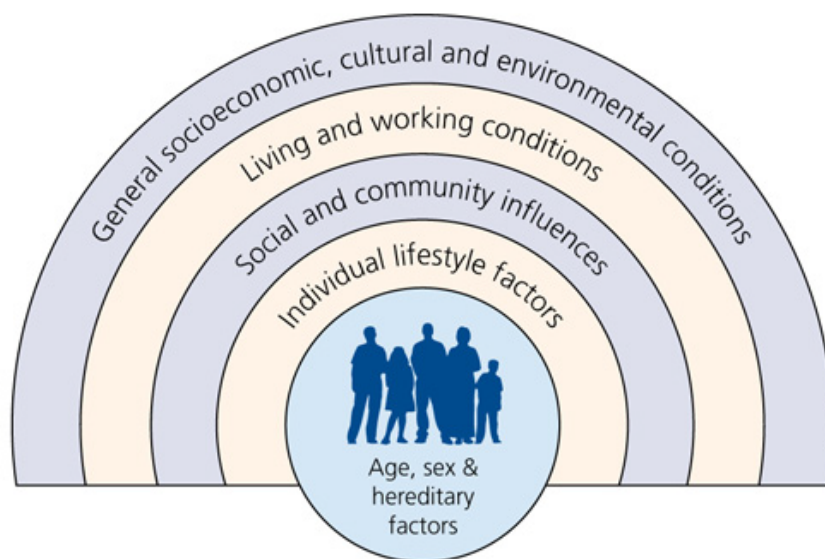
This JSNA intends to maintain this systematic approach by bringing data from Health and the Council together and to give clear direction for organisational and joint commissioning to meet these objectives.

## 2 Key trends and priorities

### 2.1 General

- Hull is ranked the 11<sup>th</sup> most deprived area in England (out of 354 authorities in England) according to the Index of Multiple Deprivation (IMD) in 2007. It has improved 2 places from 9<sup>th</sup> position in the IMD (2004).
- More than half the people living in Hull live in areas which are defined as the most deprived 20% of areas nationally and a further quarter live in areas in the next most deprived quintile nationally. On a ward basis, 17 out of Hull's 23 wards are in the most deprived 20% of all wards in England.
- Compared to the average for England, Hull is characterised by: shorter life expectancy, a higher mortality rate, more early deaths from cancer and coronary heart disease (CHD), higher teenage pregnancy rates and worse rates of poor mental and physical health.
- Deprivation is also linked to poor lifestyle factors that impact on health and well-being such as higher rates of smoking, alcohol intake, substance misuse, poor diet and a lack of physical activity.
- In terms of socioeconomic and environmental factors, the population of Hull has worse housing, lower educational attainment, higher unemployment, lower incomes and a higher dependence on benefits compared to the national average.

Figure 5 Factors influencing outcomes



## 2.2 Specific trends and priorities

### 2.2.1 Life Expectancy, Causes of Death and Priority Local Health Needs

#### Life expectancy

Life expectancy in Hull is lower than the English average. Between 2004-2006, male life expectancy was 74.7 years compared with the national average of 77.3 years and female life expectancy was 79.0 years compared with the national average of 81.6 years of age. Premature deaths attributable to circulatory diseases, cancer and respiratory diseases account for much of the gap in life expectancy between Hull and the national average.

#### Early Death

- There were 4,029 deaths for under 75s in Hull between 2002-2005.
- In 2006 there were 752 deaths from all causes per 100,000 in Hull in comparison to 621 per 100,000 in Yorkshire and The Humber and 592 per 100,000 in England.

#### Infant Mortality

- Infant mortality rates for (all maternal ages) 2004-06 were 5.3 per 1,000 live births. This was lower than the

regional average (5.8 per 1,000) but slightly higher than the national average (5 per 1,000).

### Limiting Long-Term illness

- Hull has higher levels of ill health and disability than national averages with rates of limiting long-term illness 10-25% higher than England depending on the age group.

### Cancer

- For the period 2004-2006, there was a mortality rate of 147 per 100,000 population under 75 years in Hull from “All Cancers”. The most significant cause of death from cancer for both males and females was lung cancer (12% and 11% respectively).
- 1 in 3 people who die early in Hull die from cancer.
- Death rates for men are 28% higher and for women 23% higher than the UK as a whole. (Under 75s SMRs: men 128; women 123).
- However, the death rate from cancer has been decreasing faster in Hull than the rest of England. The gap between Hull and England is therefore reducing; however the cancer death rate has a long way to go before it approaches the national rate.
- Reducing the mortality rate from all cancers at ages under 75 is a Local Area Agreement commitment, as is reducing the mortality rate from all circulatory diseases at aged under 75.
- The Cancer Equity Audit identifies that more deprived groups have worse cancer survival rates than those who are better off. This is true even if we remove lung cancer (associated with smoking) from the analysis, suggesting a burden of illness and early death from cancers bearing most heavily on the most deprived.

## Circulatory Diseases – Heart Disease and Stroke

- For the period 2004-2006, the mortality rate from all circulatory disease was 114 per 100,000 population under 75 years.

### Coronary Heart Disease

- Coronary Heart Disease (CHD) is the largest single cause of death in Hull accounting for 1 in 6 deaths (all ages). CHD accounted for 21.1% of male deaths under the age of 75 years in the period 2002-2005 and 14.5% of female deaths in Hull for the same period.
- Early death rates from CHD are higher than the national average (under 75s standardised mortality rate (SMR): men 121; women 185, i.e. 21% and 85% higher than England) Although CHD mortality rates have been decreasing for several years primarily as a result of decreasing smoking rates, the under-75 CHD mortality rate is statistically significantly higher than for England.

### Stroke

- During 2002-2005 stroke accounted for 5.3% of male deaths and 7.4% of female deaths in Hull.
- Stroke is the third largest cause of death in Hull. In 2006, approximately 92 men and 153 women (10%) die following a stroke. 9% of fatal strokes occur in people who are under the age of 65.
- Hull has the second highest stroke standardised mortality rate (SMR) in England for women under 75.
- The under 75s standardised mortality for 2003-2005 was 132 for Hull men and 149 for Hull women.
- For men, the mortality rates fell in both Hull and England between 2003-2005 and 2004-2006, but more slowly in Hull so the SMR increased slightly to 138. For women, the mortality rates increased in Hull but fell for England so the SMR increased to 175.
- Men aged 35-64 years in Hull have a mortality rate comparable to other comparator areas, but men aged 65+ tend to have relatively high mortality rates compared to comparator areas.
- For women aged under 75 years, the mortality rates are considerably higher in Hull than all other comparator

areas with only one exception (Stoke on Trent has a slightly higher mortality rate for women aged 35-64 years). Therefore whilst UK men generally have the highest risk and mortality rates for stroke, women in Hull appear to be at an increased risk.

- Compared to 10 other similar local authorities, Hull has a lower recorded prevalence of stroke or transient ischemic attack (TIA) but worse outcomes in terms of emergency readmission and mortality.
- The recorded prevalence of stroke in Hull is lower than in each comparator area, which might reflect the high mortality rates for stroke that are seen in Hull (the 26<sup>th</sup> highest SMR in men, 2<sup>nd</sup> highest in women among PCTs in England); it may relate to lower incidence, as stroke is related to age and Hull has a relatively young population, or it may reflect differential recording of patients with stroke or TIA on GP registers.

### Chronic Obstructive Pulmonary Disease (COPD)

- Chronic Obstructive Pulmonary Disease (COPD) was the cause of 4% of male deaths and 5.6% of female deaths amongst Hull's under 75 population during 2002-05.
- The COPD mortality rate for men is 29% higher in Hull than England and 61% higher for women.
- It is highly probable that the prevalence of COPD in Hull is under-reported (1.72%) given the high smoking rates in Hull. This is likely to be due to under diagnosis in primary care.
- There is a direct relationship between deprivation and increased risk from COPD in Hull, largely caused by the high smoking prevalence.
- The forthcoming COPD Equity Audit and Program Budget Marginal Analysis work in Hull will give more information on the health deficit in this area.

### Diabetes

- GP registers suggest that 4.1% of Hull's population (aged 17+) have diabetes, compared to 5.1% in the UK as a whole. It is likely that the rate of undiagnosed diabetes is higher in Hull. Analysis using the YPHO Diabetes Model estimates that the true figure is 5.8%, which suggests that there are a number of people in Hull

who do not know that they have diabetes and therefore are unable to take steps to look after their health.

- The Hull and East Riding Diabetes Equity Audit suggests that Hull performs poorly relative to the more affluent East Riding of Yorkshire in relation to the prevalence of diabetes, with excess hospital admissions and mortality in the most deprived quintile. This is also associated with higher levels of obesity, smoking, lack of exercise and lower fruit and vegetable consumption.

### Mental Health

- It is estimated that around one in six people in Hull (47,000) are affected by a mental health problem at any one time.
- Nationally, only about 20% of people with severe mental health problems and around 50% of those with less serious problems are in paid employment, yet 80% want to work.
- There is a shortage of reliable local information on the prevalence of mental health problems in Hull with the exception of serious mental illness which is collected from GP registers.
- The Hull Mental Health Equity Audit found that there was a strong association between deprivation and the percentage of the working age population claiming these benefits for poor mental health and mental illness.

### Sexual Health

- The number of uncomplicated cases of Chlamydia in Hull fell slightly for both males and females between 2002 and 2003.
- Genital Chlamydia infection is the most common sexually transmitted infection (STI) diagnosed in clinics across the UK. In 2004, within England, rates in both males (208/100,000) and females (243/100,000) were highest in Yorkshire and Humber after London (279 and 282/100,000 respectively).
- The number (incidence) of uncomplicated cases of Gonorrhoea in Hull increased sharply between 2002 and 2003 from 61 to 113 for males and from 40 to 49 for females between 2002 and 2003. Outside London, diagnostic rates in males (58/100,000) and females (31/100,000) were highest in the Yorkshire and Humber region.



- Cases of HIV continue to increase in line with national trends.

### Substance Misuse

- Estimates suggest there are 3,700 problematic drug-users (15-65 years) in Hull. It is estimated that approximately 10% of drug misusers are under 19.
- Hull has the highest prevalence rate of problematic drug use within Yorkshire and Humber (95% opiate users). Research indicates that Hull has the highest injecting prevalence in the Yorkshire and Humber region.
- The current provision for people with drug misuse problems was significantly higher than national and regional levels at 2005 to meet this higher than average demand. The need for additional floating services and accommodation based services has been identified.

### Alcohol Consumption

- Hull had the highest rate of alcohol-harm related hospital admissions per 100,000 of its 14 comparator authorities in 2006/07 as well as 2005/06 and had the second highest rate in 2004/05. This rate fell slightly between 2005/06 and 2006/07.

### Smoking

- Smoking prevalence of 33.5% for men and 29.9% for women is higher when compared to England (27% and 25% respectively for men and women).
- There is a wide variation in smoking prevalence by ward within Hull, ranging from 19% to 50% in men and 13% to 61% in women, with a strong association between smoking prevalence and local deprivation. 47% of men and 45% of women in the most deprived quintile smoked compared with 24% of men and 19% of women in the least deprived quintile.
- In Hull, over the last five years, 1,800 people died of cancer before they were 75. One third of them died of lung cancer which is strongly linked to smoking. Smoking also increases the chances of dying early from heart problems, stroke and breathing problems.
- More than one quarter of Hull women who had babies in 2006-07 were smokers at the time of delivery; this is 28% higher than the Strategic Health Authority (SHA)

average and two thirds higher than the England average.

- Smoking during pregnancy is the biggest preventable cause of low birth weight; women who smoke are three times more likely to have a low birth weight baby. It is also related to a higher risk of miscarriage, ectopic pregnancy and complications of the placenta and a 40% increased risk of stillbirth. As highlighted above, smoking throughout pregnancy is linked to deprivation.

### Teenage Conceptions

- Teenage pregnancy rates in Hull are among the highest in England (71.5 under 18 conceptions per 1,000 female population aged 15-17 years in 2005 compared to 41.3 for England). However, while neither England or Hull are on track to meet the target of halving the under-18 conception rate by 2010, the reduction in Hull has been greater than for England so the relative position of Hull has improved slightly, from an under-18 conception rate 82% higher than England in 1998 to one that was 73% higher in 2005, a reduction in the relative gap in under-18 conception rate of around 10%.

### Obesity

- In 2007, 67% of men and 55.9% of women were overweight or obese (61.4% on average). These rates were lower than the English 2006 average of 63.7% (Men: 68.6%; Women: 58.8%) In terms of adult obesity in Hull levels have changed little between 2004 and 2007 (as measured by BMI).
- Local data shows a fall in obesity amongst Year R (reception class) girls with a rise amongst boys. There is currently a fall in obesity levels in year 6 children (both sexes).
- Overall, 49% of men and 33% of women were defined as overweight (compared to 43% and 32% for England) and 23% of men and 18% of women in Hull were defined as obese compared to 22% and 24% for England.
- Hull has more people eating a poorer diet when compared with England averages. 21% of men and 25% of women in Hull eat five or more portions daily of fruit and vegetables compared to 26% and 30% in England.

### People with Learning Disabilities

- The number of people with a learning disability known to services is predicted to increase from 1,072 to 1,099 between 2011 and 2021, whilst the 'true population' is predicted to rise from 5,047 to 5,259 in the same period. People with learning disabilities are living longer which will also impact on the capacity of (ageing) informal carer support and people with co-morbidities.

### People with Physical or Sensory Disabilities

- There were 2,165 clients aged 18-65 years receiving a service during the year 2007-2008 (1,071 clients received a community service between 2007-08).
- There were 1,418 clients aged 18-65 years receiving a community service at 31<sup>st</sup> March and 3,474 clients aged 65 years and over receiving a community service at 31<sup>st</sup> March in 2007-08.
- It has been estimated that 9.8m people in Britain are covered by the broad definition of disability in the Disability Discrimination Act. Scaling down to Hull's population this would give us around 41,000 disabled people in the city.
- In February 2005 there were 21,700 people claiming Disability Living Allowance or Attendance Allowance.
- There are currently 11,181 people with Blue Parking badges issued. This is one indicator of people with severe mobility problems<sup>1</sup>.

### Ageing Population

- Hull's population is ageing. In 2007, 14% of Hull's population was aged over 65 years. By 2027 it is estimated that the number of people aged 65 years will increase by over 10,000, constituting 17% of the population.
- The number of older people with health problems requiring high levels of support is also set to increase significantly which will place increase pressure on support from informal carers.

### Dementia

- The total population with dementia aged 65 years and over is predicted to increase by 26% between 2008 and 2025, from 2,512 individuals to 3,187<sup>2</sup>.

<sup>1</sup> Hull City Council

<sup>2</sup> POPPI figures provided by Kingston upon Hull, City of (2007)

### Primary and Community Health Services

- Hull is included in the lower quartile of PCTs in terms of defined adequacy in doctor : patient ratio proportions. In Hull there are 28 practices out of 55 where the average list size is in excess of 2,000 patients per whole-time equivalent GP. The national average size list is a little over 1,600 patients per whole-time equivalent GP.
- In Hull the average GP availability is just over 48 GPs per 100,000 population and in the East Locality this falls to just 46.

### Employment

- Hull had an employment rate of 66.7% in 2005/06, 7.1% below the Yorkshire & Humber average and 7.7% below the England average.
- Whilst employment has fallen across the UK, Hull's rate of employment has fallen faster than the UK average. At June 2008, 20.1% of the working age population were claiming benefits compared to 14.5% regionally and 13.9% nationally.

### Average Earnings

- The average gross weekly full-time earnings by workplace in Hull stood at £428.20 (£473 for men; £341 for women). This was more than the Yorkshire & Humber average (£422.30) but lower than the Great Britain average (£458.60) in 2007.
- In 2005, average full-time earnings (i.e. for those working 30 hours or more) were £479.40 for men and £368.70 for women. This shows that average full-time earnings have fallen between 2004-07.
- Out of 354 local authorities in England, 247 (70%) had a higher average rate of earnings for those working in the area. However, 345 English local authorities (97%) had higher average earnings than Hull for workers living in the area.

### Decent Council Homes

- At present 56% of council housing stock is defined as non decent. This compares to just 15% in the East Riding of Yorkshire (according to RIS Baseline Data as at April 2006). The national target is for all homes to be 'Decent' by 2010.

## 2.3 JSNA Priorities Scorecard

This section summarises some of the key findings of the JSNA in terms of short-term (2008-11) measures, direction of progress, meeting local and national targets and comparisons between comparator rates (regional and national). The basis for this summary can be seen throughout the following document and in conjunction with the JSNA core data-set (a separate publication which should be looked at with this document).

Figure 6 shows the key for the JSNA Priorities Scorecard.

Figure 6 JSNA Priorities Scorecard Key

	Local Area Agreement priority
↑	Improving
=	No or negligible change over the last few years
↓	Deteriorating
	Currently meeting targets (or on course to meet them)
	Performing adequately but not meeting targets (or not on course to)
	Not improving, not meeting targets
	No related targets
No national targets	Data not available
NA	Not applicable

The JSNA Priorities Scorecard illustrated at Figure 7 presents an independent and objective view based on an analysis of data supplied by Hull.

The list of data included is not exhaustive, rather it focuses on some key measures and priorities which link closely to improvement targets for Hull's Local Area Agreement (LAA) for the period 2008-2011 and work currently being undertaken by Hull tPCT in relation to developing its World Class Commissioning strategy.

