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SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

Meeting to be held in Civic Hall, Leeds on
Wednesday, 26th September, 2012 at 10.00 am

(A pre-meeting will take place for ALL Members of the Board at 9.30 a.m.)

MEMBERSHIP

Councillors

P Truswell	-	Middleton Park;
G Hussain	-	Roundhay;
T Murray	-	Garforth and Swillington;
J Walker	-	Headingley;
C Fox	-	Adel and Wharfedale;
S Armitage	-	Cross Gates and Whinmoor;
K Bruce	-	Rothwell;
J Illingworth (Chair)	-	Kirkstall;
S Varley	-	Morley South;
S Bentley	-	Weetwood;
M Robinson	-	Harewood;

Co-optees

Joy Fisher	Leeds LINk
Sally Morgan	Equality Issues
Betty Smithson	Leeds LINk
Emma Stewart	Alliance of Service Users and Carers

Please note: Certain or all items on this agenda may be recorded

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A G E N D A

Item No	Ward/Equal Opportunities	Item Not Open		Page No
1			**APPEALS AGAINST REFUSAL OF INSPECTION OF DOCUMENTS** To consider any appeals in accordance with Procedure Rule 25* of the Access to Information Procedure Rules (in the event of an Appeal the press and public will be excluded). (* In accordance with Procedure Rule 25, notice of an appeal must be received in writing by the Head of Governance Services at least 24 hours before the meeting).	
2			**EXEMPT INFORMATION - POSSIBLE EXCLUSION OF THE PRESS AND THE PUBLIC** 1 To highlight reports or appendices which officers have identified as containing exempt information, and where officers consider that the public interest in maintaining the exemption outweighs the public interest in disclosing the information, for the reasons outlined in the report. 2 To consider whether or not to accept the officers recommendation in respect of the above information. 3 If so, to formally pass the following resolution:- **RESOLVED –** That the press and public be excluded from the meeting during consideration of the following parts of the agenda designated as containing exempt information on the grounds that it is likely, in view of the nature of the business to be transacted or the nature of the proceedings, that if members of the press and public were present there would be disclosure to them of exempt information, as follows:- **No exempt items on this agenda.**	

3			**LATE ITEMS** To identify items which have been admitted to the agenda by the Chair for consideration. (The special circumstances shall be specified in the minutes.)	
4			**DECLARATION OF DISCLOSABLE PECUNIARY AND OTHER INTERESTS** To disclose or draw attention to any disclosable pecuniary interests for the purposes of Section 31 of the Localism Act 2011 and paragraphs 13-18 of the Members' Code of Conduct. Also to declare any other significant interests which the Member wishes to declare in the public interest, in accordance with paragraphs 19-20 of the Members' Code of Conduct	
5			**APOLOGIES FOR ABSENCE AND NOTIFICATION OF SUBSTITUTES** To receive any apologies for absence and notification of substitutes.	
6			**MINUTES** To approve the minutes from the following meetings of Scrutiny Board (Health and Wellbeing and Adult Social Care: 27th June 2012 25th July 2012 9th August 2012 (minutes attached)	1 - 22

7			**UPDATE ON RECOMMENDATIONS FOLLOWING DEPUTATION TO SCRUTINY BY THE NATIONAL FEDERATION OF THE BLIND** To receive and consider the attached report of the Director of Adult Social Services	23 - 28
8			**MENTAL HEALTH NEEDS ASSESSMENT** To receive and consider the attached report of the Head of Scrutiny and Member Development	29 - 44
9			**LEEDS SUICIDE AUDIT (2008-2010)** To receive and consider the attached report of the Head of Scrutiny and Member Development	45 - 118
10			**QUARTERLY PERFORMANCE REPORT** To receive and consider the attached report of the Assistant Chief Executive (Customer Access and Performance)	119 - 136
11			**NHS AIREDALE, BRADFORD AND LEEDS - PERFORMANCE REPORT** To receive and consider the attached report of the Head of Scrutiny and Member Development	137 - 152
12			**WORK PROGRAMME** **Report to follow**	
13			**DATE AND TIME OF THE NEXT MEETING** Wednesday 24th October 2012 at 10.00am (pre meeting for all Board Members at 9.30am)	

SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

WEDNESDAY, 27TH JUNE, 2012

PRESENT: Councillor J Illingworth in the Chair

Councillors P Truswell, G Hussain, T Murray, J Walker, C Fox, K Bruce, S Varley, S Bentley, M Robinson and N Walshaw

1 Late Items

The following supplementary information was submitted:

- Item 10 – Transformation of Health and Social Care Services – comments from the Director of Adult Social Services
- Item 13 – Sources of work for the Scrutiny Board – Leeds Joint Strategic Needs Assessment (JSNA) 2012 – Executive Summary and Leeds Health Profile 2012
- Item 14 – Request for Scrutiny – letter issued to Yorkshire Ambulance Service on 21 May 2012

2 Declarations of Interest

Councillor T Murray declared a personal interest in Agenda Item 10, Transformation of Health and Social Care Services in Leeds – Draft Scrutiny Board Report due to his position on the third sector leadership board.

Councillor P Truswell declared a personal interest in Agenda Item 8, Co-opted Members due to his position on the LINk steering group.

Councillor G Hussain declared a personal interest in Agenda Item 12, Leeds NHS Performance Report as he had a relative working for the Airedale and Bradford NHS Trust.

3 Apologies for Absence and Notification of Substitutes

Apologies for absence on behalf of Councillor S Armitage were received. Councillor N Walshaw was present as substitute.

4 Minutes

RESOLVED – That the minutes of the meeting held on 16 May 2012 be confirmed as a correct record.

5 Changes to the Council's Constitution

The report of the Head of Scrutiny and Member Development provided the Board with information on recent amendments to the Council's Constitution, as agreed by Council on 21 May 2012, which directly related to and/or impact on the work of the Scrutiny Boards.

RESOLVED – That the report be noted.

6 Sources of Work for the Scrutiny Board

The report of the Head of Scrutiny and Member Development sought to assist the Board in effectively managing its workload for the forthcoming municipal year and provided information and guidance on potential sources of work and areas of priority within the Board's terms of reference.

The following were in attendance for this item:

- Councillor Lisa Mulherin – Executive Member, Health and Well-Being
- Dennis Holmes – Deputy Director, Adult Social Care
- Rob Kenyon – Head of Partnerships, Adult Social Care
- Dr Ian Cameron, Joint Director of Public Health, NHS Airedale, Bradford and Leeds/Leeds City Council

Apologies were submitted on behalf of Councillor Lucinda Yeadon, Executive Member for Adult Social Care.

The following issues were highlighted:

- Mental Health – issues including increased demand for services, voluntary sector involvement, impact of the economy, BME groups and early intervention.
- Health inequalities across the City
- Quality of residential and nursing care provision.
- Longer-term accommodation strategy for Older People in the City.
- Formulation of the Leeds Dementia Strategy.
- Integration of Social Care and NHS services – joint commissioning.and provision
- Establishment of the Health and Wellbeing Board.
- Development of Healthwatch.

In response to Members comments and questions, the following issues were discussed:

- Mental Health issues – safeguarding and vulnerability of patients, early intervention and service provision across the City.
- Health inequalities – links to deprivation and the wider determinants of health
- Transition of Public Health to the Council, the associated duties and involvement of partners.

- Local Development Framework – balancing the duties of a planning authority with public health responsibilities
- Healthwatch and the need for a robust independent body for patients.

RESOLVED – That the report and discussion be noted.

7 2011-2012 Quarter 4 Performance Report

The report of the Assistant Chief Executive (Customer Access and Performance) provided a summary of performance against the strategic priorities for the Council and City related to the Scrutiny Board (Health and Well Being and Adult Social Care). Information in the report related to the Council Business Plan and Health and Wellbeing Indicators.

The following were in attendance for this item:

- Dennis Holmes – Deputy Director, Adult Social Services
- Dr Ian Cameron – Joint Director of Public Health
- Stuart Cameron Strickland – Head of Policy, Performance and Improvement

In response to Members comments and questions, the following issues were discussed:

- Issues related to smoking – prevention, education, cessation services, access to niche tobacco, including shisha smoking.
- Information from GPs – it was reported that figures detailed in the report contained information from all but two GPs Surgeries across the City and that it was hoped that information would soon be provided by all.

RESOLVED – That the report be noted.

8 Co-opted Members

The report of the Head of Scrutiny and Member Development sought the Board's formal consideration for the appointment of Co-opted Members to the Board.

Members were informed of the previous year's arrangements which included representatives from the Local Involvement Network (LINk), Alliance of Service Users and Carers and an Equality Representative. Members also discussed the possibility of inviting a 'university/ research representative' from one of the Universities.

RESOLVED –

(1) That the report be noted.
(2) That nominations be sought for Co-opted Members based on the previous year.

(3) That the Universities be approached regarding the possibility of nominating a representative Co-opted Member.

9 Equality Improvement Priorities 2011 - 2015

The report of the Assistant Chief Executive (Customer Access and Performance) introduced the new Equality Improvement Priorities and the revised Equality and Diversity Policy. It also set out the Council's continued commitment to equality, outlined the Council's equality obligations and objectives, identified how progress would be measured and how the Council would continue to improve and further embed the equality agenda.

The Chair welcomed Lelir Yeung, Head of Equality to the meeting for this item.

In summary, the following issues were discussed:

- Health issues relating to BME communities and migrant communities.
- Gypsies and travellers health issues.
- Access to education and healthcare.

RESOLVED – That the report be noted.

10 Transformation of Health and Social Care Services in Leeds - Draft Scrutiny Board report

The report of the Head of Scrutiny and Member Development presented the draft report following the Board's inquiry into the Transformation of Health and Social Care Services in Leeds.

The Board was informed of comments made by the Director of Adult Social Services and proposed amendments to the draft report.

RESOLVED – That, subject to the inclusion of the amendments proposed by the Director of Adult Social Services, the draft report be agreed.

11 Leeds NHS Performance Report

The report of the Head of Scrutiny and Member Development provided the Board with an overview of performance against performance indicators for both NHS Leeds and NHS Bradford and Airedale. The report highlighted the key performance issues facing the Cluster organisation and showed a partial evolution towards the 2012/13 Operating Framework, whilst also showing end of year data for 2011/12.

The following were in attendance for this item:

- Graham Brown – Performance Manager, NHS Airedale, Bradford and Leeds

- Karl Milner, Director of Communications and External Affairs, Leeds Teaching Hospital NHS Trust

In response to Members comments and questions, the following issues were discussed:

- Healthcare Associated Infections and the rates of MRSA and C Difficile
- Referral to treatment (RTT) – targets and thresholds.
- Quality of stroke care
- Appointment of new nursing staff.
- Increasing pressures on accident and emergency (A&E) and ambulance services.
- Staff turnover and use of agency staff.
- Staff appraisals.

RESOLVED – That the report be noted.

12 Review of Adult's and Children's Congenital Cardiac Services - Update

The reports of the Head of Scrutiny and Member Development provided the Board with updates on the national review of both Adult's and Children's Congenital Cardiac Services.

Reference was made to the Joint Health and Overview Scrutiny Committee (JHOSC) (Yorkshire and the Humber) inquiry into the Children's review and the view that both the Adult's and Children's reviews should have been carried out together. This view had been made as part of JHOSC's submission to the Joint Committee of Primary Care Trusts (JCPCT). However, the JCPCT had stated that the review of Adult's Services was outside its current scope.

It was reported that detailed public consultation on proposals for Adult's Congenital Cardiac Services was likely to take place in 2013/14.

The following were in attendance for this item:

- Mr Kevin Watterson – Cardiac Surgeon, Leeds Teaching Hospital NHS Trust
- Alison Conchie – Children's Services Business Manager, Leeds Teaching Hospital NHS Trust

Kevin Watterson addressed the meeting and stated there was concern that any consultation following the review of services for Adult's with Congenital Heart Disease would merely be a public relations exercise, as any proposals to reconfigure services would have to be based on the outcome of the Children's Services review. Primarily, this was due to the same surgeons being involved in both adult and children's surgery.

It was suggested that the Board reiterate the views of the JHOSC, previously issued to the Secretary of State for Health, that the Adult's Review would be a fait accompli following the outcome of the Children's services review.

It was also suggested that process being followed for reviewing services for Adults compounded the democratic deficit that had been evident during the review of Children's Services. It was not felt that the decision-making process would be based on clear health planning principles (i.e. services being located to inconvenience the least number of people and being based on population density, future population projections and co-location of services and associated specialities).

Reference was also made to previous meetings of the JHOSC and lack of attendance from a JCPCT representative.

In response to Members comments and questions, the following issues were discussed:

- It was felt that the concerns over the reviews had to be highlighted to and addressed by the Secretary of State.
- The possibility of further judicial review proceedings.
- Members were informed of an informal meeting of the JHOSC that had been held and a formal meeting planned for 24 July 2012.
- The logic behind the decision to deal with the reviews separately as the same surgeons and post operative care teams would be needed.
- The JHOSC had informally agreed to amend its terms of reference to maintain an overview of the implementation phase of the children's services decision. This would be confirmed at the meeting on 24 July 2012.

RESOLVED –

(i) That a response be provided to the current public engagement process relating to services for Adult's with Congenital Heart Disease.

(ii) That the response reflect the views previously highlighted by the Joint Health and Overview Scrutiny Committee (Yorkshire and the Humber) during its inquiry into the national review of Children's Congenital Cardiac Services, and highlighted in the associated consultation response/ report..

13 Request for Scrutiny

The report of the Head of Scrutiny and Member Development referred to a request for scrutiny that had been received regarding the Patient Transport Service operated and delivered by the Yorkshire Ambulance Service (YAS).

Members were reminded of previous and similar issues highlighted by the Board when considering the YAS's draft Quality Account for 2011/12. It was suggested that a response be sought from Yorkshire Ambulance Service and

monitoring of the service be undertaken through regular consideration of progress against the priorities and targets detailed in the Quality Accounts for 2011/12..

RESOLVED –
(i) That a formal response to the issues highlighted be sought from Yorkshire Ambulance Service; and,
(ii) Specific monitoring of the Patient Transport Service be undertaken through regular consideration of progress against the priorities and targets detailed in the Quality Accounts for 2011/12.

14 Work Schedule

The report of the Head of Scrutiny and Member Development asked Members to consider the Board's Work Schedule for the forthcoming municipal year.

Members were given a recap of issues raised earlier in the meeting and the following potential areas of work were also highlighted:

- Quality Accounts – quarterly monitoring reports
- Care Quality Commission – quarterly update/ activity reports
- Performance monitoring – quarterly performance reports
- Health Service Development Working Group – established to consider proposed service changes/ developments and associated public/ patient involvement
- Support from the Centre for Public Scrutiny regarding:
  - (i) The development of local Healthwatch;
  - (ii) Joint scrutiny arrangements.

It was agreed that the Principal Scrutiny Adviser and Chair would consider items to be included in the Board's work schedule.

RESOLVED – That the Principal Scrutiny Adviser and Chair would consider items to be included in the Board's work schedule.

15 Date and Time of the Next Meeting

Wednesday, 25 July 2012 at 10.00 a.m. (Pre-meeting at 9.30 a.m.)

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SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

WEDNESDAY, 25TH JULY, 2012

PRESENT: Councillor J Illingworth in the Chair

Councillors P Truswell, G Hussain, T Murray, C Fox, S Armitage, S Varley, S Bentley and M Robinson

CO-OPTED MEMBERS Joy Fisher, Sally Morgan, Betty Smithson and Emma Stewart

16 Chair's opening remarks

The Chair welcomed everyone to the meeting, particularly Joy Fisher, Sally Morgan and Betty Smithson as returning Co-opted Members from the previous municipal year and Emma Stewart, who was attending her first meeting as a Co-opted Member of the Board since 2010/11

17 Late Items

Whilst there were no formal late items, the Board was in receipt of the following supplementary information:

A questionnaire for the draft dementia strategy (minute 21 refers)

18 Declarations of Interest

As co-Chair of the Leeds Local Involvement Network (LINk) Steering Group, Joy Fisher declared a significant interest in the agenda item on Leeds LINk Annual Report for 2010-2011 (minute 23 refers)

No other declarations were made at this point in the meeting although a further declaration was made during the meeting (minute 23 refers)

19 Apologies for Absence and Notification of Substitutes

Apologies for absence were received from Councillor Walker and Councillor Bruce

20 Minutes

The Chair reported that he had not had the opportunity to consider the draft version in detail and that they would be made available for approval at the September meeting

21 Living Well with Dementia in Leeds - draft local dementia strategy

The Board considered a report of the Director of Adult Social Care setting out the proposed steps to improve services and quality of life for people with dementia, their families and carers. Appended to the report was a copy of the joint Leeds City Council/NHS Leeds draft local strategy entitled ' Living Well with Dementia in Leeds' which had been launched for public consultation document with 30th September 2012 being the closing date for comments. A copy of the consultation questionnaire which accompanied the draft strategy was circulated at the meeting

Attending for this item were:

- Dennis Holmes (Deputy Director) – Leeds City Council, Adult Social Services
- Mick Ward (Head of Commissioning) – Leeds City Council, Adult Social Services
- Tim Sanders (Integrated Commissioning and Transformation Manager, Dementia) – NHS Leeds and Leeds City Council

Addressing the meeting, the Deputy Director outlined that the principal aim of the draft strategy was to make the City of Leeds more 'dementia friendly'. Noting that, at its previous meeting in June 2012, the Scrutiny Board had identified dementia as a specific work area it was highlighted that this provided an opportunity for the Scrutiny Board to comment on the draft strategy as part of the wider consultation process

It was highlighted that dementia had been identified as a national priority and while Leeds had a track record for being an early implementer of a number of initiatives in this area, the draft strategy should be regarded as Leeds' formal response to the national imperative

In response to Members' comments and questions, the following issues were discussed:

- Exploitation and abuse of dementia sufferers; the need for workers in all adult care settings to be aware of this; to know the reporting mechanisms if this was suspected and the role of the Adult Safeguarding Board in addressing these issues

- The importance of training especially for medical staff dealing with people with dementia who also had other, often unrelated, health issues that required treatment
- Links between dementia and suicide and the difficulty in forming conclusions on this, often as a result of coroners' verdicts
- The numbers of people with dementia as set out in the report; the basis of this information and the likelihood that the number of dementia suffers from BME groups was higher than indicated
- The importance of early diagnosis of the condition but also ensuring people with symptoms similar to early onset dementia were not misdiagnosed. It was also noted that there was some evidence to suggest it might take up to 12 months for some sufferers to seek professional help
- The need to ensure connections were being made between those people with the condition and the support services that were available
- That whilst nationally dementia was a priority, no new funding was available so delivery against the strategy would need to be funded through existing resources. However the importance of efficiencies generated through service integration across the local Health and Social Care economy was highlighted
- The use of Admiral Nurses - a model of care but currently not in use across Leeds that provided support to the carer rather than the patient
- The need to ensure that at the point of diagnosis plans were put in place for the future, particularly around financial issues, i.e. power of attorney
- Younger people with dementia and the need to ensure if they required full-time care, this was in an age-related setting
- The role of GPs and that the three CCGs in Leeds had the issue of dementia identified within their target training programme
- That family support should be provided, possibly through the provision of family conferences
- Residential care; the need to ensure this was of high quality; the difficulties when couples were separated due to care needs and the potential role of extra care housing schemes
- Bereavement support for families and the role hospices could have in providing help and advice to Local Authorities and the NHS in this area

Whilst the Board welcomed the report, the draft strategy and the opportunity to formally respond, Members highlighted a desire to consider the draft action plan produced following analysis of all the consultation responses

RESOLVED -

a) To note the publication of the draft dementia strategy and the period of public consultation ending 30th September 2012
b) That the Principal Scrutiny Adviser draft and circulate to all Board Members a proposed formal consultation response on behalf of the

Scrutiny Board (Health and Wellbeing and Adult Social Care), with a final draft to be submitted to the September 2012 meeting for approval

c) That following analysis of all the consultation responses, a draft action plan be submitted to the Board for consideration at a future meeting

22 Combating Loneliness in Leeds

Following discussions at the previous meeting on potential areas of work for Scrutiny Board (Health and Wellbeing and Adult Social Care) for the 2012/2013 municipal year, Members considered a report of the Head of Scrutiny and Member Development providing further information on the subject of loneliness; its impact on current and future health and social care needs in older populations and its links to a range of chronic conditions

Appended to the report was a copy of the Local Government Association's document entitled ' Combating Loneliness – A guide for local authorities' – which formed part of the Campaign to End Loneliness, together with The Leeds Initiative publication entitled ' The Time of Our Lives – Ageing Well in Leeds – A Framework of Principles for Organisations that work with Older People in Leeds 2012-2016. This included The Time of Our Lives Charter which had been signed up to by Councillor Wakefield, Leader of Leeds City Council and Linda Pollard, Chair of NHS Airedale, Bradford and Leeds PCT Cluster

Attending for this item to provide further information and respond to questions and comments from the Board were:

- Dennis Holmes (Deputy Director) – Leeds City Council, Adult Social Services
- Mick Ward (Head of Commissioning) – Leeds City Council, Adult Social Services

Addressing the meeting, the Head of Commissioning highlighted that through its work over a number of years, Leeds had contributed to the LGA report with some specific areas of good practice identified in the report

It was suggested that there may be some correlation between loneliness/social isolation and dementia. Reference was also made to some of the work Leeds was undertaking as part of the Age Friendly City Network

The following issues were discussed:

- The role of Neighbourhood Networks and the importance of not adopting a 'one size fits all' approach. The positive influence of these schemes in helping people's overall feeling of wellbeing. Difficulties associated with measuring these benefits were recognised, as was the need to identify tangible outcomes in order to convince other organisations, including health professionals, to (part) fund such

community projects. It was highlighted that work on devising a methodology for measuring outcomes was being undertaken with the assistance of a Professor at the London School of Economics

- The need for data not to be target driven but to contain narrative to explain individual stories behind the statistical data
- Loneliness could not be seen just as an issue for older people and the need for different strategies for different groups
- The importance of having an age-friendly city and the work being progressed on this with other Core Cities
- The importance of community assets and infrastructure, e.g. bus services, libraries, day centres, lunch clubs etc in helping to combat loneliness, balanced with difficult financial decisions local authorities were having to take in the current economic climate
- The development of Neighbourhood Plans as part of the Localism Agenda and the opportunity for Adult Social Care representatives to be involved in shaping these with regard to older people, particularly in respect of the housing strategy
- The role of Area Teams in encouraging and supporting new initiatives within localities and the concept of volunteering both by older people who have retired and wish to be of service and younger people keen to develop new skills and obtain work experience

The Board expressed a wish to carry out further work on this subject and hear from some Third Sector organisations and/or individuals involved in delivering community projects that promote 'wellbeing' and may held combat loneliness across the City

RESOLVED –

a) To note the report and discussions

b) That a further report be presented to the September meeting which

- summarises the issues raised by Members
- provides further information on the Neighbourhood Networks including the services/offer available and the gaps in provision and
- identifies potential contributors/witnesses to provide evidence as part of a Scrutiny Inquiry

Following this item, Councillor Armitage and Councillor Robinson left the meeting)

23 Leeds Local Involvement Network - Annual Report (2011/12)

The Board considered the Leeds Local Involvement Network (Leeds LINk) Annual Report for 2010-2011

In accordance with paragraphs 19-20 of the Members Code of Conduct, Councillor Truswell declared that he was a member of the LINk Steering Group as he felt it was in the public interest to do so

Attending for this item to outline the report, provide further information and respond to questions and comments from the Board were:

- Arthur Giles – Co-Chair of Steering Group, Leeds LINk
- Stuart Morrison – Community Development Officer – Leeds LINk

The Chair welcome the LINk representatives attending and invited them to introduce the report which provided details on the structure and membership of the organisation and outlined the main areas of work that had been carried out during 2011/12

Arthur Giles outlined that it had been a busy 12-month period for the LINk, both in terms of the work it had done locally and its involvement in planning for the future and the establishment of local Healthwatch, which would form the new patient and public engagement body as part of the wider NHS reforms detailed in the Health and Social Care Act 2012. Mr Giles also took the opportunity to thank all of the Leeds LINk's volunteers and staff for their hard work, dedication and contributions throughout the year

In brief summary, the key areas of discussion were:

- The under-representation of some specific groups within Leeds LINk, in particular:
  - working aged adults
  - people from BME communities
  - younger people
- The use of social media to connect and engage with people in particular younger people
- Difficulties associated with making the subject of health and wellbeing interesting
- Team building exercises through major employers and whether Leeds LINk could consider this approach when trying to attract and engage working-aged adults in the work of the LINk
- Financial details presented in the annual report, including clarification about the level of discretionary budget and the relationship with Shaw Trust (the host organisation). It was suggested that the financial details provided could benefit from a brief commentary
- The move to Healthwatch in April 2013 and the likely transitional arrangements

RESOLVED - To note the report and the comments made

24 Review of Children's Congenital Cardiac Services in England: Update on the work of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber)

The Board considered a report of the Head of Scrutiny and Member Development on the review of Children's Congenital Cardiac Services in England, following the announcement of the Joint Committee of Primary Care Trusts' (JCPCT) decision on the future service model, which was for Liverpool

and Newcastle to be the children's heart surgical units for the North of England

Appended to the report was a copy of the report considered by the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) at its meeting held on 24th July 2012, which included a summary of that Committee's previous recommendations; details of the assessment panel scores of the 11 hospitals involved in the review and the Children's Heart Surgery Fund's response to the decision made in respect of services at Leeds General Infirmary

The Chair updated the Board and stated that the unanimous decision of the Joint Health Overview and Scrutiny Committee (Yorkshire and the Humber) had been to refer the decision of the JCPCT to close the Children's Heart Surgery Unit in Leeds to the Secretary of State for Health and that work would commence on the collation of information to support that Committee's case

The Principal Scrutiny Adviser informed Members that the Scrutiny Board (Health and Wellbeing and Adult Social Care) retained the power to make a similar referral to the Secretary of State

The Board discussed this and was of the view that such were the implications of the JCPCT's decision on the LGI and patient care in Leeds, that it was appropriate to refer the decision to the Secretary of State

RESOLVED - That the decision taken by the JCPCT to close the Children's Heart Surgery Unit in Leeds be referred to the Secretary of State by Scrutiny Board (Health and Wellbeing and Adult Social Care) on the basis of the impact of the proposals being deemed as not in the interests of local health services

25 Work Schedule

Members considered a report of the Head of Scrutiny and Member Development on the Board's work schedule for the year. Appended to the report was a copy of the Executive Board minutes from 20th June 2012; the Council's Forward Plan of Key Decisions from 1st August 2012 – 30th November 2012 and a Department of Health publication entitled 'Local Authority Health Scrutiny – Proposals for consultation' which asked for views on the Government's intentions to strengthen and streamline the regulations on local authority health scrutiny following amendments to legislation encompassed within the Health and Social Care Act 2012

With reference to the previous Board's Scrutiny Inquiry into reducing smoking in Leeds, Members received in the pre-meeting, a draft of the Director of Public Health's response to the Board's recommendations. Members were informed that subject to receiving further comments from West Yorkshire Trading Standards, it was hoped to submit a further report to the September Board meeting

The Principal Scrutiny Adviser drew the Board's attention to the Department of Health's proposals on how health scrutiny would operate in the future. A one-off ad-hoc Working Party was proposed to look at this in detail and submit a response to the consultation which ended before the next scheduled Board meeting, with a report being brought back to the September meeting for formal approval

Ahead of the Board meeting scheduled for September 2012, the Chair outlined his intention to progress work around the Local Development Framework and the importance of this reflecting and taking into account the Council's pending Public Health duties as part of the legislative changes detailed in the Health and Social Care Act 2012. The Chair outlined that it was intended to bring forward a report for the Board's consideration to a future meeting

RESOLVED -

a) To note the Executive Board minutes and current Forward Plan
b) That a Working Party be established to consider and prepare a response to the consultation on local authority health scrutiny regulations and that a report on this be submitted to the September 2012 meeting
c) To note the Chair's proposed activity around the Local Development Framework and the Council's Pending Health duties under the Health and Social Care Act 2012
d) That an outline work schedule be submitted to the September 2012 meeting, which reflected the discussions and decisions taken at the meetings in June 2012 and July 2012

26 Date and Time of the Next Meeting

Wednesday 26th September 2012 at 10.00am with a pre-meeting for all Board Members at 9.30am

SCRUTINY BOARD (HEALTH AND WELL-BEING AND ADULT SOCIAL CARE)

THURSDAY, 9TH AUGUST, 2012

PRESENT: Councillor J Illingworth in the Chair

Councillors P Truswell, G Hussain, C Fox, S Armitage, K Bruce, S Varley, S Bentley, M Robinson, P Grahame and J McKenna

CO-OPTED MEMBERS Betty Smithson and Emma Stewart

27 Chair's Opening Remarks

The Chair welcomed everyone to the call-in meeting

28 Exempt Information - Possible Exclusion of the Press and the Public

RESOLVED – That the public be excluded from the meeting during the consideration of the following parts of the agenda designated as exempt on the grounds that in view of the nature of the business to be transacted or the nature of the proceedings it is likely that if members of the public were present there would be disclosure to them of the following designated exempt information:

> Appendix 1 to the report referred to in Minute No. 33. Under the terms of Access to Information Procedure Rule 10.4(3) and on the grounds that the appendix contains information which if disclosed to the public would, or would be likely to prejudice the commercial interests of the Council and/or proposed partner. It is therefore deemed in the public interest not to disclose such information

29 Late Items

The Chair admitted to the agenda exempt supplementary information which supported the documentation outlined in Appendix 1 of the report prepared by the Director of Adult Social Services (Agenda Item 7) (Minute 33 refers)

Under the terms of Access to Information Procedure Rule 10.4(3) and therefore as part of the private element of the meeting, the submission of further additional information was agreed later in the meeting (minute 33 refers)

30 Declaration of Disclosable Pecuniary and other Interests

There were no disclosable pecuniary and other interests declared at the meeting

31 Apologies for Absence and Notification of Substitutes

Apologies for absence were received on behalf of Councillor T Murray, Councillor J Walker, Sally Morgan and Joy Fisher

Notification had been received for Councillor P Grahame to substitute for Councillor T Murray and Councillor J McKenna to substitute for Councillor J Walker

32 Call in Decision - Briefing Paper

The Head of Scrutiny and Member Development submitted a report regarding the procedural aspects of the call-in process.

