

Joint Strategic Needs Assessment

Review of Health Needs Across Enfield

Executive Summary



March 2009

This summary reproduces the Forward, Introduction and Summary from the main document, which is available on the Enfield Observatory and the PCT and Council websites.

The document sets out a wealth of data, which will help inform decisions about health and social care services. It is an important output of the Joint Strategic Needs Assessment process that the Council and the PCT is required to undertake.

We will be improving and adding to the data, and also we will be asking local residents about their 'wellbeing' as well as their health and about what is important to them and their family and friends in improving their lives.

A significantly revised version will be available in September, which will take into account the improvements and additions identified above.

Foreword

The development of the Joint Strategic Needs Assessment creates a strong partnership between the Director of Public Health, the Director of Adult Social Services and the Director of Children's Services in collaboration with Directors of Commissioning for improving the health and well-being of the population in order to achieve:

- Better prevention and early intervention for improved health, independence and well-being
- More choice and a stronger voice for individuals and communities
- Tackling inequalities and improved access to services
- More support for people with long-term conditions.

This document represents the Core Data minimum datasets required for analyses to inform the JSNA for Enfield. Later in 2009 this minimum dataset will be complemented by other locally appropriate data on the wider determinants of well-being with increasing levels of detail and analysis. We will also update and refine this core data.

The new Joint Strategic Needs Assessment cannot be expected to define precisely what commissioners should 'buy' each year, nor which providers are best equipped to deliver future services, but it should enable us to:

- define achievable improvements in health and well-being outcomes for the local community
- send signals to existing and potential providers of services about possible service change
- support the delivery of better health and well-being outcomes for the local community
- inform the next stages of the commissioning cycle
- aid better decision-making
- underpin the Local Area Agreement and the choice of local outcomes and targets, as well as the PCT's own prospectus

We will use the information we have collected to help inform decisions about health and social care services. On-going engagement with patients, service users, carers, the local voluntary sector and providers will be important in building and changing the information we have. To support this we will be asking local residents about their 'wellbeing' as well as their health and about what is important to them and their family and friends in improving their lives. A consultation document with a summary of key issues will be made available.

Introduction

Section 16 of the Local Government and Public Involvement in Health Act 2007 introduces a new duty for PCT's and responsible local authorities to produce a Joint Strategic Needs Assessment (JSNA) of the health and social care needs of their local community.

This assessment will be the means by which the PCT and Local Authority will describe current and future health and social care needs of local populations. The assessment should cover those issues where the responsibilities of PCT's and local authorities overlap or where one organisation in carrying out its functions impacts to a significant extent on the other organisation's functions. The duty on local authorities and PCT's to prepare a JSNA commences on 1 April 2008.

Local Authorities will need to ensure the JSNA is taken into account in its preparation of the Sustainable Community Strategy. As the overarching strategy for the area, the issues identified in the Sustainable Community Strategy will then inform the priorities and targets in the LAA and lead to agreed commissioning priorities that will improve outcomes and reduce health inequalities.

The outputs of the JSNA are designed to:

- Encourage a 'whole system' approach to planning and delivering services by all partners;
- Facilitate integrated commissioning;
- Help develop district based service delivery and planning;
- Facilitate effective decommissioning/recommissioning of services to meet the identified needs of the community;
- Give all stakeholders access to a common set of information to generate a common understanding of the needs of the community;
- Assist with benchmarking;
- Allow planning to take place over a longer timeframe than previously possible (10-15 years) and the development of a long term joint commissioning strategy;
- Develop and encourage preventative service provision and planning;
- Achieve better utilisation of limited resources from across partner organisations and facilitate more joined up service provision;
- Enable the local community to interact with the local authority and other key partners and providers to 'have a say' in what services are delivered and how they are delivered; and
- Provide an objective 'health check' of what is currently being done.

This document is the preliminary data collection and analysis of the minimum data required for the JSNA and other relevant and of interest data.

Summary

Demographics

Enfield has a population estimated at 285,100 making it the 6th largest of the London boroughs. It has a relatively large population aged 10-14 and increasing numbers of people aged 45-64 (the age where long-term conditions become apparent). Compared to Outer London boroughs it has a large 'other white group' (12.9%) mostly comprised of Greek, Turkish Cypriot and Turkish populations, a relatively large Bangladeshi population (1.3%) and 5.3% Black Caribbean. Enfield pupils recorded themselves under 88 ethnic codes. 64% of the population describes itself as Christian, 10% as Jewish, 9% as Muslim and 11% are of no religion or did not state their religion.