Figure 7 JSNA Priorities Scorecard

Measure	Direction of progress	Traffic light assessment		Local and national comparisons		Notes
		Meeting local targets?	Meeting national targets?	Better than Yorkshire & Humber average/rate?	Better than national average/rate?	
Index of Multiple Deprivation	↑			✗	✗	<ul style="list-style-type: none"> <li>Hull is ranked the 11<sup>th</sup> most deprived area in England (out of 354 authorities in England) according to the Index of Multiple Deprivation (IMD) in 2007. It has climbed 2 places from 9<sup>th</sup> position in the IMD 2004</li> <li>Nearly a quarter of the city's households suffer income deprivation affecting 36% of Hull's children and 26.8% of people over 60</li> </ul>
Employment Overall Employment Rate (NI 151) is an LAA Target	↓			✗	✗	<ul style="list-style-type: none"> <li>Hull had an employment rate of 66.7% in 2005/06, 7.1% below the Yorkshire &amp; Humber average and 7.7% below the England average</li> <li>Whilst employment has fallen across the UK, Hull's rate of employment has fallen faster than the UK average</li> <li>At June 2008, 20.1% of the working age population were claiming benefits compared to 14.5% regionally and 13.9% nationally</li> </ul>
Average earnings Average earnings of employees in the area (NI 166) is an LAA target	↓			✓	✗	<ul style="list-style-type: none"> <li>The average gross weekly full-time earnings by workplace in Hull stood at £428.20 (£473 for men; £341 for women). This was more than the Yorkshire &amp; Humber average (£422.30) but lower than the Great Britain average (£458.60) in 2007.</li> <li>In 2005, average full-time earnings (i.e. for those working 30 hours or more) were £479.40 for men and £368.70 for women. This shows that average full-time earnings have fallen between 2004-07.</li> <li>Out of 354 local authorities in England, 247 (70%) had a higher average rate of earnings for those working in the area. However, 345 English local authorities (97%) had higher average earnings than Hull for workers living in the area.</li> </ul>
Decent Council Homes Reaching the target for Decent Council Homes (NI 158) is an LAA target	↑			✗	✗	<ul style="list-style-type: none"> <li>At present 56% of council housing stock is defined as 'non-decent', this compares to just 15% in the East Riding of Yorkshire (according to RIS Baseline Data as at April 2006)</li> <li>The national target is for all homes to be 'Decent' by 2010</li> </ul>

Measure	Direction of progress	Traffic light assessment		Local and national comparisons		Notes
		Meeting local targets?	Meeting national targets?	Better than Yorkshire & Humber average/rate?	Better than national average/rate?	
<b>Alcohol</b> Alcohol-harm related hospital admission rates (NI 39) is an LAA target	↑			×	×	<ul style="list-style-type: none"> <li>Hull had the highest rate of alcohol-harm related hospital admissions per 100,000 of its 14 comparator authorities in 2006/07 as well as 2005/06 and had the second highest rate in 2004/05</li> <li>This rate fell slightly between 2005/06 and 2006/07</li> </ul>
<b>Conceptions</b> Under 18 Conception rate (NI 112) is an LAA Target Health of Children and Young People is a proposed world class commissioning priority	↑			×	×	<ul style="list-style-type: none"> <li>Hull's under 18 years conception rate (73.3 per 1,000 female pop) was 70% higher than the Yorkshire &amp; Humber rate and 76% higher than the England rate between 2003-05. However, the rate did fall from 79.3 per 1,000 female population aged 15-17 in 2004 to 71.5 per 1,000 in 2005 (an improvement).</li> <li>Hull's rate of under 16 conceptions (15.1 per 1,000 female pop) was 70% higher than the Yorkshire &amp; Humber rate and 96% higher than the English rate for 2003-05</li> <li>By 2005 the relative gap between Hull and England under 18 conception rates had been reduced by 10%</li> <li>While neither Hull nor England are on track to meet the target of halving the under-18 conception rate by 2010, the reduction in Hull has been greater than for England</li> </ul>
<b>Smoking</b> Stop smoking (NI 123) and 16+ current smoking rate are LAA targets Smoking is identified as a cross-cutting element of the WCC strategy themes	No longitudinal data			×	×	<ul style="list-style-type: none"> <li>31.7% of adults aged over 16 smoke in Hull in 2007.</li> <li>34% of males and 30% of females smoke in Hull (Hull health and lifestyle survey 2007) compared to 24% males and 23% of females in Yorkshire &amp; Humber and 23% and 21% respectively in England as a whole.</li> </ul>
Smoking during pregnancy	↑			×	×	<ul style="list-style-type: none"> <li>27.7% of women smoked during pregnancy in 2006-07 (down from 29% in 2005-06) compared to 21.7% in Yorkshire &amp; Humber and 16.6% nationally</li> </ul>

Measure	Direction of progress	Traffic light assessment		Local and national comparisons		Notes
		Meeting local targets?	Meeting national targets?	Better than Yorkshire & Humber average/rate?	Better than national average/rate?	
Mortality from all causes	↑			×	×	<ul style="list-style-type: none"> <li>Mortality for all ages per 100,000 fell from 760 in 2005 to 752 in 2006</li> <li>The 2006 rate was higher than the Yorkshire &amp; Humber (621) and England (592) rates</li> </ul>
Circulatory diseases						
Mortality rate from all circulatory diseases at ages under 75 (NI 121) is an LAA target	↑			×	×	<ul style="list-style-type: none"> <li>Hull's rate of mortality from all circulatory diseases under 75 years fell between from 117 per 100,000 population in 2004 to 111 in 2006</li> <li>In 2006, Hull's rate was 27% higher than the regional (87) and 40% higher than national (79) rates for mortality from all circulatory diseases under 75 years</li> <li>According to the World Class Commissioning (Draft Context 2008; page 9) Report, if current trends continue the local target for circulatory diseases will be reached</li> </ul>
Coronary Heart Disease (CHD)						
CHD is a proposed world class commissioning priority	=			×	×	<ul style="list-style-type: none"> <li>CHD all ages mortality rates (127 per 100,000) for the period 2004-06 were above the regional (113) and national averages (102) but mortality rates in Hull and England have been decreasing for several years, largely as a result of falling smoking rates (a pattern observed nationally as well).</li> <li>Male mortality rates from CHD for all ages in 2004-06 were 14% higher than the English male average whilst female rates were 40% higher than the English female average</li> <li>Hull's World Class Commissioning report states that local CHD rates are not improving</li> </ul>
Stroke						
Stroke is a proposed world class commissioning priority	↑			×	×	<ul style="list-style-type: none"> <li>Between 1996 and 2006, mortality from stroke for people of all ages (Directly age-standardised rates: DSR) per 100,000 fell from 88 to 66 deaths per 100,000 population, a 33% reduction over 10 years. This rate was 25% higher than regional and 32% higher than national rates.</li> <li>During the same period the Yorkshire &amp; Humber rate fell by 56% to 53 per 100,000 in 2006 and the English rate fell by 58% to 50 per 100,000 (both rates are better than those of Hull and improving faster).</li> <li>According to the World Class Commissioning (Draft Context 2008; page 9) Report, if current trends continue the local target for circulatory diseases will be reached</li> </ul>
Cancer						
Mortality from all cancers at ages under 75 (NI 122) is an LAA target	↑			×	×	<ul style="list-style-type: none"> <li>Hull's rate of mortality from cancer under 75 years fell between from 154 per 100,000 population in 2004 to 150 in 2006</li> <li>In 2006, Hull's rate was higher than the regional (121) and national (116) rates for mortality from cancer under 75 years</li> <li>According to the World Class Commissioning (Draft Context 2008; page 9) Report, if current trends continue the local target for cancer will be reached</li> </ul>
Cancer is a proposed world class commissioning priority						



Measure	Direction of progress	Traffic light assessment		Local and national comparisons		Notes
		Meeting local targets?	Meeting national targets?	Better than Yorkshire & Humber average/rate?	Better than national average/rate?	
<p>Lung cancer</p> <p>Mortality from all cancers at ages under 75 (NI 122) is an LAA target</p> <p>Cancer is a proposed world class commissioning priority</p>	↑			✗	✗	<ul style="list-style-type: none"> <li>In Hull one in ten people who die early die of lung cancer. This represents 33% of all early cancer deaths, much higher than the rest of England (23%)</li> <li>The Association of Public Health Observatories' (APHO) figures on age standardised lung cancer incidence rates between 2003-05 for Males state Hull's rate to be 97.6 per 100,000. This rate was higher than the Yorkshire &amp; Humber average of 69.7 and the England average of 60.8. There is a similar picture for Females with Hull's lung cancer incidence rate of 56.1 exceeding the Y&amp;H (42.1) and England (34.7) averages.</li> <li>APHO's lung cancer mortality rate figures between 2003-05 also show Hull to be performing worse than Yorkshire &amp; Humber and England as a whole. Hull's age-standardised lung cancer mortality rate for Males stood at 91.1 per 100,000 compared to 59.6 for Y&amp;H and 52.1 for England. For Females Hull's mortality rate of 47.5 exceeded the Y&amp;H (34.7) and England (28.4) averages.</li> </ul>
<p>Obesity</p> <p>Percentage of participants losing a minimum of 5% bodyweight &amp; sustaining if for 12 weeks is an LAA 1 stretch target</p> <p>Obesity is identified as a cross-cutting element of the WCC Strategy Themes.</p> <p>Health of Children and Young People is a proposed world class commissioning priority</p>	↑			✓	✓	<ul style="list-style-type: none"> <li>In 2007, 67% of men and 55.9% of women were overweight or obese (61.4% on average). These rates were lower than the English 2006 average of 63.7% (Men: 68.6%; Women: 58.8%)</li> <li>In terms of adult obesity in Hull levels have changed little between 2004 and 2007 (as measured by BMI).</li> <li>Local data shows a fall in obesity amongst Year R (in girls only with a rise amongst boys) and Year 6 children (both sexes)</li> <li>The national objective is to begin reducing the rate of overweight or obese - no LA has yet managed to achieve this</li> </ul>

Measure	Direction of progress	Traffic light assessment		Local and national comparisons		Notes
		Meeting local targets?	Meeting national targets?	Better than Yorkshire & Humber average/rate?	Better than national average/rate?	
Substance misuse Drug users in effective treatment (NI 40) is an LAA Target	No longitudinal comparative data			✘	✘	<ul style="list-style-type: none"> <li>Estimates suggest there are 3,700 problematic drug-users (15-65 years) in Hull.</li> <li>It is estimated that approximately 10% of drug misusers are under 19.</li> <li>Hull has the highest prevalence rate of problematic drug use within Yorkshire and Humber (95% opiate users).</li> <li>Research indicates that Hull has the highest injecting prevalence in the Yorkshire and Humber region</li> <li>The current provision for people with drug misuse problems was significantly higher than national and regional levels at 2005 to meet this higher than average demand. The need for additional floating services and accommodation based services has been identified</li> </ul>
Chronic Obstructive Pulmonary Disorder (COPD)  COPD is a proposed world class commissioning priority	↑		No National targets for COPD	✘	✘	<ul style="list-style-type: none"> <li>COPD mortality rate for men (all ages) in 2004-06 was 27% higher in Hull than England but for women it was 64% higher (42% higher than the national average for both men and women).</li> <li>The COPD mortality rate for men was 9% higher than the Yorkshire &amp; Humber average, 39% higher for women and 22% higher than the regional average for both men and women.</li> <li>Between 2004 and 2006 all person, all ages mortality from COPD fell from 38 to 36 per 100,000 (an improvement) and this rate is down from 42 per 100,000 in 1996.</li> </ul>
Infant mortality	↑			✓	✘	<ul style="list-style-type: none"> <li>Infant mortality rates for (all maternal ages) 2004-06 were 5.3 per 1,000 live births. This was lower than the regional average (5.8 per 1,000) but slightly higher than the national average (5 per 1,000)</li> </ul>

Measure	Direction of progress	Traffic light assessment		Local and national comparisons		Notes
		Meeting local targets?	Meeting national targets?	Better than Yorkshire & Humber average/rate?	Better than national average/rate?	
Diabetes  Diabetes Commissioning Strategy Local Priority	↓			✘	✔	<ul style="list-style-type: none"> <li>Hull GP's register data suggest that 4.1% of the population (aged 17 +) have diabetes (compared to 5.1% in the UK). In fact it is likely that the rate of undiagnosed diabetes is higher in Hull. Using statistical models we estimate in Hull the true figure is 5.8%.</li> <li>However, Hull's World Class Commissioning Report cites a lower figure sourced from a Diabetes Equity Audit for 2007-08 carried out in Hull and East Riding. Using a modelled estimate, the prevalence of diagnosed and undiagnosed diabetes in people over 17 years registered with Hull GPs was estimated to be 5.29% (13,121 patients, i.e. approximately 3,700 patients undiagnosed).</li> <li>The only comparative regional data available was from the Diabetes Equity Audit for 2007-08 for Hull and East Riding which states that Hull performs poorly relative to the more affluent East Riding of Yorkshire in relation to the prevalence of diabetes and measures of on-going care such as HbA1c, due to its increased deprivation.</li> <li>With increasing levels of obesity it is anticipated that the number of people with diabetes will increase. QOF data estimates that there will be 14,000 people with Diabetes in Hull by 2012/13.</li> </ul>
Mental Health  Mental Health is a proposed world class commissioning priority				✘	✘	<ul style="list-style-type: none"> <li>Hull's World Class Commissioning report (version draft September) states that Hull has an above national average incidence of poor mental health (3.1% with a range of 1-8% across wards) of working age population on Incapacity Benefit or Severe Disablement Allowance where the main reason for the claim was mental health (May 2006)</li> <li>The same report cites The Mental Illness Needs Index 2000 (MINI) which has been used for funding purposes to adjust estimates of national prevalence to local population need, based on poverty, unemployment and social isolation (Eastern Region Public Health Observatory, 2007). Eastern and West Hull PCTs were given MINI values of 1.35 and 1.28 respectively denoting a higher 'need' compared to England as a whole (as a comparison East Yorkshire PCT and Yorkshire Wolds and Coast PCT were given values of 0.81 and 0.88 respectively). Therefore, nationally it is recognised that Hull has greater need in terms of mental health compared to other more affluent geographical areas nearby.</li> </ul>
Sexual Health  Health of Children and Young People is a proposed world class commissioning priority	↓			No Comparable Data available	✘	<ul style="list-style-type: none"> <li>The number of uncomplicated cases of Chlamydia in Hull fell slightly for both males and females between 2002 and 2003</li> <li>Genital Chlamydia infection is the most common sexually transmitted infection (STI) diagnosed in clinics across the UK. In 2004, within England, rates in both males (208/100,000) and females (243/100,000) were highest in Yorkshire and Humber after London (279 and 282/100,000) respectively.</li> <li>The number of uncomplicated cases of Gonorrhoea in Hull incidence increased sharply between 2002 and 2003 from 61 to 113 for males and from 40 to 49 for females between 2002 and 2003. Outside London, diagnostic rates in males (58/100,000) and females (31/100,000) were highest in the Yorkshire and Humber region.</li> <li>Cases of HIV continue to increase and this is in line with national trends</li> </ul>

## 2.4 Short and Long Term Priorities

The following key short-term priorities can be identified from the JSNA Priorities Scorecard:

- COPD
- Lifestyle factors (smoking (particularly smoking during pregnancy), obesity, alcohol consumption, substance misuse, teenage conceptions and sexual health)
- CHD
- Stroke
- Diabetes
- Mental Health
- Employment rate
- Average earnings
- Decent council homes

Key challenges for Hull over the short-term (2008-11) are:

- **Accelerating the rate of current positive progress on measures that are moving in the right direction.** This includes teenage conceptions, smoking during pregnancy, CHD, circulatory diseases and cancer to ensure that local and national targets are achieved, that the inequalities gaps with England are reduced and that better outcomes are achieved in the short-term.
- **Ensuring a strategic shift to prevention, early intervention/diagnosis and rehabilitation for conditions such as COPD, CHD, and Diabetes.** This will also involve ensuring improved access to primary and community care and tackling the deficit of GP availability.
- **Addressing data gaps in relation to local needs in particular, mental health, physical and sensory disabilities and dementia.**

Over the medium to longer-term (over next 5-10 years) the JSNA analysis has identified the following issues:

- The impact of demographic change:
  - Changing BME population
  - Increasing migration
  - Ageing population and the challenges this may present (e.g. increasing rates of dementia, increasing support for carers, increasing pressure on services)
  - Increasing number of adults with severe learning difficulties living longer and with ageing carers
- Personalisation policy agenda, rising expectations and service modernisation in the context of tighter funding settlements.

- Ensuring sustainable and year on year improvements in behavioural and lifestyle outcomes for Hull’s population which will impact substantially over the longer-term on the prevalence of CHD, cancer, stroke, COPD, diabetes, and teenage conceptions.
- Economic development and regeneration programmes in Hull in relation to reducing poverty and deprivation and the significant impact this could have on improved health and well-being outcomes.

Figure 8 below gives an indication of how long different foci may take to reach the population and impact on Hull’s outcomes.

Figure 8 Focus against time taken for results to reach population

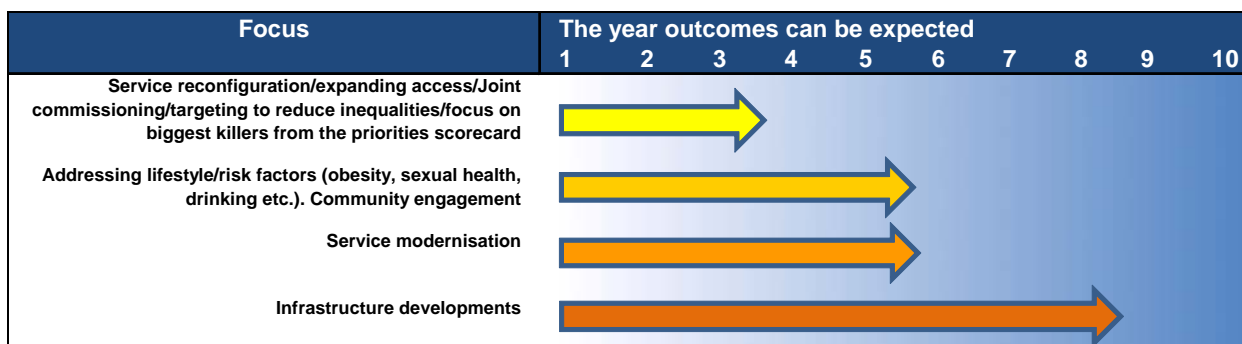


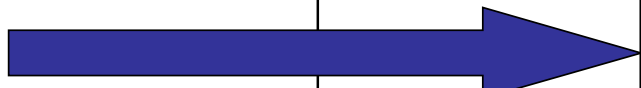
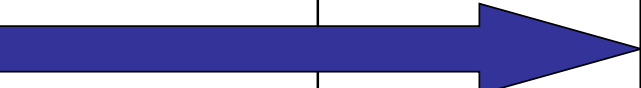


Figure 9 provides a demonstration of how Hull can effect change over both the short and longer-term.

Figure 9 Transformation Matrix

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Access & Joint Commissioning	<ul style="list-style-type: none"> <li>Virtual Joint Intelligence Unit</li> <li>Integrated Teams &amp; Joint Services</li> <li>Locality commissioning &amp; PBC</li> <li>Analytical &amp; predictive modelling tools</li> <li>Gaps</li> <li>Redesigning care pathways</li> <li>Performance monitoring</li> </ul>		<ul style="list-style-type: none"> <li>Positive direction for all JSNA scorecard priorities</li> <li>More targeted services on key vulnerable client groups</li> <li>Predictive modelling tools at locality level</li> <li>Needs assessment for sexual health</li> <li>Improved joint performance processes</li> </ul>						<ul style="list-style-type: none"> <li>Fully integrated community based well-being services</li> <li>Major redesign of care pathways with more care delivered in home and community settings</li> <li>Whole-system real-time data</li> <li>Performance monitoring at postcode level</li> <li>Individually targeted services</li> </ul>	
Lifestyle & risk factors	<ul style="list-style-type: none"> <li>Reducing obesity amongst primary school children and adults</li> <li>Reducing Under 18 conception rate</li> <li>Improved diet &amp; eating habits</li> <li>Smoking, drinking &amp; sexual health – social marketing</li> <li>Reduction in substance misuse</li> </ul>		<ul style="list-style-type: none"> <li>Reduced rates of obesity in primary schools children</li> <li>Reduced under 18 conception rate</li> <li>More adults living healthier lifestyles</li> <li>Reductions in smoking, binge drinking and STDs</li> <li>Reductions in younger adults with LTCs</li> </ul>						<ul style="list-style-type: none"> <li>Behaviour change fully embedded with sustained reductions in obesity rates for primary school children</li> <li>Gains from 08/09 showing for younger adults with reductions in biggest killers &amp; LTCs</li> <li>Big reductions in smoking rates and binge drinking</li> <li>Big reduction in under 18 conception rate</li> </ul>	
Service Modernisation	<ul style="list-style-type: none"> <li>Supported housing for people with learning difficulties, mental health difficulties, teenage parents &amp; older people</li> <li>More personalised services</li> </ul>		<ul style="list-style-type: none"> <li>More adults living independently</li> <li>New supported housing</li> <li>AT mainstreamed &amp; increase in housing adaptations</li> <li>All adults have a personal budget</li> </ul>						<ul style="list-style-type: none"> <li>Independent living for all</li> <li>Full range of supported housing schemes</li> <li>Fully developed local market</li> <li>Enablement mainstreamed</li> </ul>	
Infrastructure	<ul style="list-style-type: none"> <li>Regeneration</li> <li>Housing &amp; transport</li> <li>Economic development</li> <li>Reducing worklessness</li> <li>Reduction in child poverty</li> </ul>		<ul style="list-style-type: none"> <li>New housing &amp; transport</li> <li>Growth in local SMEs &amp; more support for long-term unemployed</li> <li>Year on year reductions in child poverty</li> </ul>						<ul style="list-style-type: none"> <li>All housing is high standard</li> <li>Large reduction in child poverty</li> <li>Fully accessible transport links</li> <li>Large reduction in unemployment</li> </ul>	

## 2.5 Knowledge Development

The JSNA process has revealed areas where knowledge and its use could be further developed. The following provides examples of where developments could be made.