Members were advised of the process for reviewing the decision was as follows:

- Members who have requested the Call In invited to explain their concern/reason for Call In request
- Relevant Executive Board Member (supported by appropriate officers) asked to explain decision
- Further questioning from the Board as appropriate

Members were further advised of the options available to the Board in respect of this particular called-in decision as follows:

Option 1 – **Release the decision for implementation**. Having reviewed the decision, the Scrutiny Board (Health and Well-being and Adult Social Care) could decide to release it for implementation. If this option was chosen, the decision would be released for immediate implementation and the decision could not be called-in again.

Option 2 – **Recommend that the decision be reconsidered**. Having reviewed the decision, the Scrutiny Board (Health and Well-being and Adult Social Care) may decide to recommend to the decision maker that the decision be reconsidered. This option requiring a report to be submitted to the Executive Board, outlining the Scrutiny Board's reasons for doing so

In the case of an Executive Board decision, the report of the Scrutiny Board would be prepared within three working days of the Scrutiny Board meeting and submitted to the Executive Board. The Executive Board would reconsider its decision at its next meeting and publish the outcome of its

deliberations within the minutes of the meeting. Any subsequent decision would not be eligible for further 'call in', whether or not the decision was varied

Option 3 - **Recommend that the decision be reconsidered and refer the matter to full Council if recommendation not accepted**

This course of action would only apply if the Scrutiny Board determined that a decision **fell outside the Council's Budget and Policy Framework** and this determination were confirmed by the Council's Section 151 Officer (in relation to the budget) or Monitoring Officer (in relation to other policies)

If, at the conclusion of this meeting, the Scrutiny Board forms an initial determination that the decision in question should be challenged on the basis of contravening the Budget and Policy Framework, then confirmation will subsequently be sought from the appropriate statutory officer

RESOLVED – That the report outlining the process of the call-in meeting be noted

33 Call In - Shared Service Partnership with Calderdale Metropolitan Borough Council to Meet Adult Social Care Technology Requirements

The Head of Scrutiny and Member Development submitted a report, together with background papers, relating to a review of a decision made by the Executive Board on 18th July 2012 in relation to 'Shared service partnership with Calderdale Metropolitan Borough Council to meet Adult Social Care technology requirements'.

Appended to the report were copies of the following documents for the information/comment of the meeting:-

- Copy of the completed call-in request form
- Shared service partnership with Calderdale Metropolitan Borough Council to meet Adult Social Care technology requirements – Report of the Director of Adult Social Services submitted to the Executive Board meeting held on 18th July 2012
- Relevant extract of the Executive Board draft minutes of 18th July 2012

In addition to the above documents, a copy of exempt supplementary information which supported the documentation outlined in Appendix 1 of the report prepared by the Director of Adult Social Services was circulated for Members' information. The information was exempt under the same terms of Access to Information Procedure Rule 10.4(3) as Appendix 1 of the Executive Board report. That is, on the grounds it contained information which if disclosed to the public would, or would be likely to prejudice the commercial interests of the Council and/or proposed partner. It is therefore deemed in the public interest not to disclose such information.

The decision had been called-in for review by Councillors A Lamb, B Anderson, R Wood, C Fox and N Buckley on the following grounds:-

- The report failed to make reference of the history of this scheme, in particular the estimated costs set out in June 2010 which were almost £10m less than the total costs for this scheme overall
- There was a lack of clarity as to why the costs had inflated to such an extent and around the reasons for abandoning the joint procurement approach, especially given the increase in the project costs
- The outcomes that had now been delivered in the report did not seem proportional to the desired outcome of delivering a replacement system for the ESCR system and that a like for like replacement that addressed the concerns raised in inspection reports would not have been as expensive as the option approved in the report
- The need for clarification as to whether the possibility of pursuing joint procurement and then adjusting to meet the different needs of the two departments had been considered
- The need for clarification of the aims of the project when initially developed in 2010 and the reasons why the costs had inflated to such an extent and whether or not details of these costs had been explained to elected members

Councillor A Lamb attended the meeting and was invited by the Chair to explain the reasons for 'calling-in' the decision. In summary the main points raised were as follows:

- A brief history behind the management system covering the period 2003-2011
- Concerns about the Executive Board decision to enter into a partnership arrangements with Calderdale
- Concerns that an 'in-house' solution had not been deemed 'fit for purpose' in 2010
- The need for an in-house Social Care Record System
- Concerns about the delay in delivering a replacement system, the associated implications for front-line staff and alleged increases in estimated costs since June 2010
- The need to incorporate a flexible system that would be capable of interacting with various health service systems and the new Children's Services system

The following representatives were also in attendance at the meeting and were invited to comment/respond to the points raised by Councillor Lamb:

- Councillor L Yeadon, Executive Member with portfolio responsibility for Adult Social Care
- Dennis Holmes, Deputy Director Adult Social Services
- John Malone, Senior Project Manger, Resources

In explaining the reasons for the Executive Board decision, Councillor Yeadon and officers made the following comments:-

- The importance of making the right decision was recognised and further scrutiny of the decision welcomed
- A partnership arrangement with Calderdale was viewed as the right decision, especially in terms of developing 'shared services' between Councils
- Across local government, shared services were likely to become more prominent in the future
- Calderdale had the necessary skills and expertise for developing and implementing systems in this area
- Significant changes had occurred over the past decade, which had seen the separation of Social Care for Adults and Children – with the latter becoming part of the Council's wider Children's Services Directorate
- The future of Adult Social Care would see more integration health partners, both in terms of commissioning and delivering services
- Calderdale had an established track record (of over 30 years) of providing in-house IT solutions and support
- It was reinforced that a partnership arrangement with Calderdale was the right decision

The Chair invited questions and comments from Board members for the Executive Board Member and officers present on the evidence submitted.

In summary, the main areas of discussion were:-

- Ensuring the proposed partnership arrangement was fit for purpose now and for the future – including the integration/ability for the system to be adaptable and able to work with a range of other systems, including health and Children's Services
- The need for efficient use of resources and the increasing likelihood for more shared service arrangements across local government in the future
- The safeguards built into the agreement to share risks and protect the Council
- Additional developments since 2010/2011 across health and social care that have informed the decision to recommend a solution based on a partnership arrangement
-

The Chair then moved to consideration of Appendix 1 to the submitted report, designated as exempt under Access to Information Procedure Rule 10.4(3), together with the exempt supplementary information be considered in private. Members of the press and public were asked to leave for this part of the meeting

This gave Board members an opportunity to ask specific detailed questions on the financial aspects of the partnership agreement and other options considered, as detailed in the report

As part of his evidence to the Board, Councillor Lamb referred to a copy of a report in relation to 'Social Care Systems Review' which was previously considered at an Executive Board meeting held on 22nd June 2010 and contained exempt financial information in Appendix 2 of the report.

Following discussions by Board Members, it was agreed that a copy of this report be circulated at the meeting and detailed discussion of the exempt financial information outlined in Appendix 2 took place as part of the private discussion

Following this process, the Chair allowed officers and the Call-In signatories to sum up and make any final comments

In conclusion, the Chair thanked Councillor Lamb, together with Councillor Yeadon and the officers present for their attendance and contribution to the call in meeting.

RESOLVED- That the report and information provided be noted.

34 Outcome of Call In

Having considered the evidence presented Councillor Hussain proposed that the decision be released for implementation. The Chair put this proposal to all voting members of the Board, which was subsequently agreed

RESOLVED – To release the decision for implementation.

Leeds CITY COUNCIL

Report author: Dennis Holmes
Tel: 0113 247 4959

Report of Director of Adult Social Services

Report to Scrutiny Board (Health and Wellbeing and Adult Social Care)

Date: 25 July 2012

Subject: Update on recommendations following deputation to Scrutiny by the National Federation of the Blind (16 January 2012)

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

Summary of main issues

1. This report provides feedback on how the recommendations from Scrutiny on 16 January 2012 have been implemented.

2. This report provides a summary of the contract performance between January and March 2012.

Recommendations

1. To note the content of this report and the actions that were undertaken by Adult Social Care (ASC) and Leeds Vision Consortium (LVC) to address the recommendations.

2. Members of the Health and Wellbeing (Adult Social Care) Scrutiny Board are recommended to accept this report as the final update report as the recommendations made in the previous Municipal year have now been fully implemented. Adult Social Care commissioning officers will continue to actively monitor this service in line with the terms and conditions of the contract.

1 Purpose of this report

1.1 The purpose of this report is to provide a response to the recommendations of the scrutiny working group of the 16 January 2012.

2 Background information

3 In October 2011, the Scrutiny Board (Health and Wellbeing and Adult Social Care) was presented with a request for scrutiny regarding the arrangements for meeting the needs of Visually Impaired adults in Leeds.

3.1 At that meeting, the Scrutiny Board noted that a deputation was made to Full Council at its meeting on 16 November 2011. Following on from the deputation, Scrutiny Board established a working group to consider the issues raised, agreeing that this should arrange to meet prior to the Executive Board so that any findings and/or recommendations could be submitted back to the Executive Board to assist their consideration of the issues raised by the deputation at Full Council.

3.2 A meeting of the working group was held on 16 January 2012. The working group considered the content of the issues raised in the deputation and ancillary matters brought to the attention of Scrutiny Members. In response, a range of written evidence was produced by LVC and Adult Social Care officers. This allowed the working group to consider additional information that provided useful context to the current position and the request for scrutiny.

4 Main issues

4.2.1 Following consideration of all the issues and the responses provided, the working group agreed the following recommendations with the services provided by LVC essentially aimed at improving the experience of all people accessing facilities at Fairfax House (the base used by LVC for it's activities)

4.2.2 In line with the recommendations, LVC implemented the following programme of improvements to the ground floor meeting room which is used by people experiencing Dual Sensory Loss (DSL):

- **Toilets**: alterations to the position of the toilet door have been carried out providing greater privacy.

- **Drinks station**: a cold water dispenser and a hot water urn are now provided at a counter in a corner of the Dual Sensory Loss (DSL) room for hot and cold drinks availability at all times throughout the DSL days. Staff and volunteers are on hand to dispense drinks when service users request.

- **Curtains**: LVC has consulted with all the people accessing this service with regard to the fitting of high level curtains. People overwhelmingly decided against fitting curtains as it was felt they would darken the room. Therefore the original blinds have been retained to let as much light into the room as possible.

- **Soft furnishings**: Two sofas and cushions have been installed in the DSL room and a corner has been partitioned off for quiet conversation.

- **Talking microwave**: LVC have installed a 'talking microwave', which enables service users who previously brought sandwiches to have a hot meal if they wish to. People using this service can heat food themselves or staff or volunteers can assist on their behalf.

4.1.2 In relation to the future of the Shire View site, options continue to be considered by the Asset Management Board of the Council who are now responsible for determining the future use of the building. Adult social care officers continue to advise colleagues with regard to the views expressed by people with a continuing interest in the use of the site. To that end, a meeting has taken place with the Executive Lead Member for ASC, the ASC officer responsible for the contract and representatives from the original Deputation from the National Federation of the Blind. Further meetings are scheduled and there is an agreement to continue to meet to discuss a range of issues. Adult Social Care has recommended that the Asset Management Board consider allocating a community room within Shire view for the use of by the Federation and its members. The Chair of the Federation has been given consent to submit a report to Corporate Asset Management Board regarding this request.

4.1.3 The current lease for Fairfax House is due to end in June 2014. Preceding this, discussions will take place with regard to whether this will continue to be the favoured location for DSL services or whether an alternative venue should be sought . This process will naturally closely involve consultation with people using the current service and the full range of other stakeholders.

4.1.4 LVC continues to support the social groups either at Fairfax House, at the satellite sites or at other venues across the city.

4.1.5 In recognition that further development is needed around establishing and maintaining effective 'peer support' and 'peer learning' opportunities for people experiencing sight loss, LVC have commenced this work and, as a direct result of this a specific group has now been established at Fairfax House. The expectation is that this element of the work will continue to grow in this the second year of the contract.

4.1.6 ASC continues to receive quarterly performance reports from LVC and will continue to do so for the duration of the contract. The monitoring report for the period January 2012 to March 2012 is referenced in the construction of this report as is a performance update prepared in May 2012. The next performance report for April to June 2012 is due to be produced in mid July and a performance and end of year meeting will take place at the end of July.

5 Corporate Considerations

5.1 Consultation and Engagement

5.1.1 Prior to ASC undertaking the procurement exercise a series of regular consultation events took place at Shire View. People were able to provide feedback on the content of the service specification and amendments were made

to the specification following their comments. The consultation events from the outset provided details about the position with the lease and people using or attending the centre were made aware that the services operated from there would in all likelihood need to be relocated to a more central location.

5.1.2 Following the award of the contract LVC had a weekly presence at Shire View until the contract transferred formally to them on 13 June 2011. This provided the opportunity for LVC to meet with service users, staff and volunteers. The Senior Managers from LVC and the Adult Commissioning Manager also attended two large meetings with over 100 people, staff, volunteers and concerned individuals at Shire View. These sessions provided the opportunity for information to be shared in an open and transparent way and for all questions to be responded to.

5.1.3 ASC sent out a letter to 5200 adults that are registered as being blind or partially sighted providing them with information about the new service and this generated a significant number of new referrals and enquiries resulting in temporary staff having to be employed by LVC to respond to the level of demand.

5.1.4 LVC will continue to consult with people using these services for the duration of this contract on their satisfaction levels of the services provided. There is also a stakeholder group that meets on a regular basis at LVC, it's chief focus is to receive direct feedback from people using the services on offer.

5.2 Equality and Diversity / Cohesion and Integration

5.2.1 Since the new service commenced on 13 June 2011 there has been an increase in the number of adults from BME communities receiving services from LVC. Up to the end of September 2011, 62 adults from BME communities had accessed LVC in comparison to the same time in the previous year with the previous provider when just 3 people had accessed the comparable offer.

5.2.2 There are specific pieces of work being undertaken to engage with BME communities that are particularly affected by certain eye health problems such as glaucoma related to diabetes. Partnership arrangements have been established with other voluntary sector organisations that work with BME communities in Leeds which are already proving effective in the short time that the service has been open.

5.3 Council policies and City Priorities

5.3.1 ASC has a duty under the National Assistance Act 1948 to make arrangements for promoting the welfare of adults who are blind or partially sighted.

5.3.2 The Leeds Vision Strategy 2009-2014 was developed by the Leeds Vision Strategy group, of which ASC was a key partner. The Strategy sets out Leeds' ultimate goal for eye care and sight loss services, a goal that Leeds should always be striving towards: "Leeds offers a flexible and seamless service of eye care and sight loss support tailored to meet individual needs and targeted to address inequalities in the city and offers barrier-free access to all opportunities within the city."

5.4 Resources and value for money

5.4.1 The value of this contract per year is £500,000. This budget was agreed upon prior to the procurement exercise and was based upon the expenditure on the contract with the previous provider. The budget for this service was not reduced nor has there been any disinvestment in the level of service delivery.

5.5 Legal Implications, Access to Information and Call In

5.5.1 This is a report to Scrutiny Board (Health and Wellbeing and Adult Social Care).

5.6 Risk Management

5.6.1 The points raised by the Deputation have been included in the monitoring of the contract and service delivery. The contract performance and service delivery are being rigorously monitored by ASC commissioning officers. A new monitoring framework is in place, which consists of monthly and quarterly contract monitoring meetings. LVC piloted a new outcome measurement tool to be used with service users and this will accurately measure the distance travelled by service users who access the service. It will focus on the delivery of individual outcomes that will have been identified via a comprehensive assessment. This outcome is now being used within LVC and is proving to be effective in its measurement of service user outcomes.

6 Conclusions

6.1 ASC is satisfied that LVC have implemented all of the recommendations arising out of the Scrutiny enquiry and will continue to monitor the level of service user satisfaction. LVC have demonstrated absolute willingness to ensure that they do all that they can to deliver an effective service to a growing client base.

7 Recommendations

7.1 to note the content of this report and the actions that were undertaken by Adult Social Care (ASC) and Leeds Vision Consortium (LVC) to address the recommendations.

7.2 Members of the Health and Wellbeing (Adult Social Care) Scrutiny Board are recommended accept this report as the final update report as the recommendations made in the previous Municipal year have now been fully implemented. Adult Social Care commissioning officers will continue to actively monitor this service in line with the terms and conditions of the contract.

8 Background documents[1]

8.1 LVC performance report April 2012 & May update

8.2 Health & Wellbeing Scrutiny Board working Group recommendations (Feb 2012)

[1] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

Date: 26 September 2012

Subject: Leeds Mental Health Needs Assessment and Provision

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

Summary of main issues

1. At its meeting in June 2012, issues around the provision of Mental Health services and the Leeds Mental Health Assessment were identified as areas for consideration by the Scrutiny Board.

2. Attached is a summary paper detailing the main finding and recommendations from the Leeds Mental Health Assessment and some of the service provision available across the City. It should be noted that a separate report relating to Leeds' Suicide Audit (2008 – 2010) is presented elsewhere on the agenda.

3. Representatives from NHS Airedale Bradford and Leeds, Adult Social Care and Leeds' Public Health team have been invited to attend for this item and address relevant comments/ questions from the Scrutiny Board.

Recommendations

4. That Members consider the information presented around Leeds Mental Health Assessment and service provision and identify any areas where additional information is needed and/or that require further scrutiny.

Background documents [1]

- None used

[1] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

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Scrutiny Board (Health and Wellbeing and Adult Social Care)
26 September 2012

Paper title: Leeds Mental Health Needs Assessment and Service Provision

Authors: Victoria Eaton, Consultant in Public Health, NHS Airedale, Bradford and Leeds
Michele Tynan, Adult Social Care, Leeds City Council
Richard Wall, Head of Commissioning (Mental Health/LD), NHS Airedale, Bradford and Leeds
Catherine Ward, Emotional Health and Wellbeing Lead, NHS Airedale, Bradford and Leeds

1 Background

1.1 A Mental Health and Wellbeing Needs Assessment (MHWNA) for Leeds was completed in May 2011, as one part of the Joint Strategic Needs Assessment (JSNA) for Leeds. This aimed to inform our understanding of mental health and wellbeing within our city, in order to influence decision-making on the factors affecting mental health and wellbeing. The report was written for a wide range of organisations involved in commissioning, developing and providing services to improve mental health and wellbeing. It is intended to be used to inform the most appropriate use of resource to improve health outcomes and reduce inequalities in mental health and wellbeing.(Mental Health and Wellbeing in Leeds: An Assessment of Need in the Adult Population – May 2011). The initial report is now part of the live database of available intelligence relating to health and wellbeing, as part of the Leeds JSNA, on the Leeds Observatory. www.westyorkshireobservatory.org

1.2 The MH&WNA was written in the context of the national mental health strategy "No Health without Mental Health" (Dept of Health 2011). The strategy's two aims are to improve the mental health and wellbeing of the population and keep people well; and to improve outcomes for people with mental health problems through high quality services that are equally accessible to all.

2 Key findings, recommendations and progress

2.1 The scope of the strategy includes population mental health and wellbeing for adults. This includes older people's mental health and wellbeing, with the exception of dementia. It also does not include learning disabilities, peri-natal mental health and children and young people under 18. The report uses data and intelligence in different forms including local activity data, national prevalence data, and qualitative information, including community intelligence.

2.2 A summary of key findings and recommendations, which includes short term actions as well as key messages around designing services informed by need, is presented at Appendix 1.

2.3 The key findings and recommendations have been presented to and taken forward by a range of partners across Leeds, and progress on recommendations informed by the members of the Leeds Joint Strategic Group for Mental Health.

2.4 Examples of progress on immediate actions include:

- Completion of the suicide audit (a more detailed report is presented elsewhere on the agenda);

- Further work on understanding self-harm incidence and the commissioning of an enhanced self-harm team at A&E; and,
- A new employment support service for those with mental health difficulties.

2.5 On a more strategic level, the recommendations have influenced organisations within the city to take into account population need when planning and delivering services. Examples include:

- The two year Mental Health Improvement Plan for Leeds being informed by population need; and,
- Responding to the increasing prevalence and distribution of depression through targeted work within the Increasing Access to Psychological Therapy (IAPT) service in Leeds.

2.6 A fuller list of progress against recommendations is detailed in Appendix 2.

3 Adult Social Care Mental Health Provision

Assessment and Care Management Teams

3.1 Adult Social Care (ASC) is in the process of integrating the social care teams with the Leeds and York Partnership Foundation Trust (LYPFT) clinical community teams within Adult mental health. The teams have been co-located for some years and there are positive relationships with LYPFT colleagues. In order to build upon this arrangement, ASC is currently in the process of signing a Section 75 partnership agreement to consolidate the existing good practice and to further integrate services. This will enable both organisations to meet assessed need and produce improved outcomes for service users and family carers on a joint basis underpinned by the principles of recovery.

3.2 The formal partnership will be overseen in terms of robust governance by a Partnership Board who will meet quarterly to ensure that processes are effective and efficient and that both organisations are achieving added value for money with the common purpose of increasing access to Self Directed Support and reducing duplication along the health and social care pathway.

3.3 LYPFT will be the host organisation for the community teams and social care managers will be managed on a Matrix Management basis by LYPFT colleagues. The matrix agreement clearly sets out the expectation of the Local Authority in relation to health managers managing ASC staff and provides the facility for professional supervision by senior ASC managers to ensure that both line management objectives are being achieved and also that individuals are up to date with new and emerging social work practice. The terms and conditions of the social care workforce will be retained i.e. as Local Authority employees and the Trade Unions have been extensively consulted and engaged within this particular process.

3.4 A joint bid for Transformation in the guise of increasing the number of individuals with mental illness having access to Personal Budgets and the implementation of a quality Recovery Service has been won and NHS Leeds has recently awarded the £380k to pursue and realise these ambitions. A small task and finish group has been established to guide this development over the next 12 months. ASC will recruit 6 Peer Support Workers in order to develop a peer support network, these post holders will be individuals who have had or still have mental health issues and who have used

services or continue to do so in order to support people through recovery on the principles of credibility and expert by experience basis. This will generate employment and equal career opportunities for a variety of former and current service users.

Mental Health Day Service Transformation

3.5 There are 3 large mental health day centres in the City:

- Stocks Hill in Armley;
- The Vale in Hunslet; and,
- Lovell Park in Sheepscar.

3.6 The service also has a Community Alternatives Team that works entirely in the community, supporting people in mainstream facilities to take up educational, sport and recreational activities.

3.7 All 4 services operate a socially inclusive and recovery orientated service. However some parts of the service are very traditional and do not appeal to younger people with mental health needs. There is also some duplication in service provision with that provided in the voluntary sector.

3.8 Following the proposal in 2010/11 to close two of the day centres and the ensuing response coupled with some anxiety and upset from service users, the suggestion was that work be undertaken with service users and staff. A commitment was given to work with all stakeholders to develop options in relation to a new service model.

3.9 A review/consultation exercise was undertaken in October 2011 with the support of staff members. These were held to collate information in relation to what service users valued about the service and what services they may wish to access in the future. A Mental Health Advisory Board was set up in March last year and, as part of its constitution, a co-chair role was created to be filled by a service user representative. A significant level of work has been undertaken to rebuild the trust of service users, including:

- Involvement in service delivery;
- Attendance at managers meetings;
- Visits to other services that have recently been through a period of change; and,
- Supporting the review of local policies and procedures.