There is a net emigration out of the borough mainly to the Shire counties north of the Borough. Like many London boroughs the age profile is changed by young adults moving in and older families and retirement groups moving out.

Approximately 15.7% of the population have a limiting long-term illness (44,800 people), 34,500 people aged 16-75 are disabled and 24,190 people claim the main state benefits (Incapacity Benefit, Disability Living Allowance (DLA) and Attendance Allowance). The number of people seen by Social Services for physical disability grew by 36% between 2001/02 to 2005/06. The majority of Incapacity DLA Claimants live in the most deprived parts of the borough.

Poverty

Although there are areas of affluence Enfield has areas within the 10% most deprived in England, mostly east of the A10. Using the Index of Multiple Deprivation the overall ranking of the borough has worsened to 70th of the 354 English Local Authorities in 2007, from 104th in 2004. Over the 5 years to May 2006 Enfield had the highest percentage increase of all authorities in Great Britain for Income Support.

There are significant numbers of young people living in poverty; 20% of all children living in Enfield live with lone-parents on benefits.

28.5% of households do not have a car (31,496), 50,201 (45.5%) have 1 car and 28,701 have 2 cars.

4% of households have an income of £0-5K, 10.2% of £0-10K, 24.3% of between £0-15K and 36.4% of between £0-20K

Housing

The 2001 census showed Enfield as the 21st worst Local Authority for housing and overcrowding. In April 2008 22% of the Council Housing Stock did not meet the Decent Homes standard. In the private sector this is approximately 6.8%.

In 2006 there were 46,926 households registered as married couples (40.9%), 10,042 as cohabiting couples (8.7%), 11,072 as lone parents (9.6%), 8,696 as other multi-person (7.6%) and 38,086 as one person (33.2%). 13,486 people aged over 65 are predicted to live alone and this figure is expected to rise by 23% to 16,613 by 2025. In 2001 11.39% of people aged over 65 did not have any central heating.

Life-style and Risk Factors

Life expectancy in Enfield is 77.9 for males and 81.9 for females. This compares to the England average of 77.3 and 81.6. Leading causes of death are Coronary Heart Disease and other circulatory disease, Cancers and Respiratory diseases. For nearly every condition there are health inequalities with poorer health in the south and east of the borough.

23.5% of the Enfield population smokes (London 23.3%), 27.7% eat 5 portions of fruit and vegetables / day (London 29.7%) and 19.7% undertake recommended levels of physical activity (nationally 21%). Alcohol-related hospital admissions in Enfield have tripled in the four years from 2002/03, rising at a faster rate than for both London and England.

Enfield has a high rate of teenage pregnancy (48.1 per 1,000 females aged 15-17) compared to London (45.6) and England (40.4). 12% of children in Reception and 22% in Year 6 are obese. Obesity and overweight currently costs the PCT £75.7 million a year.

In 2003-5 the infant mortality rate was 6.7 per 1000 live births. This compares to the London rate of 5.2.

The number of reported cases of sexually transmitted infections has risen over the last 10 years. 10% of people aged 15-24 tested for Chlamydia are positive. There are 613 people living in Enfield who have been diagnosed with HIV (this does not include undiagnosed cases).

Oral dental health seems to be worsening; in 2001/2 the mean number of dmft (decayed, missing or filled) teeth per 5-year-old child was 0.65. By 2003 this had increased to 0.81 and by 2005/6 it was 0.87.

The prevalence of dementia as a percentage of registered population for all ages is 0.3 which is lower than England (0.4) but higher than London (0.27).

In 2004-06 the rate of suicides per 100,000 was 5.72 compared to London 7.88 and England 8.25.

Services

In 2007/8 there were 9,223 social care clients. 85% of these are community-based clients. 73% of clients have a physical disability, 18% a mental health issue, 7% learning disability, and 3% classed as vulnerable.

By December 2007 75 schools in Enfield had achieved Healthy School status. 20% of all children are thought to have some mental health issue and 23% of all Enfield state school pupils have some form of provision for special needs. 23% of those in treatment for substance misuse issues are aged under 18, in London this is 10%.

Generally, compared to the national average waits for accessing Children and Mental Health Services (CAMHS) are good.

Winter flu vaccination uptake has increased in recent years from 66% in 2003/4 to 72% in 2006/7. MMR vaccination rates are low and Enfield therefore has a population susceptible to measles, mumps and rubella.