### 2.5.1 Baseline data gaps

The JSNA core data set illustrates where data development would provide a more complete data-set. This is not an exhaustive list and should be considered alongside other priorities, but development in the following data areas may be beneficial:

- More data concerning veterans.
- Projections concerning BME population growth
- Projections concerning migration

Hull may also wish to consider including education data as part of their JSNA core data-set going forward. This is not stipulated in Department of Health guidance but may assist in building a more complete evidence base for Hull going forward.

### 2.5.2 Performance Data

Hull may benefit from continuing to develop performance data and monitoring provider outcomes to demonstrate where interventions are successfully impacting on outcomes. This process could be linked into the JSNA refresh to help decision making. Having a greater understanding of performance outcomes will allow Hull to make more evidence-led decisions and strengthen commissioning.

Such performance data could be more focused on impact and outcomes, rather than on outputs and activity.

In particular Hull should continue and expand innovative current work on Program Budgeting Marginal Analysis in order to continue improvement of service offerings.

### 2.5.3 Locally Targeted Needs Assessment

Hull may wish to consider as part of the JSNA process setting up more systematic engagement and consultation routes with groups that may be considered “hard-to-reach” and also groups about which more evidence may assist services. One particular area identified through the JSNA is Veteran Health.

#### Veteran Health

Data on the demography and morbidity of ex-service personnel in the UK is lacking and this makes it difficult to draw firm

conclusions on how the Council and the PCT can interact to improve outcomes for this group.

Nevertheless, tentative estimates suggest that in Hull there are 21,255 Veterans in the City of which there are:

- 227 Gulf War Veterans
- 120 Falklands Veterans
- 170 Territorial Army
- 360 Members of the Royal British Legion

A search of the UK literature indicates the urgent need for further quality research into the health care needs of Veterans in the UK.

Some illnesses, particularly mental health problems, may not develop or show themselves until some time after a service man or woman has left the armed forces. As many health professionals have little or no knowledge of life in the forces and encounter only very small numbers of patients with this type of background, there is a real risk that physical and mental health problems caused directly or indirectly by military service may be missed or misdiagnosed.

It is thought that 'Gulf War syndrome', functional deafness, fatigue, post traumatic stress disorder, anxiety, and depression are the main debilitating impacts on the health related quality of life of Hull Veterans. In addition, the effects on family stability and wellbeing should not be underestimated.

The PCT has already taken steps to redress the balance for this hard to reach group.

In 2007 the PCT Board has agreed a new policy whereby veterans who are not war pensioners but who are suspected to have a condition related to their military service receive faster access to treatment. Following this policy being introduced by the PCT the UK Government adopted the same policy across the UK.

This JSNA acknowledges the gaps in national and hence in local knowledge in this important area and recommends further quantitative and qualitative research, to bring together knowledge which will help to improve health and wellbeing for this group of people.

### Other Vulnerable Population Groups

Hull may also wish to consider targeting engagement and consultation at groups including:

- Those with physical disability and sensory impairment



- BME communities
- Those with Mental Health issues
- Young mothers

Again the above is by no means a definitive list but rather shows what types of group Hull may wish to have more knowledge about.

Such consultation and engagement could feed into a refresh of the JSNA.

#### 2.5.4 Data/Evidence into Knowledge and Effective Interventions

Hull could consider methods of making the transition from intelligence to knowledge more effective. For instance, Hull tPCT and Hull City Council could:

- Use the JSNA to foster joint working in quantitative data collection and statistical analysis. Both organisations could explore new ways of drawing main messages from the large quantities of qualitative data which will be gathered within the Council Panel project and the PCT Listening Exercise and Membership scheme. The JSNA steering group should build on existing predictive modelling activities in order to foster better understanding of impacts of strategies.
- Sharing and formulating joint approaches and strategies.
- Disseminating knowledge and formulating joint approaches and strategies that address improving outcomes through the undertaking of Health Impact Assessments (HIA).
- HIA is an approach that ensures decision making at all levels. It considers the potential impacts of decisions on health and health inequalities. Hull tPCT and Hull City Council are engaged in innovative HIA work in three areas – Housing, Regeneration and Education. The rationale is to foster joint working, embed health into strategic plans and improve health outcomes by identifying opportunities for joint commissioning.
- Disseminating knowledge and information externally in terms of social marketing (building on the work that Hull is already doing in relation to smoking, alcohol, obesity and domestic violence), social capital, and participative approaches and involving the community in Hull's achievements.

## 2.6 Developing Commissioning

Areas where commissioning strategies and processes could be developed include:

- Priority areas identified by the JSNA directly impact on the development of new commissioning strategies (including the World Class Commissioning strategy) being developed by Hull tPCT and Hull City Council (including joint commissioning strategies).
- Commissioning which focuses on 'end to end' care and support pathways with a strategic shift towards prevention, early diagnosis and intervention and rehabilitation, with a particular focus on priority areas identified by the JSNA.
- Tackling specific commissioning gaps for particularly vulnerable population groups such as substance misuse services – for example, floating support based services for women who are victims of domestic violence with drug dependency issues – and the needs of veterans.
- JSNA findings would support commissioning strategies that may target and identify groups where outcomes may be improved, both in the short- and long-term. This could, for example, include a focus on groups commonly referred to as "hard-to-reach".
- Commissioning should take account of a context where demographic pressures and resource constraint combined with changing expectations (personalisation) are bringing real challenges in relation to service reconfiguration and modernisation and also difficult decommissioning challenges.
- The JSNA is used to build on the considerable investment Hull has already made in social marketing approaches in relation to smoking, obesity, alcohol and domestic violence and strengthening community engagement approaches, with consideration of extending this approach to other priorities identified by the JSNA.
- Consideration of more robust performance management approaches to services which identify what works and why, and what does not work and why, in relation to improving outcomes.
- Hull tPCT and Hull City Council should continue and build on the current Health Impact Assessment activity in order to ensure that health impacts are at the heart of

commissioning strategy decisions. This information should form part of the reiterative process of JSNA.

- Over the longer term, commissioning which is “transformational” will require enabling changes in attitudes, knowledge and behaviours from targeted, vulnerable population groups who are amenable to change.

## 2.7 Outcomes and Reducing Inequalities

The JSNA should assist Hull to ensure that commissioning activity achieves improved and sustainable outcomes for its population. These can be identified as:

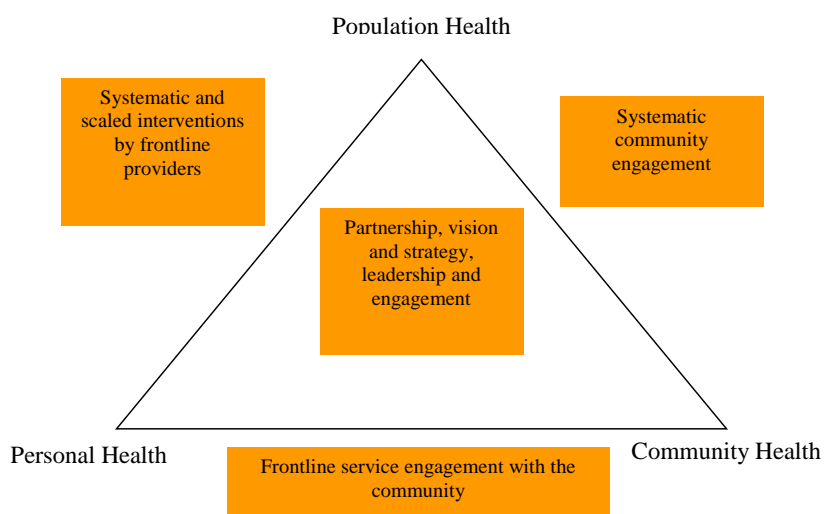
- Individual care and support outcomes such as effective care and support pathways that enable independent living (e.g. NHS Next Stage Review, Putting People First, Our Health, Our Care, Our Say etc).
- Shared health and care outcomes in terms of gains for specific or general communities through service improvement or redesign or new services, including reducing inequalities - reflected in **shared** LAA improvement targets.
- Community outcomes which may not relate directly to health and care activity but could result from improvements in another part of the system, for instance through a regeneration programme that enables well-being gains – taking account of the LAA as a whole.



For individual health and community level interventions to have a sustainable impact in Hull over the medium to longer-term they will need to be scaled up and applied systematically. The preconditions shown in Figure 10 below are:

- Committed leadership, an effective local strategic partnership and a locally owned, coherent vision and strategy.
- Frontline providers proactively pursuing health outcomes
- Systematic community engagement and empowerment.
- Frontline services connected in the heart of communities

Figure 10 Ensuring sustainable impact



In order to have the sustainable impacts in improved health and well-being which Hull wishes to achieve over the medium to longer-term, there needs to be a conceptual leap from project to programme thinking that is evidence based, outcomes orientated, systematically applied, scaled up appropriately, adequately resourced and long term. In order to achieve improved outcomes:

- Commissioners will need to use the JSNA to ensure expressed demand matches need, resources are distributed equitably (e.g. greater resources for more vulnerable to achieve equitable outcomes) and to ensure that those accessing services get the intervention they need.
- Providers will need to implement evidence based practice, develop effectiveness through governance and audit, ensure services are cost effective, engage public and patients systematically and achieve an appropriate balance between bringing services closer to citizens and communities and ensuring effectiveness for optimal overall impact.

Key characteristics of successful programmes are as follows:

- **Evidence based** – concentrating on interventions where research findings and professional consensus are strongest.
- **Outcomes orientated** – with measures locally relevant and locally owned.
- **Systematically applied** – not depending on exceptional circumstances and exceptional champions.
- **Scaled up appropriately** – ‘industrial scale’ processes requiring different thinking to small ‘bench’ experiments.
- **Appropriately resourced** – refocus on core budgets and services rather than short bursts of project funding.
- **Persistent** – continue for the long term, capitalising on, but not dependent, on fads, fashion and policy priorities.

## 2.8 Developing Community Engagement and Empowerment

The community perspective is integral to understanding the need and unmet need in Hull. Community engagement activities in Hull can be described at five levels based on the ‘Ladder of Participation’ model<sup>3</sup>. These levels are:

- **Information** - telling people what is available and what is planned.
- **Consultation** - offering options, encouraging feedback on new ideas.
- **Deciding together** - encouraging new ideas and options, joint decision making
- **Acting together** - deciding together what is best, carrying out joint decisions.
- **Supporting independent community interests** - offering funds, advice and other support to local groups to develop their own agendas within guidelines.

### Social Capital

Social capital is a concept that refers to connections within and between social networks. Social capital is a process where communities and individuals can form networks and relationships which give reciprocal support. There is a great deal of evidence that there is a strong relationship between high levels of social capital and good health. The PCT and the Council are working jointly in understanding the patterns of Social Capital in Hull There have been two surveys of Social Capital over the last 4 years and another is planned for January 2009. The findings of the surveys will enable Hull to understand how recent initiatives have impacted on Social Capital and also help in planning new strategies.

<sup>3</sup> Joseph Rowntree Foundation. Community participation and empowerment: putting theory into practice. August 1994.

## Social Marketing

Social marketing is the systematic application of marketing techniques along with other concepts and techniques to encourage people to improve health behaviour and to enable the NHS and Councils to provide better services. Social marketing techniques have been used to ask people not to smoke in public areas, to encourage them to use seat belts, prompt them to make them follow speed limits, etc. In Hull, a significant investment is being employed to gain insight into health behaviour and to find out how people would like services to be provided. For example, do they want group or individual smoking cessation or weight management services? Hull tPCT are examining four main areas: Smoking, Obesity, Alcohol and Domestic Violence in order to improve access to services for 'hard to reach' groups and to encourage participation in health improvement initiatives.

Hull's model of social marketing is illustrated in Figure 11 below.

Figure 11 Hull's Social Marketing Approach



Source: National Social Marketing Centre for Excellence, Social Market Pocket Guide, Ed. 1 2005

We would recommend that Hull considers extending its social marketing campaigns and programme to other priority areas identified by the JSNA which would include:

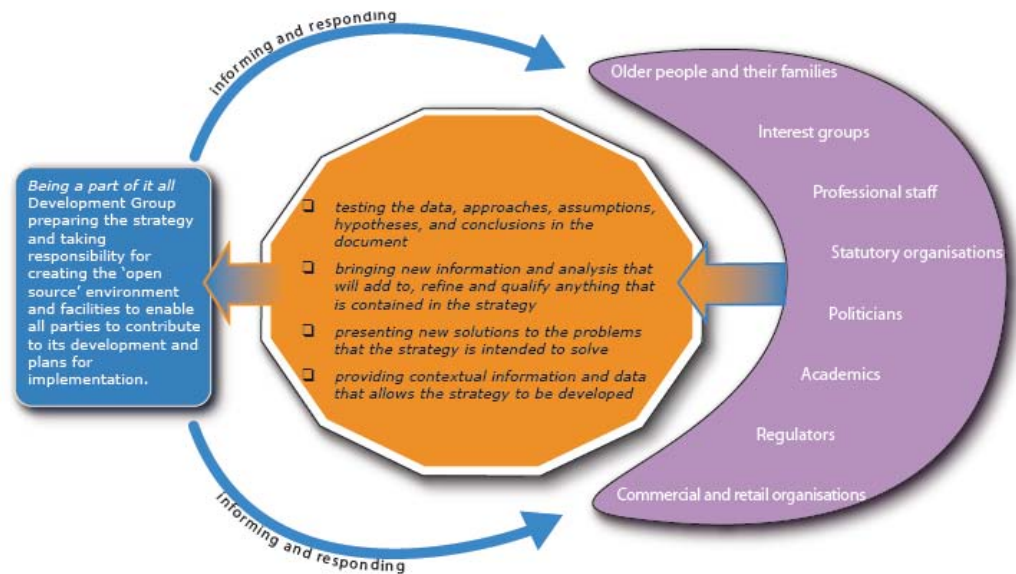
- Stroke
- CHD
- Diabetes
- COPD
- Mental Health
- Cancer

## Developing 'Open Source' Approach to Community Engagement

A key point raised by participants at the Stakeholder Event on 25 September and which has been discussed by JSNA Steering Group is to utilise web based technology to allow people to engage more directly with the ongoing JSNA process. Future refreshes of the JSNA will have the objective of gaining an even more comprehensive picture of health and well-being

in Hull that will include more information gained through active dialogue with local people, service users and their carers. A way of enabling ongoing and active dialogue with members of the local community which could be considered further by Hull is to utilise the techniques used in developing open sourced products on the internet, as illustrated in Figure 12 below.

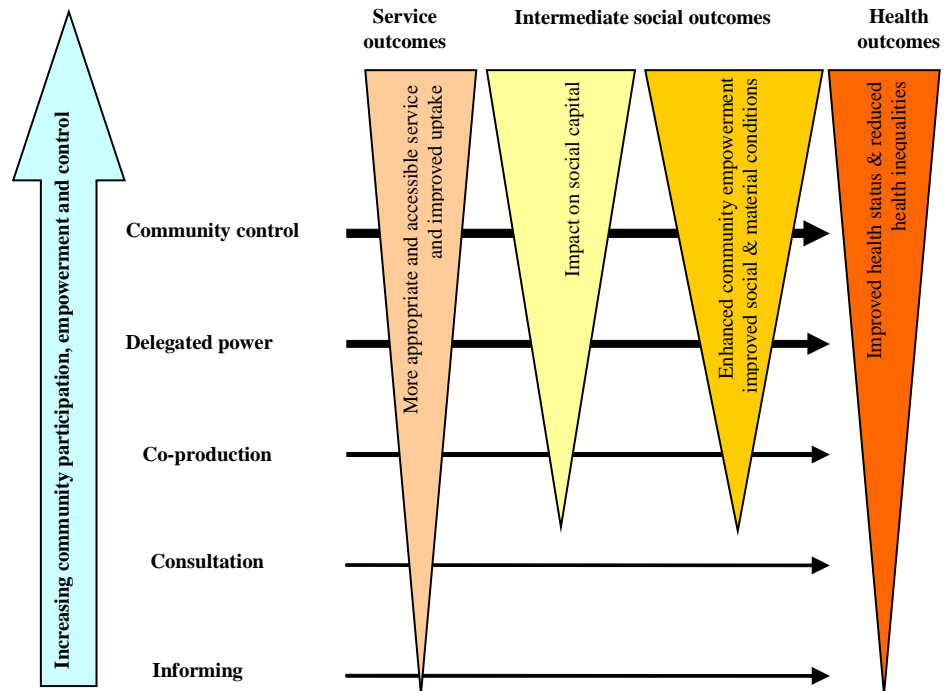
Figure 12 An Open Source Approach to developing the JSNA



Hull tPCT and Hull City Council have already undertaken impressive work in relation to social capital and social marketing. They may wish to build on this to fully engage with communities over the medium to longer-term to address priorities identified through the JSNA. The degree to which this is done will influence the extent to which targeted communities in Hull will be empowered by and gain ownership of the process and thereby support improved gains in health and well-being.

Different terms such as 'community consultation', 'community participation', 'community development' and 'community control' can be used to portray the level of engagement. They describe contiguous points along a continuum which ends in full community ownership and control as illustrated in Figure 13 below.

Figure 13 Pathways from community participation, empowerment and control to health & well-being improvement



## 2.9 JSNA findings by population group

This section provides brief summaries for key groups that are based on the analyses in this report.

### 2.9.1 Children and Younger Adults

#### Unintended and deliberate Injuries

- Of the 10 comparator PCTs, Hull had the second highest admission rate for unintended and deliberate injuries in children under 19 years. The rate was 39% higher than the Yorkshire and Humber average and 50% higher than the England average.
- In Hull there is a clear correlation between the admission rate for deliberate and unintended injuries and high deprivation.

#### Limiting long-term illness

- The percentage of Hull's children and young people with limiting long-term illnesses was higher than the national average in 2001, particularly amongst those aged 10-14 years<sup>4</sup> (this could be an area for further investigation by Hull).

<sup>4</sup> Office of National Statistics: April Census 2001



### Deprivation

- 36% of Hull's children live in homes suffering income deprivation.

### Drug misuse

- It is estimated that approximately 10% of people who misuse substance in Hull are under 19 years.

### Obesity

- Local data shows a fall in obesity amongst Year R (reception) (in girls only with a rise amongst boys) and Year 6 children (both sexes).
- Increasing children and young people's participation in high-quality PE and sport is one of Hull's Local Area Agreement priorities.