3.10 The Mental Health Advisory Board has worked to produce an outline service model which incorporates the suggestions made by service users and staff. These suggestions have also been ratified by commissioners and strategically align with the current voluntary sector provision in the City.

The Proposed Service Model and Asset Bases:

3.11 There are six key elements to the proposed service model, namely:

- Staff led recovery groups
- User led recovery groups
- One to one work
- Safe spaces/peer support
- Support pathways through acute services
- Signposting to other services

3.12 The following proposals have been identified for the existing asset bases:

- Lovell Park to become a community 'hub' with a possibility of sharing some of the available space with voluntary sector mental health services
- Stocks Hill has options in relation to sharing the building with Health. This is currently being explored to test viability
- The Vale – to explore alternative base/s in the South of the City, but not to withdraw from The Vale until new safe spaces are operational.

Consultation

3.13 Formal consultation on the proposals commenced on Tuesday 11th September 2012 and will run until December 2012.

3.14 Events will take place with all stakeholders including service users, carers and staff throughout this period. Presentations will be held each month with the support of service users who have offered to help present these.

3.15 Other methods of communication being used are:

- Letters;
- Bucket e-mail accounts;
- Questionnaires;
- Suggestion boxes;
- Working groups; and,
- The Councils 'Talking Point' forum.

3.16 The majority of service users now feel that the impending changes to their service have been talked about for long enough and are very keen for changes to actually happen.

3.17 Following the formal consultation process a report will be submitted to the Council's Executive Board outlining the outcome of the consultation and associated recommendations around the future service model and provision.

References/ background papers

1. No Health Without Mental Health: Delivering Better Mental Health Outcomes, Department of Health 2011

2. Mental Health and Wellbeing in Leeds: An Assessment of need in the Adult Population, NHS Airedale, Bradford & Leeds/Leeds City Council, May 2011

Leeds Mental Health and Wellbeing Assessment
Summary of key findings and recommendations

Summary of key findings

From the key sources of data included within the report, findings are summarised below. Further work will be needed to explore the factors involved for some key findings, which is reflected in the recommendations.

Population Mental Health and Wellbeing

- Psychiatric morbidity data for Leeds broadly reflects national modelling on expected prevalence. However, there are higher levels of mental health problems within population groups experiencing multiple risk factors, resulting in inequalities in mental health outcomes within the Leeds population, for example 90% of all prisoners are estimated to have a diagnosable mental health problem.

- Higher levels of poor mental health and wellbeing and mental illness are inextricably linked with deprivation within Leeds. Local mapping highlights these issues and emphasises the social gradient of mental health and wellbeing.

- We have some insight into the needs of the groups with the poorest mental health in Leeds, but this is limited and needs to be further developed.

- Data on mental wellbeing is limited and patchy. There is also still an emerging consensus around agreed measures for mental wellbeing. Available data reflects the pattern of inequalities in mental wellbeing within the city.

- There is evidence that some mental health problems are becoming more prevalent. This is reflected by Leeds data in an increased prevalence of depression, although gaps in local data suggest much under-reporting, particularly amongst older people. Only a third of older people with depression ever discuss it with their GP, yet depression is the most common mental health problem in older people. The number of older people in our population is growing, with a corresponding increase in those at risk of depression.

- Local data suggests that Leeds has significantly higher levels of recorded psychotic disorders than predicted from national prevalence data. This is both for males and females, but is particularly high in the number of males diagnosed.

- According to national prevalence data we would expect to see higher prevalence of psychotic disorders amongst women than men. Data for Leeds shows we have more males than females with diagnosed psychotic disorders. The differences between expected prevalence and recorded diagnosis are also related to age; there are relatively high levels of diagnosis of psychotic disorders in older age groups (45-74) in contrast with lower levels of expected prevalence.

Suicide and Self Harm

- The overall suicide rate in Leeds has risen slightly since 2004. Local data suggests the highest suicide rate is in the 35 – 64 age range, suicide rates in Leeds are higher in under-65s than regional and national rates, and lower in the over-65 age groups. In Leeds the overall suicide rate is 3 times higher for males than females.

- There is insufficient quality data collection for completed suicides for the over 75 generic age group. This is not a Leeds specific issue, but should be taken into account when interpreting local data.

- Self-harm recorded through admissions to hospital treatment show high rates of first episodes mainly due to self poisoning. Local data shows higher rates of self-harm amongst young women. This data is limited as it only reports incidence of self-harm resulting in hospital admission.

Secondary mental health services

- Data suggests the rate of access to NHS secondary mental health services is higher in Leeds in comparison to the national rate for England.

- Local data on activity within NHS secondary mental health services highlights some key differences for Leeds compared with England and PCT Peers: this includes:
  - a lower rate of social worker contact
  - a higher rate of Community Psychiatric Nurse contact
  - a higher percentage of formally detained inpatients

Employment and Financial Inclusion

- Unemployment and the economic downturn is having an impact on mental health across the city and not just in 'deprived Leeds'.

- Leeds has a relatively high level of its working age adult population in receipt of Incapacity Benefit due to mental ill health (50% of IB claimants identify a mental health problem)

- Employment rates for female users of mental health service users in Leeds are significantly below the national average.

- Around half of all lifetime mental health problems start in childhood and are associated with multiple risk factors, including inequalities. Leeds data informs us that one fifth of all children in the city live in families where no-one in the household is in work. In 'deprived Leeds' over 40% of children live in workless households.

Integrated Mental Health and Wellbeing

- Addressing mental health and wellbeing is a key priority within many programmes and services in Leeds, as captured in a review of all health needs assessments across the city.

- Local data highlights the need for new or extended screening for mental health problems in services in other many other settings, programmes and services, recognising the importance of the voluntary sector outside mental health services.

- Mental health problems, particularly depression, are more common in people with physical illness including long term conditions. Local data shows over 128,000 people living in Leeds who considered themselves as having a limiting long-term illness (18% of the total resident population), with greater numbers concentrated in 'deprived Leeds'.

- Local data suggests that the prevalence and complexity of dual diagnosis is increasing locally and collaboration between mental health and substance misuse services increasingly needed to achieve the best outcomes for service users.

- People with severe mental illness die on average 20 years earlier than the general population, and have higher levels of physical morbidity.

Recommendations

The purpose of carrying out this needs assessment within the broader context of the Joint Strategic Needs Assessment for Leeds is to inform and influence decision-making on the factors affecting mental health and wellbeing of the population of Leeds.

Key recommendations are:

1. An overarching recommendation is for available intelligence on need to be actively used to contribute to decisions and priorities on the best use of available resources to improve mental health and wellbeing outcomes across the city.

2. Future needs assessment should be undertaken to capture the needs of those outside the scope of this report, for example dementia, the needs of children, people with long-term conditions, peri-natal mental health and people with learning disabilities.

3. Further focused work should be carried out to gain a greater insight into communities with the greatest need and poorest mental outcomes and levels of wellbeing. This should include population groups and communities of interest as well as geographical areas of need, and build on learning from models of good practice in other areas (e.g. North West Mental Wellbeing Survey).

4. Services and programmes to improve mental health and wellbeing should be designed to meet needs rather than respond to demands. This includes designing mainstream services from this intelligence on need to maximise engagement and access from those with the greatest need.

5. Further work should be carried out to understand local differences in prevalence and service use, including:
    - Data relating to higher reported prevalence of psychotic disorders – including potential reasons for this difference.
    - Data around suggested local differences in social worker and CPN contacts and proportion of inpatients detained in the context of most appropriately meeting local needs and improving outcomes.

6. Responding to the increasing prevalence of depression should be a local priority for integrated service development and partnership working for Leeds, particularly including the needs of older people. This approach should include a broad range of services including primary care and the Voluntary and Community Sector as well as specialist mental health and social care services.

7. A suicide audit for Leeds should be undertaken to provide more up to date intelligence on the factors affecting suicide in Leeds since last carried out in 2006.
8. The suicide prevention action plan should reflect the contribution of all key partners. It should include a focus on depression and financial exclusion as a major risk factor and address issues around the needs of older people.

9. Further work should be carried out on understanding needs around self-harm incidence not resulting in a hospital admission. Preventative work with people who repeatedly self harm should be included in a local self-harm reduction action plan, in addition to stronger joint work with alcohol and substance use programmes and services.

10. There is a need to build on current programmes and services to address the employment and worklessness agenda in relation to improving population health and wellbeing. This should include ensuring job retention and employment support is included in patient pathways and is integral to care management. We should also maximise the access to appropriate support for those claiming benefit with mental health needs.

11. Further work should be undertaken on strengthening collaboration between physical and mental health programmes and services, recognising the inter-relationship between both. We also need to build on work currently in place to improve the physical health of people with mental health problems.

12. Services and programmes to meet the increasing and complex needs around Dual Diagnosis (including drugs and alcohol) should be further developed.

13. In relation to the needs of older people, we need to ensure real or perceived barriers do not exist in accessing services. We should also ensure that specialist services for older people are properly resourced and prioritise prevention. This should include ensuring good access to primary mental health support for older people.

14. Investment in public mental health, prevention & early intervention should be prioritised. This is most likely to improve outcomes at an individual and population level, as well as reduce costs across the mental health programme budget.

Appendix 2

Leeds Mental Health and Wellbeing Assessment: Progress update

Recommendation	Progress
1. An overarching recommendation is for available intelligence on need to be actively used to contribute to decisions and priorities on the best use of available resources to improve mental health and wellbeing outcomes across the city.	• The mental health and wellbeing agenda is an integral part of the Joint Strategic Needs Assessment (JSNA) for Leeds, which is the primary source of data to inform decisions around use of resource to maximise health outcomes. • The use of this intelligence is central to the Mental Health Improvement Plan for Leeds. The data and intelligence will be readily available and refreshed annually.
2. Future needs assessment should be undertaken to capture the needs of those outside the scope of this report, for example dementia, the needs of children, people with long-term conditions, peri-natal mental health and people with learning disabilities.	• Dementia needs assessment in progress • Children's mental health needs assessment process to commence • Learning Disabilities (LD) needs assessment in discussion
3. Further focused work should be carried out to gain a greater insight into communities with the greatest need and poorest mental outcomes and levels of wellbeing. This should include population groups and communities of interest as well as geographical areas of need, and build on learning from models of good practice in other areas (e.g. North West Mental Wellbeing Survey).	• Local Insight work has been commissioned for various target groups including young women who self harm and men who are at risk of suicide • National Wellbeing programme measurements available from July 2012
4. Services and programmes to improve mental health and wellbeing should be designed to meet needs rather than respond to demands. This includes designing mainstream services from this intelligence on need to maximise engagement and access from those with the greatest need.	• Commissioners and providers across the city progressing this recommendation. • BME communities services enhanced by Touchstone's Community Development Worker (CDW) service in acute mental health setting • Leeds Involvement project (LIP) working with local commissioners to maximise engagement.

Recommendation	Progress
5. Further work should be carried out to understand local differences in prevalence and service use, including: • Data relating to higher reported prevalence of psychotic disorders – including potential reasons for this difference. • Data around suggested local differences in social worker and Community Psychiatric Nurse (CPN) contacts and proportion of inpatients detained in the context of most appropriately meeting local needs and improving outcomes.	• Leeds & York Partnership Foundations Trust (LYPFT) using this intelligence to inform service transformation programmes. • Data is collected via the mental health minimum data set. Any work undertaken to consider the issues raised will require commissioning managers to work with LYPFT to better understand the issues raised.
6. Responding to the increasing prevalence of depression should be a local priority for integrated service development and partnership working for Leeds, particularly including the needs of older people. This approach should include a broad range of services including primary care and the Voluntary and Community Sector as well as specialist mental health and social care services.	• Increasing Access to Psychological Therapy (IAPT) services – direct access number – to increase self referral. • Targeted champion work within IAPT service – will focus to increase numbers of people being referred to service. Developing some targeted marketing material for older people. • Pilot with Age UK in South Leeds working with primary care around social prescribing model commenced. • Development of peer support models within community mental health services. • Increased investment in befriending services to provide citywide coverage. • Review of information provided on mental health issues and work undertake with Public health Resource Centre to increase spread of information. • NHS Leeds commissioned a Train the Trainers course for agencies to deliver to range of client groups – that build personal resilience and ability to manage independence. This contributes to future employability.

Recommendation	Progress
7. A suicide audit for Leeds should be undertaken to provide more up to date intelligence on the factors affecting suicide in Leeds since last carried out in 2006.	• Completed in May 2012. • Workshop held across the city to disseminate findings, share recommendations and future ways of working. *(NB Detailed report presented elsewhere on the agenda.)*
8. The suicide prevention action plan should reflect the contribution of all key partners. It should include a focus on depression and financial exclusion as a major risk factor and address issues around the needs of older people.	• Using evidence base of audit and workshop have set of recommendations which will inform action plan. • Victoria Eaton will chair the refreshed Suicide Prevention Group to reconvene in November 2012. This group will shape the action plan and report to the Leeds Joint Strategic Commissioning Group for Mental Health.
9. Further work should be carried out on understanding needs around self-harm incidence not resulting in a hospital admission. Preventative work with people who repeatedly self harm should be included in a local self-harm reduction action plan, in addition to stronger joint work with alcohol and substance use programmes and services.	• Self harm data group established, Chaired by Richard Wall NHS ABL, is addressing this recommendation. • Pieces of work have been commissioned to understand needs around self harm incidence, evaluation of a local service and insight with young women. • Following objectives have been identified and progressing 1. Redesign of Inpatient Pathway 2. Repeat Attendees Targeting work 3. Discharge and follow up pathways 4. Prevention and Marketing work

Recommendation	Progress
10. There is a need to build on current programmes and services to address the employment and worklessness agenda in relation to improving population health and wellbeing. This should include ensuring job retention and employment support is included in patient pathways and is integral to care management. We should also maximise the access to appropriate support for those claiming benefit with mental health needs.	• NHS Leeds commission Work Place Leeds – a mental health employment service integrated into secondary mental health services. Also a Job Retention service for the same group and those referred from the Primary Care MH Service. Contracted to work with 500 people per year. Service is currently meeting targets – and job retention exceeding targets • A time limited partnership project between employment agencies and mental health services – has initiated a piece of work with Job Centre Plus to better identify what "mental health" needs are being presented to JCP and how best to work through issues these present. Referral to mental health services is not always appropriate. • Debt advice and Welfare Benefits advice are available in mental health day services and Becklin Centre. • Good links with public health commissioners for wider welfare benefits advice and links to citywide Financial Inclusion group led by LCC.
11. Further work should be undertaken on strengthening collaboration between physical and mental health programmes and services, recognising the inter-relationship between both. We also need to build on work currently in place to improve the physical health of people with mental health problems.	• Further work needs to be established in primary care and across the city on this agenda. • A joint post (health improvement specialist) is in place, funded by both NHS ABL and LYPFT to work on this agenda in an acute setting.

Recommendation	Progress
12. Services and programmes to meet the increasing and complex needs around Dual Diagnosis (DD) (including drugs and alcohol) should be further developed.	• NHS Leeds funds Project Manager post and chairs citywide Dual Diagnosis (DD) Strategy Group. • Established a service user led Expert Reference Group that is active at The Space. • NHS Leeds Commissioning Level 2 training for staff across all sectors. • Work being done with LCC commissioners in exploring options for more bespoke CBT based intervention that is located in Drug Services – outside of current IAPT pathway. • DD Practitioner Network supported by Project manager – and current care pathway management being evaluated. • Level 2 training has been developed by Leeds Addiction Unit and delivered to acute in-patient staff.
13. In relation to the needs of older people, we need to ensure real or perceived barriers do not exist in accessing services. We should also ensure that specialist services for older people are properly resourced and prioritise prevention. This should include ensuring good access to primary mental health support for older people.	• See recommendation/ action point 6 (above) • LYPFT have recently transformed access to crisis, day care and intensive community support services to make this an ageless service. • Access to inpatient beds remain defined by age currently. They are working towards ageless services. • No age barriers in secondary mental health services.

Recommendation	Progress
14. Investment in public mental health, prevention & early intervention should be prioritised. This is most likely to improve outcomes at an individual and population level, as well as reduce costs across the mental health programme budget.	• For people aged 16 – 35 “Early intervention in psychosis” service delivered by Community Links – with an integrated employment support worker – as improved outcomes for individuals and reduced likelihood of moving into becoming long term user of secondary mental health services. • Public Mental Health is a key programme within the Leeds public health agenda, with dedicated capacity within the Specialist Public Health team and future operating model for public health following transition to Leeds City Council. In April 2013. Prevention, early intervention and a focus on needs and outcomes within commissioning of NHS mental health services will continue to be supported as part of the Public Health Healthcare Advice Service ‘core offer’ to Leeds Clinical Commissioning Groups.

Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

Date: 26 September 2012

Subject: Leeds Mental Health Needs Assessment and Provision

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

Summary of main issues

1. At its meeting in June 2012, issues around the provision of Mental Health services and the Leeds Mental Health Assessment were identified as areas for consideration by the Scrutiny Board. A specific report on this is presented elsewhere on the agenda.

2. One of the key recommendations identified in the Leeds Mental Health Assessment was the need to undertake a suicide audit for the City. An audit covering the period 2008-2010 has been completed and a summary of the key areas highlighted by the audit is appended to this report. A full copy of the audit is also presented for information.

3. Representatives from Leeds' Public Health team have been invited to attend for this item and address relevant comments/ questions from the Scrutiny Board.

4. It should be noted that Ward members from Armley have raised this matter with the Chair of the Scrutiny Board and requested detailed consideration of the findings and outcomes of Leeds' Suicide Audit. Appropriate Councillors will be invited to attend the meeting to contribute to this item.

Recommendations

5. That Members consider the information presented around Leeds Suicide Audit (2008-2010) and identify any areas where additional information is needed and/or that require further scrutiny.

Background documents [1]

- None used

[1] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

Scrutiny Board (Health and Wellbeing and Adult Social Care)
26th September 2012

Paper title: Leeds Suicide Audit (2008-2010)

Authors: Victoria Eaton, Consultant in Public Health, NHS Airedale, Bradford and Leeds
Catherine Ward, Emotional Health and Wellbeing Lead, NHS Airedale, Bradford and Leeds

1 Background

1.1 The Leeds Mental Health and Wellbeing Needs Assessment (2011) (MHWNA), which is linked into the Joint Strategic Needs Assessment, identified the need to undertake a suicide audit for Leeds to provide more up to date intelligence on the factors affecting suicide across the City.

1.2 Some of the key findings/ recommendations arising from the MHWNA related to the completion of a suicide audit and associated suicide prevention action plan, as detailed below:

(a) A suicide audit for Leeds should be undertaken to provide more up to date intelligence on the factors affecting suicide in Leeds since last carried out in 2006.
(b) The suicide prevention action plan should reflect the contribution of all key partners. It should include a focus on depression and financial exclusion as a major risk factor and address issues around the needs of older people.

1.3 Nationally, the consultation on the cross-government suicide prevention strategy for England (2011) highlighted six key areas for action. The last citywide audit in Leeds had been carried out in 2006, therefore the national work on a suicide prevention strategy for England, together with the MHWHA, provided the impetus for the suicide audit.

1.4 The purpose of this paper is to present the details of the suicide audit and associated work.

2 Audit of Suicides and Undetermined Deaths in Leeds 2008-10

2.1 The purpose of the Audit of Suicides and Undetermined Deaths in Leeds 2008-2010 is to increase understanding of local suicide data and patterns in order to shape local decisions and priorities around suicide prevention The detailed is audit report is attached as Appendix 1.

2.2 The audit was completed in May 2012 and reviewed 3 years of data from 2008 up to and including 2010.The last citywide audit was carried out in 2006. The report has identified figures in line with those of the Office of National Statistics but in addition provides greater depth of understanding of themes around suicide locally. The total rates for Leeds was the same as for Yorkshire and the Humber region, but slightly higher than the rate for England.

2.3 The key findings and recommendations of the Leeds Suicide Audit (2008-10) are summarised below:

Summary of Findings

2.4 Audit derived rates for suicide for the Leeds population:

- Identified **179** suicides and undetermined deaths in Leeds for the period 2008-2010.
- Are similar to those calculated by the Office of National Statistics
- Do not appear to be changing over time

2.5 Of those taking their own life in Leeds:

- 79% **(141**) were male
- 61% (**109**) were from a white British background
- 57% (**103**) were born in Leeds
- 47% (**85**) were In the 30-50 age group

2.6 Time and place:

- The highest number of recorded deaths was in the LS12 postcode, followed by LS11, LS14, LS15, LS8 and LS9 postcodes
- More suicides occur towards the end of the week

2.7 Figures for risk factors are:

- 42% **(77)** were unemployed or on long term sick leave / disabled
- 40% **(72)** had relationship problems
- 76% **(130)** were single, divorced or separated
- 37% **(68)** were known to have either a drug or alcohol problem or both
- 43% **(78)** had previously attempted suicide and 30% **(56)** had self harmed

2.8 Methods

- 60% **(108)** died by hanging /strangulation
- 25% **(44)** died by poisoning (with no one agent predominating
- 75% **(133)** died in their own home, with the next most common location of death being in a park or woodland

2.9 Contact with services:

- 60 % **(106)** had contact with primary care in the three months prior to death
- 31% **(56)** made their last contact with primary care for a mental health problem
- 17% **(30)** had made contact with accident and emergency
- 37% **(67)** were known to be in contact or previously had contact with mental health services

2.10 This audit aims to increase our understanding of local suicide data and patterns in order to shape local decisions and priorities around suicide prevention.

2.11 The recommendations for Leeds have been set out to mirror the consultation on a national suicide prevention strategy (Dept of Health 2011) and work was undertaken to consult citywide partners at the suicide audit workshop in July

2012. This work is being developed alongside the reducing self-harm programme for Leeds.

2.12 The audit identified figures in line with those of the Office of National Statistics but in addition provided greater depth of understanding of themes around suicide locally. Those individuals taking their own life tend to be locally born white men between the ages of 30-50 years, with higher rates within specific areas of Leeds.

2.13 While the audit is limited to some extent by source records, it provides a current picture of suicide in Leeds. Overall figures have not changed greatly compared to previous audits which emphasises the need for further work to address entrenched patterns.

Recommendations

2.14 In 2011, the Government published "No Health Without Mental Health" which includes new measures to develop individual resilience from birth through the life course, and build population resilience and social connectedness within communities.

2.15 These are powerful suicide prevention measures, however to ensure this approach is effective, there has to be equal commitment and responsibility for suicide prevention from key organisations across the City.

2.16 Evidence shows that there is no "one" single approach to local suicide prevention work, therefore we need a broad and coordinated system working with a wide range of partners, organisations and sectors including people who have been affected by the suicide of a close family member.

2.17 A series of recommendations are presented at Appendix 2. These are based on findings from the audit and the review of the evidence base for suicide prevention strategies, and are listed within the framework of the key recommendations of the National Prevention Strategy

Actions following the audit

2.18 A city-wide workshop was held in July 2012 to disseminate findings of the audit, consult on the six recommendations and inform the content of a suicide prevention plan.

2.19 Forty delegates attended from a wide range of organisations across the city, and engaged in workshops specifically looking at the recommendations for Leeds. Information on the suicide audit workshop can be found in Appendix 3.

2.20 Following the workshop, work has begun on reviewing the suicide prevention plan for Leeds to reflect local need, evidence of effectiveness and national strategy.

2.21 A refreshed membership for the suicide prevention group is being established, which will focus on developing and implementing this agenda across the city. We

are developing work with key partners at a local level where there is evidence of high suicide rates, for example local work with voluntary and community sector organisations to address men's mental health & wellbeing in Inner West Leeds.

3 Recommendations

3.1 That the Scrutiny Board notes the details of the audit and associated work.

3.2 That the Scrutiny Board identifies any further or specific areas to be considered at a future meeting.

References

1. No Health Without Mental Health: Delivering Better Mental Health Outcomes, Department of Health 2011

2. Mental Health and Wellbeing in Leeds: An Assessment of need in the Adult Population, NHS Airedale, Bradford & Leeds/Leeds City Council, May 2011

3. Consultation on Preventing Suicide in England: A Cross-governmental Outcomes Strategy to Save Lives, Department of Health 2011

4. Audit of Suicides & Undetermined Deaths in Leeds 2008-10, NHS Airedale, Bradford & Leeds/Leeds City Council, May 2012

1) *Reduce the risk of suicide in key high-risk groups*

- By working with the men of working age identified as high risk in Leeds, particularly those :
    - Living alone
    - With relationship difficulties
    - With alcohol/substance abuse
    - With a history of self-harm and suicide attempts

A potential intervention for which there is good evidence from observational studies is the use of peer support workers/community mental health educators (gatekeeper)

2) *Tailor approaches to improve mental health in specific communities*

- Continue risk minimisation processes in the mental health services
- Developing resilience in children and young people
- Improving mental health in offenders
- Strategies to reduce alcohol and drug use in the local population
- Improving mental health in the workplace
- Developing neighbourhood networks

Potential approaches are detailed in No Health Without Mental Health: Delivering better mental health outcomes[i], Making Children's Mental Health Everyone's Responsibility[ii], Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug-free life[iii]

3) *Reduce access to the means of suicide*

- Continue to ensure absence of potential ligature points in mental health hospitals and prisons

As death by hanging in private homes is the most common method in Leeds, and no individual medication or poison predominated in cases of self poisoning, there is no specific intervention that can address the methods used by the majority people in Leeds. However it is advised that approaches include those addressed in 5) around preventing dramatisation of any particular method in the media.

4) *Provide better information and support to those bereaved or affected by a suicide*

- Working in partnership with the Coroner's Office and the Police, there will be access to information for bereaved families and friends of those statutory and voluntary agencies in Leeds who are able to provide support and advice

Both health professional and voluntary sector led group therapy for adults and psychologist led group therapy for children have been shown to reduce the level of maladaptive grief reactions. A number of key partners in the public and voluntary sectors are listed in the National Prevention Strategy.