### Conceptions

- Hull's under 18 years conception rate (73.3 per 1,000 female population) was 70% higher than the Yorkshire and Humber rate and 76% higher than the England rate between 2003-05. However, the rate did fall from 79.3 per 1,000 female population aged 15-17 in 2004 to 71.5 per 1,000 in 2005 (an improvement).
- Hull's rate of under 16 conceptions (15.1 per 1,000 female population) was 70% higher than the Yorkshire and Humber rate and 96% higher than the English rate for 2003-05.
- By 2005 the relative gap between Hull and England's under 18 conception rates had been reduced by 10%.
- The under 18 years conception rate is one of Hull's Local Area Agreement priorities.

## 2.9.2 Adults

### Alcohol

- Hull had the highest rate of alcohol-harm related hospital admissions per 100,000 of its 14 comparator authorities in 2006/07 as well as 2005/06 and had the second highest rate in 2004/05.
- This rate fell slightly between 2005/06 and 2006/07.
- Alcohol-harm related hospital admission rates are a Local Area Agreement priority for Hull.

### Smoking

- 31.7% of adults aged over 16 smoked in Hull in 2007.

- 34% of males and 30% of females smoked in Hull (Hull health and lifestyle survey 2007) compared to 24% of males and 23% of females in Yorkshire and Humber and 23% and 21% respectively in England as a whole.
- 27.7% of women smoked during pregnancy in 2006-07 compared to 21.7% in Yorkshire and Humber and 16.6% nationally.
- 16+ years smoking prevalence is a Local Area Agreement priority for Hull.

### Obesity

- In 2007, 67% of men and 55.9% of women were overweight or obese (61.4% on average). These rates were lower than the English 2006 average of 63.7% (Men: 68.6%; Women: 58.8%).
- Adult obesity levels in Hull have changed little between 2004 and 2007 (as measured by Body Mass Index (BMI)).

### Eating habits

- On average, 76% of Hull's residents do not meet their 5-a-day fruit and vegetables requirement for healthy eating.

### Physical disability and sensory impairment

- There were 2,165 clients receiving a service during the year 2007-2008 aged 18-65 years (1,071 clients received a community service between 2007-08).
- There were 1,418 clients aged 18-65 years receiving a community service at 31<sup>st</sup> March and 3,474 clients aged 65 years and over receiving a community service at 31<sup>st</sup> March in 2007-08.
- It has been estimated that 9.8m people in Britain are covered by the broad definition of disability in the Disability Discrimination Act. Scaling down to Hull's population this would give us around 41,000 disabled people in the city.
- In February 2005 there were 21,700 people claiming Disability Living Allowance or Attendance Allowance.
- There are currently 11,181 people with Blue Parking badges issued. This is one indicator of people with severe mobility problems<sup>5</sup>.

### Learning disabilities

- Hull CC estimated that there are some 4,929 people with a learning disability (4,413 adults) in Hull in 2008.

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<sup>5</sup> Hull City Council

- Of this number approximately 725 adults have a severe or profound learning disability.
- 575 adults received a service in 2007/08 and 460 clients received a community service during the year aged 18-65 years.
- The number of people with a learning disability known to services is predicted to increase from 1,072 to 1,099 between 2011 and 2021, whilst the 'true population' is predicted to rise from 5,047 to 5,259 in the same period.

### Mental Health

- There were 641 clients receiving a service during 2007-2008 aged 18-65 years. 533 clients with a mental health problem received a community service during the year aged 18-65 years.

### Substance misuse

- Estimates suggest there are 3,700 problematic drug-users (15-65 years) in Hull.
- Hull has the highest prevalence rate of problematic drug use within Yorkshire and Humber (95% are opiate users).
- The number of drug-users in effective treatment is a Local Area Agreement priority for Hull.

## 2.9.3 Older People

### Ageing population

- Hull's population is ageing. In 2007, 14% of Hull's population was aged over 65 years. By 2027 it is estimated that the number of people aged 65 years will increase by over 10,000, constituting 17% of the population.

### Older people living alone

- By 2025 it is estimated that 16,042 older people aged 65+ years will be living alone.

### Increasing number of older people requiring high levels of support

- The number of older people with health problems requiring high levels of support is also set to increase significantly.

### Limiting long-term illness

- The total population of older people aged 65 years and over who had a limiting long-term illness was estimated

to be 19,355 in 2008 and is projected to rise by 26% by 2025.

### Healthy life expectancy

- Healthy life expectancy at 65 years for residents of Hull is 10.8 years for males and 12.8 years for females. This rate was lower than regional (11.7 years and 13.6 years respectively) and national (12.5 and 14.5 years respectively) healthy life expectancies.

### Physical disability and sensory impairment

- There were 6,485 clients aged 65 years and over receiving a service in 2007-08 and 5,356 clients aged 65 years and over received a service in the community during the same year.

### Learning disabilities

- In 2007-08, 76 older people aged 65 years or over were receiving a service. 45 older clients received a learning disability service in the community in the same year.

### Mental Health

- In 2007-08, 474 clients aged 65 years and over received a service and 220 older clients with a Mental Health problem received a community intervention in the same year.

## 2.9.4 Cross-cutting

### Deprivation

- Hull was ranked as the 11th most deprived local authority out of the 354 in England. More than half the people living in Hull live in areas which are defined as the most deprived 20% of areas nationally and a further quarter live in areas in the next most deprived quintile nationally. None of Hull's residents live in geographical areas defined nationally as the 20% least deprived.
- This means deprivation and its associated health and social problems are spread throughout the city rather than concentrated in particular areas.
- Nearly a quarter of the city's households suffer income deprivation, affecting 36% of Hull's children and 26.8% of people over 60.
- 48% of households in Hull had no car or van in 2001.

### Benefits claimants

- At June 2008, 20.1% of the working age population were claiming benefits<sup>6</sup> compared to 14.5% regionally and 13.9% nationally.
- There were 33,290 benefit claimants among adults of working age in November 2007. 4.4% of working age adults were claiming job seekers allowance, 8.8% incapacity benefit, 3.3% lone parents benefit, 1.5% carer benefits, 0.8% other income related benefits, 1.1% disability benefits and 0.2% bereavement benefits (based on main reason for claim).
- Hull had a higher percentage of claimants who had claimed for between 6-12 months and over 12 months than Yorkshire and Humber and England as a whole
- Working age people claiming out-of-work benefits in worst performing neighbourhoods is a Local Area Agreement priority for Hull.

### Average income

- The average gross weekly full-time earnings by workplace in Hull stood at £428.20 (£473 for men; £341 for women). This was higher than the regional (£422.30) but lower than the national average (£458.60) in 2007.
- Average full-time earnings have fallen in the period 2004-07.
- Average earnings of employees in the area is a Local Area Agreement priority for Hull.

### Limiting long-term illness

- In 2001, approximately 20% of the population had a limiting long-term illness. This rate was higher than the Yorkshire and Humber (19%) and England average (17%).

### Employment

- Hull had an employment rate of 66.7% in 2005/06, 7.1% below the Yorkshire and Humber average and 7.7% below the England average.
- The local level of employment is a Local Area Agreement priority for Hull.

<sup>6</sup> DWP benefit claimants - working age client group

## Housing

- At present 56% of council housing stock is non decent, this compares to just 15% in the East Riding of Yorkshire.
- There is a lack of larger, 'aspirational' and family-oriented properties and this has been identified as an inhibiting factor to development of the local economy due to a lack of attractive housing for graduates, knowledge workers, professionals and wealthier families<sup>7</sup>.
- There is also a projected shift to a greater proportion of single person households who are likely to require smaller housing.
- The Decent Homes Target (of all homes being decent by 2010) is a Local Area Agreement priority for Hull.

### 2.10 Key Recommendations

1. The JSNA is used to build on the good work already underway through the One Hull Partnership and to further strengthen cross-cutting, partnership working feeding into the development of a revised Community Strategy with a clear focus on tackling the key priorities identified through the JSNA.
2. This is Hull's First JSNA and is recognised as a key stage towards a more comprehensive picture of health and well-being. Future refreshes of the JSNA will include more information gained through active dialogue with local people, service users and their carers.
3. The findings of the JSNA drive any proposed revisions, changes or additions to local improvement targets in the new Local Area Agreement.
4. The findings of the JSNA are used to impact directly on revised commissioning strategies, including the 5-year Commissioning Strategy Hull tPCT is currently preparing for the World Class Commissioning Assurance process. Revised or new joint commissioning strategies developed from 2009-10 should evidence a direct linkage to the JSNA findings.
5. The JSNA is used as the basis to further strengthen joint commissioning arrangements between Hull tPCT and Hull City Council, with a focus on redesigning key care pathways across, in particular, health, housing

<sup>7</sup> Kingston upon Hull City Wide Housing Strategy 2008-11 (2008; 12)

and adult social care; and addressing identified local data gaps such as mental health.

6. Commissioning should focus on 'end to end' care and support pathways to achieve improved outcomes, with a strategic shift towards prevention, early diagnosis and intervention and rehabilitation with a particular focus on priority areas identified by the JSNA.
7. The JSNA is used to build on the considerable investment Hull has already made in social marketing approaches in relation to smoking, obesity, alcohol and domestic violence and strengthening community engagement approaches, with consideration of extending this approach to other priorities identified by the JSNA. Consideration should be given to extending social marketing approaches to other key priority area such as Stroke, CHD, Diabetes, COPD, Mental Health and Cancer.
8. JSNA is used to ensure that strategic crosscutting issues such as the importance of housing, transport and age-proofing mainstream services are fully considered in relation to developing new or revised joint commissioning strategies for specific population groups such as older people.
9. JSNA becomes embedded across both Hull PCT and Hull City Council as a continuous rather than a one – off/annual process.
10. JSNA is used to strengthen/change performance management and evaluation processes in order to ensure direct linkages (“what works”) can be made to individual outcomes, outcomes achieved as a result of specific services and interventions for targeted population groups and wider population/strategic outcomes.
11. Hull Teaching PCT and Hull City Council should use the JSNA to foster joint working in quantitative data collection and statistical analysis. The organisations should explore new ways of drawing main messages from the large quantities of qualitative data which will be gathered within the Council Panel project and the PCT Listening Exercise and Membership scheme. The JSNA steering group should build on existing predictive modelling activities in order to foster better understanding of impacts of strategies.
12. Hull tPCT and Hull City Council should continue and build on the current Health Impact Assessment activity in order to ensure that health impacts are at the heart

of strategy decisions. This information should form part of the reiterative process of JSNA.

13. The JSNA is used to promote improved health and well-being in Hull across all sectors including employers and the business community.
14. The JSNA is used as an evidence base to support an increased focus on community empowerment and increasing social capital including consideration of 'Connected Care' models based on a whole system approach targeted at the most deprived areas of Hull.
15. The findings of the JSNA should be communicated as widely as possible in the context of stimulating innovative responses from providers and the voluntary and community sector.



## 3 Demography

### 3.1 Analysis of JSNA core dataset

#### 3.1.1 Key demographic trends

- Hull's all ages mortality and infant mortality rates are higher than the English national average.
- The healthy life expectancy for people aged 65 years or over living in Hull is over 20 months less than the national average for both men and women and is almost a year less for both sexes compared to regional averages.
- The city's economic activity, employment and average income are all lower than the national average whilst the unemployment rate for the area is higher.
- Whilst projected population estimates vary, the consensus is that Hull's population will increase slightly over the next two decades.
- The number of people aged 65 years and over will increase by about 10,000 by 2025. The number of older people with health problems requiring high levels of support is also set to increase significantly.

#### 3.1.2 Ethnicity

- The Office for National Statistics estimated the Black and Minority Ethnic (BME) population in Hull to be 7.38% of the population in 2005, up from 3.84% in 2001. The same dataset found that Hull's non-white population had increased from 2.48% to 5.06% over the same period<sup>8</sup>.
- A more recent study provided a slightly lower estimate, stating that the city's BME population was around 6.2% of the City's population at that time (approximately 16,000 people at that time)<sup>9</sup>.
- The ONS dataset found that, in 2005, the proportion of men in Hull from BME groups is larger than the proportion of women (8.22% and 6.46% respectively). Similarly, there are a higher proportion of non-white men (5.71%) than women (4.33%)<sup>10</sup>.

#### 3.1.3 Growth of the BME population

- The growth of all BME groups is greater in Hull than the Yorkshire & Humberside region as a whole (except 'White/ Black African'). In many cases the rate of population growth of Hull's BME communities is double, or even treble, that of the region<sup>11</sup>.

<sup>8</sup> ONS 2005 mid-year estimates; Ethnicity in Hull 2005 spreadsheet

<sup>9</sup> Hull's Health and Lifestyle survey of 2007

<sup>10</sup> ONS 2005 mid-year estimates; Ethnicity in Hull 2005 spreadsheet

<sup>11</sup> ONS 2005 mid-year estimates; Ethnicity in Hull 2005 spreadsheet

- The rate of population growth is fastest in the 'Asian Other' and 'Black African' communities.
- Further growth in all of Hull's BME populations is projected until at least 2030<sup>12</sup>.
- Whilst it is very difficult to project future BME populations accurately due to the unpredictable nature of migration<sup>13</sup> further growth in all of Hull's BME populations is expected until at least 2030<sup>14</sup>.

#### 3.1.4 Limiting long-term illness

- In 2001, approximately 20% of the population had a limiting long-term illness. This rate was higher than the Yorkshire & Humber (19%) and England average (17%).
- The percentage of households with one or more person with a limiting long-term illness (37.5%) was approximately 4% higher than the England average<sup>15</sup>.
- The percentage of Hull's children and young people with limiting long-term illnesses was higher than the national average in 2001, particularly amongst those aged 10-14 years<sup>16</sup> (more research may be worthwhile in this area).

#### 3.1.5 Disability

- 8.6% of Hull's total population (all ages) was registered disabled in 2007<sup>17</sup>.
- The total population of older people aged 65 years and over who had a limiting long-term illness was estimated to be 19,355 in 2008 and is projected to rise by 26% by 2025<sup>18</sup>.

#### 3.1.6 Migration

- Migration from accession countries (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovak Republic and Slovenia) has increased dramatically over the last couple of years.
- Details from National Insurance registrations for 2006/07 shows that the largest number of registrations were from Poland (1,420), followed by Latvia (190), Lithuania (150) and the Slovak Republic (140). After these are non-EU countries of China (70), Iraq (60), Russian Federation (60) and India and Pakistan (both 50)<sup>19</sup>.

<sup>12</sup> University of Leeds School of Geography, 2006

<sup>13</sup> Hull PCT: World Class Commissioning Context section (version July 2008; page 20)

<sup>14</sup> University of Leeds School of Geography, 2006

<sup>15</sup> Office of National Statistics: April Census 2001

<sup>16</sup> Office of National Statistics: April Census 2001

<sup>17</sup> Hull's Health and Lifestyle survey of 2007

<sup>18</sup> POPPI projections based on Census April 2001 figures

<sup>19</sup> The Yorkshire & Humber Assembly research into Analysis of Migration Trends and Drivers (2007;90)

## 3.2 Priorities identified by Hull's health and social care assessments and strategies

### 3.2.1 Life expectancy and mortality

Life expectancy, and healthy life expectancy after 65 years are much lower and all ages and infant mortality are much higher than the English average.

Hull's interventions relating to these issues are discussed in later sections.

### 3.2.2 Older people

Hull's older population is growing. The challenges relating to services and housing provision are addressed in the 'Social and Environmental Context' section of this analysis.

### 3.2.3 Disability

The challenges relating to the disabled population are expanded upon in the 'Services' section of this report.

### 3.2.4 Ethnicity and migration

Hull's BME and 'non-white' populations are growing both in absolute terms as well as relative to the 'White British' population. Furthermore, external migration and economic migration from European accession and other countries as well as immigration resulting from refugees and asylum seekers means further growth in the minority ethnic population in Hull.

This will create additional demands and challenges in terms of delivering culturally sensitive services in future.

## 3.3 Developing Knowledge

### 3.3.1 Limiting long-term illness

Consideration should be given to conducting more evidence-based interventions involving people with life limiting long-term illnesses (e.g. rehabilitation strategies; strategies relating to aiding people to find employment, etc.).

### 3.3.2 Ethnicity and migration

Data could be improved in relation to projected future scenarios of the BME population as well as the challenges posed by external migration.

## 4 Social and Environmental Context

### 4.1 Analysis of core dataset

#### 4.1.1 Deprivation

- Averaging the scores from the 163 Hull Lower Layer Super Output Areas (LLSOAs), the IMD 2007 score for Hull was 38.3, ranking it the 11th most deprived local authority out of the 352 in England. This was an improvement on the 2004 score that ranked Hull as the 9th most deprived authority. This suggests Hull is moving in the right direction, showing improvement relative to other areas.
- More than half the people living in Hull live in areas which are defined as the most deprived 20% of areas nationally and a further quarter live in areas in the next most deprived quintile nationally. None of Hull's residents live in geographical areas defined nationally as the 20% least deprived.
- This mean deprivation and its associated health and social problems are spread throughout the city rather than concentrated in particular areas.
- St Andrew's, Orchard Park & Greenwood, Myton, Southcoates East and Marfleet continue to be the most deprived wards in Hull and most of the 23 wards in Hull have a similar rank based on the IMD 2007 as they did for the IMD 2004<sup>20</sup>.

#### 4.1.2 Employment and income

- At June 2008, 20.1% of the working age population were claiming benefits<sup>21</sup> compared to 14.5% regionally and 13.9% nationally.
- There were 33,290 benefit claimants among adults of working age in November 2007. 4.4% of working age adults were claiming job seekers allowance, 8.8% incapacity benefit, 3.3% lone parents benefit, 1.5% carer benefits, 0.8% other income related benefits, 1.1% disability benefits and 0.2% bereavement benefits<sup>22</sup> (based on main reason for claim).
- Hull had a higher percentage of claimants who had claimed for between 6-12 months and over 12 months than Yorkshire & the Humber and England as a whole<sup>23</sup>.
- Hull had an employment rate of 66.7% in 2005/06, 7.1% below the Yorkshire & Humber average and 7.7% below the England average<sup>24</sup>.

<sup>20</sup> Hull PCT: Hull PCT: World Class Commissioning (Draft Context July 2008) (Draft July 2008) 2008; 8

<sup>21</sup> DWP benefit claimants - working age client group

<sup>22</sup> DWP benefit claimants - working age client group; <https://www.nomisweb.co.uk>

<sup>23</sup> JSA claimants by age and duration (June 2008): <https://www.nomisweb.co.uk/>

- Average wage levels are 81% of the national average<sup>25</sup>.
- Nearly a quarter of the city's households suffer income deprivation affecting 36% of Hull's children and 26.8% of people over 60<sup>26</sup>.
- 48% of households in Hull had no car or van in 2001<sup>27</sup>.

#### 4.1.3 Older People

- It is estimated that, by 2017, there will be 40,700 older people aged 65 years or over residing in Hull. This number will rise to 47,900 by 2027<sup>28</sup>.
- By 2025 there will be 6,016 older people aged between 65-74 years living alone in Hull and 10,026 older people aged 75+ years living alone<sup>29</sup>.
- 24% of older people aged 65 years and over had no central heating in their homes in 2001<sup>30</sup>.

#### 4.1.4 Housing

- At present 56% of council housing stock is "non decent", this compares to just 15% in the East Riding of Yorkshire<sup>31</sup>.
- Hull has a significant social rented sector (almost 31%, largely made up of Local Authority stock), which is proportionally larger than the national or regional averages<sup>32</sup>.
- There is a lack of larger, 'aspirational' and family-oriented properties and this has been identified as an inhibiting factor to development of the local economy due to a lack of attractive housing for graduates, knowledge workers, professionals and wealthier families<sup>33</sup>.
- There is also a projected shift to a greater proportion of single person households who are likely to require smaller housing.
- The Housing Market Assessment (HMA) estimates household growth at 918 new households per year to 2026, but a reduction in household size from 2.25 persons in 2004 to 1.95 persons by 2026.
- The HMA states that Hull should plan at a minimum to provide 989 new homes per year up until 2026<sup>34</sup>.

<sup>24</sup> Annual Local Area Labour Force Survey (ALALFS) and Annual Population Survey (APS) employment rates, 1997/98 to 2005/06\* (August 2007)

<sup>25</sup> Housing Strategy 2008-2011: 2008; 93 ([www.nomisweb.co.uk](http://www.nomisweb.co.uk), ONS, Annual Survey Hours & Earnings)

<sup>26</sup> Housing Strategy 2008-2011: 2008; 93 ([www.nomisweb.co.uk](http://www.nomisweb.co.uk), ONS, Annual Survey Hours & Earnings)

<sup>27</sup> Office of National Statistics UV62 (Census April 2001)

<sup>28</sup> Older People's Draft Strategy 2008-11 (2008; 35)

<sup>29</sup> POPPI: Figures are taken from the General Household Survey 2004, table 3 Households, families and people, section 3.4 Percentage of men and women living alone by age, ONS.

<sup>30</sup> POPPI: Figures are taken from Office for National Statistics (ONS) 2001 Census, Standard Tables, Table SO54 Shared / unshared dwelling and central heating and occupancy rating by age.

<sup>31</sup> RIS Baseline Data as at April 2006 cited in Kingston upon Hull City Wide Housing Strategy 2008-11 (2008; 31)

<sup>32</sup> Kingston upon Hull City Wide Housing Strategy 2008-11 (2008; 26)

<sup>33</sup> Kingston upon Hull City Wide Housing Strategy 2008-11 (2008; 12)

<sup>34</sup> Kingston upon Hull City Wide Housing Strategy 2008-11 (2008; 26)

- 4,184 households are living in overcrowded conditions<sup>35</sup>.

## 4.2 Priorities identified by Hull's health and social care assessments and strategies

This section will provide an overview of the National Indicators (NIs) that are relevant to evaluating Hull's performance in terms of the 'Social and Environmental context'. It will also include a summary of locally identified priorities including those included as improvement targets in Hull's new Local Area Agreement and those identified in Hull's Community Strategy.

### 4.2.1 Relevant National Indicators

In October 2007 the Government announced a new National Indicator Set (NIS) of 198 indicators for English local authorities and local authority partnerships (13 for which will be introduced in 2009/10). It brings together national standards and priorities set by government with local priorities informed by the vision developed by the local authority and its partners.

The NIS was developed as part of the Comprehensive Spending Review (CSR). The indicators measure success in the local delivery of the Government's priority outcomes expressed through the Public Services Agreements (PSAs) set out in the Comprehensive Spending Review (CSR) and are therefore key to ensuring the Government achieves its aspirations for the period 2008/09 to 2010/11. The PSAs most directly relevant to improving health and well-being are:

- PSA 12: Improve the health and well-being of children and young people.
- PSA 16: Increase the proportion of socially excluded adults in settled accommodation and employment, education or training.
- PSA 17: Tackle poverty and promote greater independence and wellbeing in later life.
- PSA 18: Promote better health and wellbeing for all.
- PSA 19: Ensure better care for all.
- PSA 25: Reduce the harm caused by alcohol and drugs.

31 of the indicators contained in the NIS which relate to health and well-being are also 'Vital Signs' for PCTs in relation to the new performance framework for PCTs set out in the 2008/09 NHS Operating Framework and relate directly to key themes and priorities set out in this JSNA. In particular, we have focused on the National Indicators (NIs) which were agreed with the Government Office as improvement targets in Hull's new Local Area Agreement (LAA).

<sup>35</sup> Marianne Toutountzi: Hull CC Housing Department

The new performance framework for the NHS contains three Tiers of priorities which are measured by the Vital Signs.

- Tier 1 – National Requirements (i.e. Department of Health ‘must dos) these include:
  - Reducing MRSA infections,
  - Reducing Clostridium Difficile,
  - Delivery of 18-week referral to treatment,
  - Improving access to primary care,
  - Implementation of the national cancer strategy,
  - Implementation of the stroke strategy.
- Tier 2 – National Priorities for local delivery – where Hull PCT has local flexibility as to how these priorities are delivered.
- Tier 3 – A set of agreed local priorities which PCTs can prioritise for themselves to drive service improvement harder in areas that will make the most difference to their population. In choosing local targets PCTs are not limited to the indicators included in Tier 3 of the Vital Signs as listed in the NHS 2008/09 Operating Framework.

#### 4.2.2 Hull’s Local Area Agreement (LAA)

Hull’s new Local Area Agreement (LAA)<sup>36</sup> includes a range of improvement targets agreed with the Government Office based upon the circumstances, needs and individual characteristics of Hull’s population

Figure 1 below maps Local Government National Indicators against PCT Vital Signs and improvement targets included in Hull’s LAA.

*Figure 14 Local Government National Indicators mapped against PCT Vital Signs and improvement targets selected for Hull’s LAA (highlighted in yellow)*

NIS No.	Indicator	PCT Vital Sign Tier 2 or 3 ?	LAA Improvement Target?
NI 116	Proportion of children in poverty	No	Yes
NI 138	Satisfaction of people over 65 with both home and neighbourhood	No	No
NI 146	Adults with learning disabilities in employment	Yes – Tier 3	No
NI 149	Adults in contact with secondary mental health services in settled accommodation	Yes – Tier 3	No
NI 150	Adults in contact with secondary mental health services in employment	Yes – Tier 3	No

<sup>36</sup> Local Area Agreement Version 2/ LAA2

NIS No.	Indicator	PCT Vital Sign Tier 2 or 3 ?	LAA Improvement Target?
NI 151	Overall employment rate	No	No
NI 152	Working age people on out of work benefits	No	Yes
NI 153	Working age people claiming out-of-work benefits in worst performing neighbourhoods	No	No
NI 154	Number of additional houses	No	Yes
NI 158	Decent homes target*	No	No
NI 166	Average earnings of employees in the area	No	No
NI 173	People falling out of work and on to incapacity benefits	No	No
NI 187	Tackling fuel poverty	No	Yes
NI 8	Percentage of adult population who participate in sport	No	Yes
NI 39	Alcohol-harm related hospital admission rates	Yes – Tier 3	No
NI 40	Drug users in effective treatment*	Yes – Tier 2	No
NI 53	Prevalence of breast-feeding at 6-8 weeks from birth	Yes – Tier 2	No
NI 55	Obesity among primary school children in Reception Year	Yes- Tier 2	No
NI 56	Obesity among primary school children in Year 6	Yes- Tier 2	Yes
NI 57	Children and young people's participation in high-quality PE and sport*	No	No
NI 112	Under 18 conception rate	Yes – Tier 2	Yes
NI 123	Stopping smoking	Yes – Tier 2	No
NI 48	Children killed or seriously injured on roads	No	No
NI 70	Hospital admissions caused by unintentional and deliberate injuries to children and young people	Yes – Tier 3	No
NI 113	Incidence of Chlamydia in under 25 year olds	Yes – Tier 2	No
NI 119	Self-reported measure of people's overall health and wellbeing	Yes – Tier 3	No
NI 120	All-age all cause mortality rate	Yes – Tier 2	Yes
NI 121	Mortality rate from all circulatory diseases at ages under 75	Yes- Tier 2	No
NI 122	Mortality from all cancers at ages under 75	Yes- Tier 2	No
NI 123	16+ current smoking rate prevalence	Yes – Tier 2	No
NI 137	Healthy life expectancy at age 65	Yes – Tier 3	No
NI 127	Self reported experience of social care users	Yes – Tier 3	No
NI 132	Timeliness of social care assessment	Yes – Tier 3	No
NI 135	Carers receiving needs assessment or review and a specific carer's service, or advice and information	Yes – Tier 3	Yes



NIS No.	Indicator	PCT Vital Sign Tier 2 or 3 ?	LAA Improvement Target?
NI 136	People supported to live independently through social services (all ages)	Yes – Tier 3	Yes
NI 139	People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently	No	No
NI 140	Fair treatment by local services	No	No
NI 141	Percentage of vulnerable people achieving independent living	No	Yes

\* Note: LAA Stretch target carried over from LAA1

The following table lists the four improvement targets (highlighted in yellow) that were selected from the NIS for inclusion in Hull's new LAA that related directly to the 'Social and Environmental Context' section of the JSNA.

Figure 15 National Indicators relating to 'Social and Environmental context' selected for JSNA dataset by Hull CC (Hull's LAA priority NIs are highlighted in yellow)

National Indicator (LAA Priority where highlighted)	Indicator specifications
NI 116	Proportion of children in poverty
NI 138	Satisfaction of people over 65 with both home and neighbourhood
NI 146	Adults with learning disabilities in employment
NI 149	Adults in contact with secondary mental health services in settled accommodation
NI 150	Adults in contact with secondary mental health services in employment
NI 151 (LAA Target)	Overall employment rate
NI 152	Working age people on out of work benefits
NI 153 (LAA Target)	Working age people claiming out-of-work benefits in worst performing neighbourhoods
NI 158 (LAA Target)	Decent council homes
NI 166 (LAA Target)	Average earnings of employees in the area
NI 173	People falling out of work and on to incapacity benefits

Hull's LAA chose employment, housing and average income as key areas for future focus. **This matches the priorities identified by the JSNA analysis which identified deprivation, low income, employment and housing as key areas of focus for Hull.**

#### 4.2.3 Priorities identified by Hull's Community Strategy 2006-11

The following priorities relating to 'Social and Environmental context' were identified by Hull's Community Strategy:

- Increase the employment rate in Hull to the national average. This will require an extra 9,000 people resident in Hull to be in employment by 2011<sup>37</sup>. The target is to reach a level of 75.2% employment by 2011<sup>38</sup>.
- The rate of business start-ups in the City to grow at twice the national average. This would require double the number of businesses being created every year until 2011 than are being created at the moment<sup>39</sup>.
- Narrow the earnings gap between Hull and the rest of the country. Wages in Hull will need to increase by over £100 per week in order to meet the target in 2011<sup>40</sup>. A target of average weekly earnings of £496 per week by 2011 has been set by Hull CC<sup>41</sup>.

<sup>37</sup> Extracted from Hull's Community Strategy 2006;11

<sup>38</sup> Extracted from Hull's Community Strategy 2006;34

<sup>39</sup> Extracted from Hull's Community Strategy 2006;11

<sup>40</sup> Extracted from Hull's Community Strategy 2006;11

<sup>41</sup> Extracted from Hull's Community Strategy 2006;34

- The growth in jobs requiring high-level skills in the city to be double the national average. Over 10,000 extra individuals would need to be employed in high-level jobs in 2011 for this target to be reached<sup>42</sup>.
- Improve the quality of the housing stock within the city which will involve ensuring that all social sector housing reaches the minimum, quality standard by 2011<sup>43</sup>.

#### 4.2.4 Other documents

A key objective in the Older Person Corporate Strategy is the commissioning of a wide choice of extra care housing for older people which promotes well-being, independence and choice<sup>44</sup>.

### 4.3 Current interventions deployed by Hull CC and PCT to meet key objectives

#### 4.3.1 Improved prosperity

##### Addressing deprivation, employment and low income

Hull has regeneration plans in place which are detailed below in the 'Housing' section.

#### 4.3.2 Housing

Improving and diversifying Hull's housing has been established as crucial in the process of stimulating Hull's economy, increasing the attractiveness of the area to key workers and establishing the city as a sub-regional hub for commerce.

##### Meeting growing demand

Hull is seeking to meet the challenge of supplying (a minimum of) 918 additional properties per year by reducing the number of long-term empty properties by 275 in 2006<sup>45</sup>. This process is to continue between 2008 and 2011. Hull projects that, in the period 2008 to 2011, 2,507 new homes will be completed<sup>46</sup>.

##### Addressing problems with housing mix

Hull is aiming to address the lack of diversity in the housing stock by prioritising certain types of housing, aiming to ensure (where appropriate) larger family housing represents more than 50% of new build provision<sup>47</sup>.

English Partnerships has also provided a grant of £9.3m for first time buyer initiative funding in order to address the asymmetry in the public to private ownership ratio in Hull<sup>48</sup>.

<sup>42</sup> Extracted from Hull's Community Strategy 2006;11

<sup>43</sup> Extracted from Hull's Community Strategy 2006; 27

<sup>44</sup> Kingston upon Hull City-wide Housing Strategy 2008-11 (2008;3)

<sup>45</sup> Kingston upon Hull City-wide Housing Strategy 2008-11 (2008;3)

<sup>46</sup> Kingston upon Hull City-wide Housing Strategy 2008-11 (2008;125)

<sup>47</sup> Kingston upon Hull City-wide Housing Strategy 2008-11 (2008;29)

<sup>48</sup> Kingston upon Hull City-wide Housing Strategy 2008-11 (2008;117)

### Improving quality of housing stock

The Council has made a firm commitment to get all of its housing stock to the Decent Homes Standard by 2010-11 and is on target in spite of the flooding of 2007. Private sector owners are also being supported in reaching this standard with vulnerable owner occupiers being prioritised. This could address the problems identified regarding a lack of central heating in the homes of older residents in the Hull area.

Through partnership with Gateway 150 new homes and 500 refurbishments were completed between 2006-08 an allocation of £87 million has been secured for this work to continue between 2008-11<sup>49</sup>.

#### 4.3.3 Housing led regeneration: Gateway regeneration programme

Hull City Council and its partners have developed the City's Spatial Strategy which lays out the council's plans to develop transport infrastructure (e.g. improving east-west movement and connections between neighbourhoods and the City Centre and beyond into the East Riding of Yorkshire), increase employment, promote district centres as hubs for sustainable communities and prioritise areas for regeneration.

*The strategy sets out a 'phased process for housing-led regeneration with the initial focus being on the areas of Newington and St Andrews (NaSA) and the Estates of Preston Road and Ings in the Holderness Road Corridor... these areas are linked to economic regeneration in the city centre and along the waterfront'<sup>50</sup>.*

The council and its partners has committed to expenditure of £91m for 2008-11<sup>51</sup>.

#### 4.3.4 Older people

At 2005, the current provision for older people was assessed by Supporting People as being similar to regional figures but less than the national figures.

There was an agreement in 2005 for a strategic review of services for older people across Supporting People, health, housing and voluntary agencies with a view to reconfiguring services and spend to better meet needs including additional extra care provision<sup>52</sup>.

Services for older people with support needs dominate the Supporting People programme. This can be broken down into:

<sup>49</sup> Kingston upon Hull City-wide Housing Strategy 2008-11 (2008;3)

<sup>50</sup> Kingston upon Hull City-wide Housing Strategy 2008-11 (2008;17)

<sup>51</sup> Kingston upon Hull City-wide Housing Strategy 2008-11 (2008;117)

<sup>52</sup> Supporting People 5 Year Strategy 2005-10 (2005; 9)

- 3,383 units<sup>53</sup> within accommodation based services (including 40 units of Extra Care housing)
- 32 units of floating support.
- 3,388 units of community alarm services.
- 200 Home Improvement agency interventions<sup>54</sup>.

Plans are in place (as of Summer 2008) to develop the joint commissioning of support for older people at home in order to increase the number of older people receiving care packages tailored to their individual needs<sup>55</sup>.

Hull's Older People Strategy will also begin widening the use of Supporting People money so that it goes beyond 'traditional' support for 'blocks' of people in 'sheltered' accommodation which will enable owner-occupiers to access Supporting People money (work beginning not later than December 2008). Additionally, a new repairs service is being launched in summer 2008 which should help older people to live at home for longer.

In terms of increasing the number of housing units suitable for older people, Hull City Council's Housing Department has put in place a plan to convert single bedroom bungalows into two bedroom accommodation in order to increase capacity and reduce the number of older people living in isolated housing: 25 have been completed and a further 1,116 have been earmarked for conversion between 2008-11<sup>56</sup>.

Hull is undertaking the following interventions in older people's services:

- Deploy and support Health Trainers to work with older people in the community to promote and overcome barriers to active living<sup>57</sup>.
- Developing a systematic approach to reducing health inequalities and improving life expectancy including a cardiovascular disease (heart disease and stroke) risk assessment and intervention programme for 40-64 year olds and a programme to increase identification of undiagnosed Atrial Fibrillation in the over 65s.
- Further developing Hull's Falls prevention service
- Review current stroke services in the light of the 10 year National Stroke Strategy published in December 2007<sup>58</sup>.
- Focusing on improving mental health services for older people<sup>59</sup>.

<sup>53</sup> A unit is defined as including a house, an apartment, a mobile home, a group of rooms, or a single room that is occupied (or if vacant, is intended for occupancy)

<sup>54</sup> Supporting People 5 Year Strategy 2005-10 (2005; 18)

<sup>55</sup> Hull Older People Draft Action Plan (2008:6)

<sup>56</sup> Hull Older People Draft Action Plan (2008:6)

<sup>57</sup> Hull Older People Draft Action Plan (2008:2)

<sup>58</sup> Hull Older People Draft Action Plan (2008:3)

<sup>59</sup> Ibid. (2008:4)

- Encouraging physical activity and exercise (e.g. Active in Age; Swimfit)<sup>60</sup> and building voluntary, community and faith organisations' capacity to deliver such services.
- Health screening and advice for carers and assist carers in taking short breaks.

These interventions contribute towards and focus on the cross-cutting targets of all-cause all-age mortality rate, circulatory disease mortality rates, increasing independence and enabling 'aging in place' as well as improving mental health services in Hull.

## 4.4 Developing Commissioning

### 4.4.1 Housing

Hull forecasts a new build total of 2,507 new homes between 2008-11. This is 460 homes below the minimum requirement of 2,967 new homes recommended by the HMA (989 new homes per year until 2026).

In the same period, Hull projects that it will free up 160 long-term empty properties<sup>61</sup>. This leaves a shortfall of 300 properties (calculated from the projected *minimum* requirement) between 2008-11.

## 4.5 Developing Knowledge

### 4.5.1 Adults with Learning Disabilities in employment

According to Hull CC plans are in place to collect data concerning this from October 2008 given its inclusion in the National Indicator Set for Local Government. We recommend that this data be included in future JSNA refreshes.

### 4.5.2 Adults in contact with secondary mental health services in settled accommodation and/or employment

According to Hull CC plans are in place to collect data concerning this from October 2008 given its inclusion in the National Indicator Set for Local Government. We recommend that this data be included in future JSNA refreshes.

<sup>60</sup> Ibid. (2008;5)

<sup>61</sup> Kingston upon Hull City-wide Housing Strategy 2008-11 (2008;125)

## 5 Lifestyle and Risk Factors

### 5.1 Analysis of JSNA core dataset

#### 5.1.1 Smoking

- 31.7% of adults aged over 16 smoked in Hull in 2007<sup>62</sup>. 34% of males and 30% of females smoked in Hull (Hull health and lifestyle survey 2007) compared to 23% and 21% respectively in England as a whole<sup>63</sup>.
- 27.7% of women smoked during pregnancy in 2006-07 compared to 21.7% in Yorkshire & Humber and 16.6% nationally<sup>64</sup>.