5) *Support the media in delivering sensible and sensitive approaches to suicide and suicidal behaviour*

- By working with Yorkshire Evening Post to
  - Prevent dramatisation of any particular method in the media and graphic description of reported suicide cases
  - Highlight where individuals at risk of suicide can access support from the professional or voluntary sector
  - Dispel myths and reduce stigma

This is in line with the Press Complaints Commission Code of Practice[iv]

6) *Support research, data collection and monitoring*

- Through a quarterly audit process
- To enable shared learning to take place between providers of secondary care mental health services, the police, the coroner and the auditors agreement regarding the sharing of information will be sought

i. No Health Without Mental Health: Delivering better mental health outcomes, Department of Health 2011
ii. Making Children's Mental Health Everyone's Responsibility, Report of the National Advisory Council for Children' s Mental Health and Psychological Wellbeing 2011
iii. Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug-free life, Home Office Drug Strategy, 2010
iv. Press Complaints Commission Code of Practice, http://www.pcc.org.uk/cop/practice.html

Leeds CITY COUNCIL

NHS
Airedale, Bradford and Leeds

Suicide Audit Workshop Agenda

3rd July 2012
9 – 1.30pm
The Northern Ballet School

9.00	Registration and networking
9.30	Welcome & purpose of the workshop
9.45	Setting the scene for Leeds
10.00	David Hinchliff; A Coroner's Perspective
10.20	Findings and plenary
11.10	Break
11.25	Facilitated Workshop - focussing on recommendations - how do we take this forward in Leeds?
12.30	Summary with next steps
12.45	Lunch

List of attendees

Name	Organisation
John Anderson	Community Links
Katie Baldwin	Yorkshire Evening Post
Caroline Bamford	Leeds and York Partnerships NHS Foundation Trust (LYPFT)
Victoria Betton	LYPFT
Bernie Bell	Leeds Community Healthcare
Guy Brookes	LYPFT
Charlotte Brooks	NHS Airedale, Bradford & Leeds
Mike Bush	Advisor
Charlotte Coles	NHS Airedale, Bradford & Leeds
Jaime Delgadillo	Leeds Community Healthcare
Justin Drake	Head of Residence - HMP Leeds
Tessa Denham	Women's Counselling and Therapy Service
Victoria Eaton	NHS Airedale, Bradford & Leeds
Brenda Fullard	NHS Airedale, Bradford & Leeds
Mark Firth	HMPS
Richard Gibson	NHS Airedale, Bradford & Leeds
Pip Goff	Volition
David Hinchliff	Coroner's Office
Charlotte Hanson	NHS Airedale, Bradford & Leeds
Fran Hewitt	NHS Airedale, Bradford & Leeds
Lisa Hollingworth	NHS Airedale, Bradford & Leeds
Kat Humphries	HMP Wealstun
Claire Humphries	NHS Airedale, Bradford & Leeds
Janet Johnson	LYPFT
Kathryn Ingold	NHS Airedale, Bradford & Leeds
Jeanette Lawson	LYPFT
Joanne Leach	NHS Airedale, Bradford & Leeds
Nick Leigh-Hunt	NHS Airedale, Bradford & Leeds
Joanne Loft	NHS Airedale, Bradford & Leeds
Alison Lowe	Councillor
Norman McCelland	LYPFT
Shaid Mahmood	Leeds City Council
Paul R Mason	Leeds City Council
Rachel McCluskey	NHS Airedale, Bradford & Leeds
Sarah Milligan	GP
Tracey McCaffrey	Leeds Community Healthcare

Name	Organisation
Kwai Mo	Leeds City Council
Lisa Mulherin	Councillor
Janette Munton	NHS Airedale, Bradford & Leeds
Bernadette Murphy	NHS Airedale, Bradford & Leeds
Maxine Naismith	Leeds City Council
Paul Nyakupinda	LYPFT
Tim O'Shea	Leeds City Council
Lynne Parkinson	LYPFT
Kevin Reynard	Leeds Teaching Hospital Trust
Geraldine Ryan	Leeds Irish Health & Homes
Irene Stockwell	NHS Airedale, Bradford & Leeds
Clare Snodgrass	CAMHS Wetherby YOI
Jo Thorpe	Healthy Living Network Leeds
Tim Taylor	Leeds City Council
Fiona Venner	Leeds Survivor Led Crisis Service
Catherine Ward	NHS Airedale, Bradford & Leeds
Jane Williams	NHS Airedale, Bradford & Leeds
Richard Wall	NHS Airedale, Bradford & Leeds
Sue Watts	Leeds Bereavement Forum
Gemma Wharton	LYPFT
Joanne White	HMP Leeds
James Womack	NHS Airedale, Bradford & Leeds

Groupwork

Table discussion focussed on each recommendation from Leeds Suicide Audit

Reduce the risk of suicide in key high-risk groups

1. Fiona Venner - LSCS
2. Bernie Bell - IAPT
3. David Hinchcliff - Coroner
4. Sarah Milligan - GP
5. Tim O'Shea - ASC
6. Kevin Reynard - LTHT
7. Tim Taylor - LCC
8. Richard Wall – NHS Leeds
9. Lisa Mulherin - Councillor

Reduce the risk of suicide in key high-risk groups

1. Jane Williams – NHS Leeds
2. Shaid Mahmood - LCC
3. Bernadette Murphy – NHS Leeds
4. Maxine Naismith - LCC
5. Victoria Eaton – NHS Leeds
6. Lynne Parkinson - LYPFT
7. Richard Bell – Volition director
8. Karen Newshall – Volition director

Tailor approaches to improve mental health in specific communities

- Continue risk minimisation processes in the mental health services
- Improving mental health in offenders
- Strategies to reduce alcohol and drug use in the local population

1. Lisa Hollingworth – NHS Leeds
2. Guy Brookes - LYPFT
3. Charlotte Coles – NHS Leeds
4. Jeanette Lawson - LYPFT
5. Justin Drake – HMP Leeds
6. Kat Humphries – HMP Wealstun
7. Joanne White – HMP Leeds
8. Paul Mason - ASC

Tailor approaches to improve mental health in specific communities

- Developing resilience in children and young people
- Improving mental health in the workplace
- Developing neighbourhood networks

1. Catherine Ward – NHS Leeds
2. Claire Humphries – NHS Leeds
3. Janet Johnson - LYPFT
4. Janette Munton – NHS Leeds
5. Clare Snodgrass – Wetherby YOI
6. John Anderson – Community Links
7. Paul Nyakupinda - LYPFT
8. Mark Firth - HMPS

Provide better information and support to those bereaved or affected by a suicide

1. Charlotte Hanson – NHS Leeds
2. Brenda Fullard – NHS Leeds
3. Alison Lowe - Councillor
4. Rachel McCluskey – NHS Leeds
5. Jo Thorpe – Healthy Living Network
6. Tracey McCaffrey - CAMHS
7. Sue Watts – Leeds Bereavement Forum
8. Irene Stockwell – NHS Leeds
9. Tessa Denham –Women Counselling and therapy
10. Joanne Loft – NHS Leeds

Support the media in delivering sensible and sensitive

1. Fran Hewitt – NHS Leeds
2. Victoria Betton - LYPFT
3. Gemma Wharton - LYPFT
4. Charlotte Brooks – NHS Leeds
5. Mike Bush - Advisor
6. Joanne Leach – NHS Leeds
7. Pip Goff – Volition
8. Sandip Deshpande – LYPFT
9. Kathryn Ingold NHS Leeds

Support research, data collection and monitoring

1. Nicholas Leigh-Hunt – NHS Leeds
2. Jaime Delgadillo – Primary Care Mental Health Service
3. Richard Gibson - NHS Leeds
4. Norman McCelland- NHS Leeds
5. Kwai Mo – Leeds City Council
6. James Womack NHS Leeds
7. Caroline Bamford - LYPFT
8. Geraldine Ryan – Leeds Irish Health and Homes
9. Charlotte Smith (TBC) – Coroner's Office

Evaluation of workshop

40+ people attended (40 signed in) – 31 people filled in the evaluation

	Not at all	Somewhat	Quite	Very
1. How informative did you find the event?		2	5	24
2. Will you use this to inform your work, i.e. targeting specific communities?		1	6	22
3. How satisfied were you with the venue?			5	26

Do you feel if there were any gaps in the Suicide Audit? If so, what?

- Ethnicity/ sexuality was highlighted by 14 people as a gap; however this issue has since been clarified to all attendees of the workshop and is no longer an issue.
- 4 people stated they would like more detail about the data and/or comparisons with national data
- 2 people highlighted that their needs to be more work about how people use services
- Other issues raised include; understanding why certain groups have a higher risk; links to community wellbeing and what interventions can make a difference.

What could your organisation take forward in relation to suicide prevention?

- 9 people highlighted their plans to work in a more targeted way with high risk groups.
- 11 people mentioned the role of partnership working and ensuring this issue is built into strategic plans
- 4 people plan to focus more on marketing their service
- Other issues raised were; considering the broader risk factors for suicide, gaps in services and commissioning of prevention campaigns

Any other comments?

- There were many positive comments about the event and the quality of the audit.

Suggestions for future work:

- Feel commissioners need to analyse their services commissioned in relation to figures e.g. there are no specific services aim/targeted at men, the men's shelter network in not funded, yet there are a number of women specific services funded through statutory services.
- Is it in the Health & Wellbeing strategy? What does LCC think about this?
- Various work streams across the city – Crisis work, self-harm, suicide prevention – require co-ordinated approach to wider awareness around the city. To develop wider inter agency sharing or info.

- A very good and well organised event, though a shame there was not a longer workshop time to get down to some more specific actions re way forward. Maybe it would be useful to send an e-mail reminder to participants at intervals in the next year to encourage them to progress their agenda in their own sphere of influence. I would like to be reminded and invited, as the suicide prevention strategy moves forward to see how I can champion and integrate it. We need to ensure this agenda is included in relevant emerging strategies e.g. Joint Health & Wellbeing strategy/children's plan etc
- Should the emphasis be moved away from MH to Public Health – MH services over-represented.
- Mental Health and alcohol education in schools.
- Feel motivated to campaign! Enjoyed the event, want to be involved in future suicide prevention work related to my role. Joined the media table – nation work need to inform, educate & signpost esp. Social Media. Work needed in Primary Care esp. as half are there before they commit suicide.
- Please forgive my ignorance if some of these are already in place. Considering the main demographic identified by the audit then copying some of the strategies used for other Men's Health issues e.g. testicular cancer, prostrate etc should be considered. So linking work around:
    - Sporting events
    - Music events
    - Alcohol usage

  As a way of getting messages to people

  Would love to see some targeted locality work e.g. in Armley to look at a focused group as suggested. Would also really like a presentation for the voluntary sector to discuss contributions to this & unpick some of the info & very happy to organise this.
- As above, I have contributed to the Leeds City Suicide Prevention Group for many years now and look forward to doing so in a strengthened group.

Catherine Ward July 2012

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Audit of Suicides & Undetermined Deaths in Leeds 2008-2010

NHS Airedale, Bradford and Leeds

Leeds City Council

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Executive Summary

The Leeds Mental Health and Wellbeing Needs Assessment (2011), which is linked into the Joint Strategic Needs Assessment, identified the need to undertake a suicide audit for Leeds to provide more up to date intelligence on the factors affecting suicide in Leeds. The last citywide audit was carried out in 2006. Nationally, the consultation on the cross-government suicide prevention strategy for England (2011) has highlighted six key areas for action. Together these documents provide the impetus for this audit.

This audit aims to increase our understanding of local suicide data and patterns in order to shape local decisions and priorities around suicide prevention. The findings are presented in terms of the national strategy recommendations; these will inform the partnership workshop in July 2012 which will be attended by key stakeholders. The aim is to begin the process of decision making and take positive steps towards developing a suicide prevention strategy for Leeds.

The report has identified figures in line with those of the Office of National Statistics but in addition provides greater depth of understanding of themes around suicide locally. Those individuals taking their own life tend to be locally born white men between the ages of 30-50 years, with higher rates within specific areas of Leeds. Overall figures have not changed greatly compared to previous audits which emphasises the need for further work to address entrenched patterns.

While this report is limited to some extent by source records, it does provide a picture of suicide in Leeds today. It will allow the challenge of reducing suicide to be taken up, and we envisage, following this report, a local evidence based suicide prevention strategy will be agreed and prioritised by senior partners across the city.

Summary of Findings

- Audit derived rates for suicide for the Leeds population
  - Are similar to those calculated by the Office of National Statistics
  - Do not appear to be changing over time

- Of those taking their own life in Leeds:
  - 79% were male
  - 61% were from a white British background
  - 57% were born in Leeds
  - 47% were in the 30-50 age group

- Time and place:
  - The highest number of recorded deaths was in the LS12 postcode, followed by LS11, LS14, LS15, LS8 and LS9 postcodes
  - More suicides occur towards the end of the week

- Figures for risk factors are:
  - 42% were unemployed or on long term sick leave
  - 40% had relationship problems
  - 76% were single, divorced or separated
  - 37% were known to have either a drug or alcohol problem or both
  - 43% had previously attempted suicide and 30% had self harmed

- Methods:
  - 60% died by hanging /strangulation
  - 25% died by poisoning (with no one poison predominating)
  - 75% died in their own home, with the next most common location of death being in a park or woodland

- Contact with services:
  - 76% had contact with primary care in the three months prior to death
  - 31% made their last contact with primary care for a mental health problem
  - 17% had made contact with accident and emergency
  - 37% were known to be in contact or previously had contact with mental health services

Recommendations

In 2011, the Government published "No Health Without Mental Health[3]" which includes new measures to develop individual resilience from birth through the life course and build population resilience and social connectedness within communities.

These are powerful suicide prevention measures, however to ensure this approach is effective, there has to be equal commitment and responsibility for suicide prevention from key organisations across the city.

Evidence tells us that there is no "one" single approach to local suicide prevention work, therefore we need a broad and coordinated system working with a wide range of partners, organisations and sectors including people who have been affected by the suicide of a close family member.

These recommendations are based on findings from the audit and the review of the evidence base for suicide prevention strategies (Appendix 3), and are listed within the framework of the key recommendations of the National Prevention Strategy[2]

1) Reduce the risk of suicide in key high-risk groups

- By working with men of working age identified as high risk in Leeds, particularly those :
  - Living alone
  - With relationship difficulties
  - With alcohol/substance abuse
  - With a history of self-harm and suicide attempts

A potential intervention for which there is good evidence from observational studies is the use of peer support workers/community mental health educators (gatekeeper)

2) Tailor approaches to improve mental health in specific communities

- Continue risk minimisation processes in the mental health services
- Developing resilience in children and young people
- Improving mental health in offenders
- Strategies to reduce alcohol and drug use in the local population
- Improving mental health in the workplace
- Developing neighbourhood networks

Potential approaches are detailed in No Health Without Mental Health: Delivering better mental health outcomes[1], Making Children's Mental Health Everyone's Responsibility[2], Reducing Demand, Restricting Supply, Building Recovery: Supporting people to live a drug-free life[3]

3) Reduce access to the means of suicide

- Continue to ensure absence of potential ligature points in mental health hospitals and prisons

As death by hanging in private homes is the most common method in Leeds and no individual medication or poison predominated in cases of self poisoning, there is no specific intervention that can address the methods used by the majority people in Leeds. However it is advised that approaches include those addressed in 5) around preventing dramatisation of any particular method in the media

4) Provide better information and support to those bereaved or affected by a suicide

- Working in partnership with the Coroner's Office and the Police, there will be information available for bereaved families and friends regarding statutory and voluntary agencies in Leeds who are able to provide support and advice

Both health professional and voluntary sector led group therapy for adults and psychologist led group therapy for children have been shown to reduce the level of maladaptive grief reactions. A number of key partners in the public and voluntary sectors are listed in the National Prevention Strategy[2]

5) Support the media in delivering sensible and sensitive approaches to suicide and suicidal behaviour

- By working with local media to
  - Prevent dramatisation of any particular method in the media and graphic description of reported suicide cases
  - Highlight where individuals at risk of suicide can access support from the professional or voluntary sector
  - Dispel myths and reduce stigma

This is in line with the Press Complaints Commission Code of Practice[4]

6) Support research, data collection and monitoring

- Through a quarterly audit process
- To enable shared learning to take place between providers of secondary care mental health services, the police, the Coroner and the auditors agreement regarding the sharing of information will be sought

Introduction

Suicide is one of the leading preventable causes of death under 65 years and the 2011 Leeds Mental Health Assessment [5] highlighted a need for more accurate figures. This audit therefore set out to establish a figure for deaths due to suicide that was more inclusive of all potential suicides as opposed to a figure based solely on deaths formally classified as suicide.

Aims of the Audit

Aims of this audit were to:

- Compare data with findings from previous audits and the mental health needs assessment, and therefore evaluate previous prevention strategies
- Compare local data and trends with national and regional data and trends
- Identify local risk factors, groups at risk or localities of higher incidence
- Inform future prevention strategies in conjunction with a review of the evidence base for them
- Have baseline data for monitoring future trends and evaluate future prevention strategies
- Develop a sustainable system for future data collection

Policy

National Policies & Guidance this work supports are

National Suicide Prevention Strategy

The draft suicide prevention strategy for England[6] outlines seven key areas for action

- Reduce the risk of suicide in key high-risk groups
- Tailor approaches to improve mental health in specific groups
- Reduce access to the means of suicide
- Provide better information and support to those bereaved or affected by a suicide
- Support the media in delivering sensible and sensitive approaches to suicide and suicidal behaviour
- Support research, data collection and monitoring
- Making it happen locally and nationally

No Health without Mental Health

The six principles outlined in No Health without Mental Health[7]are all applicable to suicide prevention work:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Public Health Outcomes Framework

The Public Health Outcomes Framework[8] suggests indicators on:

- D5.2 Suicide rate (the three year rolling average age standardised mortality rate from suicide and injury of undetermined intent)
- D5.8 Mortality rate of people with mental illness

The NHS Outcomes Framework

NHS Outcomes Framework[9] contains the indicator:

- 1.5 Under 75 mortality rate in people with serious mental illness

Local Policies & Guidance this work supports are

The Annual Report of the Director of Public Health in Leeds[10] states that decreasing the suicide rate contributes to the key outcome of reducing death before 75 years.

In the 2011 Leeds Mental Health Assessment [1], it was recommended that a new and updated audit should be undertaken to inform a citywide suicide strategy.

Closing the Gap - Service needs and prohibitions to access: The LGB community, self-harm, suicidal ideation and suicide[11] listed a number of recommendations around mental health services for the LGB community.

Findings from the Mental Health Needs Assessment

Data on suicide for 2006 to 2008 from the Office of National Statistics (ONS) has been published in the 2011 Leeds Mental Health Assessment[1], alongside regional and national data for comparison:

Table 1: ONS rates per 100,000 population for suicides by age group, Leeds, Yorkshire & Humber and England 2006-2008

Age Band	Leeds	Yorkshire & Humber	England
1-4	0.0	0.0	0.0
5-14	0.4	0.2	0.1
15-34	6.7	6.4	5.8
35-64	10.8	9.8	9.3
65-74	3.5	5.1	3.6
75+	3.7	7.0	4.6
Total	**6.7**	**6.7**	**6.1**

Source: Mental Health and Wellbeing in Leeds: An Assessment of Need of the Adult Population 2011

The total suicide rate for Leeds was the same as for Yorkshire and the Humber region for the 2006-2008 period, but slightly higher than the rate for England. Reported rates in Leeds were higher in the under 65 age groups compared to the regional and England figure, but lower in the over 65s. Rates for Leeds are reported as having risen slightly over time, most of the increase within the 15-64 age groups, but a reported fall in the over 65 age groups:

Table 2: ONS rates per 100,000 population for suicides by age group, Leeds 2004-2006 to 2006-2008

Age Band	2004-2006	2005-2007	2006-2008
1-4	0.0	0.0	0.0
5-14	0.0	0.0	0.4
15-34	6.0	6.1	6.7
35-64	10.2	10.4	10.8
65-74	4.1	4.1	3.5
75+	4.4	2.5	3.7
Total	**6.3**	**6.3**	**6.7**

Source: Mental Health and Wellbeing in Leeds: An Assessment of Need of the Adult Population 2011

Caution needs to be taken in the interpretation of these figures due to data quality issues for the over 65 age group.

Table 3: ONS rates per 100,000 population for suicides by gender and age group, Leeds 2006-2008

Age Band	Female	Male
1-4	0.0	0.0
5-14	0.8	0.0
15-34	2.9	10.3
35-64	4.3	17.5
65-74	2.2	5.0
75+	2.0	6.5
Total	**3.0**	**10.7**

Source: Mental Health and Wellbeing in Leeds: An Assessment of Need of the Adult Population 2011

The reported rates for 2006-2008 were higher for men than women for all age groups except children.

Findings from Previous Audits

Table 4: Findings from 2004-5 and 2006 Audits

Dates of Audit	**April 2004-December 2005**	**January 2006- December 2006**
Time Period	9 months	1 year
Number	27	49
Median age group	40-49 years	40-45 years
Sex	70% male 30% female	69% male 31% female
Method for men	63% hanging 16% self poisoning 11% jumping from height	54% hanging 26% self poisoning 5% jumping from height
Method for women	38% hanging 50% self poisoning 13% jumping from height	13% hanging 53% self poisoning 20% jumping from height
Risk factors	48% relationship problems 22% unemployed	25% relationship problems 29% debt/redundancy
GP visit ≤1 week prior to death	41%	12% of men 33% of women
GP visit ≤1 month prior to death	56%	30% of men 53% of women
Known to mental health services	48%	42%

Audit 2008-2010

Method

This audit considered suicides for the calendar years 2008-2010 from cases identified via Coroner's records and reports contained therein but did not inspect clinical records

The notes reviewed as part of the audit are a snapshot of the lives of individuals, some of whom experienced complex lifestyle changes and significant recent breakdown in employment and/or relationships. The audit team were given access to the records by the HM Coroner's office in Leeds and are mindful of the privileged position of reading through the events leading to the last intimate moments of a person 's life and the sensitivities therein. .

Initially paper records comprising lists of deaths reported to the coroner were inspected to identify possible and known suicides. Subsequently summary details of individuals initially identified from these paper records were inspected on the Coroner's electronic database to exclude those where it was evident that death was not due to suicide.

Individuals excluded on this inspection of the electronic database had:

- Deaths clearly stated to be from natural causes, e.g. from a medical pathology
- Injuries due to an external agent, e.g. road traffic accidents, murder
- Deaths due to alcohol alone with no other cause or known psychiatric history and where intent was unknown
- Deaths due to substance misuse with no other cause or known psychiatric history and where intent was unknown
- Deaths due to alcohol and substance misuse with no other cause or known psychiatric history and where intent was unknown

The remaining files were examined in full, and therefore included those for all individuals with:

- Suicide verdicts
- Open verdicts
- Narrative verdicts
- Deaths due to self inflicted violent means
- Deaths due to alcohol and either another cause or if there was a known psychiatric history or where intent was unknown
- Deaths due to substance misuse and either another cause or if there was a known psychiatric history or where intent was unknown

On review of the case notes the same inclusion and exclusion criteria were applied; the table below summaries the numbers of cases included at each stage of the process:

Table 5: Numbers Included & Excluded

Year	Initially detected	After database review	After case note review
2008	164	78	62
2009	148	74	57
2010	144	70	60
Total	456	222	179

In this audit process figures for the different verdicts and undetermined deaths have been combined though this does not imply or infer any legal judgement.

Results

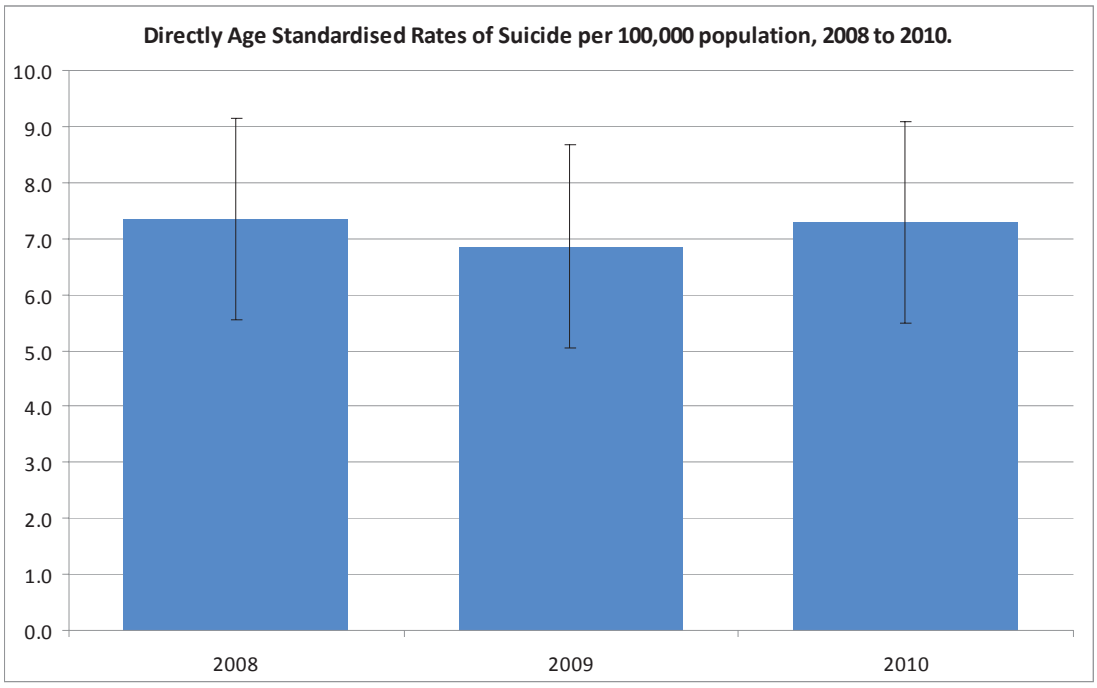
Trends

Directly standardised rates for the Leeds population for each year and the three year rolling average based on the figures from the audit are shown in Table 6 and graphically in Chart 1 below

Table 6: Audit derived directly standardised suicide and undetermined death rates for the Leeds population, 2008-2010

	Number	Population	Directly Standardised Rate per 100,000	95% C.I.
2008-2010	179	2,384,549	7.2	1.0
2008	62	785,814	7.3	1.8
2009	57	795,398	6.9	1.8
2010	60	803,337	7.3	1.8

Chart 1: Audit derived directly standardised suicide and undetermined death rates for the Leeds population, 2008-2010



These figures are similar to the Office of National Statistics derived figure of 6.7 per 100,000 for 2006-2008.

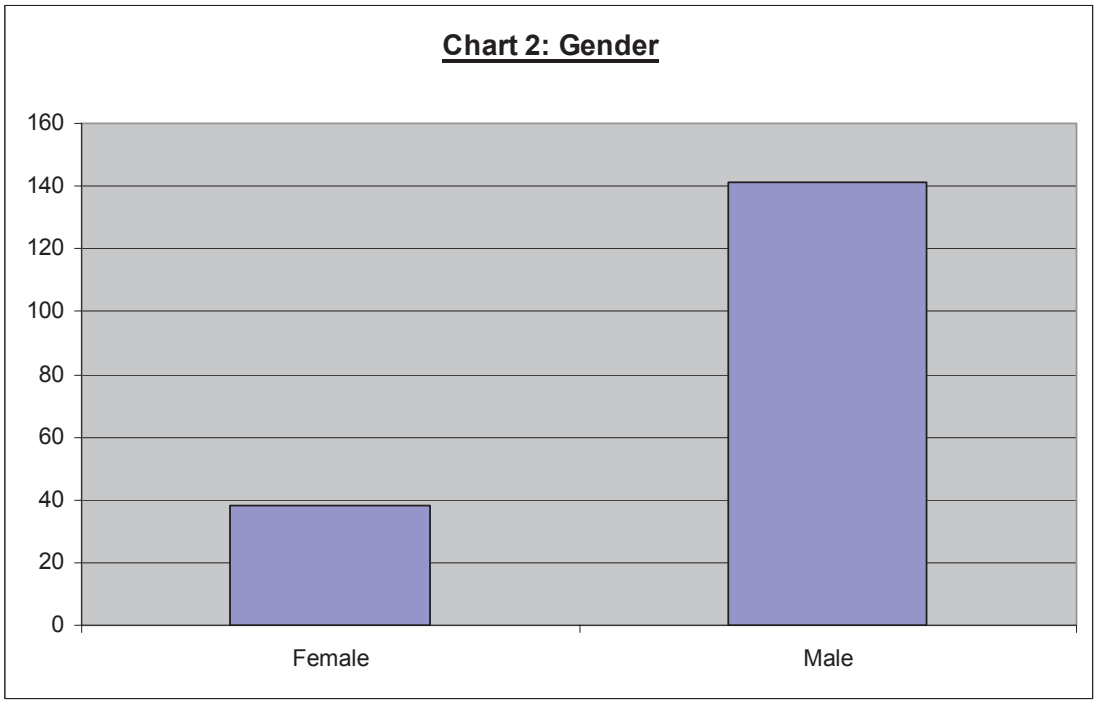
The age specific crude rates for each year and the three year average are in Table 7.

Table 7: Audit Derived Age Specific Crude Rates, 2008-2010

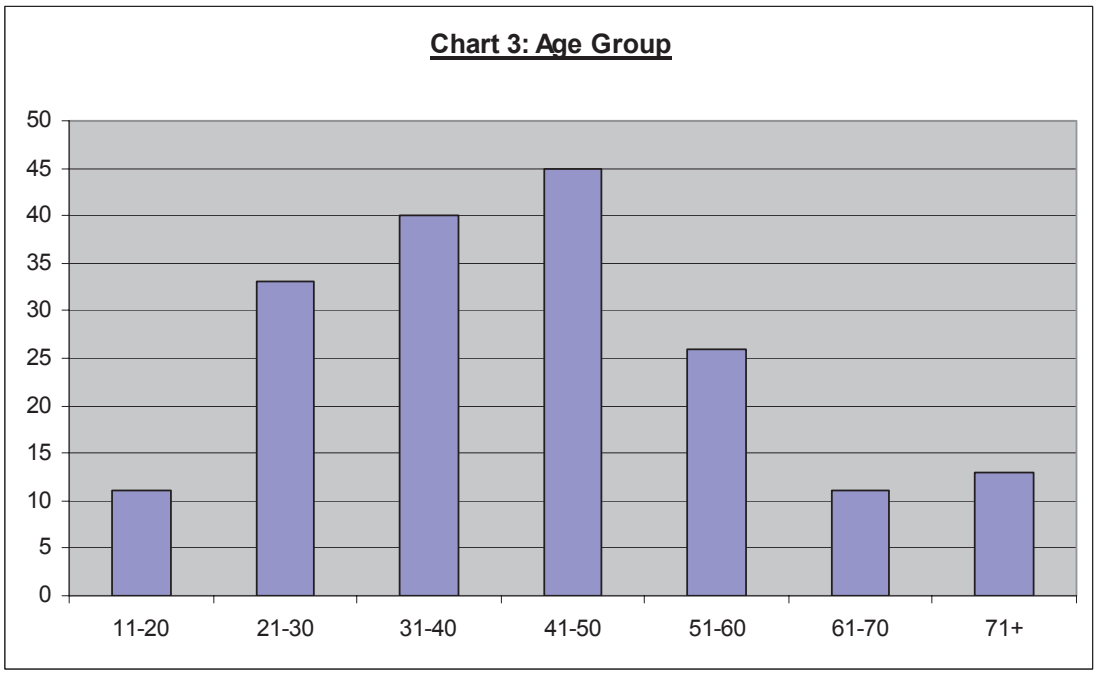
Age Group	Rates per 100,000 population			
	2008	2009	2010	2008-10
0-4	0	0	0	0
5-9	0	0	0	0
10-14	0	0	0	0
15-19	7.3	1.8	7.4	5.5
20-24	13.4	3.9	5.1	7.4
25-29	13.1	7.0	5.5	8.5
30-34	6.8	3.4	11.4	7.2
35-39	19.9	16.8	8.5	15.1
40-44	7.0	22.5	14.0	14.5
45-49	15.8	3.9	18.6	12.8
50-54	9.2	13.6	15.4	12.8
55-59	4.8	12.2	5.0	7.3
60-64	5.1	5.0	12.3	7.5
65-69	0	3.4	3.3	2.2
70-74	7.4	10.9	0	6.1
75-79	4.4	9.0	4.5	5.9
80-84	0	6.1	6.0	4.1
85 plus	0	6.9	6.7	4.6

Demographics

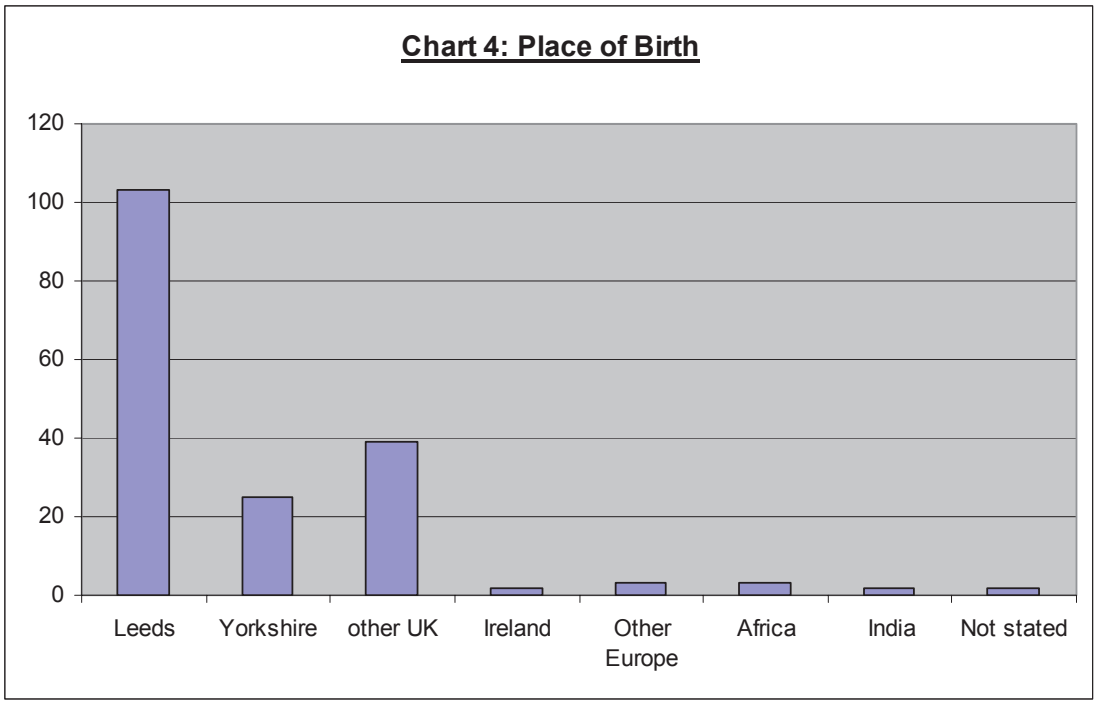
21% were women versus 79% male



More deaths occurred in individuals under the age of 50 years with the highest number in the 41-50 year age group.



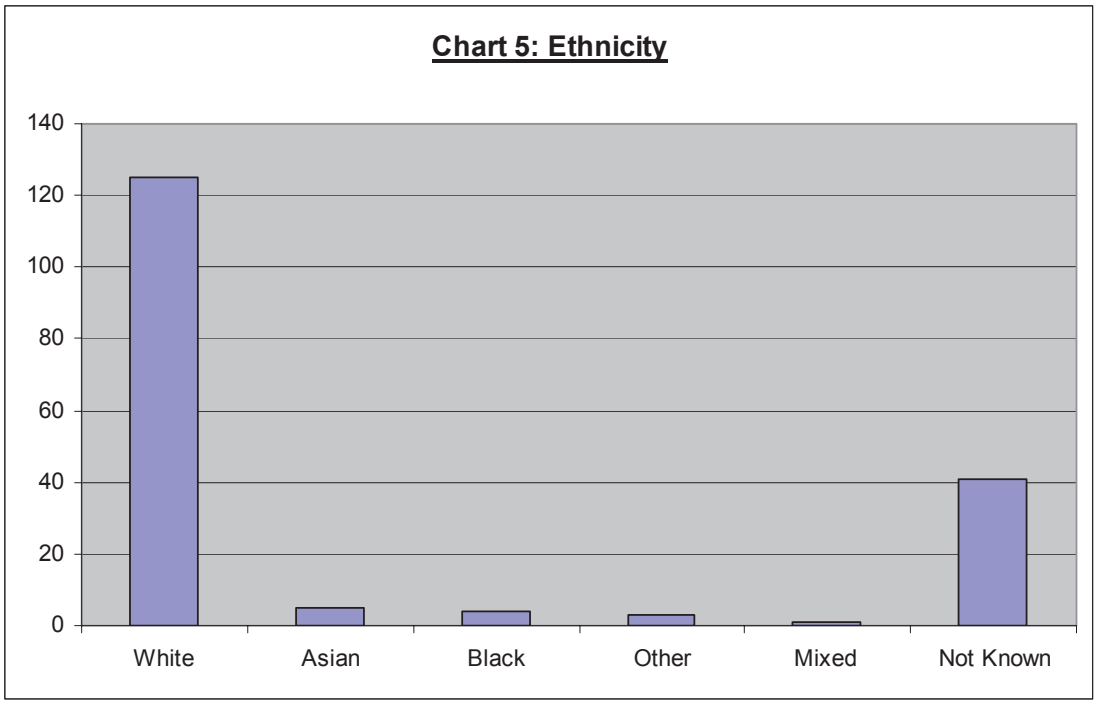
57% were born in Leeds, 14% in Yorkshire, 22% elsewhere in the UK, 3% from elsewhere in Europe and 3% from the rest of the world. Place of birth was easily identifiable from the Coroner's records.



61% were of white British background, 9% from another white background, and 7% from a non-white background though information was not apparent from the notes for 23%. Ethnicity status is not a defined category on the summary notes record and is only found on either police reports, notification of death by drugs submissions or the pathologist's post mortem report.

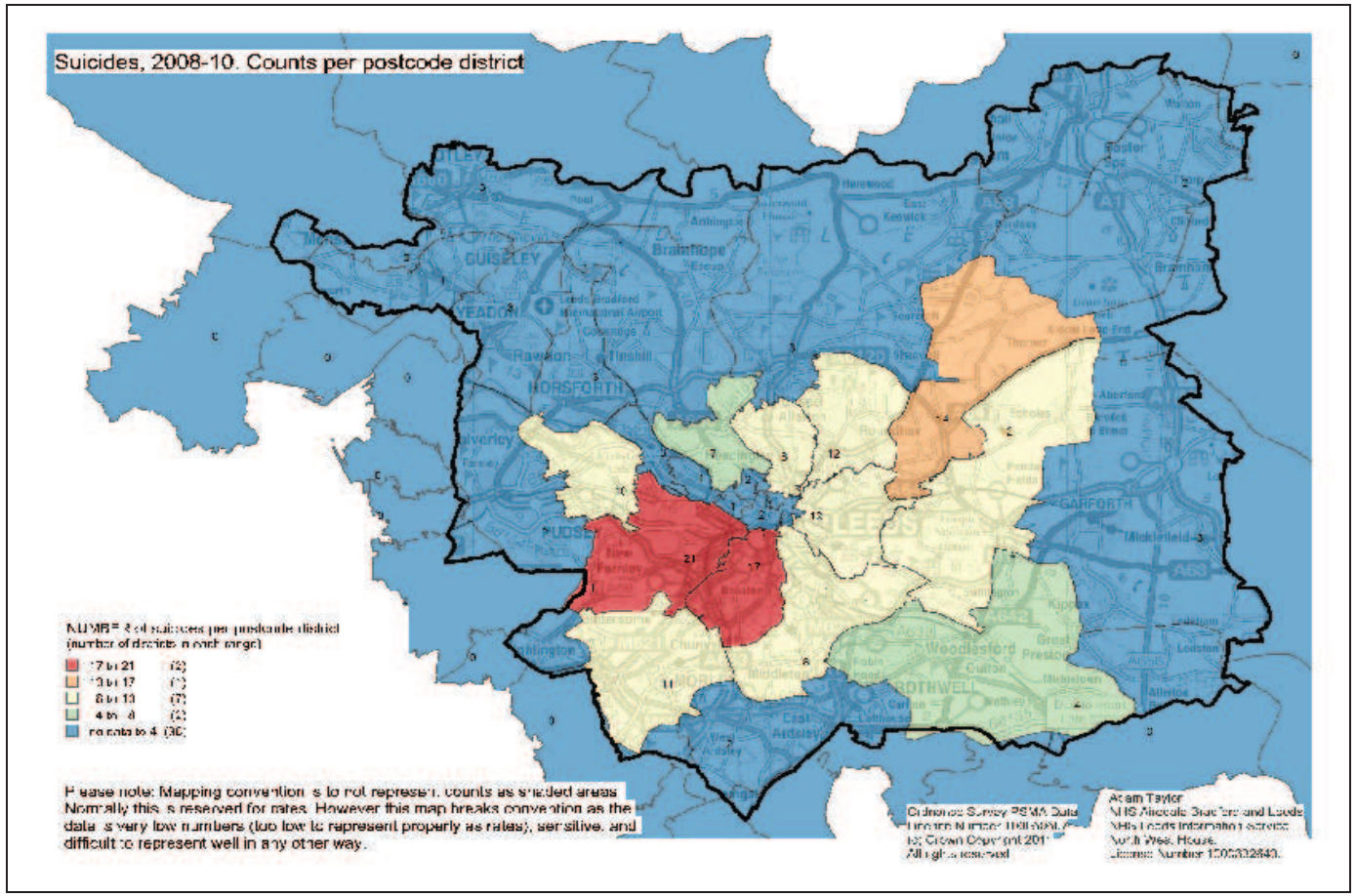
There were at least four deaths of lesbian, gay, bisexual or transgender individuals, though sexuality was rarely documented as a category. However police and coroners officer statements did state sexuality as a narrative where the informant described their relationship with the deceased.

Therefore, whilst information was available to make assumptions regarding sexuality and ethnicity, only when clearly stated in the notes was this then recorded



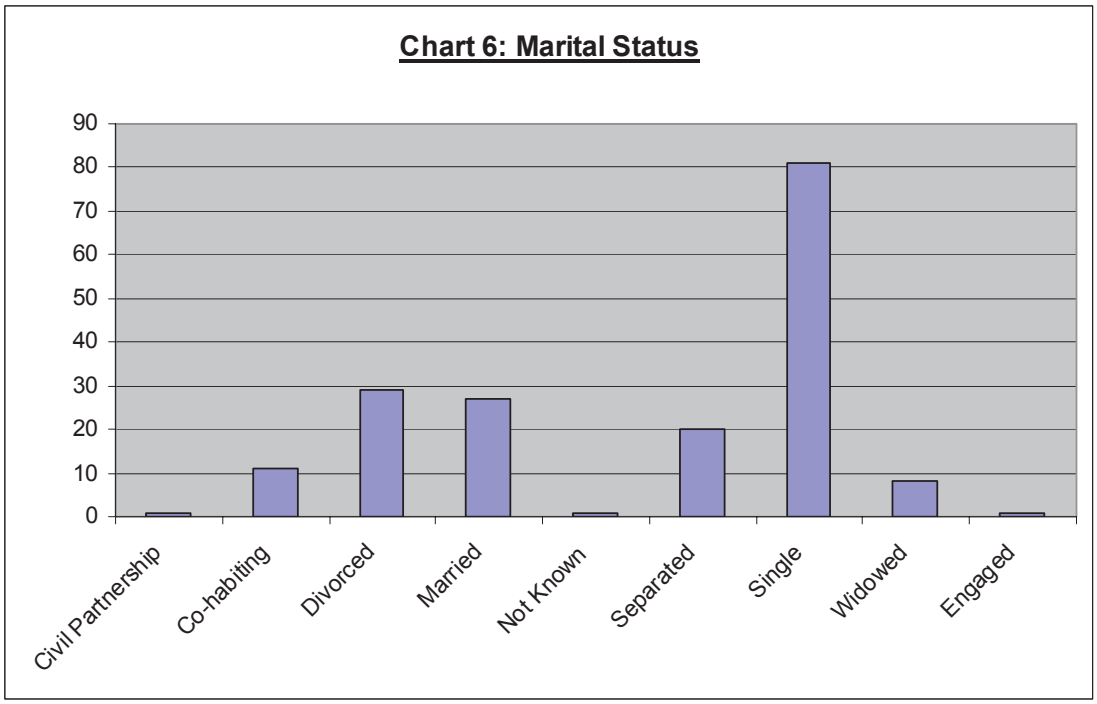
The LS12 postcode had the highest number of recorded deaths, followed by LS11, LS14, LS15, LS8 and LS9 postcodes. Counts by postcode for deaths in each area of Leeds are shown in Figure 1 overleaf.

Figure 1: Suicide and Undetermined Deaths, Counts by Postcode District

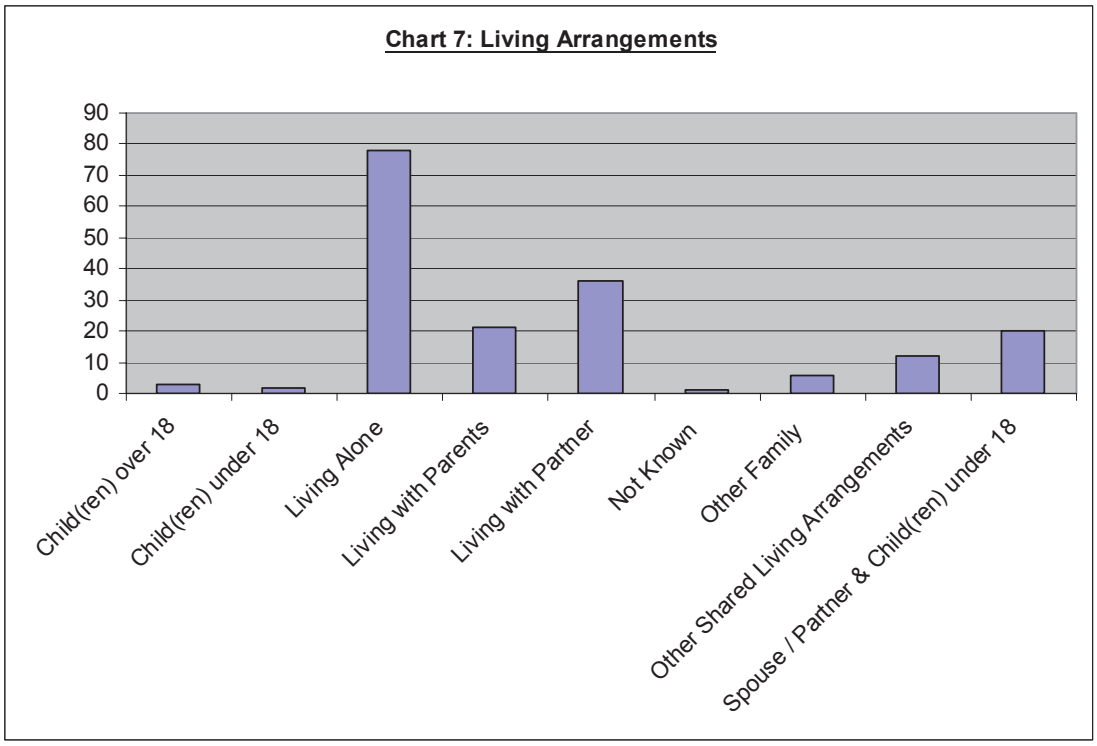


Risk factors

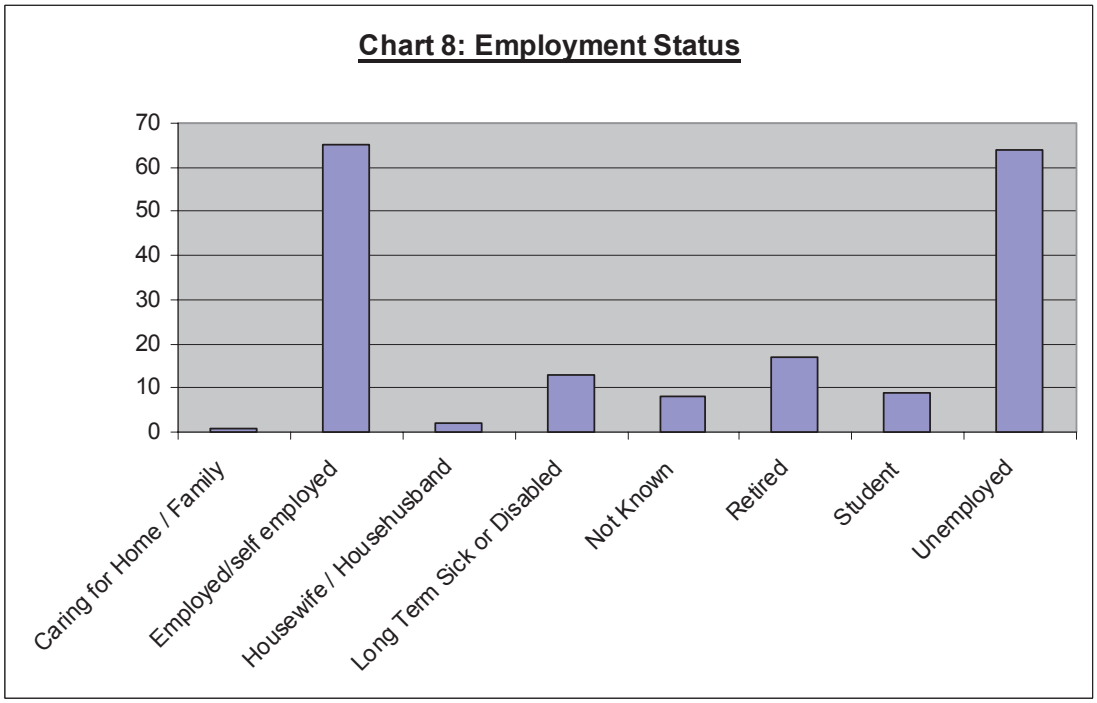
76% were single, divorced or separated compared to 22% married, cohabiting or in a civil partnership



43% were living alone and 12% living with parents compared to 31% living with a partner and with or without children. Complexities of relationship breakdown were evident in the majority of individual lives. The theme of relationship breakdown was identified as a contributing factor in a high proportion of the case files analysed. Violence in the home either through witnessing domestic violence as a child or being abused by partner or parent was identified for a smaller group of individuals and significant to mention. Many of these individuals were known to both statutory and voluntary services at some point in their lives and this was evident from the GP reports contained within the Coroner's records.

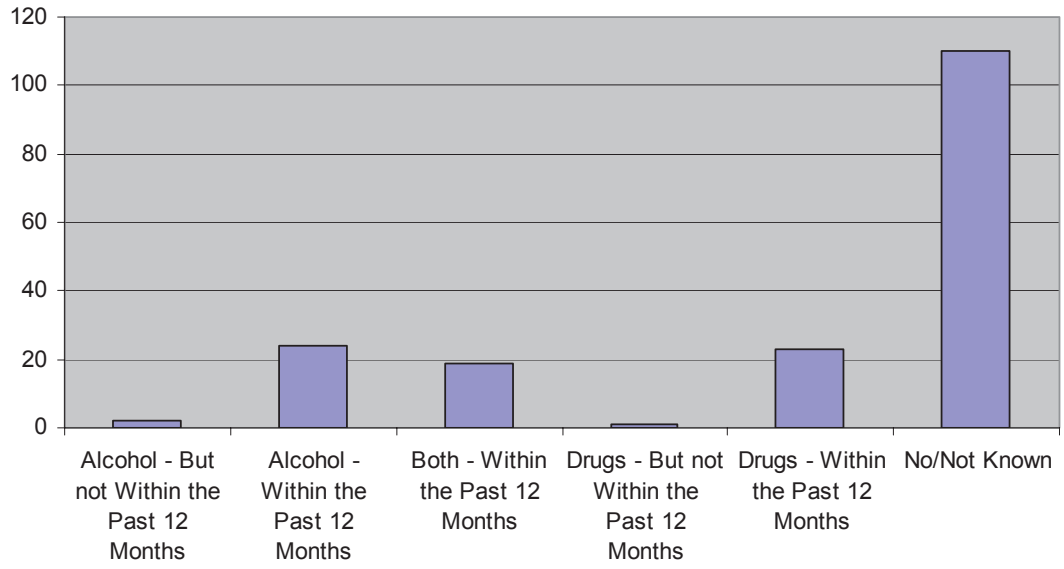


35% were unemployed, 10% were retired and 7% were on long term sick or disabled, 36% were employed or self-employed. Qualitative data suggests that some people were recently unemployed, self employed and not working at the time of death or on shorter term sick leave.



13% had an alcohol problem and 13% had a drugs problem in the year before death, and 11% had both a drugs and alcohol problem, with smaller numbers having had a drugs or alcohol problem more than a year before. Alcohol was a compounding factor for a number of individuals. This was generally identified as a history of longer term alcohol problems and over half of this information was identified through GP reports to the Coroner which indicates disclosure and primary care involvement.