#### 5.1.2 Alcohol

- Hull had the highest rate of alcohol-harm related hospital admissions per 100,000 of its 14 comparator authorities in 2006/07 and in 2005/06 and had the second highest rate in 2004/05<sup>65</sup>.
- 22% of respondents to the Hull Health and Lifestyle Survey 2007 admitted to binge drinking<sup>66</sup> in the past 7 days.

#### 5.1.3 Eating Habits

- Only Doncaster out of a list of 15 comparators in the Yorkshire & Humber Strategic Health Authority (see figure 76 in the JSNA core data-set document) had a lower rate of breastfeeding of infants at 6-8 weeks than Hull in 2006/07 (51.7%)<sup>67</sup>.
- On average, 76% of Hull's residents do not meet their 5-a-day fruit and vegetables requirement for healthy eating<sup>68</sup>.

#### 5.1.4 Exercise

- Only 29% of men and 24% of women in Hull achieved the Government guidelines of exercising moderately or vigorously for at least 30 minutes on at least five occasions per week compared to 37% of men and 25% of women in England. (Hull figures from 2007 Health and Lifestyle Survey, and England's figures from Health Survey for England, 2004)<sup>69</sup>.

<sup>62</sup> Hull health and lifestyle survey 2007 ([www.hullpublichealth.org](http://www.hullpublichealth.org))

<sup>63</sup> Hull PCT: World Class Commissioning Context Section (version July 2008): 2008; 83

<sup>64</sup> Hull PCT: World Class Commissioning Context Section (version July 2008): 2008; 121

<sup>65</sup> Vital Signs 2006/07

<sup>66</sup> Defined as drinking eight or more alcohol units for men or drinking six or more alcohol units for women on a single day at least one day per week

<sup>67</sup> Vital Signs 2006/07

<sup>68</sup> Hull 2007 health and lifestyle survey ([www.hullpublichealth.org](http://www.hullpublichealth.org))

<sup>69</sup> Hull 2007 health and lifestyle survey ([www.hullpublichealth.org](http://www.hullpublichealth.org))

### 5.1.5 Conceptions

- Hull's under 18 years conception rate (73.3 per 1,000 female pop) was 70% higher than the Yorkshire & Humber rate and 76% higher than the England rate between 2003-05<sup>70</sup>.
- Hull's rate of under 16 conceptions (15.1 per 1,000 female pop) was 70% higher than the Yorkshire & Humber rate and 96% higher than the English rate for 2003-05<sup>71</sup>.
- In future Hull may wish to consider collecting data concerning the proportion of teenage mums who were themselves born to teenage mothers.

### 5.1.6 Obesity

- Obesity is a risk factor for health problems in later life (e.g. obesity is the key risk factor for Diabetes).
- In 2007, 67% of men and 55.9% of women were overweight or obese (61.4% on average). Whilst these rates were lower than the English 2006 average this still presents a significant challenge due to related future health outcomes<sup>72</sup>. In terms of adult obesity in Hull, levels have changed little between 2004 and 2007 (as measured by Body Mass Index (BMI))<sup>73</sup>.
- For the most recent school year 2006/07 reception year children (aged 4-5 years), 14.2% of boys and 15.8% of girls were overweight and 13.8% of boys and 9.6% of girls were obese.
- For Reception Year children (aged 4-5 years), the annual obesity rate for girls showed the second successive fall, from a peak of 12.5% in 2004/05 to 9.6% in 2006/7. However for boys there is no sign of a halt in the rise in obesity, with a new high of 13.4% recorded, an increase of 1.3 % on 2005-06. This should be addressed<sup>74</sup>.
- For the 2006/07 school year for children in Year 6 (aged 10-11 years), 16.2% of boys and 15.4% of girls were overweight and 20.8% of boys and 21.1% of girls were obese.
- For Year 6 children (aged 10-11 years) the trends in obesity (if not the actual levels) are encouraging. For girls, obesity levels fell from 22.6% in 2005/06 to 20.9% in 2006/07 and for boys there was a similar fall from 22.6% to 21.1%.

<sup>70</sup> Information Centre for Health and Social Care: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base ([www.nchod.nhs.uk](http://www.nchod.nhs.uk) or [nww.nchod.nhs.uk](http://nww.nchod.nhs.uk))

<sup>71</sup> Ibid.

<sup>72</sup> Hull PCT: World Class Commissioning (Draft Context July 2008) report 2007 figures (2008; 104) and most recent England data (2006) found at the NHS Information Centre:

<http://www.ic.nhs.uk/pubs/opadjan08>

<sup>73</sup> Hull PCT: World Class Commissioning (Draft Context July 2008) report: 2008;10

<sup>74</sup> Extracted from: Hull Childhood Obesity Report, Public Health Sciences October 2007, revised April 2008; Hull PCT: World Class Commissioning (Draft Context July 2008) : 2008;10



### 5.1.7 Unintended and deliberate Injuries

- Of the 10 comparator PCTs Hull had the second highest admission rate for unintended and deliberate injuries in children under 19 years. The rate was 39% higher than the Yorkshire and Humber average and 50% higher than the England average<sup>75</sup>.
- In Hull there is a clear relationship between the admission rate for deliberate and unintended injuries and high levels of deprivation.

## 5.2 Priorities identified by Hull's health and social care assessments and strategies

### 5.2.1 National indicators and Hull's Local Area Agreement

The following table lists the National Indicators (NIs) which have been selected for special scrutiny in Hull's JSNA. Those indicators which were selected as improvement targets as part of Hull's Local Area Agreement (LAA) have been highlighted in yellow.

*Figure 16 List of National Indicators relating to 'Lifestyle/ Risk factors' selected for JSNA scrutiny by Hull CC (Hull's LAA priority NIs are highlighted in yellow)*

National Indicator	Indicator specifications
NI 39 (LAA Target)	Alcohol-harm related hospital admission rates
NI 40 (LAA Target)	Drug users in effective treatment*
NI 53	Prevalence of breast-feeding at 6-8 weeks from birth
NI 55	Obesity among primary school children in Reception Year
NI 56	Obesity among primary school children in Year 6
NI 57 (LAA Target)	Children and young people's participation in high-quality PE and sport*
NI 112 (LAA Target)	Teenage pregnancy (reduce by 50%) by 2010
NI 123 (LAA Target*)	Stopping smoking

\*Note: LAA Stretch target carried over from LAA1

Hull's LAA selected alcohol-related harm, drug misuse, low levels of children and young people's participation in sport/obesity, teenage pregnancy and smoking as the key areas for Hull to focus on. These priorities match those identified by the analysis carried out for Hull's JSNA.

### 5.2.2 Hull's Children's and Young People's Plan 2006-2008

Hull's Children's and Young People's Plan 2006-2008 (Hull City Council, 2006a) included 12 priority areas as follows. Those

<sup>75</sup> Hull PCT: World Class Commissioning (Draft Context July 2008;11)

priorities relevant to the Lifestyle/ Risk factors section of the JSNA are as follows:

- Prevent the harm caused by drug, alcohol, tobacco or substance misuse involving children, young people, their parents and families.
- Promote healthy lifestyles for children and young people, and their parents and families.
- Promote opportunities for all children to have fun and enjoy life.

The key health-related measures of success identified by the Children & Young People's Strategy which are directly related to the 'Lifestyle/ Risk factors' section of the JSNA are as follows:

- Reduction in under 18 conception rates.
- Reduction in under 16 conception rates.
- Reduction in the proportion of expectant mothers smoking during pregnancy.
- Reduction in deaths from suicide and undetermined injury.
- Take up of sporting opportunities by 5-16 year olds.
- Reduction in the percentage of children under 11 classified as obese.
- An increase in the take up of cultural and sporting opportunities among young people over the age of 16.

Themes of teenage conceptions, smoking (particularly during pregnancy), obesity and access to sporting activities and exercise were highlighted as key areas for Hull to focus on. These key themes and areas for prioritisation of resources were also identified by Hull's JSNA analysis.

### 5.3 Current interventions commissioned by Hull CC and PCT to meet key objectives

#### 5.3.1 Teenage Conception, Pregnancy and Parents

##### Teenage parents

Whilst provision for teenage parents is higher than the national and regional averages<sup>76</sup>, the need for further services was identified in 2005 by the Teenage Pregnancy and Parenting Group work plan (2004-06). In 2005, 39 units of floating support<sup>77</sup> were provided for teenage parents. Additional emergency accommodation (mother and child assessment) and

<sup>76</sup> As of 2005-06: Cited in Supporting People Strategy 2005-2010 (2005; 27)

<sup>77</sup> Floating support is provided by staff who visit people in their homes. These services are usually open to people living in different types of accommodation, including those renting council or housing association accommodation or those living in private rental accommodation. It is often used in short-term periods of difficulty and can cover a range of issues, tailored to individual needs. For example, it may be used to help set up home, to gain access to other services, to develop independent living skills and for help with financial management.

reconfiguring of existing floating support provision for teenage parents was recommended and made a commissioning priority for the Supporting People Strategy in 2005<sup>78</sup>.

### Teenage conceptions

Reduction in teenage pregnancy was also identified as a key issue. Hull has introduced a scheme into a number of secondary schools which offers contraception and pregnancy tests through School Nurses. This service is now available in eight schools. Discussions have taken place with Heads of target schools and work is progressing to roll out service to all secondary schools. Services are also now available in a range of non clinical settings (e.g. The Warren) with short term funding mainstreamed to ensure continuity of provision.

The impact and outcomes of young people accessing sexual health and relationship education services is also being assessed through the service Apause<sup>79</sup>, which is being rolled out to all secondary schools in Hull. It is currently in 9 schools and includes its own impact assessment over two years of delivery<sup>80</sup>.

### 5.3.2 Obesity

The Hull and East Riding of Yorkshire Integrated Obesity Strategy was published in January 2007. The Strategy covers the prevalence of obesity in children and adults in Hull and East Riding of Yorkshire, mapping of services available in relation to severity of the overweight or obesity problems and suggested care pathways for children and adults who want to lose weight. The strategy covers all people so it is possible that people who are more health-conscious or have more co-morbidities will access these services.

In Hull, two groups have formed from the Integrated Obesity Group, the Paediatric Obesity Task Group and the Adult Obesity Task Group. Local action plans and care pathway services are being developed from these groups. The objectives for Hull's action plans are to:

- Bring together local key partners to oversee the development and implementation of obesity-related initiatives;
- Develop a Hull Weight Management Service including a range of different services to help all sectors of the community in Hull (adults and children and young people) to successfully lose or manage their weight;

<sup>78</sup> Supporting People Strategy Appendix 31 March (2005; 95)

<sup>79</sup> Apause is a community of practice involving health and educational commissioners, teenage pregnancy coordinators, education advisers and specialists, school heads and managers, teachers, health professionals and young people who are involved with the delivery of relationships education that we all believe will help young people to more successful, enjoyable and healthier sexual careers.

<sup>80</sup> Children & Young People's Plan Latest Refresh (2007;26)

- Raise awareness of obesity and overweight issues and develop promotion and marketing strategies to increase access to weight management services;
- Help local health practitioners to identify, support and refer overweight and obese patients to appropriate services; and
- Develop and implement a range of approaches to prevent overweight and obesity.

Different levels of overweight and obesity are also being mapped to services.

- **Level 1** refers to basic intervention at the population level involving opportunistic advice on general healthy eating and physical activity advice sign-posting services. For example, using the Health Trainers.
- **Level 2** refers to weight management services for clients with a BMI 25 to 39.9 without co-morbidities, and referral to services such as Looking Good Feeling Good, Why Weight, Stay Healthy Live Longer.
- **Level 3** refers to weight management services for clients with a BMI 30 to 34.9 with co-morbidities involving a multi-disciplinary approach, such as involving the Active Lifestyles Service or dieticians, etc.
- **Level 4** refers to specialist weight management services for clients with a BMI 35 or more with significant co-morbidities or a BMI 40 or more.

The development of the Strategy (and further work underway to develop a Diabetes Equity Audit) has led to the development of a range of projects and initiatives outlined at 5.4.2.

All children in Reception and Year 6 were weighed and measured during 2006/07 and this practice is ongoing as a national requirement. Community Paediatric Dieticians are in place and a range of interagency initiatives are available to improve healthy lifestyles. A Healthy Lifestyle Team was also due to be in place by March 2008<sup>81</sup>.

### 5.3.3 Alcohol

Alcohol consumption has been identified as a particular problem. A study for the Hull & East Riding Alcohol Strategy Group estimates that overall Hull experiences well over the national average of alcohol problems, and is amongst the 15% of local authorities in England suffering the greatest negative impact from alcohol<sup>82</sup>.

<sup>81</sup> Children & Young People's Plan Latest Refresh (2007;29)

<sup>82</sup> Hull PCT: World Class Commissioning Context Section. (version July 2008; 10)

In Hull, excess alcohol consumption is particularly a problem for young men (18-24): 17% drink excessively, 16% drink dangerously and 54% report 'binge drinking'.

The most deprived quintile of Hull residents is more likely to have a higher proportion of respondents who never drink but also a higher proportion who report 'binge drinking'. Again a broad approach should be used to target people and encourage them to drink more sensibly, but with an emphasis on people under 45 who smoke and drink<sup>83</sup>.

In July 2006, the Hull and East Riding 2006-2008 Alcohol Strategy was published. The strategy included a local action plan structured around four areas:

- **Family and Social Networks** which aims 'To raise awareness of the effect of alcohol on families, children and young people, vulnerable groups and communities.' The plan includes:
  - Training a range of groups in alcohol awareness.
  - Working closely with schools and young carers organisations.
  - Working on community based issues.
- **Health** which aims 'To increase screening and detection of harmful and dependent drinkers in line with the development of enhanced services'. The plan includes:
  - Undertaking an integrated needs assessment.
  - Working with commissioners to develop service models to meet provision gaps.
- **Workplace** which aims: 'That by 2008 every large organisation and small and medium enterprise in Hull and the East Riding will have in place an appropriate and effective policy for addressing issues around alcohol in the workplace. The plan includes:
  - Developing model policies.
  - Promote the benefits of dealing with workplace alcohol issues.
- **Crime and Disorder** which aims 'To contribute to the 30% reduction in contact crime.' The plan includes:
  - Reducing levels of underage drinking.
  - Work with the alcohol industry (bars and clubs in Hull) to raise standards in licensed premises.
  - Promote safer drinking with adults and young people.

<sup>83</sup> Hull PCT: World Class Commissioning Context Section. (version July 2008) : 2008; 10

- Promote a positive image of the night time and day time economy.

Hull's Citysafe Partnership is in the process of developing a commissioning plan for alcohol treatment, with PCT localities, underpinned by the alcohol strategy<sup>84</sup>. For future JSNA refreshes more detailed information on what interventions are being taken to combat problem alcohol consumption would be informative. Interventions involving Children & Young People are delivered by the general drug misuse programme 'reFresh'<sup>85</sup>.

#### 5.3.4 Drug misuse

Drug misuse and Hull CC and PCT's service response is discussed in the 'Services' section of this document.

#### 5.3.5 Smoking

##### Children & Young People

A 'Chuck It' smoking cessation programme has been put in place to assist young people to quit smoking. A network of smoking cessation advisors assist young people with their attempts to quit. In 2006-07 131 under-18 year olds were assisted and 55 had quit smoking at 4 weeks (42% quit rate).

In addition, a tackling teen smoking education programme is being implemented in the Neighbourhood Renewal Fund (NRF) area primary and secondary schools with funding from NRF. Interventions include a no smoking education programme in curriculum time, smoking cessation classes, theatre production, and work with trading standard officers regarding illegal sales and installation of smoke alarms to act as a deterrent<sup>86</sup>.

##### During pregnancy

Prevalence rates of women continuing to smoke throughout pregnancy fell in Hull from 29% in 2005-06 to 27% in 2006-07, although the rate is above the national average of 17%. A 24% prevalence rate by 2010 is a stretch target in the Local area agreement, and is a key target for all Children's Centres.

##### General

Hull PCT delivers a range of smoking cessation services and is expanding delivery of the Active Lifestyles programme, already being delivered in East Hull, across the City<sup>87</sup>.

Information and support services have been made available in all Children's Centres to advise parents and aid those who would like to stop smoking.

<sup>84</sup> Hull's Citysafe partnership Adult Drug Treatment Plan (2008;4)

<sup>85</sup> reFresh is a drug & alcohol service supporting young people under 19 years of age

<sup>86</sup> Children & Young People's Plan Latest Refresh (2007;10)

<sup>87</sup> Hull Community Strategy 2006-11 (2006;28)

### 5.3.6 Exercise

#### Adults

The national recommended guideline for exercise is to undertake at least 30 minutes of vigorous or moderate exercise at least five times per week. Exercise levels are relatively low in Hull compared to England, and similarly vary with gender and age.

To address this, Hull has developed 'Active Hull - a five year programme (2006-2011) of action to increase physical activity levels in the City of Hull' which has resulted in the commissioning of a range of projects and services:

- As part of the Stay Healthy Live Longer project in Hull, there are also various physical activity taster sessions that are held such as gym sessions, soccer sensations, salsa/aerobics classes, aerobics classes, boxercise classes, Fit To Be A Parent programme, keep fit, men's health football. These classes and programmes are held at different locations in Hull, generally early evening, at a subsidised payment rate.
- The Active Lifestyles Service in Hull receives referrals from practice doctors, nurses and dieticians for patients aged 12 years or older who lead sedentary lifestyles who could benefit significantly from being more physically active. The scheme is not appropriate for high risk individuals such as those with high blood pressure, unstable angina, unstable diabetes, severe mental health problems and severe cardiovascular disease, but suits people at mild to moderate risk. Patients meet with a qualified instructor for a free session to assess their health needs and create a programme specifically designed for the individual. The programme may include home-based activities, walking, and exercise class referral (such as gentle exercises to music, aqua aerobics, gentle cycling and chair-based exercises). Patients are shown how to use equipment where necessary. The cost of gym sessions and exercise classes vary, but many of the services offer a reduced rate initially. There are around 15 locations throughout Hull where exercise can take place. The patient returns to see their Active Lifestyle Advisor after 3, 6 and 12 months to monitor progress.

As with obesity, the lack of adequate exercise is of concern for all deprivation quintiles so a broad focus is needed to address the problem<sup>88</sup>.

<sup>88</sup> Hull PCT: World Class Commissioning Context Section (version, July 2008; 10)

Future JSNA refreshes could benefit from including performance management on the effectiveness of these various programmes and initiatives which have been commissioned as a result of the Obesity and Active Hull Strategies to gain a clearer understanding of 'what works' in terms of evaluating long-term investment in systematic roll-out and sustainability.

### Children & Young People

The first data collection in relation to a new performance indicator (5-16 year olds in school sports partnerships engaged in more than 2 hrs per week high quality PE or school sport) took place in July 2006. It was found that 65% reached this standard. It is anticipated that this will have risen to more than 75% by July 2007<sup>89</sup>.

## 5.4 Developing Commissioning

### 5.4.1 Teenage pregnancy and sexual health

Teenage pregnancy rates are falling in Hull. Fewer young women under the age of 18 years are conceiving (reduction from 79 per 1,000 girls aged 15-17 years in 2004 to 71.3 per 1,000 in 2005). This is also the case with girls under the age of 16 years<sup>90</sup>.

While neither Hull nor England are on track to meet the target of halving the under-18 conception rate by 2010, the reduction in Hull has been greater than for England, so the relative position of Hull has improved slightly, from an under-18 conception rate 82% higher than England in 1998 to one that was 73% higher in 2005 (a reduction in the relative gap in under-18 conception rates of around 10%)<sup>91</sup>.

Hull is engaged in an ambitious program of Social Marketing and Service Enhancement to tackle sexual health needs.

### 5.4.2 Obesity

The rate of obesity amongst the adult population in Hull is lower than the national average but this issue is still important in terms of long term health outcomes. The development of the Hull and East Riding of Yorkshire Integrated Obesity Strategy has led to the commissioning of a range projects and initiatives.

As identified elsewhere in this report Hull is engaged in an ambitious program of Social Marketing and Service Enhancement to tackle the obesity time bomb.

<sup>89</sup> Children & Young People's Plan Latest Refresh (2007;13)

<sup>90</sup> Children & Young People's Plan Latest Refresh (2007;6)

<sup>91</sup> Hull PCT: World Class Commissioning (Draft Context July 2008): 2008; 57



- From the Attitudes to Health Survey completed during 2007 in Hull for people aged 40-60 years, it is apparent, even in a relatively deprived area like Hull, that lack of knowledge is not necessarily an issue in terms of knowledge about risk factors for poor health.
- Focus group participants knew reasonably well what a healthy weight was, what a healthy diet consisted of, and that they should exercise regularly. It is likely that people who are more health conscious and have more knowledge about healthy diets and feel more confident cooking would participate in such focus groups.
- Participants attributed lack of cooking skills to others, and felt that there had been a loss of skills and knowledge across several generations in relation to home cooking and that the family practice of preparing meals no longer exists in many homes. Many people saw low income as a barrier to eating healthily and thought that people did not know how to cook on a budget. Processed foods, supermarkets and advertising were seen as the source of the problem. Older people were concerned about who would teach the young. Therefore, there could be a need for more education on home cooking in particular on how to cook simple meals on a budget.
- Some local programmes provide nutritional advice, food tasting and cookery demonstrations as part of weight management programmes.
- There is also a proposal for a “Cooking Bus” with the aim of improving knowledge and confidence of food and preparing food (especially focusing on young people).
- The Why Weight? Programme is a community based weight management programme in Hull which helps groups of people lose weight and maintain a healthy weight. This is done via an eight week rolling programme held in a community setting at various locations throughout the city. The Why Weight? Team undertake their own marketing and promotion of the sessions aimed at the locality where the programme is to be run. There are approximately 15 people who attend each session. The programme provides free nutritional advice based on the recommendations from the Department of Health, e.g. Eat Well Plate, 5 A DAY, recommended levels of fat, salt and sugar as provided by the Food Standards Agency and advice on food labelling. An exercise element is included in four out of the eight sessions as an introduction as many of the clients live a fairly sedentary lifestyle. Food tasting and

cooking demonstrations also feature predominantly in the programme and this element of the programme has proved extremely popular as demonstrated in the evaluation at week eight. Clients are made aware of how easy it is to create a healthy and nutritious dish using seasonal ingredients, recipes are handed out and many recreate the dish at home hence the whole family benefits from the messages relayed by the Why Weight? Team.

- The Stay Healthy Live Longer project is a multi-agency project, working to improve the health and wellbeing of Eastern Hull community members and their families. The project achieves this by assessing lifestyles, setting goals, and supporting, educating and encouraging residents to help make sustainable lifestyle changes that will improve their own life and their family's quality of life and also contributes towards a change in existing culture for future generations.
- The Shape Slimming Club is a major component of the overall project and is a multi-faceted programme that incorporates elements on healthy eating and the take up of physical activity. The components incorporate menu planning, basic cooking skills, family recipes, meals on a budget, personal goal setting and weight loss indicators. The project also signposts to other local services; including smoking cessation and dietetic services. The slimming club is a drop-in service and there are currently six slimming clubs every week, two meals in minutes cooking session (each block lasting 6 weeks), 2-3 physical activity sessions held every week as well as delivery/collection of bags of fruit (seven pieces of mixed fruit for £1) for local residents.
- The project is also involved in running the Mind, Exercise, Nutrition...Do it! (MEND) programme a 10 week intervention to enable a significant, measurable and sustained reduction in childhood overweight and obesity levels and to support overweight children (aged 7-13) and their families to make lifestyle changes that will improve their health and well-being. As the focus is in the more deprived areas in Hull, people living in these areas will be more likely to attend. However, it could be that the more health-conscious may be more likely to attend and access these resources. As at June 2008, there were six Slimming classes underway and two cooking sessions.

### 5.4.3 Drug misuse

Significant resources have been spent on drug misuse, treatment and cessation services. Hull's raised rates of drug

use in comparison with comparators and the national average suggests that further focus on this area may be required (see 'Services' section).

#### 5.4.4 Smoking

Between 2004 and 2007 the absolute increase in the percentage of smokers who perceived that stopping smoking would have a big impact on their health status increased by 13% (women) and 15% (men) which suggests that health messages are getting through<sup>92</sup>.

Prevalence rates of women continuing to smoke throughout pregnancy are falling in Hull. The rate has fallen from 29% in 2005-06 to 27% in 2006-07<sup>93</sup>. Whilst this rate remains above the national average of 17% this shows that progress is being made in the right direction.

Hull is engaged in an ambitious program of Social Marketing and Service Enhancement to tackle the smoking problem.

### 5.5 Developing Knowledge

#### 5.5.1 Obesity and Exercise

Future JSNA refreshes would benefit from the inclusion of performance evaluations of the range of projects and initiatives commissioned following the publication of Hull and East Riding of Yorkshire Integrated Obesity Strategy in January 2007 in order to get a clearer sense of 'what works' and the prioritisation of longer-term investment.

#### 5.5.2 Teenage parents

Future JSNA refreshes would benefit from data to confirm whether the additional emergency accommodation (mother and child assessment) and reconfiguring of existing floating support provision for teenage parents cited in the Supporting People Strategy 2005-10 had taken place.

#### 5.5.3 Alcohol

Future JSNA refreshes should include performance evaluations of the range of projects and interventions which were commissioned as a result of the development of the Hull and East Riding Alcohol Strategy 2006-08 (reFresh is addressing misuse of alcohol by Children & Young People).

Hull is engaged in an ambitious program of Social Marketing and Service Enhancement to tackle excessive alcohol consumption.

<sup>92</sup> Hull PCT: World Class Commissioning (Draft Context July 2008): 2008; 10

<sup>93</sup> Children & Young People's Plan Latest Refresh (2007;7)

## 6 Ill health and disability

### 6.1 Analysis of JSNA core dataset

#### 6.1.1 Circulatory Diseases

- Hull's rate of mortality from all circulatory diseases under 75 years for 2004-06 (114 per 100,000 resident population) is 34% higher than the Yorkshire and Humber (91 per 100,000) and 35% higher than the England (84 per 100,000) averages<sup>94</sup>.
- Whilst men in Hull had a higher absolute premature mortality rate compared to women in terms of circulatory disease, women in Hull aged under 75 years had worse relative rates of mortality from circulatory diseases compared to the national rate (57% higher than the rate for all women in England) than men (23% higher than rate for all men in England) in 2004-06.

#### 6.1.2 Stroke

- Stroke has a huge impact in terms of long term resource needs and impact on quality of life, since only one third of stroke patients make a full recovery<sup>95</sup>.
- Deaths from stroke represented 5.3% of all premature deaths for men and 7.4% of all premature deaths for women in Hull during 2002-2005<sup>96</sup>.
- Hull has a lower recorded prevalence of stroke compared to regional and national rates but worse outcomes in terms of mortality<sup>97</sup>. However, it is very possible that the prevalence (from GP disease registers) is incomplete and, therefore, the rates of undiagnosed stroke may be higher in Hull compared to nationally or regionally.
- The mortality rate from stroke for under 75s (Indirectly Standardised Ratios- SMR) for females for 2004-06 (175 vs. a standardised national rate of 100) was higher than the SMR for males for the same period (138 vs. 100).
- In 2006, the all-ages stroke mortality rate was worse for both men and women compared to regional and national averages.
- The premature (under 75) mortality rate for women is slightly lower than men in Hull. However, regionally and nationally, the rates for women are considerably lower than for men. This implies that women in Hull have higher premature mortality rates for strokes compared to other women in other parts of England.

<sup>94</sup> Information Centre for health and social care: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base ([www.nchod.nhs.uk](http://www.nchod.nhs.uk) or [www.nchod.nhs.uk](http://www.nchod.nhs.uk))

<sup>95</sup> Hull PCT Hull PCT: World Class Commissioning (Draft July 2008) report 2007 figures (Draft July 2008; 16)

<sup>96</sup> Ibid.

<sup>97</sup> Ibid.

### 6.1.3 CHD

- Coronary Heart Disease (CHD) is the largest single cause of death in Hull (which is no different from other areas of England), accounting for 1 in 6 deaths<sup>98</sup>.
- CHD all ages mortality rates (127 per 100,000) for the period 2004-06 were above the regional (113) and national averages (102) but mortality rates in Hull and England have been decreasing for several years, largely as a result of falling smoking rates<sup>99</sup> (a pattern observed nationally as well).
- Whilst male mortality rates (166 per 100,000) were higher than female mortality rates (94 per 100,000) in 2004-06 (mirroring regional and national trends), relative female mortality rates were of particular concern.
- Male mortality rates from CHD for all ages in 2004-06 were 14% higher than the English male average whilst female rates were 40% higher than the English female average<sup>100</sup>.
- The heightened behavioural risk factors of smoking, poor diet, lack of exercise, excessive alcohol consumption, high blood pressure etc. account for Hull's raised mortality.

### 6.1.4 Respiratory

#### COPD

- The Chronic Obstructive Pulmonary Disease (COPD) mortality rate for men (all ages) in 2004-06 was 27% higher in Hull than England but for women it was 64% higher<sup>101</sup>. This is likely to be associated with the prevalence of smoking observed in the 2007 health and lifestyle survey in Hull. This found that the prevalence of smoking was higher in women in the deprived areas compared to men, and that the prevalence of women smokers has increased in some of the most deprived areas between health and lifestyle surveys conducted in 2003 and 2007.

### 6.1.5 Cancer

- Age standardised rates for 2003-05 show that cancer incidence in Hull is 14.5% higher for males than the average England and 9% higher for females than the English average.

<sup>98</sup> Hull PCT Hull PCT: World Class Commissioning (Draft July 2008) report 2007 figures (Draft July 2008; 10)

<sup>99</sup> The Information Centre for health and social care: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base ([www.nchod.nhs.uk](http://www.nchod.nhs.uk) or [nww.nchod.nhs.uk](http://nww.nchod.nhs.uk))

<sup>100</sup> *Ibid.*

<sup>101</sup> Information Centre for Health and Social Care: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base ([www.nchod.nhs.uk](http://www.nchod.nhs.uk) or [nww.nchod.nhs.uk](http://nww.nchod.nhs.uk))

- The same data shows that male mortality rates were 28% higher than the national average and female rates were 13% higher<sup>102</sup> for 2003-05.
- Hull had the highest incidence rates in 2002-04 and highest mortality rates in 2004-06 in the Yorkshire and Humber region for all cancers combined excluding non-melanoma skin cancer<sup>103</sup>.
- However, mortality rates are improving against national averages and treatment is competitive with other areas<sup>104</sup>.

#### 6.1.6 Diabetes

- GP registers suggest that 4.15% of Hull's population (aged 17+) have diabetes, compared to 5.1% in the UK. It is likely that the rate of undiagnosed diabetes is higher in Hull. Analysis undertaken by Hull estimates that the true figure is 5.8%, which suggests that there are a number of people in Hull who do not know that they have diabetes and therefore are unable to take steps to look after their health.
- Findings from the Diabetes Equity Audit suggests that Hull performs poorly relative to the more affluent East Riding of Yorkshire in relation to the prevalence of diabetes, with excess hospital admissions and mortality in the most deprived quintile also associated with higher levels of obesity, smoking, lack of exercise and lower fruit and vegetable consumption.

#### 6.1.7 Suicide

- Suicide and undetermined injury mortality rates in Hull were much higher than the English 2004-06 average<sup>105</sup>.
- Rates for males aged 15-34 years (20.6 per 100,000 population) were 52% higher than the English average (13.5) and rates for males aged 35-65 years (28.6 per 100,000) were 54% higher than the English average (18.6).
- Similarly, rates for women aged 15-34 years (6.1 per 100,000) were 52.5% higher than the English average (4 per 100,000) and rates for women aged 35-64 (9.5 per 100,000) were 51% higher than the English average (6.3 per 100,000 population)<sup>106</sup>.

<sup>102</sup> Information Centre for health and social care: Compendium of Clinical and Health Indicators / Clinical and Health Outcomes Knowledge Base ([www.nchod.nhs.uk](http://www.nchod.nhs.uk) or [www.nchod.nhs.uk](http://www.nchod.nhs.uk))

<sup>103</sup> Hull PCT Hull PCT: World Class Commissioning (Draft July 2008) report 2007 figures (Draft July 2008; 14)

<sup>104</sup> Ibid.

<sup>105</sup> Hull PCT: World Class Commissioning Context Section (version July 2008): 2008;134

<sup>106</sup> Ibid.

### 6.1.8 Injuries

- Hull's proportion of deliberate or unintended injuries to children and young people (per 10,000 aged under 19) was much higher than comparator local authorities<sup>107</sup>.

### 6.1.9 Dementia

- The total population with dementia aged 65 years and over is predicted to increase by 26% between 2008 and 2025, from 2,512 individuals to 3,187<sup>108</sup>.

### 6.1.10 Sexual health

- The number of uncomplicated cases of Chlamydia in Hull fell slightly for both males and females between 2002 and 2003.
- Genital Chlamydia infection is the most common sexually transmitted infection (STI) diagnosed in clinics across the UK. In 2004, within England, rates in both males (208/100,000) and females (243/100,000) were highest in Yorkshire and Humber after London (279 and 282/100,000) respectively.
- The number of uncomplicated cases of Gonorrhoea in Hull increased sharply between 2002 and 2003 from 61 to 113 for males and from 40 to 49 for females between 2002 and 2003. Outside London, diagnostic rates in males (58/100,000) and females (31/100,000) were highest in the Yorkshire and Humber region.
- Cases of HIV continue to increase and this is in line with national trends.

## 6.2 Priorities identified by Hull's health and social care strategies

### 6.2.1 National indicators and Hull's Local Area Agreement

The following table lists the National Indicators (NIs) relating to 'Burden of ill health and disability' which Hull selected for special scrutiny in its JSNA. Those indicators which were selected for specific focus by the local authority as part of Hull's Local Area Agreement (LAA) have been highlighted in yellow.

<sup>107</sup> Vital Signs 2006/07

<sup>108</sup> POPPI figures provided by Kingston upon Hull, City of (2007)

Figure 17 List of National Indicators relating to 'Burden of ill health and disability' selected for JSNA scrutiny by Hull CC (Hull's LAA priority NIs are highlighted in yellow)

National Indicator	Indicator specifications
NI 48	Children killed or seriously injured on roads
NI 70	Hospital admissions caused by unintentional and deliberate injuries to children and young people
NI 113	Incidence of Chlamydia in under 25 year olds
NI 119	Self-reported measure of people's overall health and wellbeing
NI 120	All-age all cause mortality rate
NI 121 (LAA Target)	Mortality rate from all circulatory diseases at ages under 75
NI 122 (LAA Target)	Mortality from all cancers at ages under 75
NI 123 (LAA Target)*	16+ current smoking rate prevalence
NI 137	Healthy life expectancy at age 65

\*Note: LAA stretch target carried over from LAA1

Hull's LAA has prioritised mortality from circulatory diseases and cancer for people under the age of 75 years and reducing adult smoking. These three themes were also identified as key priority areas by the JSNA analysis.

The JSNA analysis also found COPD prevalence rates to be raised, with asymmetries between the sexes. However, there is a very strong association between COPD and smoking. For instance, it is estimated that 84% of all deaths from COPD are caused by smoking (ASH Factsheet 2<sup>109</sup>). As a result, reduction in the smoking prevalence will have a long-term influence on reducing COPD mortality.

### 6.2.2 Hull's Children's and Young People's Plan 2006-2008

Hull's Children's and Young People's Plan 2006-2008 (Hull City Council, 2006a) includes 12 priority areas. The following relates to the 'Burden of ill health and disability' section of the JSNA:

- Improve sexual health of young people.
- Promote healthy lifestyles for children and young people, and their parents and families.
- Ensure that children and young people are valued within our family friendly city.

The key measures of success which are directly health-related are as follows:

- Reduction in sexually transmitted infections.
- Reduction in deaths from suicide and undetermined injury.

<sup>109</sup> <http://old.ash.org.uk/html/factsheets/html/fact02.html>



As with the analyses conducted for the JSNA, the reduction of suicide and undetermined injury rates (amongst children and young people) have been highlighted as key areas for focus by Hull's Children and Young People's Plan (2006-08).

## 6.3 Current interventions deployed by Hull CC and PCT to meet key objectives

### 6.3.1 Circulatory diseases

As outlined elsewhere in this JSNA, Hull has commissioned a range of services aimed at reducing the risks of developing circulatory diseases such as CHD by improving behavioural choices (such as reducing smoking; exercise; improving diet). There is some evidence that these programmes (e.g. smoking cessation) are having an impact on behaviour and we would recommend that Hull's innovative social marketing approaches continue and are expanded. A more systematic evaluation of the range of services currently being commissioned may be required over the medium-term to gain a clearer understanding of 'what works'.

Furthermore, whilst the prevalence of circulatory diseases which include CHD, stroke and transient ischemic attack (ITA), heart failure and atrial fibrillation as recorded by GPs are lower than comparators, it is likely that the prevalence is underestimated on the GP disease registers due to under-diagnosis (this is also likely to be similar elsewhere).

### 6.3.2 Cancer

In Hull, one-third of all premature (under 75) cancer deaths during 2001-2004 were due to lung cancer. As it is estimated that 84% of all deaths from lung cancer are due to smoking (89% in men and 75% in women), smoking cessation will have a large impact on premature mortality in the medium to long term<sup>110</sup>.

Risk factors such as smoking are being addressed by Hull. Smoking cessation has been a focus for Hull and details are given in other sections of this report (see 'Lifestyle and Risk Factors' section). As with COPD, we would recommend a continuation of addressing behavioural causes through the range of preventative interventions Hull is developing to ensure sustainable progress over the medium to long term.

<sup>110</sup> <http://old.ash.org.uk/html/factsheets/html/fact02.html>

### 6.3.3 Smoking

As has been established, smoking is a risk factor for both cancer, respiratory and circulatory disease and, consequently, all three of these health-related areas have been identified as subjects for local focus by Hull's LAA and proposed priorities for Hull tPCT World Class Commissioning Strategy.

### 6.3.4 Sexual health of children and young people

Additional Chlamydia screening sites have been opened to improve accessibility across the city, and there was a 35% increase in screening delivered to under 18 year olds during 2005/06. The Genito-Urinary Medicine (GUM) clinic has identified a drop in the number of Chlamydia diagnosed patients in Hull<sup>111</sup>.

Additionally, Hull has also introduced a number of schemes into secondary schools which offer contraception through school nurses as well as providing similar services in non-clinical settings<sup>112</sup>.

## 6.4 Developing Commissioning

### 6.4.1 Circulatory diseases

Whilst mortality rates for circulatory diseases in Hull are falling, which on the surface suggests that interventions are working, they are falling at a slower rate than regionally and nationally. If the recent trends continue, the *absolute* gap in under 75 standardised circulatory disease mortality rates between England and Hull would decrease from 29.7 deaths per 100,000 in 2003-2005 to 25.8 deaths per 100,000 in 2009-2011.