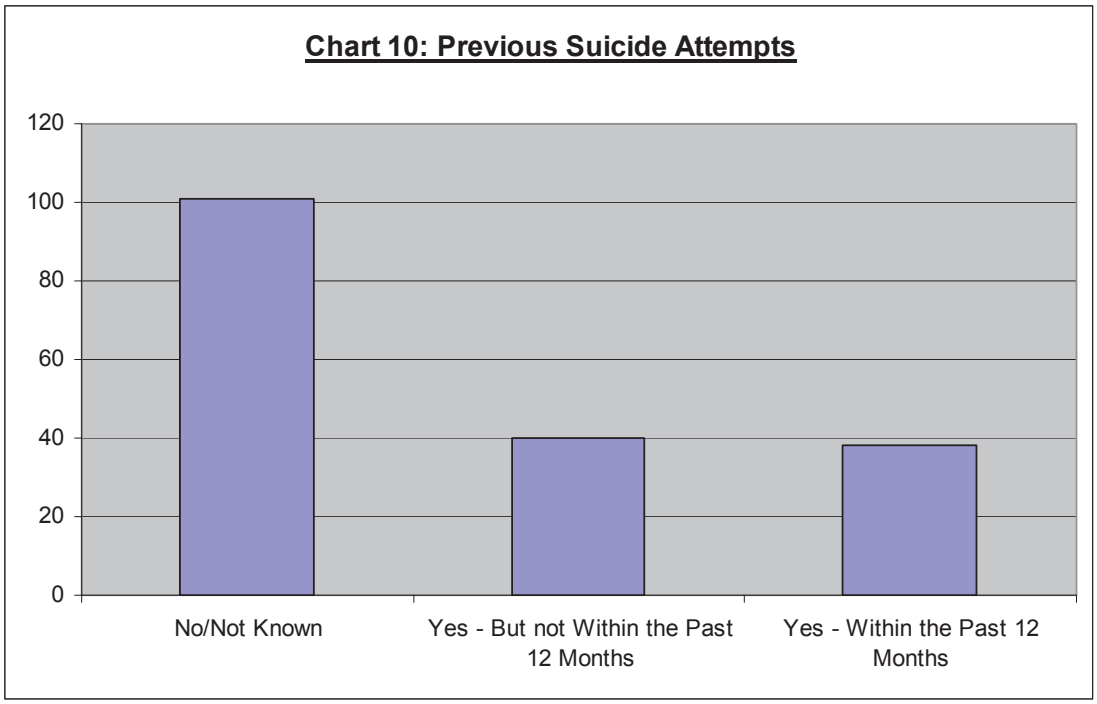
Chart 9: Drug and Alcohol Problems



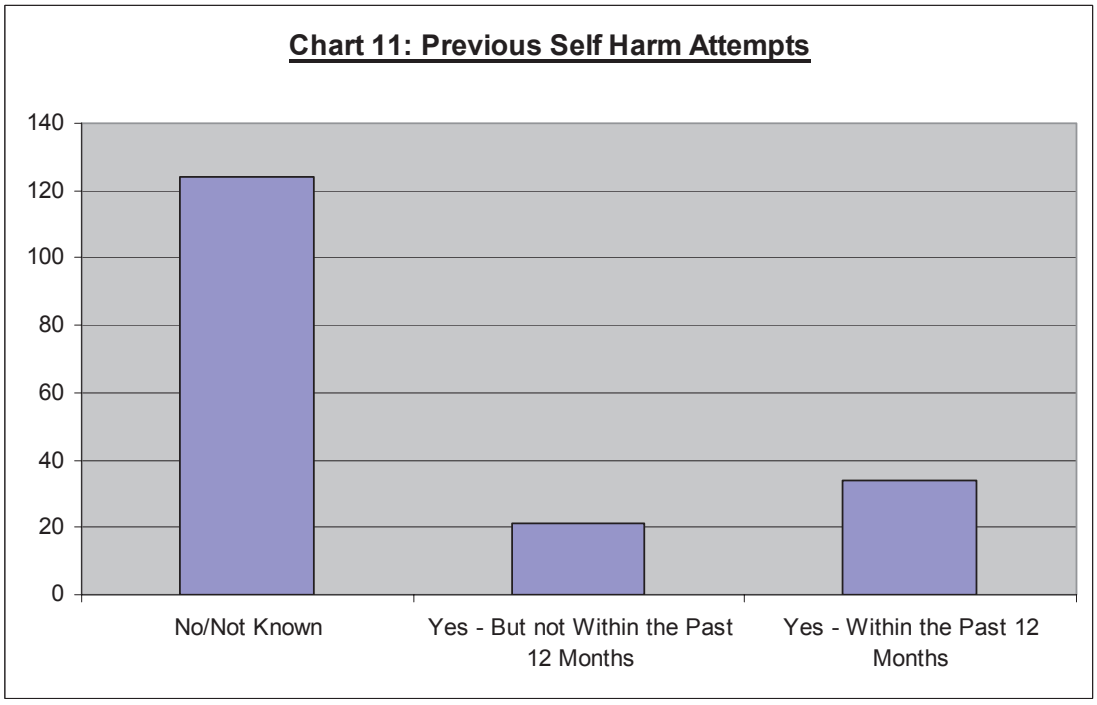
40% had a relationship or family problem, 15% had a physical illness or disability, 7% had debt problems or were bankrupt and 6% had contact with the criminal justice system. 9% had been bereaved, a theme that was also identified in the qualitative analysis. Often the bereavement was of parents, siblings or partners. Many were grieving the loss of a loved one over year later.

History of self harm and suicide attempts

21% had attempted suicide in the past year and 22% had attempted suicide more than a year ago, compared to 56% who had no known previous attempts. 6% had a family history of suicide. A previous suicide attempt was distinguished from a self harm incident and these were recorded separately.

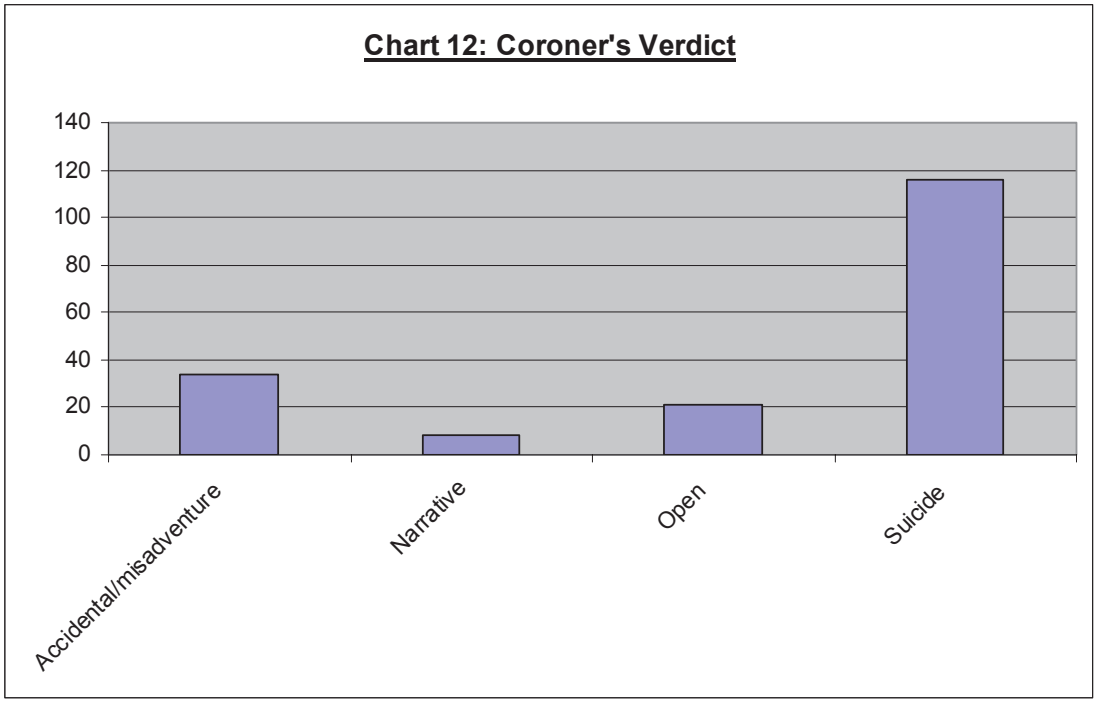


19% had self-harmed in the past year and 11% had self-harmed more than a year ago, compared to 69% who had no known history of self-harm which was evident in the Coroner's report.

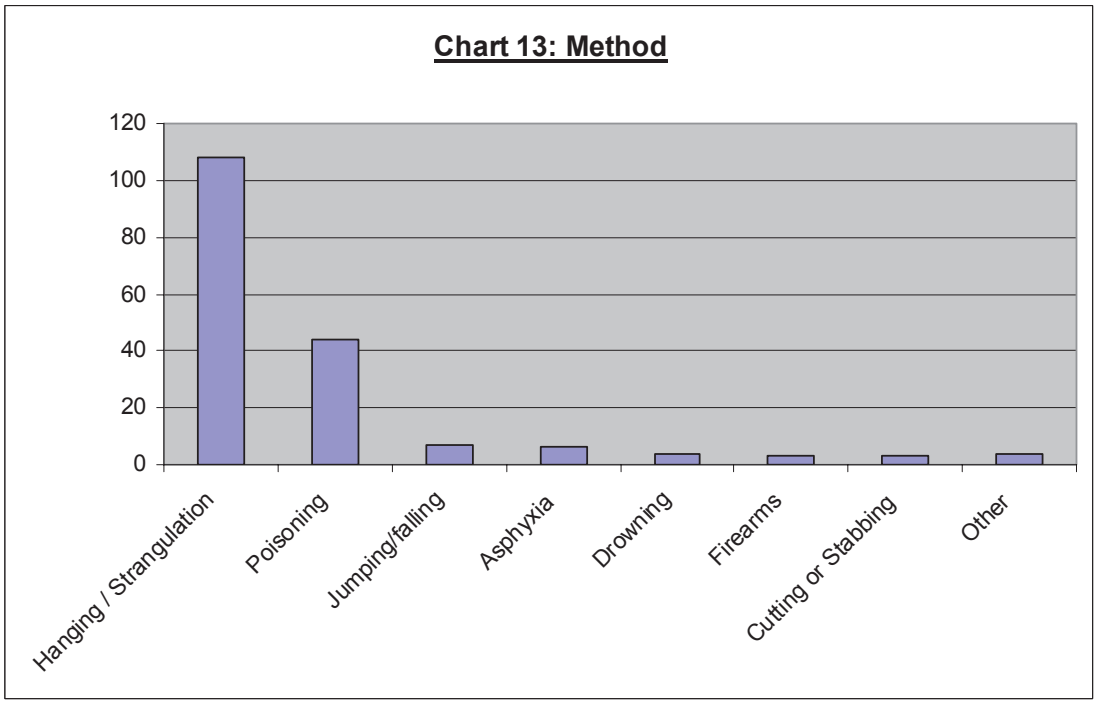


Details of Act & Method

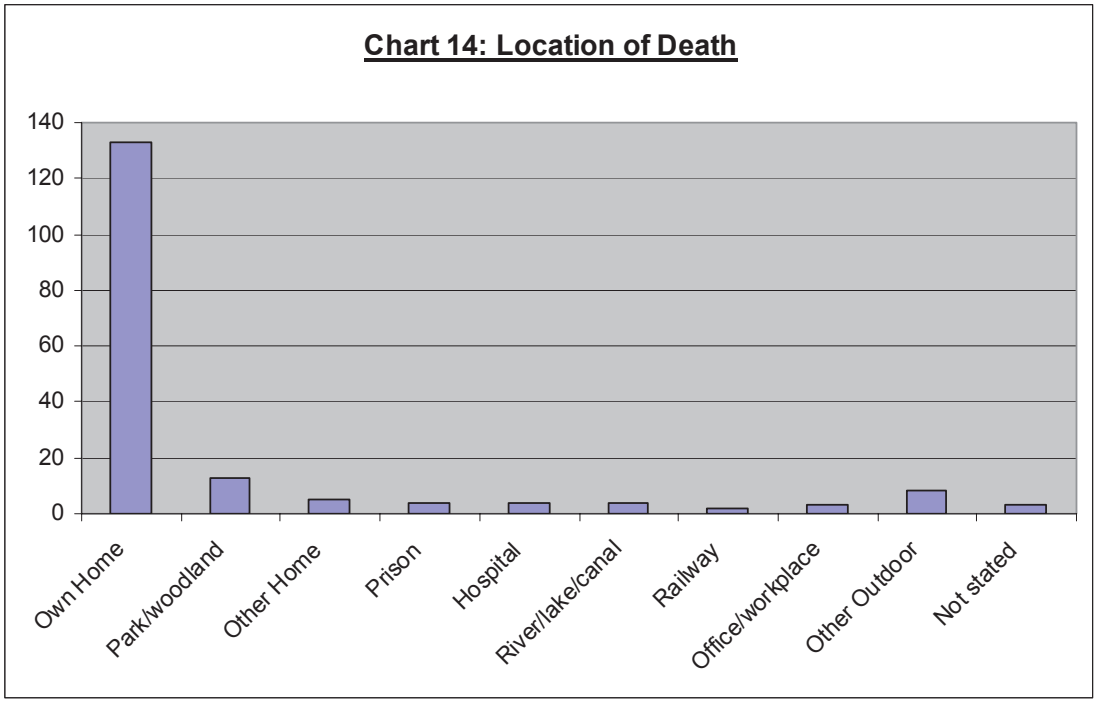
65% had a verdict of suicide, 19% a verdict of accidental death/misadventure, and 16% had a narrative or open verdict.



60% died by hanging /strangulation, with 25% dying by poisoning. Where a prescription drug was used, no one drug predominated.



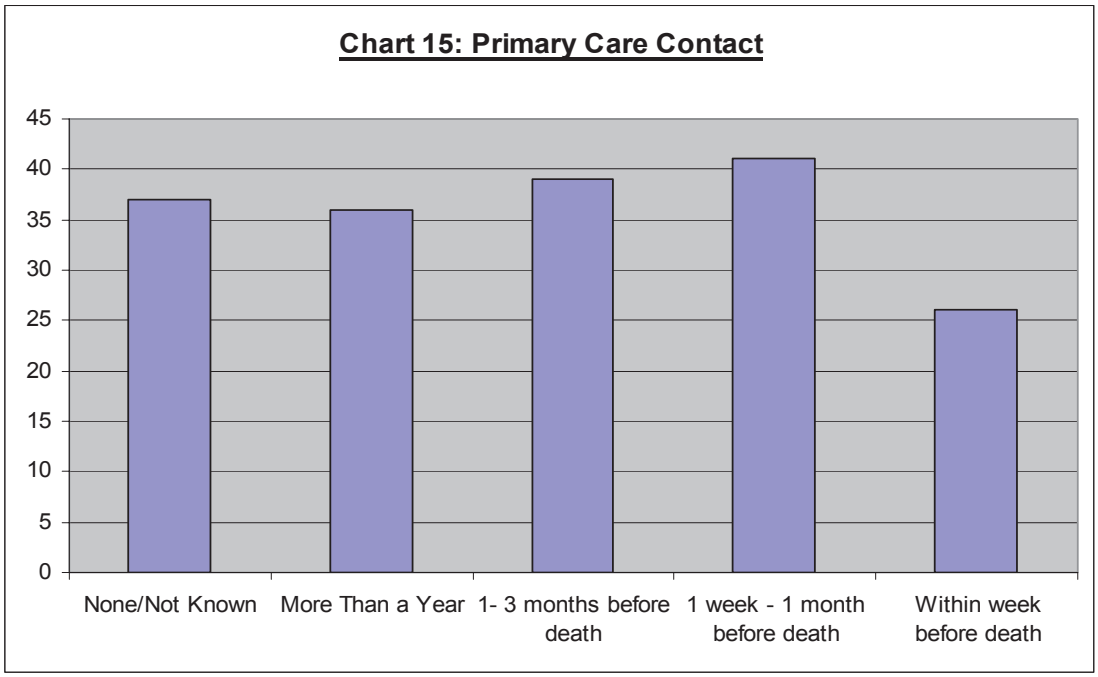
75% died in their own home, with the next most common location of death being in a park or woodland, 7%. This supports evidence there is no predominant location in Leeds. A written message of some form was left by 36% including hand written notes, emails and text messages.



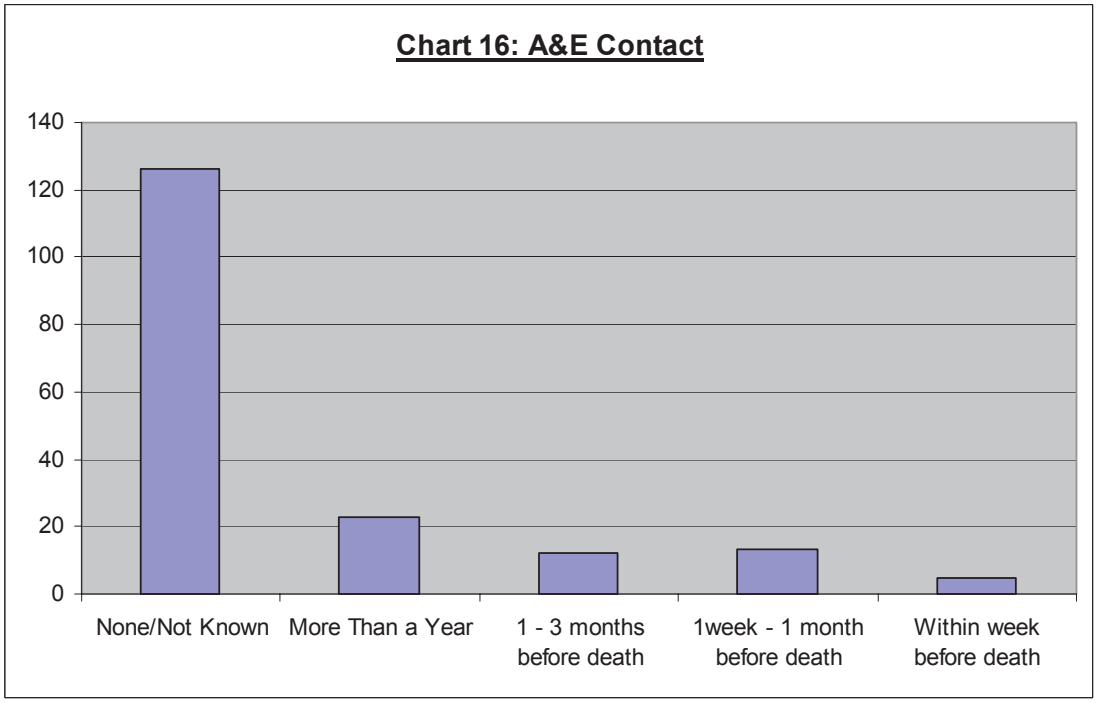
A number of inquests for deaths in custody and other offender health related deaths during 2008-2010 had not been heard by the Coroner's court by the time the notes were audited. Complexities of gathering evidence, statutory procedures and dates for jury sittings all add to the length in time for offender related deaths to be heard. These could not be included in the audit and therefore the number of deaths in prison in this report is fewer than those recorded for Leeds.

Contact with services

38% had contact with primary care in the month before death with 15% having contact in the week before, and 22% having contact between one and three months prior to death. 31% had made their last contact with primary care for a mental health problem and 34% had made contact for a physical problem. By detailed interrogation of the notes 25% of individuals had a long term condition diagnosed and/or were suffering with pain, being prescribed regular analgesia for pain relief and in contact with primary care. Physical ill health was often a compounding factor.

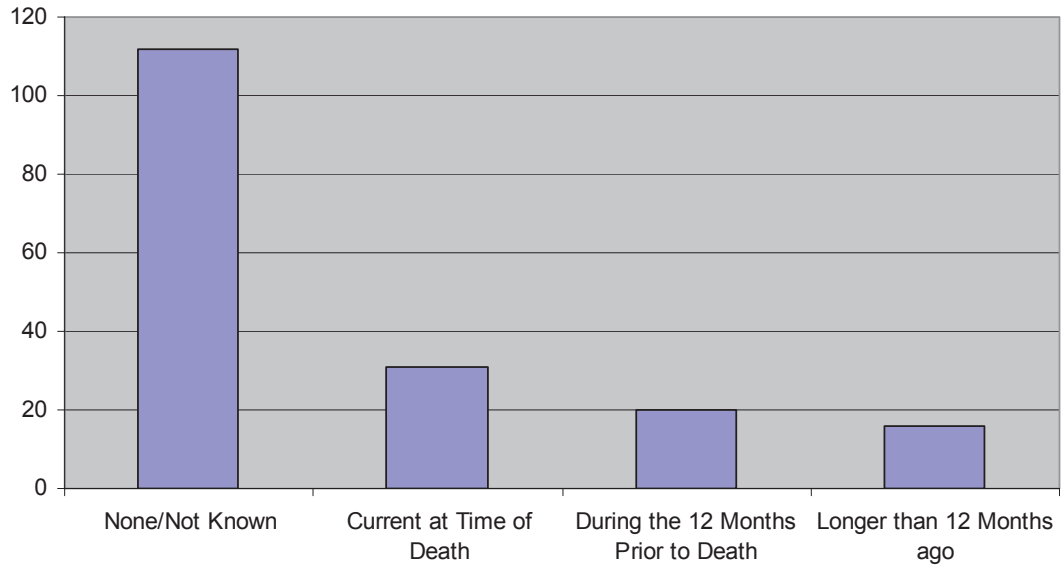


10% had contact with an accident and emergency department in the month before death and 7% had contact between one and three months prior to death. 19% had made their last contact for a mental health problem and 10% had made contact for a physical problem at an accident and emergency department.



17% had ongoing contact with specialist mental health services at the time of death, 11% had contact with them in the year prior to death and 9% had had contact with them more than a year before death. This means that while 37% of individuals were known or previously known to mental health services, the remaining 63% had no contact with mental health services. This is in line with national data that shows that the majority of people who complete suicide are not in contact with secondary mental health services.

Chart 17: Contact with Mental Health Services



18% had a diagnosis of depression, 6% a diagnosis of schizophrenia or psychosis, with smaller numbers of other mental health diagnoses.

Small numbers had contact with other services with around 5% of individuals having had contact with any single type of non-medical service. Referrals made by primary care to other services i.e. psychiatric referrals or substance use services were not always followed up by the individual or delays in accessing services in a timely manner were identified.

Communication between services and primary care regarding non attendance were not identified with alacrity by providers. It is difficult to ascertain from the Coroner's records if primary care referrers had been informed that their patient had failed to attend for an appointment. If communication was received by primary care it was months later or came to light post death.

Comparison with Previous Audits

Table 8 below gives some idea of the trends from audits undertaken in Leeds:

Table 8: Comparison between Audits

Dates of Audit	**April 2004-December 2005**	**January 2006-December 2006**	**January 2008-December 2010**
Time Period	9 months	1 year	3 years
Number	27	49	179
Median age group	40-49 years	40-45 years	40-50 years
Sex	70% male 30% female	69% male 31% female	79% male 21% female
Method for men	63% hanging 16% self poisoning 11% jumping from height	54% hanging 26% self poisoning 5% jumping from height	67% hanging 18% poisoning 2% jumping
Method for women	38% hanging 50% self poisoning 13% jumping from height	13% hanging 53% self poisoning 20% jumping from height	34% hanging 45% poisoning 2% jumping
Risk factors	48% relationship problems 22% unemployed	25% relationship problems 29% debt/redundancy	40% relationship problem 15% disability/physical illness 9% bereaved 7% debt/bankruptcy 6% forensic history
GP visit ≤1 week prior to death	41%	12% of men 33% of women	12% of men 24% of women
GP visit ≤1 month prior to death	56%	30% of men 53% of women	33% of men 53% of women
Known to mental health services	48%	42%	36% of men 45% of women

Appendix 1: Case File Summarised Examples

Male aged eighty six years who had a long term condition was admitted to hospital for surgery. He told a member of nursing staff of his intention to take his life if he was not able to cope alone at home post operatively. He stated on a number of occasions that he did not want to be a burden to anyone. No action was taken by health professionals during his inpatient stay despite him articulating his intention. He killed himself twenty four hours after his discharge home. His wife had died one year earlier and they had been married for over sixty years.

Male aged fifty seven years recently diagnosed with Parkinson's disease. He was extremely anxious regarding the impact of this diagnosis on his long term future. He stated in a note left to loved ones the he couldn't face life with mental and physical disability. We are unaware from the notes what support he had received from health care professionals regarding his diagnosis as there was limited information from his general practitioner.

Male aged forty four years on long term sickness and opiate use as a result of a long term condition. He made regular visits to his general practitioner who made a referral to the community drugs service. He did not engage with the service and his friends reported his physical health had deteriorated prior to his death.

Male aged forty seven years old. He had experienced various adverse life events all of which had an effect on his confidence levels. He had a previous history of obsessive compulsive disorder, low mood and was socially isolated. He was referred to a local community mental health team but they had difficulty in contacting him. As a result he was discharged from the service and latterly took his life.

Female aged sixteen years who was beset with a number of personal and emotional issues. She had previous contact with the CAMHs service but was not in touch with them at the time of her death. She was receiving positive support from the voluntary sector as she was experimenting with recreational drugs. She had good support from both her family and friends at the time of her death but had reported feeling bullied at school.