However, the *relative* gap would increase over this time period, with rates in Hull 49.2% higher than England in 2009-2011, compared with 32.9% in 2003-2005<sup>113</sup>.

### 6.4.2 Stroke

The prevalence rates for stroke for 2006/2007 are lower in Hull relative to 10 comparator areas (which have similar characteristics to Hull in terms of demography and deprivation). However, it is possible that the prevalence rates of stroke and transient ischemic attack as recorded on the general practice disease registers under-represents the true situation locally. The outcomes from the ongoing indicators of care as measured by the general practice registers are also poor for Hull relative to 10 comparator areas. The mortality rates for the financial year 2006/2007 are 24% higher than the Yorkshire and Humber region and 32% higher than England. For these reasons,

<sup>111</sup> Children & Young People's Plan Latest Refresh (2007;6)

<sup>112</sup> Children & Young People's Plan Latest Refresh (2007;26)

<sup>113</sup> Hull PCT: World Class Commissioning (Draft Context July 2008; 69)

stroke has been rightly prioritised by the LAA and PCT as an area for focus.

#### 6.4.3 Areas where there are poorer health outcomes for women

Women in Hull have poorer relative outcomes compared to the national average than men for all circulatory diseases (under 75 years mortality rate), CHD (all ages mortality rates 2004-06) and COPD (under 75 years rates for 2004-06; all ages mortality rates for 2004-06).

## 7 Services

### 7.1 Analysis of JSNA core dataset

In the section below when it is stated that a service is being received or accessed it is in relation to services which address one or more of: physical disability and sensory impairment, learning disabilities, mental health and substance misuse.

A service received in the community is one that relates to the above issues but is delivered in the recipient's community.

#### 7.1.1 Physical disability and sensory impairment

- According to Referrals, Admissions and Packages of Care (RAP) data there were 2,165 clients receiving a service during the year aged 18-65 years and 6,485 clients aged 65 years and over in 2007-08.
- The same data source states that there were 1,071 clients with a community service during the year aged 18-65 years and 5,356 clients aged 65 years and over in 2007-08.
- There were 1,418 clients aged 18-65 years receiving a community service at 31<sup>st</sup> March and 3,474 clients aged 65 years and over receiving a community service at 31<sup>st</sup> March in 2007-08.
- It has been estimated that 9.8m people in Britain are covered by the broad definition of disability in the Disability Discrimination Act. Scaling down to Hull's population this would give us around 41,000 disabled people in the city.
- In February 2005 there were 21,700 people claiming Disability Living Allowance or Attendance Allowance.
- There are currently 11,181 people with Blue Parking badges issued. This is one indicator of people with severe mobility problems<sup>114</sup>.

#### 7.1.2 Learning disabilities

- According to figures provided by Hull CC it is estimated that there are some 4,929 people with a learning disability (4,413 adults) in Hull in 2008.
- Of this number approximately 725 adults have a severe or profound learning disability.
- According to Referrals, Admissions and Packages of Care (RAP) data there were 575 adults aged between 18-65 years receiving a service in 2007/08 and 76 older people aged 65 years or over receiving a service.
- In 2007-08, there were 460 clients receiving a community service during the year aged 18-65 years

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<sup>114</sup> Hull City Council

and 45 clients aged 65 years and over receiving a learning disability community service.

- The number of people with a learning disability known to services is predicted to increase from 1,072 to 1,099 between 2011 and 2021 whilst the 'true population' is predicted to rise from 5047 to 5259 during the same period<sup>115</sup>.

### 7.1.3 Mental health

- According to Referrals, Admissions and Packages of Care (RAP) data there were 641 clients receiving a service during the year aged 18-65 years and 474 clients aged 65 years and over receiving a service during 2007-08.
- The same data source states that there were 533 clients with a mental health problem with a community service during the year aged 18-65 years and 220 clients with a Mental Health problem aged 65 years and over receiving a community intervention in 2007-08.
- There were 416 clients aged 18-65 years with a mental health problem receiving a community intervention at 31<sup>st</sup> March and 175 clients with a Mental Health problem aged 65 years and over receiving a community intervention at 31<sup>st</sup> March 2007-08.

### 7.1.4 Substance misuse

- Estimates suggest there are 3,700 problematic drug-users (15-65 years) in Hull<sup>116</sup>.
- It is estimated that approximately 10% of drug misusers are under 19.
- Hull has the highest prevalence rate of problematic drug use within Yorkshire and Humber (95% are opiate users).
- Research indicates that Hull has the highest injecting prevalence in the Yorkshire and Humber region.
- The data suggests a 76% male, 24% female split of opiate and crack users, while National Drug Treatment Monitoring Service (NDTMS) data for 2006/7 shows that 30% of those in treatment were female.
- The numbers accessing and remaining in treatment continued to increase in 2006/7. However the number of new presentations into structured treatment dropped by 26%.
- BME groups are not effectively engaged in mainstream services, despite a separately funded BME project<sup>117</sup>.
- There were 124 clients with a substance misuse problem receiving a service during the year aged 18-65

<sup>115</sup> Learning Disability Strategy (2006;5)

<sup>116</sup> Kingston upon Hull Strategic Direction and Partnership Strategy for Drug Treatment (2008; 4)

<sup>117</sup> Ibid. (2008; 7)

years and 6 clients aged 65 years and over receiving a service during 2007-08.

- According to Referrals, Admissions and Packages of Care (RAP) data there were 120 clients aged 18-65 years with a substance misuse problem receiving a community service during the year and less than 5 clients aged 65 years and over receiving a community intervention in 2007-08.
- The same data source states that there were 96 clients aged 18-65 years receiving a substance misuse community intervention at 31<sup>st</sup> March and less than 5 clients aged 65 years and over receiving a substance misuse community intervention at 31<sup>st</sup> March 2007-08.

Core issues identified by the JSNA analysis relate to increasing provision to cater for the growing number of people with learning disabilities and increasing provision to deal with Hull's drug misuse problems.

Future JSNA refreshes would benefit from more evidence and data concerning mental health services and services for people with a physical disability and sensory impairment.

## 7.2 Priorities identified by Hull's health and social care strategies

### 7.2.1 National indicators and Hull's Local Area Agreement

The following table lists the National indicators (NIs) relating to 'Services' which Hull selected for special scrutiny in its JSNA. None of these indicators were selected for specific focus by the local authority as part of Hull's Local Area Agreement (LAA).

*Figure 18 List of National Indicators relating to 'Services' delivered in Hull selected for JSNA scrutiny by Hull CC*

National Indicator	Indicator specifications
NI 127	Self reported experience of social care users
NI 132	Timeliness of social care assessment
NI 135	Carers receiving needs assessment or review and a specific carer's service, or advice and information
NI 136	People supported to live independently through social services (all ages) PSA 18
NI 139	People over 65 who say that they receive the information, assistance and support needed to exercise choice and control to live independently
NI 140	Fair treatment by local services

### 7.2.2 Supporting People Strategy 2005-10

The Supporting People Strategy 2005-10 identified the following areas for prioritisation of funding in order to develop the following services:

- People with a dual diagnosis (multiple, complex needs): An accommodation-based service for people with complex multiple needs.
- People with learning disabilities: An accommodation-based service for this client group and their elderly carers<sup>118</sup>.
- Older people: Provide additional 'extra care' places by reconfiguring funding in older people's services following a strategic review.
- Women fleeing domestic violence: in particular, an accommodation-based service for women fleeing domestic violence and their children.
- People with mental health problems: create accommodation with enhanced support for people discharged from mental health forensic units.
- Teenage parents: accommodation-based service with on-site assessment and support.
- Improved services for drug misusers: this client group has been identified through the Combined Housing and Treatment Group and their information sharing events, stakeholder interviews and Inclusive Forums.

Immediate priorities for commissioning in 2005-06 were services for dual diagnosis, young people and people with learning disabilities<sup>119</sup>.

The core priorities identified by the Supporting People Strategy match some of the key messages drawn out of the JSNA analysis. These include a focus on services for learning disabilities, drug misuse services, housing for older people (see above) and teenage parents (see above).

## 7.3 Current provision

### 7.3.1 Sexual health services

Hull's rate of offering appointment for GUM services within 48 hours of enquiry was higher than the Yorkshire and Humber average (and was consistently higher between February-August 2007), but was 5% below the national average at August 2007<sup>120</sup>.

### 7.3.2 Substance Misuse

The current provision for people with drug misuse problems was significantly higher than national and regional levels at 2005<sup>121</sup>. In 2005 there were 18 units of accommodation based services and 20 units of floating support. However, the need for further

<sup>118</sup> Supporting People Strategy 2005-10 (2005;36)

<sup>119</sup> Supporting People Strategy 2005-10 (2005;10)

<sup>120</sup> Health Protection Agency:

<http://www.hpa.org.uk/webw/HPAweb&Page&HPAwebAutoListName/Page/1201094610255?p=1201094610255>

<sup>121</sup> Supporting People Strategy 2005-10 (2005;27)

services was identified, in particular additional floating support and accommodation based services for women who were victims of domestic violence with drug dependency issues<sup>122</sup>.

### Children and young people

Following a review of the Substance Misuse Services a new service has been launched for children and young people (reFresh). This service now supports all schools to provide effective drug education to all pupils. reFresh also delivers targeted group work to vulnerable children and young people. Recent programmes have been focused on solvents, alcohol and poly drug use<sup>123</sup>.

This service also now provides consultation and support to education staff in designing and delivering drug education within schools. Rolling drug education programmes have also been introduced into Pupil Referral Units (PRUs) and Sutton Place.

Consultation with all children's homes was undertaken in January 2007. All homes have a designated reFresh practitioner. Monthly drop-ins and a drug and alcohol resource file have been provided to all homes.

Strong links have also been developed with Positive Futures with regular drug and alcohol sessions delivered. Hull is currently working with Positive Futures to provide drug education to groups of asylum seekers using translators.

There were also plans to develop an education support pack which will contain information on resources, training and leaflets, including information on the Common Assessment Framework (CAF)/ screening tool and referral pathways into reFresh. There were plans to develop a cannabis treatment programme and a 'Crack prevention programme' in the summer of 2007<sup>124</sup>. Future JSNA refreshes would benefit from information to allow confirmation of whether these interventions have been successfully developed and rolled out.

### Adults

Hull's Citysafe drug treatment programme reports that closer involvement with strategic partners, including the local prison, housing and younger peoples' services have been developed. These have resulted in a range of joint-working groups and initiatives, but have increased demands on the services<sup>125</sup>. As a result, Hull's Adult Drug Treatment Plan for 2008-09 includes the recruitment of new staff in order to provide additional capacity<sup>126</sup>. The strategy also includes provision to review the

<sup>122</sup> Supporting People Appendix 31 March (2005; 93)

<sup>123</sup> Children & Young People's Plan Latest Refresh (2007;28)

<sup>124</sup> Children & Young People's Plan Latest Refresh (2007;28)

<sup>125</sup> Hull's Citysafe partnership Adult Drug Treatment Plan (2008;2)

<sup>126</sup> Hull's Citysafe partnership Adult Drug Treatment Plan (2008;3)



partnership's drug awareness and harm reduction training to ensure training is available to all stakeholders (including inserting a training plan into the local workforce development action plan<sup>127</sup>). Feedback mechanisms are also being strengthened to improve understanding on the effectiveness of various treatment programmes.

Attempts are being made to improve the accessibility of drug treatment programmes by introducing street based services to identify target groups and hotspots<sup>128</sup>. Interventions are also planned to improve retention of drug misusers in treatment services<sup>129</sup> as well as improving support for service users once they leave treatment (e.g. peer support; education and training; aftercare provision)<sup>130</sup>.

### 7.3.3 People with learning disabilities

The provision for this group was lower than national and regional levels (in 2005) and for comparator authorities. In 2005, there were 126 accommodation based units and 4 floating support places<sup>131</sup>. An accommodation based scheme for people with learning disabilities and their carers was due to open in the spring of 2005.

Stakeholder interviews identified the need for a review of services for people with learning disabilities and the development of extra care services, through re-configuring existing services following review<sup>132</sup>.

### 7.3.4 People with a physical disability and sensory impairment

Services for people with a physical disability in Hull were significantly higher than regional, and national levels and for the other comparator authorities in 2005. This fact, however, should be considered in the context of the higher than average incidence of long term limiting illness in the city. In 2005, there were 128 units of accommodation-based services for people with a physical disability or sensory impairment<sup>133</sup>. No new needs were identified at the time of Supporting People's strategy development in 2005.

### 7.3.5 People with mental health problems

Supporting People services for people with mental health problems in Hull were higher than the region in 2005 but similar to national service levels. Hull had a higher prevalence of mental ill health than other parts of the region. In 2005, 170

<sup>127</sup> Hull's Citysafe partnership Adult Drug Treatment Plan (2008;6)

<sup>128</sup> Ibid.

<sup>129</sup> Hull's Citysafe partnership Adult Drug Treatment Plan (2008;9)

<sup>130</sup> Hull's Citysafe partnership Adult Drug Treatment Plan (2008;12)

<sup>131</sup> Supporting People Appendix 31 March (2005; 93)

<sup>132</sup> Supporting People Strategy 2005-10 (2005;28)

<sup>133</sup> Supporting People Appendix 31 March (2005; 94)

accommodation based units and 29 floating support units existed to support this group<sup>134</sup>.

The need for additional women only services was identified in The Women's Mental Health Strategy (September 2004) and Hull and East Riding's Community Health Strategy Direction (2005- 2008). Specific housing-related research into mental health housing support needs was commissioned. Identified needs included women-only provision and a service for people leaving mental health forensic services. An accommodation-based service for people with Dual Diagnosis (multiple, complex needs often including substance misuse) is contained in Shadow Strategy<sup>135</sup>, which remains outstanding.

Plans were put in place in 2005 to develop a 14 bed accommodation based service for dual diagnosis (people with mental health problems and substance misuse/other problems) as well as accommodation and enhanced support for people being discharged from mental health forensic units.<sup>136</sup>

### 7.3.6 Older people

Services for older people have been addressed in the 'Social and Environmental context' section.

## 7.4 Developing Commissioning

### 7.4.1 Drug misuse

Future JSNA refreshes would benefit from data concerning the development of accommodation-based services to meet the identified need of women who were victims of domestic violence with drug dependency issues. Whilst there were 13 accommodation-based units and 39 floating support units for women fleeing domestic violence<sup>137</sup>, currently there is no evidence of the specialist support recommended by Supporting People in the data provided by the Drug and Alcohol Team.

### 7.4.2 Primary and Community Care

Hull is included in the lower quartile of PCTs in terms of defined adequacy in doctor : patient proportions, In Hull there are 28 practices out of 55 where the average list size is in excess of 2,000 patients per whole-time equivalent GP. The national average size list is a little over 1,600 patients per whole-time equivalent GP.

In Hull, the average GP availability is just over 48 GPs per 100,000 population and in the East Locality this falls to just 46.

<sup>134</sup> Supporting People Appendix 31 March (2005; 94)

<sup>135</sup> Supporting People Strategy 2005-10 (2005;29)

<sup>136</sup> Supporting People Appendix 31 March (2005; 94)

<sup>137</sup> Ibid.

Increasing access to primary care will be crucial to addressing priorities from the JSNA<sup>138</sup>.

## 7.5 Developing Knowledge

### 7.5.1 Physical Disability and Sensory impairment

Future JSNA refreshes would benefit from more information regarding projected and identified needs for people with physical disabilities and sensory impairment.

### 7.5.2 Mental health services

Future JSNA refreshes would benefit from more information regarding projected and identified needs for people with mental health problems.

### 7.5.3 Outcomes of Supporting People Strategy

Future JSNA refreshes would benefit from more information regarding specific priorities and strategies beyond the Supporting People Strategy 2005-10. This strategy states that 'the remaining priorities will be included in subsequent annual commissioning plans once available resources are known following completion of service reviews and the announcement of the Supporting People grant award for 2006-07 and beyond'.

Future JSNA refreshes would benefit from information regarding progress made on needs identified by the Supporting People Strategy 2005-10 in respect to services for:

- People with learning disabilities
- People with mental health problems
- People with a physical disability and sensory impairment

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<sup>138</sup> Hull tPCT Draft World Class Commissioning Strategy (version September, 2008)

## 8 Conclusion

This first JSNA has led to a number of specific recommendations in relation to improving health and well-being outcomes in Hull over both the short and longer-term:

1. The JSNA is used to build on the good work already underway through the One Hull Partnership and to further strengthen cross-cutting, partnership working feeding into the development of a revised Community Strategy with a clear focus on tackling the key priorities identified through the JSNA.
2. This is Hull's First JSNA and is recognised as a key stage towards a more comprehensive picture of health and well-being. Future refreshes of the JSNA will include more information gained through active dialogue with local people, service users and their carers.
3. The findings of the JSNA drive any proposed revisions, changes or additions to local improvement targets in the new Local Area Agreement.
4. The findings of the JSNA are used to directly impact revised commissioning strategies including the 5-year Commissioning Strategy Hull tPCT is currently preparing for the World Class Commissioning Assurance process. Revised or new joint commissioning strategies developed from 2009-10 should evidence a direct linkage to the JSNA findings.
5. The JSNA is used as the basis to further strengthen joint commissioning arrangements between Hull tPCT and Hull City Council with a focus on redesigning key care pathways across, in particular, health, housing and adult social care; and addressing identified local data gaps such as mental health.
6. Commissioning should focus on 'end to end' care and support pathways to achieve improved outcomes with a strategic shift towards prevention, early diagnosis and intervention and rehabilitation with a particular focus on priority areas identified by the JSNA.
7. The JSNA is used to build on the considerable investment Hull has already made in social marketing approaches in relation to smoking, obesity, alcohol and

domestic violence and strengthening community engagement approaches, with consideration of extending this approach to other priorities identified by the JSNA. Consideration should be given to extending social marketing approaches to other key priority area such as Stroke, CHD, Diabetes, COPD, Mental Health and Cancer.

8. JSNA is used to ensure that strategic crosscutting issues such as the importance of housing, transport and age-proofing mainstream services are fully considered in relation to developing new or revised joint commissioning strategies for specific population groups such as older people.
9. JSNA becomes embedded across both Hull PCT and Hull City Council as a continuous rather than a one – off/annual process.
10. JSNA is used to strengthen/change performance management and evaluation processes in order to ensure direct linkages (“what works”) can be made to individual outcomes, outcomes achieved as a result of specific services and interventions for targeted population groups and wider population/strategic outcomes.
11. Hull Teaching PCT and Hull City Council should use the JSNA to foster joint working in quantitative data collection and statistical analysis. The organisations should explore new ways of drawing main messages from the large quantities of qualitative data which will be gathered within the Council Panel project and the PCT Listening Exercise and Membership scheme. The JSNA steering group should build on existing predictive modelling activities in order to foster better understanding of impacts of strategies.
12. Hull tPCT and Hull City Council should continue and build on the current Health Impact Assessment activity in order to ensure that health impacts are at the heart of strategy decisions. This information should form part of the reiterative process of JSNA.
13. The JSNA is used to promote improved health and well-being in Hull across all sectors including employers and the business community.
14. The JSNA is used as an evidence base to support an increased focus on community empowerment and increasing social capital, including consideration of ‘Connected Care’ models based on a whole system approach targeted at the most deprived areas of Hull.

15. The findings of the JSNA should be communicated as widely as possible in the context of stimulating innovative responses from providers and the voluntary and community sector.



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