Appendix 2: Data Tables

Gender	Count
Female	38
Male	141
Total	179

Age Group	Count
11-16	<5
17-20	10
21-30	33
31-40	40
41-50	45
51-60	26
61-70	11
71-80	9
81-90	<5
Total	179

Postcode of Usual Residence	Count
LS1	<5
LS2	<5
LS3	<5
LS4	<5
LS5	<5
LS6	7
LS7	8
LS8	12
LS9	12
LS10	8
LS11	17
LS12	21
LS13	10
LS14	14
LS15	12
LS16	10
LS16	<5
LS17	<5
LS18	<5
LS19	<5
LS20	<5
LS21	<5
LS22	<5
LS23	<5
LS25	<5
LS26	<5
LS27	11
LS28	<5
WF3	<5
Total	179

Sexual Orientation	Count
Bisexual	<5
Heterosexual	82
Homosexual	<5
Not Known	92
Transgender	<5
Total	179

Marital Status	Count
Civil Partnership	<5
Co-habiting	11
Divorced	29
Married	27
Not Known	<5
Separated	20
Single	81
Widowed	8
Engaged	<5
Total	179

Home Situation	Count
Child(ren) over 18	<5
Child(ren) under 18	<5
Living Alone	78
Living with Parents	21
Living with Partner	36
Not Known	<5
Other Family	6
Other Shared Living Arrangements	12
Spouse / Partner & Child(ren) under 18	20
Total	179

Ethnicity	Count
Black African	<5
Black Caribbean	<5
Indian	<5
Mixed White / Black African	<5
Not Known	41
Other Asian Background	<5
Other Ethnic Background	<5
Other White Background	13
Pakistani	<5
White British	109
White Irish	<5
Total	179

Place of Birth	Count
Leeds	103
Yorkshire	25
other UK	39
Ireland	<5
Other Europe	<5
Africa	<5
India	<5
Not stated	<5
Total	179

Employment Status	Count
Caring for Home / Family	<5
Employed/self employed	65
Housewife / Househusband	<5
Long Term Sick or Disabled	13
Not Known	8
Retired	17
Student	9
Unemployed	63
Prison	<5
Total	179

Manner of Death	Count
Burning	<5
Cutting or Stabbing	<5
Drowning	<5
Electrocution	<5
Firearms	<5
Hanging / Strangulation	108
Jumping/falling	7
Poisoning	44
Asphyxia	6
Stood in front of a train	<5
Unascertained	<5
Total	179

Day of Week	Count
Monday	20
Tuesday	18
Wednesday	22
Thursday	34
Friday	32
Saturday	32
Sunday	21

Location of Death	Count
Hospital	<5
Not stated	<5
Other Home	5
Own Home	133
Prison	<5
Railway	<5
Bridge	<5
Park/woodland	13
Office/workplace	<5
Cemetery	<5
River/lake/canal	<5
Street/lane	<5
Quarry/wasteland	<5
Private Lock-up	<5
Total	179

Poison Substance	Times used
Amisulpride	<5
Amitriptyline	5
Amlodipine	<5
Amphetamine	<5
Amitriptyline	<5
Atenolol	<5
Atracurium	<5
Clozapine	<5
Codeine	<5
Coproxamol	<5
Co-codamol	<5
Diazepam	<5
Dihydrocodeine	<5
Diphenhydramine	<5
Dothiepin	<5
Heroin	5
Ibruprofen	<5
Methadone	5
Morphine	<5
Nytol	<5
Olanzapine	<5
Oxycodone	<5
Paracetomol	6
Propofol	<5
Quetiapine	<5
Sertraline	<5
Not stated	<5

Evidence of Risk	Count
No/Not Known	169
Yes	10
Total	179

Previous History of Suicide	Count
No/Not Known	101
Yes - But not Within the Past 12 Months	40
Yes - Within the Past 12 Months	38
Total	179

History of Self Harm	Count
No/Not Known	124
Yes - But not Within the Past 12 Months	21
Yes - Within the Past 12 Months	34
Total	179

History of Drugs/Alcohol	Count
Alcohol - But not Within the Past 12 Months	<5
Alcohol - Within the Past 12 Months	24
Alcohol and drugs - Within the Past 12 Months	19
Drugs - But not Within the Past 12 Months	<5
Drugs - Within the Past 12 Months	23
No/Not Known	110
Total	179

Social & Physical Risk Indicators	Count
Bereavement	17
Debt / Bankruptcy	13
Forensic History	11
Physical Illness / Disability	27
Redundancy	7
Relationship/Family Problems	72
Work stress/stress	<5
Terminally ill relative	<5

Family History	Count
No/Not Known	169
Yes	10
Total	179

Supporting Evidence Note	Count
No	115
Yes	64
Total	179

Contact with GP - Time	Count
None/Not Known	37
More Than a Year	36
Within Previous 3 Months	39
Within Previous Month	41
Within Previous Week	26
Total	179

Contact with GP - Reason	Count
None stated/known & other	60
Mental Health Problem	56
Physical Health Problem	61
Physical and Mental Health Problems	<5
Total	179

Contact with A+E - Time	Count
None/Not Known	126
More Than a Year	23
Within Previous 3 Months	12
Within Previous Month	13
Within Previous Week	5
Total	179

Contact with A+E - Reason	Count
None stated/known & other	127
Mental Health Problem	34
Physical Health Problem	18
Total	179

Contact with Specialist MH Service	Count
None/Not Known	112
Current at Time of Death	31
During the 12 Months Prior to Death	20
Longer than 12 Months ago	16
Total	179

Mental Health Diagnosis	Count
Alcohol Misuse	6
Anxiety / Phobia / Panic Disorder / OCD	<5
Bipolar Affective Disorder	6
Depressive Illness	33
Drug Misuse	<5
Eating Disorder	<5
Not Known	17
Personality Disorder	<5
Schizophrenia & Other Delusional Disorders	12
Adjustment dis-order/reaction	<5
Attachment disorder	<5
Hyperactive & behaviour problems	<5

Contact with Services other than medical	Count
Alcohol Services	13
Faith Community	<5
None Known	139
Occupational Health	<5
Probation Service / Youth Justice	6
Substance Misuse Services	14
Voluntary Sector Services	5
Total	179

Coroner's Verdict	Count
Accidental/misadventure	34
Narrative	8
Open	21
Suicide	116
Total	179

Appendix 3: The Evidence Base for Suicide Prevention Strategies

Search Strategy

In order to identify the evidence for suicide prevention strategies, a search for systematic reviews in the subject area in the following databases was undertaken: Medline, PsycINFO, CINAHL, EMBASE, NICE, Bandolier, Google, NHS evidence clinical knowledge summaries, CRD/HTA/DARE, Cochrane Library. A total of 34 systematic reviews were identified, but 8 were unobtainable, leaving 26 from which the evidence below was drawn.

The studies are listed in tables 9 and 10 on pages 5 and 13 respectively, and each graded according to the hierarchy of evidence below:

Level of evidence	Type of evidence
1++	High-quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
1+	Well-conducted meta-analyses, systematic reviews of RCTs, or RCTs with a low risk of bias
1–	Meta-analyses, systematic reviews of RCTs, or RCTs with a high risk of bias*
2++	High-quality systematic reviews of case–control or cohort studies. High-quality case–control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal
2+	Well-conducted case–control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal
2–	Case–control or cohort studies with a high risk of confounding bias, or chance and a significant risk that the relationship is not causal
3	Non-analytic studies (for example, case reports, case series)
4	Expert opinion, formal consensus

In general there is little strong evidence for any type of intervention or for what is most effective in any individual population group. For many of the studies changes in suicidal behaviour or ideation were chosen as the outcome of interest, and fewer looked at changes in suicide rates; because of the relative rarity at which suicide occurs in a given population, it is difficult to detect a significant change in rate except in large studies

Findings from the studies are summarised according to the interventions and the population groups they are applicable to. It should be noted that this is not a comprehensive literature search and does not include studies for all types of intervention and population group, only those included in recent systematic reviews.

Education & Awareness Training

Suicide awareness and education campaigns for the public have rarely been systematically evaluated and often show no benefit; where effectiveness has been shown it may be related to good access to treatment or linked to short term improvements in awareness and knowledge (Dumesnil & Verger, 2009; Mann et al, 2005; Van der Feltz-Cornelis, 2011). They may be effective in specific groups, such as the military and young people (Bagley et al, 2011; Crowley et al, 2004). There is some evidence to support primary care physician education especially in the recognition and treatment of unipolar and bipolar depression (Mann et al, 2005; Van der Feltz-Cornelis, 2011).

Media

There is limited evidence of effectiveness for media restrictions and conflicting evidence for their effect on youth suicide prevention (Mann et al, 2005; Crowley et al, 2004). Evidence of impact following introduction of media guidelines is largely based on studies of railway suicides; their findings may be subject to publication bias, as the few studies suggesting no impact were published prior to 1990 (Krysinska & De Leo, 2008; Sisask & Värnik, 2012).

Access to means

Restriction of access to means such as pesticides, firearms, prescription medications, barriers at jumping sites and reducing access to railway tracks may reduce means-specific rates but not overall rates as a result of substitution of other means (Sarchiapone et al, 2011; Mann et al, 2005; Krysinska & De Leo, 2008; Van der Feltz-Cornelis, 2011; Leitner, 2008). There is little or no evidence of impact for such prevention programmes on youth suicide rates (Crowley et al, 2004).

Gatekeepers

There is good evidence from observational studies to show that professional and non-professional gatekeeper training reduces suicide rates, particularly in the military and institutions (Bagley et al, 2011; Isaac et al, 2009; Mann et al, 2005).

Population screening

There is limited evidence for general population screening, though there is good evidence for screening of the over 65s (Mann et al, 2005; Oyama et al, 2008).

Pharmacological Interventions

There is some evidence to show that some types of pharmacological treatments may reduce suicidal behaviour or risk factors, but no strong evidence showing that any one is effective in reducing suicide rates (Guo et al, 2003).

Lithium is effective at reducing rates of attempted and completed suicide in individuals with mood disorders but should be used cautiously (Cipriani et al, 2005; Leitner, 2008). Evidence suggests that other antidepressants reduce suicidal thoughts in depressive patients and the elderly but due to very low rate of suicidal behaviour in these studies there is no strong evidence that antidepressants reduce suicide attempts or suicide (Daigle et al, 2011; Heisel et al, 2006; Leitner, 2008; Mann et al, 2005; Moller, 2006). There is no clear evidence showing differences in the speed or capacity to reduce suicidal thoughts between antidepressants (Moller, 2006). Ecological studies suggest that increased prescribing of antidepressants is associated with a decline in national suicide rates in several countries, particularly in those with previously high rates (Mann et al, 2005; Moller, 2006).

Psychosocial Interventions

There is some evidence to show that some types of psychosocial treatments may reduce suicidal behaviour or risk factors, but no strong evidence showing that any one is effective in reducing suicide rates (Guo et al, 2003) (Mann et al, 2005). There is evidence for reductions in attempted suicide for cognitive behaviour therapy and dialectical behaviour therapy but little evidence for the effectiveness of psychosocial interventions for suicidal ideation or following self-harm (Crawford et al, 2007; 2011; Guo & Harstall, 2003; Leitner, 2008).

Evidence is equivocal for psychosocial interventions to prevent repeat suicidal behaviour delivered to children or adults by health and non-health practitioners in clinical, community or home settings (Daigle et al, 2011; Newton et al, 2010; Repper, 1999; Robinson et al, 2010). Psychosocial interventions for bereaved adults or children may reduce anxiety and depression, but there is no evidence of effect on rates of suicide (McDaid et al 2008).

Follow up

There is limited evidence for the effectiveness of follow-up care (Mann et al, 2005). A small number of studies have shown consistent reductions in completed suicide for the maintenance of ongoing contact with the suicidal person, and in attempted suicide for informal social support for the suicidal person (Leitner, 2008). Telephone contacts may also be effective at preventing repetition of suicidal behaviour, though hospitalisation and intensive outreach do not appear effective (Daigle et al, 2011).

Children and Young People

School-based prevention programmes, both universally and selectively targeted, improve knowledge around suicide and reduce risk factors but do not significantly change behaviour or suicide rates (Crowley et al, 2004; Cusimano & Sameem, 2011; Guo & Harstall, 2003; Miller et al, 2009)

There is some evidence of impact of GP awareness and education interventions on suicide rates, weak evidence for contact cards, conflicting evidence for media restrictions, but little or no evidence of impact on suicide rates of programmes targeting family risk factors, access to means or crisis hotlines (Crowley et al, 2004). Psychosocial interventions for bereaved children may reduce anxiety and depression, but there is no evidence of effect on rates of suicide (McDaid et al 2008)

Evidence is equivocal for psychosocial interventions to prevent repeat suicidal behaviour delivered to children by health and non-health practitioners in clinical, community or home settings (Daigle et al, 2011; Newton et al, 2010; Repper, 1999; Robinson et al, 2010).

Ethnic minority groups

There is a lack of evidence for prevention strategies specifically targeted at black and minority ethnic groups (Bhui & McKenzie, 2006).

Military personnel

Multi-component interventions may be effective at reducing suicide rates for military personnel (Bagley et al, 2011). There is good evidence from observational studies to show that professional and non-professional gatekeeper training reduces suicide rates in military personnel (Isaac et al, 2009).

Bereaved

Combined health professional and volunteer led group therapy for adults and psychologist led group therapy for children may reduce anxiety and depression, and a psychiatric nurse counsellor led brief CBT family intervention results in fewer maladaptive grief reactions, but there is no evidence of effect of these interventions on rates of suicide (McDaid et al 2008).

Table 9: Reviews of Primary Research Studies

Author, date & Level of Evidence	Studies included	Databases	Population Group	Interventions	Findings
Bagley et al, 2011 **2++**	7 non-randomised studies	Medline, Cochrane Library, PsychInfo, 2005-2008	Military or ex-military personnel	Multi-component interventions including education on risk factors, flash cards, tracking at risk soldiers, gatekeepers, life skills training and gambling treatment programmes	Declines in suicides and suicide attempts observed but no control for secular trends, or statistically significant effect sizes reported
Bhui & McKenzie, 2006 **3**	3 non-randomised studies	Not stated	Black and minority ethnic groups in England and Wales	Not clearly stated	There is a lack of evidence for prevention strategies targeted at BME groups
Cipriani et al, 2005 **1+**	32 RCTs	Medline, EMBASE, CINAHL, PsycLIT, PSYNDEX, LILACS, CENTRAL, to 2002	Diverse	Lithium for individuals with mood disorders versus other medication	In 7 studies individuals receiving lithium were less likely to die by suicide (OR 0.26, 95% CI 0.09-0.77). The likelihood of suicide and self harm taken together was also lower in those receiving lithium (OR 0.21, 95% CI 0.08-0.50)

Author & date	Studies included	Databases	Population Group	Interventions	Findings
Crawford et al, 2007 **2++**	18 RCTs	EMBASE, PsycINFO, Medline, to 2005	Individuals of all ages following self harm	Intervention of a fixed number of sessions of psychosocial interventions such as cognitive–behavioural therapy, interpersonal psychotherapy and dialectical behaviour therapy versus none	No evidence that psychosocial interventions following self harm reduce the likelihood of subsequent completed suicide, pooled root difference in suicide rate was 0.0 (95% CI -0.03-0.03)
Cusimano & Sameem, 2011 **2-**	I RCT and 7 semi-randomised studies	MEDLINE, CINAHL, PsycINFO, Cochrane Library, HTA DARE, CTR, NHSEED, WoS to 2009	Adolescents in middle and high schools	School-based prevention programmes seeking to improve knowledge around suicide and help-seeking behaviour, train peers to recognise the signs of potential suicide, or modify maladaptive cognitive processes	Knowledge and attitudes were improved in most studies though help-seeking behaviour was not always changed. In the 2 studies where the impact on suicide attempts was measured a small decrease was noted
Daigle et al, 2011 **2++**	35 RCTS	Pubmed and PsycINFO 1966 to 2010	Individuals previously attempting suicide	Pharmacological or psychological treatments, regular visits by outreach workers, postal or telephone contacts, emergency card provision, hospitalisation or more intensive outreach programmes	Only 2 of the 6 pharmacological treatments were significantly better than a placebo, while CBT and psychodynamic therapies may prevent repetition of suicidal behaviour. Telephone contacts may be effective, though hospitalisation and intensive outreach did not appear effective

Author & date	Studies included	Databases	Population Group	Interventions	Findings
Dumesnil & Verger, 2009 **2-**	(1 RCT, 3 cohort and 11 before and after studies	Medline, Cochrane Library, HDA PsycINFO, DARE, WoS, 1987 to 2007	Diverse	Public education campaigns aimed at Improving awareness of suicidal crises and depression	Public education campaigns improve public awareness and knowledge at least in the short term, however only 1 non-randomised study showed a fall in suicide rates
Heisel et al, 2006 **1-**	4 RCTS	Medline, PsycINFO, 1966 to 2005	Adults aged over 65 years	Comparisons of different pharmacological and other interventions , antidepressants with or without psychotherapy versus usual care, outreach visits to nursing homes	There was no clear difference between venlafaxine versus dothiepin or nortryptyline versus paroxetine, all reducing suicidal ideation with improvement related to underlying severity of the condition rather than age. Outreach visits reduced depression scores with no effect on suicidal ideation
Isaac et al, 2009 **2++**	1 RCT 12 Cohort Studies	MEDLINE, PsycINFO, to 2009	Diverse	Interventions using professional and non-professional gatekeeper training for suicide prevention	Despite no RCT evidence, a 33% relative risk reduction in suicide rate was observed in a cohort of 5 million military personnel with significant decreases in smaller cohort studies. In the 7 studies assessing improvement in knowledge positive outcomes were identified

Author & date	Studies included	Databases	Population Group	Interventions	Findings
Krysinska & De Leo, 2008 **2+**	15 observational studies	Medline, PsycINFO 1966 to 2007	Railway suicides	Various interventions including deep channels between the rails, sliding doors at platforms limiting access to the track, airbags or skirts at fronts of trains, fencing along track in proximity of psychiatric hospitals and suicide hot spot stations, improving station surveillance, responsible media reporting and community media campaigns	Limited evidence of some effect when used alone or as part of a complex intervention
Lapierre et al, 2011 **2-**	19 studies describing 11 interventions (includes Oyama et al, 2008)	Cochrane library, MEDLINE, ERIC, PsycINFO 1966–2009	Individuals aged 60 years and older	Primary care collaborative interventions, telephone counselling, clinical treatment and strategies to improve resilience, or community based outreach programmes	Evidence suggests such programmes reduce suicidal ideation and behaviour to varying degrees with outreach reducing suicide rates

Author & date	Studies included	Databases	Population Group	Interventions	Findings
McDaid et al 2008 **2+**	4 RCTS 1 controlled study 3 observational studies with control	30 databases, including Medline, EMBASE, PsycINFO and the Science Citation Index, grey literature, to 2007	adults or children bereaved through suicide, with no restriction on relationship to individual committing suicide	A variety of interventions including support groups, self-help groups, volunteer-led groups and health professional delivered therapeutic interventions, given in diverse settings such as school, university the family home, the scene of the suicide, and a suicide prevention centre.	Limited evidence to suggest that psychologist led group therapy for children, and combined health professional and volunteer led group therapy for adults may reduce anxiety and depression, and that a brief CBT family intervention by a trained psychiatric nurse counsellor results in fewer maladaptive grief reactions. However there is no evidence of effect on rates of suicide by the bereaved
Miller et al, 2009 **2+**	11 controlled studies and 2 observational studies	PsycINFO, ERIC, 1967 to 2008	School age children	School-based prevention programmes	All studies of both universally and selectively targeted interventions had methodological weaknesses and provide only limited evidence with none for impact on suicide rates

Author & date	Studies included	Databases	Population Group	Interventions	Findings
Moller, 2006 **2+**	23 RCTS 16 epidemiological studies	Medline to 2005	Diverse	Antidepressants for suicide	Evidence from RCTS suggests that antidepressants reduce suicidal thoughts in depressive patients but due to very low rates of suicidal behaviour in these studies there is no evidence that antidepressants reduce suicide attempts or suicide. There is no clear evidence showing differences in the speed or capacity to reduce suicidal thoughts between antidepressants. Ecological studies suggest that increased prescribing of antidepressants is associated with a decline in national suicide rates in several countries, particularly in those with previously high rates
Newton et al, 2010 **2+**	7RCTs 3 quasi-RCTs	15 database including Medline, 1985 to 2009	Paediatric A&E patients with suicidal behaviour	Mental health-based interventions focused on suicide prevention initiated in A&E or immediately after discharge from the A&E department	Problem solving skills-based treatment, manual assisted cognitive behavioural therapy, interpersonal problem-solving skills training, hospital admission or a community-based outreach programme did not significantly reduce suicide or self harm attempts, though a brief educational intervention with referral options reduced suicide rates and a rapid response outpatient team model reduced suicide related hospitalisation

Author & date	Studies included	Databases	Population Group	Interventions	Findings
Oyama et al, 2008 **2++**	Five quasi-experimental studies	MEDLINE, PsycINFO CINAHL to 2007	Japanese aged over 65 years	Universal annual population two-step depression screening performed by public health nurse and psychiatrist and health education in a community setting with follow-up by GP or psychiatrist versus no intervention	Large studies with pooled incidence rate ratios for completed suicide: With psychiatrist follow up for men: 0.30 (95% CI: 0.13–0.68) women: 0.33 (95% CI: 0.19–0.58) With GP follow up: for men: 0.73 (95% CI: 0.45–1.18) women: 0.36 (95% CI: 0.21–0.60)
Repper, 1999 **1-**	7 RCTS	MEDLINE, CINAHL, Science Citation Index 1990 to 1999	Individuals presenting to A&E one or more episodes of self poisoning or deliberate self harm	Counselling or psychotherapy given by health and non-health practitioners in clinical or home settings	Little or no difference in suicidal ideation, mood and deliberate safe harm outcomes between those receiving intervention and control groups, but study sizes small. No data on numbers of individuals completing suicide

Author & date	Studies included	Databases	Population Group	Interventions	Findings
Robinson et al, 2010 **1-**	15 RCTs	Cochrane Central Register of Controlled Trials, Medline, Embase, PsycINFO 1980 to 2010	Individuals aged 12-25 years	Psychological or other therapeutic interventions for the management of suicide risk and deliberate self harm where intent was not specified	Some evidence for effectiveness when compared to usual care but not to a control intervention. CBT reduced suicidal ideation and number of DSH attempts but not the number of individuals carrying out DSH, but there was no evidence for effectiveness for individual problem solving or skills based therapies, and evidence for group-based problem solving and family therapies was unclear
Sarchiapone et al, 2011 **2-**	50 studies	Pubmed, Web of Science Cochrane Library	Diverse	Interventions to reduce access to means of committing suicide	Restriction of access to means such as pesticides, firearms, prescription medications, barriers at jumping sites and their descriptions in the media may reduce means-specific rates but not overall rates

Table 10: Reviews Including Systematic Reviews

Author & date	Studies included	Databases	Population Group	Interventions	Findings
Crowley et al, 2004 **2++**	7 systematic reviews includes Guo & Harstall, 2003	Multiple databases from medical, nursing, social sciences, specialist reviews, HTAs and the grey literature to 2003	Young people aged 15 to 24 years	Interventions to prevent youth suicide delivered through school, primary care, or targeting family risk factors or at risk groups, preventing access to means, media restrictions, or identifying potential points of access to those contemplating suicide	GP education on recognition, management and prevention of youth suicidal behaviour may have some impact on suicide rates Weak evidence for contact cards., and conflicting evidence for media restrictions Insufficient evidence for school-based universal or high risk group programmes Little or no evidence of impact on suicide rates of programmes targeting family risk factors, access to means or crisis hotlines

Author & date	Studies included	Databases	Population Group	Interventions	Findings
Guo et al, 2003 **2++**	Health Technology Assessment of 10 Systematic Reviews	10-20 medical and sociological literature databases and Websites	Diverse	Systematic reviews of interventions for suicide prevention strategies measuring suicide related outcomes	No strong evidence showing that any one suicide prevention strategy is effective in reducing suicide rates, though some evidence to show that some types of psychosocial and pharmacological treatments may reduce suicidal behaviour or risk factors
Guo & Harstall, 2003 **2++**	10 systematic reviews	Multiple medical and sociological databases and Websites, 1990 to 2003	Diverse	School based strategies Adult interventions	School based strategies reduce risk factors and behaviour though there is no evidence for impact on suicide rates There is some evidence of benefits for cognitive behavioural therapy and weaker evidence for other interventions for specific risk groups

Author & date	Studies included	Databases	Population Group	Interventions	Findings
Leitner et al, 2008 **1-**	200 primary studies and 37 systematic reviews, Includes Cipriani et al, 2005 Mann et al, 2005 Repper,1999	18 databases from medical, nursing social sciences, specialist reviews, HTAs and the grey literature to 2006	Diverse, but mainly Canadian and U.S. studies	Pharmacological interventions (most of studies in review) Non-pharmacological interventions Psychotherapies	Lithium may reduce attempted and completed suicide but should be used cautiously. Due to the range of agents studied evidence for the effect of antidepressants on suicidal behaviour and ideation is equivocal, but very little for self harm Limited number of studies showing consistent reductions in completed suicide for restrictions in the access to means and the maintenance of ongoing contact with the suicidal person, and consistent reductions in attempted suicide for restrictions in the access to means and informal social support for the suicidal person Consistent evidence for reductions in attempted suicide for cognitive behaviour therapy and dialectical behaviour therapy, the latter having a stronger evidence base, but little evidence for the effectiveness of non-pharmacological interventions for suicidal ideation

Author & date	Studies included	Databases	Population Group	Interventions	Findings
Mann et al, 2005 **2++**	10 systematic reviews and meta-analyses 18 RCTS 24 cohort studies 41 ecological or population based studies Includes Guo & Harstall, 2002	MEDLINE, Cochrane Library, PsychINFO 1966-2005	Diverse	Awareness and education of general public, primary care physicians, or other gatekeepers Screening Treatment by Pharmacotherapy, psychotherapy and follow-up care after suicide attempts Means Restriction Media restrictions	Public awareness and education campaigns have rarely been systematically evaluated and often show no benefit. Some evidence to support primary care physician education and gatekeeper training, particularly in institutions for the latter Limited evidence for screening Limited RCT evidence on suicide outcomes for trails of antidepressants but ecological studies show lower suicide rates with greater use of SSRIs. A number of psychotherapies have been shown to reduce suicide attempts and behaviour. Limited evidence for the effectiveness of follow-up care Restricting access to lethal means may prevent use of a particular method and may lead to substitution of other means, with no effect on overall rates of suicide Limited evidence

Author & date	Studies included	Databases	Population Group	Interventions	Findings
Sisask & Värnik, 2012 **2+**	4 systematic reviews 4 meta-analyses 48 research articles. Includes Mann et al, 2005	MEDLINE PsycINFO, Cochrane Library	Diverse	Studies looking at the impact of media reporting and suicidal behaviour	Most of the studies support the theory that media reporting has an effect on suicidal behaviour but such findings may be subject to publication bias, as only four studies did not report an association and were published prior to 1990. Six studies, five of them Austrian, showed that introduction of media guidelines reduced the number of subway suicides and suicide attempts .
Van der Feltz-Cornelis, 2011 **2+**	6 systematic reviews includes Mann et al. (2005) Leitner et al. (2008) Isaac et al. (2009) Dumesnil et al. (2009)	Pubmed, Cochrane, DARE	Diverse	Effective interventions for the prevention of suicidal behavior	Effective best practices were: 1) Training GPs in the recognition and treatment of mental disorders, especially unipolar and bipolar depression 2) Awareness campaigns, provided there is good access to treatment 3) Training gatekeepers for those at risk 4) improvement of healthcare services targeting people at risk, such as making adequate inpatient and outpatient aftercare for people who have attempted suicide 5) Training journalists in responsible reporting about suicide or imposing of media blackouts 6) Restricting access to lethal means of suicide

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Leeds CITY COUNCIL

Report author: Heather Pinches
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Report of Assistant Chief Executive (Customer Access and Performance)

Report to Health and Wellbeing and Adult Social Care Scrutiny Board

Date: 26 September 2012

Subject: 2012/13 Q1 Performance Report

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

Summary of main issues

1. This report provides a summary of performance against the strategic priorities for the council relevant to the Health and Wellbeing and Adult Social Care Scrutiny Board.

Recommendations

2. Members are recommended to:

    - Note the Q1 performance information and the issues which have been highlighted and consider if they wish to undertake further scrutiny work to support improvement over the coming year in any of these areas.

1 Purpose of this report

1.1 This report presents to scrutiny a summary of the quarter one performance data for 2012-13 which provides an update on progress in delivering the relevant priorities in the Council Business Plan 2011-15 and City Priority Plan 2011-15.

2 Background information

2.1 The City Priority Plan 2011 to 2015 is the city-wide partnership plan which sets out the key outcomes and priorities to be delivered by the council and its partners. There are 21 priorities which are split across the 5 strategic partnerships who are responsible for ensuring the delivery of these agreed priorities. The Council Business Plan 2011 to 2015 sets out the priorities for the council - it has two elements - five cross council priorities aligned to the council's values and a set of directorate priorities and targets.

2.2 This report includes 2 appendices:

- Appendix 1 – Performance Reports for the 4 Health and Wellbeing City Priority Plan Priorities
- Appendix 2 – Adult Social Care Directorate Priorities and Indicators

3 Main issues - Quarter 1 Performance Summary

Council Business Plan

3.3 **Adult Social care Directorate Priorities and Indicators –** there are 12 directorate priorities and 9 are assessed as green, and 3 amber The amber priorities are:

- Support adults whose circumstances make them vulnerable to live safe and independent lives,
- Help people with poor physical or mental health to learn or relearn skills for daily living.
- Extend the use of personal budgets.

3.4 In terms of performance indicators 2 green, 1 amber and 4 red and 1 has no result at Q1. The red indicators are:

- Increase the number of people successfully completing a programme to help them relearn the skills for daily living.
- Increase percentage of service users and carers with control over their own care budget
- Increase percentage service users who feel that they have control over their daily life.
- Increase percentage of safeguarding referrals which lead to a safeguarding investigation

3.5 **Re-ablement service:** Joint health and adult social care re-ablement (SkILs) teams have been established across the city and are delivering successful outcomes. Pathways are open to receive referrals from the community, on

existing service users and following hospital discharge. Performance data indicates that the service compares very favourably with national high performers, with 70% of customers requiring no ongoing package of care once reablement complete. However, the numbers coming through the service at Q1 (187) are significantly below target (2000 per annum) with activity limited by a shortage of supervisors. The Directorate are looking to make up this shortfall from supervisors currently within the long term home care service or to recruit to vacancies where this is not possible.

3.6 **Service users and carers with control over their own care budget:** Leeds Adult Social Care exceeded it's target in 2011/12 to ensure 45% of people were in receipt of self directed support with 52% of eligible service users meeting the criteria. At quarter 1 this indicator has dipped slightly to 42% but it will need a further step change forward if Leeds is going to meet the 100% target to ensure that self directed social care is available to all. The major vehicle for the development of personalised social care is through the 'Think Local Act Personal' concordat. A part of this work is 'Making it Real,' which includes a framework for measuring progress in the establishment of personalised, community based support. Leeds Adult Social Care (ASC) has made a commitment to progress the delivery of personalisation in co-production with people who use services. A forum of service users has been identified to start identifying priority areas for improvement.

3.7 **Service users who feel that they have control over their daily life:** A survey about self directed support was undertaken with social care service users during April and May 2012. This showed a drop in performance to 68% from 76% at quarter 4 against an ambitious target of 85%. The results show that the majority of people who don't manage their own support choose council managed support. A proportion, however, said that they chose not to manage their own budgets as they are concerned about how they will find services, etc. These results will inform further work to increase support for people to use direct payments. Two social workers recruited to work with carers improving access to personalised support including personal budgets. Work includes the development of systems for allocation. A project has been established to develop personal health budgets (PHB) and personalised care planning (PCP) for individuals eligible for Continuing Health Care (CHC) Funding within NHS Leeds. This is a two year DH approved pathfinder project to develop systems and processes and facilitate a culture shift in commissioning behaviours and care planning.

3.8 The percentage of **safeguarding referrals that led to an investigation** has dropped from 35% to 30% against a target of 45%. Whilst this does not in itself indicate an increased safeguarding risk a higher conversion rate is some measure of the success of the implementation of multi agency policies, procedures and training which includes guidance on thresholds for investigation and referral. The Safeguarding Adults Board performance sub-group are scrutinising the data on cases that were referred but did not go forward to investigation, to quality assure the decision making on cases did not meet the threshold for investigation.

3.9 **Delayed discharges from hospital:** Since quarter 4 progress has been made in reducing delayed discharges due to ASC and performance is now better than the median for local authorities although it remains below target at quarter 1. On the

1st May 2012 a summit of health and social care partners at which a plan of action was agreed to generate improvements in the management of demand for urgent hospital care and thereby reduce the pressures on hospital discharge systems. Key elements of this include:

- Reducing the number of people requiring hospital admission through A&E with conditions such as blocked catheters by improving training for staff in catheter care.
- Reducing pressure on the urgent care system through the further development of Ambulatory Pathways
- Exploring the potential for more effective use of telecare for patients in care homes
- Improving information systems between key partners

City Priority Plan

3.10 There are 4 priorities in the City Priority Plan relevant to Health and Wellbeing and Adult Social Care Board and of these 1 is assessed as green, 2 amber and is 1 is red. The red priority is health inequalities:

3.11 **Health Inequalities:** the annual update of the mortality data has been provided this quarter and life expectancy is increasing across the whole population of Leeds including the most deprived communities. However life expectancy is increasing faster in the most affluent areas compared to the speed of increase in the most deprived thereby widening the gap. Reducing the gap will depend on successful outcomes from the current action plans – to ensure children have the best start in life; to maximise income and reduce debt; improve housing, transport and the environment; increase employment and healthy workplaces; to maximise educational attainment; and improve access to services that prevent and treat ill health.

3.12 **Smoking:** Tobacco smoking is the biggest lifestyle risk factor contributing to inequalities in death rates between the richest and poorest communities. The smoking priority is currently assessed as amber - as prevalence rates remain static in Leeds. Evidence from the JSNA is that two thirds of smokers start before they are 18 and nearly all smokers have started by the time they are 24. More work is required to prevent younger people in taking up smoking (as recently raised by the Board in their recent Scrutiny Enquiry). Smoking initiation is associated with a wide range of risk factors including parental and sibling smoking, easy access to cigarettes, smoking by friends, living in more disadvantage communities, exposure to tobacco marketing, and depictions of smoking in films, television and other media. A pilot is planned for Belle Isle North (the area of the city with the worst smoking rates) in order to identify and develop innovative approaches to tackle this important issue as well as to build the evidence base.

4 Corporate Considerations

4.1 Consultation and Engagement

4.1.1 This is an information report and as such does not need to be consulted on with the public. However all performance information is published on the council's and Leeds Initiative websites and is available to the public.

4.2 Equality and Diversity / Cohesion and Integration

4.2.1 This is an information report and not a decision so due regard is not relevant. However, this report does include an update on equality issues as they relate to the various priorities.

4.3 Council policies and City Priorities

4.3.2 This report provides an update on progress in delivering the council and city priorities in line with the council's performance management framework.

4.4 Resources and value for money

4.4.1 There are no specific resource implications from this report; however, it includes a high level update of the Council's financial position. This is in terms of the cross council priority within the Business Plan of "spending money wisely".

4.5 Legal Implications, Access to Information and Call In

4.5.1 All performance information is publicly available and is published on the council and Leeds Initiative websites. This report is an information update providing Scrutiny with a summary of performance for the strategic priorities within its remit and as such is not subject to call in.

4.6 Risk Management

4.6.2 The Performance Report Cards include an update of the key risks and challenges for each of the priorities. This is supported by a comprehensive risk management process in the Council to monitor and manage key risks. These processes also link closely with performance management.

5 Conclusions

5.1 This report provides a summary of performance against the strategic priorities for the council relevant to the Health and Wellbeing and Adult Social Care Scrutiny Board.

6 Recommendations

6.1 Members are recommended to:

- Note the Q1 performance information and the issues which have been highlighted and consider if they wish to undertake further scrutiny work to support improvement over the coming year in any of these areas.

7 Background documents[1]

7.2 City Priority Plan 2011 to 2015

7.3 Council Business Plan 2011 to 2015

[1] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

Meeting: Health and Wellbeing Board

Population: All adults in Leeds

Outcome: people live longer and have healthier live

Priority: Help protect people from the harmful effects of tobacco.

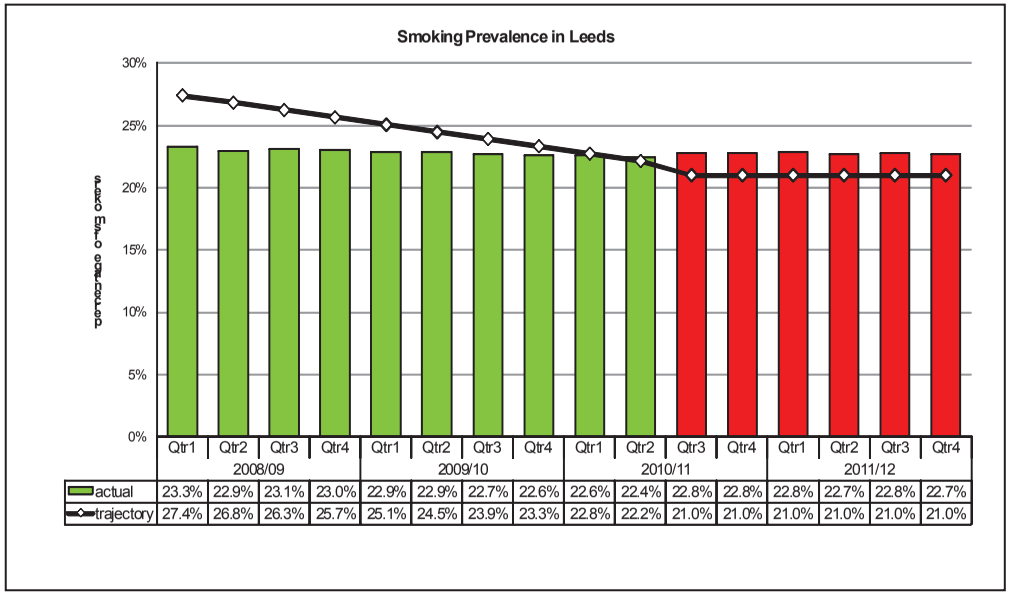
Why and where is this a priority The use of tobacco is the primary cause of preventable disease and premature death. It is not only harmful to smokers but also to the people around them through the damaging effects of second-hand smoke. Smoking rates are much higher in some social groups, including those with the lowest incomes. These groups suffer the highest burden of smoking-related illness and death. This is the single biggest cause of inequalities in death rates between the richest and poorest in our communities. Levels of smoking have fallen since the 1960s. However there are still 24% of adults living in Leeds who smoke and this decline in smoking rates has stopped and may be reversing.

Overall Progress:

Amber

Story behind the baseline

Headline Indicator: Reduce the number of adults over 18 that smoke.



- Leeds is currently experiencing a plateau in terms of smoking prevalence, which is reflected in the national trend. However, it should be noted that some areas of the country are starting to see an increase in smoking rates; this is particularly noticeable in some northern areas, highlighting the need to continue to prioritise **all** areas of tobacco control if further reduction is to be achieved.
- The 4 week quit rate target for Leeds for 2011/12 was 4450 quitters and our achievement was 4672 (104% of target) showing an improvement on last year by 1.4%.
- Analysis of the results from stop smoking services is one of the top performing services in England in terms of success rates which is consistent across the whole city with the majority of service users (60%) who quit smoking with the specialist team of advisors living in the most deprived areas of the city. There is a need to increase the number of people referred to the service
- In addition to collecting data from GP registers to monitor prevalence on a quarterly basis, further data is collected from the stop smoking services re. service use and outcomes at both 4 and 52 weeks following a quit day. Systems are also being explored and developed to monitor other related activity e.g. advice given from GP practices, LTHT and Leeds Community Healthcare.
- The national smokers toolkit which monitors attitudes toward quitting have noted that smokers appear to becoming less motivated to quit and less likely to set a quit date, which seems to be reflected in the current national trends of prevalence.
- Due to the collection methods for smoking services, data is always provided for the quarter prior to the one being reported on. This is due to the timing of the follow up of clients at 4 weeks following the setting of a quit date i.e. if a quit date is set at the end of Q1 there is a time lag to obtain the outcome of the quit attempt and data collection and collation.

What do key stakeholders think

- The draft citywide action plan for tobacco control completed and circulated to stakeholders for consultation by 13th July. The final plan will also be amended to take into account comments from the final Scrutiny Inquiry Report on 'Reducing smoking in Leeds' (May 2012)
- The newly commissioned Lifestyle Service, to be offering lower level smoking interventions, is conducting a engagement programme with potential service users and referrers to the service to help inform service development.

What we did

Environmental services continue to monitor adherence to smoke free legislation. Service requests relating to the smoke-free legislation:

- Total number of service requests: 17
- Number of requests relating to alleged smoking inside premises: 12
- Number of requests for advice, eg smoking shelter requirements: 5

Of the 12 service requests about smoking in premises, two of them related to the same premises and one of them related to a delivery man smoking in his van. In each case, contact was made with the business and the requirements of the Smoke-free (Premises and Enforcement) Regulations 2006, were confirmed in writing to them.

- Further funding secured to support the implementation of NICE Guidance PH26 'Quitting Smoking in Pregnancy and Following Child Birth'. This will allow community midwives to be equipped with carbon monoxide monitors to help in the identification and referral of pregnant women for support to stop smoking.
- Leeds Let's Change team worked with Clinical Commissioning Groups to increase the numbers of people being supported by GP practices to access smoking services. Both Leeds South and East and Leeds North CCGs developed local incentive schemes and established targets for practices in 2012/13.

What worked locally /Case study of impact

To support the standardised packaging for tobacco products consultation, a community engagement event was organised for local residents to learn more about the campaign and share their support with their local MP. 29 people committed their support in writing and presented their views to Hilary Benn. Other local organisations and agencies who were unable to attend the event have been encouraged to support their service users completed responses to the consultation and forward to Parliament. The consultation has now been extended into August so further support has been offered to the third sector to help engage local communities and enable Leeds residents to respond

New Actions

- LCC HR HOS have commenced drafting an updated LCC smokefree policy to reflect more comprehensive approach to tobacco control and employee health
- LTHT held a tobacco workshop in May, this has resulted in leads being identified for key themes including: smoke free excellence award, targeted smoking cessation work in priority clinical areas (cardiology and respiratory) and pre operative, action plans are now being developed.
- Applications for funding have been submitted to:
  - Develop niche tobacco work in South and East North East Leeds
  - Further develop the Leeds Let's Change website to include a self assessment smoking support tool.
  - Continue to develop and deliver the Leeds Let's Change communication plan throughout 2012/13.
- Funding has been agreed by the Yorkshire and Humber Tobacco Control Collaborative to provide a Trading Standards coordination role up until, at least the end of this financial year. The key aims of that role are to advocate and influence the involvement of trading standards in the region in smoking reduction strategies, with particular emphasis on:
  - Reducing tobacco related inequalities in health by promoting work which targets DH identified priority groups that regularly purchase illicit tobacco;
  - Stopping the promotion of tobacco;
  - Making tobacco less affordable;
  - Effective regulation of tobacco products
  - Communications and education

Data Development

A request for postcode data of pregnant women who have a positive smoking status has been submitted to the information governance department at Leeds Teaching Hospitals Trust. This information will help in the monitoring of service provision compared with need.

Risks and Challenges any significant risks from the existing risk registers and/or any current challenges or issues with an impact on delivery

- Although a comprehensive tobacco action plan has been developed to include activity and actions suggested in the national plan there is a need for further investment to be able to deliver the plan on the scale needed to significantly change prevalence.

Meeting: Health and Wellbeing Board

Population: All adults in Leeds

Outcome: People are supported by high quality services to live full, active and independent lives.

Priority: Support more people to live safely in their own homes.

Why and where is this a priority: The vision for the future is to enable people, regardless of age, with complex health and social care needs, including those with mental health needs, to be cared for at home or closer to home avoiding the need for unplanned hospital attendances and admissions and reducing the need for long term admission to residential or nursing care homes.

Overall Progress: AMBER ⟷

The Story behind the Baseline

There has been an overall downward trend in the number of older people starting to require financial support by the Local Authority for permanent admission to care homes over the last seven years.

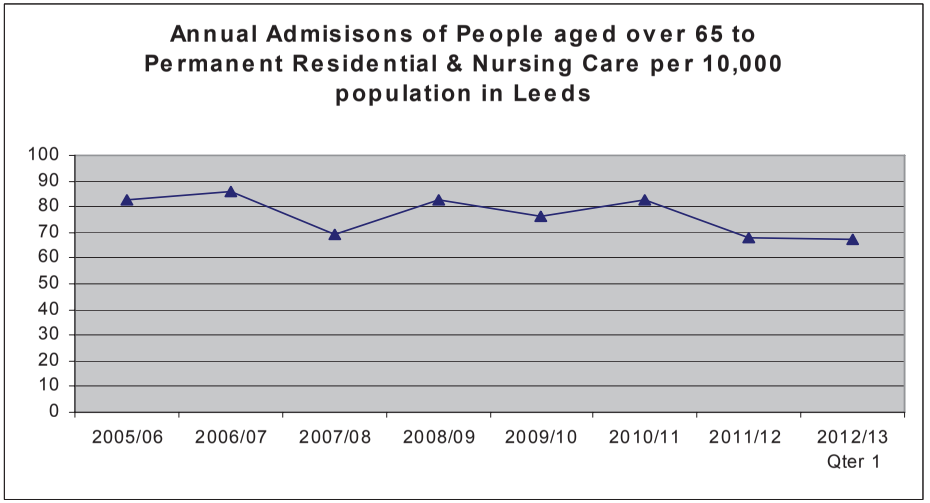
An analysis of average bed weeks purchased for older people show that:

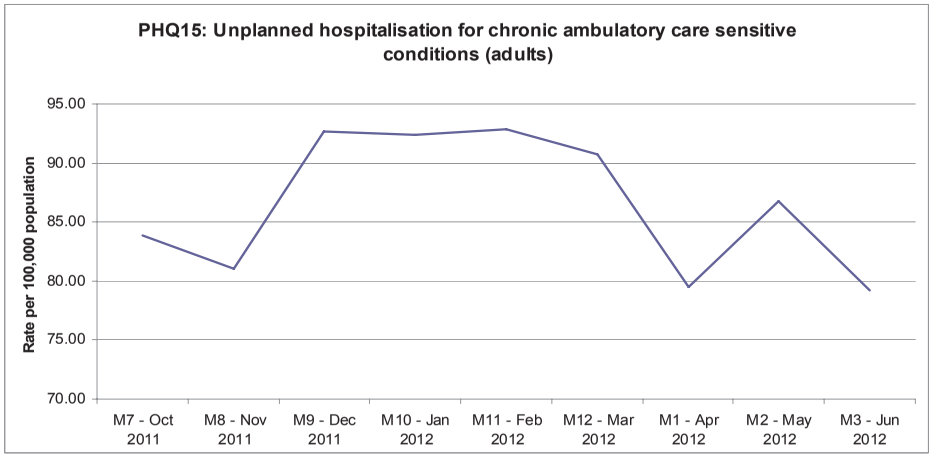
- Leeds commissioned 138,996 bed weeks in older people's care homes in 2011/12. This is a reduction of 3.2% over the previous year.
- Permanent nursing care bed weeks for older people reduced from 48,915 to 46,764 (4.4%) over the previous year.
- Permanent bed weeks for older people in local authority managed homes fell from 27,212 in 2010/11 to 22,932 in 2011/12 (15.7%).
- The number of permanent bed weeks commissioned in the independent sector remained almost the same as the previous year.
- At 31st March 2012 the Council supported 2,368 older people permanently in care homes. This is a reduction of 5.5%.

The figures suggest that older people are retaining independence for longer periods and are requiring care home support at later stages in their lives. Over the last few years the city has faced a number of challenges which have increased pressures upon the Local Authority to support people with their care. These include rising demographic pressures; an increasing number of older people who had previously funded their own residential and nursing care exhausting their own resources, and ongoing changes to the health delivery infrastructure generating short term pressures on community services as hospital ward places are reduced and investment is transferred into community alternatives.

What do key stakeholders think - The key messages from stakeholders:
Help people to continue to live independently in their own homes by meeting local needs locally, providing support closer to peoples homes means public money can be used more efficiently and effectively. People need access to high quality information to allow them to make informed choices about how and where they receive care.

Headline Indicators:





What we did:

Progress on the Holt Park Wellbeing centre continues following a 'turning of the sod' ceremony in February and is planned to open in Autumn 2013. Over the next few months focus will start to shift from design to operational issues and starting to determine greater detail about programming, partnership arrangements and procurement.

Reablement (SkILs) teams have been established across the city, and are now at full capacity. Pathways are open to receive referrals from the community, on existing service users and following hospital discharge. Performance data indicates that the service compares very favourably with national high performers, with 70% of customers requiring no ongoing package of care once reablement complete.

A revised JSNA with a sharper focus upon community and networks has been published in May 2012 and a joint information strategy for health & ASC is being agreed.

Through the Leeds Health and Social Care Transformation Programme the following key actions have been undertaken:

- Procurement of an interim contract for those patients currently in receipt of Telehealth provided by Bosch has been completed.
- Further Integrated Health and Social Care Team demonstrator sites have been identified in the following areas: Chapeltown, Armley and Hunslet.
- Leeds is one of only 6 pilots chosen from across the country to pilot the Year of Care. The pilot will test the proof of concept for the Year of Care funding model.

What worked locally /Case study of impact:

Margaret's story – After collapsing in November with Pneumonia Margaret was taken to ST James's hospital and went from being a vibrant lady to someone who had no confidence. Margaret also had other health issues such as asthma, heart failure and diabetes. "I could not even make a cup of tea let alone look after myself". The SkILs team became involved in supporting Margaret when she came out of hospital 'They chivvied me along and got me going' she adds, they gave me so much encouragement, they helped me with meals and helped me to wash and helped me make it. They are so kind especially Sue, Karen and Gail.

'It was a pleasure because Margaret is a trier explains Sue and Karen agrees.

'I cannot speak highly enough of these lovely girls' says Margaret ' long may they continue to help the community.

New Actions:

The new Integration of ICT and Reablement Project was officially launched on 23rd March 2012. An outline business case is now being developed, and a visioning workshop was held in May to review results from research, the options appraisal etc.

Further work is required to open remaining pathways for reablement to improve the Mental Health reablement service and align capacity and demand within the SkILs service. Options for an electronic brokerage system are also being explored. Work to establish reablement plans to be completed by September 2012.

Adult Social Care, health and partners are working to develop the 'AT Hub', a one stop shop for assistive technology in Leeds. A consultation event with older and disabled people will take place in September 2012.

A 2 year pathfinder has been established to develop personal health budgets (PHB) and personalised care planning (PCP) for individuals eligible for Continuing Health Care (CHC) Funding within NHS Leeds.

Through the Leeds Health and Social Care Transformation Programme the following key actions will be undertaken:

- Dementia – development of a city-wide strategy. A CQUIN indicator for secondary care to be monitored. The CQUIN aims to increase awareness around dementia as people are admitted to hospital.
- End of Life – development of a city-wide strategy is underway which will look to join up working between statutory and voluntary organisations.

Data Development:

Work to develop intelligence systems and sharing across social care and health continues. Health and social care are looking to procure software which can be used to collate and analysis data from both organisations.

Risks and Challenges:

- Adult Social Care and Health fail to develop and maintain effective partnership working and processes at locality and city-wide strategic level between partners to reduce health inequalities.
- There is a risk of inadequate resources being available to support Leeds Health and Social Care Transformation Programme and project infrastructure and the implementation stage of the projects.
- Adults' Social Care fails to deliver the whole of its Business Systems Transformation Programme.

Meeting: Health and Wellbeing Board

Population: All adults in Leeds

Outcome: People are supported by high quality services to live full, active and independent lives services.

Priority: Give people choice and control over their health and social care services

Why and where is this a priority The vision for the future is to enable people, regardless of age, with complex health and social care needs, including those with mental health needs, to be cared for at home or closer to home and to have increased choice and control over their health and social care services

Overall Progress:

GREEN ⟷

Story behind the baseline:

Leeds like many other cities has a large population whose needs include both social care and health services. Long term conditions account for 70% of health and social care costs, and almost three quarters of the gap in life expectancy between those living in the most deprived areas of Leeds and Leeds overall.

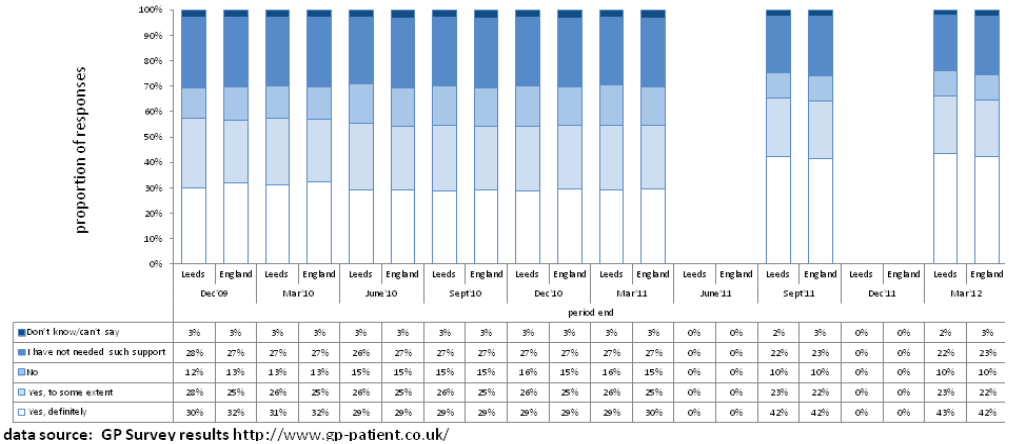
The statistics for Leeds follow the national trend of a slight increase in the negative experience people are feeling in terms of the support they are receiving to manage their long term condition.

'Transforming Social Care' LAC (DH) (2008) outlined the national policy for all people to be given the opportunity to design their support or care arrangements in a way that best suits their specific needs. At the end of 2009/10 17% of all service users had had this opportunity. By the end of 2010/11 this had increased to 29% of all service users (4,550 people). Final figures for the year end 2011/12 show that the target of 45% has been exceeded, with 52% of eligible community based service users being in receipt of self directed support.

Please note National and Local GP survey data collection is being undertaken on a bi-annual basis.

Headline Indicator: Increase the proportion of people with long-term conditions feeling supported to be independent and manage their condition.

National and Local patient responses to the GP survey Question
Had enough support from local services to help manage long-term health condition(s)



	Dec'09		Mar'10		June'10		Sept'10		Dec'10		Mar'11		June'11		Sept'11		Dec'11		Mar'12	
	Leeds	England	Leeds	England	Leeds	England	Leeds	England	Leeds	England	Leeds	England	Leeds	England	Leeds	England	Leeds	England	Leeds	England
Don't know/can't say	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	3%	0%	0%	2%	3%	0%	0%	2%	3%
I have not needed such support	28%	27%	27%	27%	26%	27%	27%	27%	27%	27%	27%	27%	0%	0%	22%	23%	0%	0%	22%	23%
No	12%	13%	13%	13%	15%	15%	15%	15%	16%	15%	16%	15%	0%	0%	10%	10%	0%	0%	10%	10%
Yes, to some extent	28%	25%	26%	25%	26%	25%	26%	25%	26%	25%	26%	25%	0%	0%	23%	22%	0%	0%	23%	22%
Yes, definitely	30%	32%	31%	32%	29%	29%	29%	29%	29%	29%	29%	30%	0%	0%	42%	42%	0%	0%	43%	42%

data source: GP Survey results http://www.gp-patient.co.uk/

What do key stakeholders think:

A survey was undertaken regarding Self Directed Support. The majority of people asked (65%) understood the concept of personal budgets and of the remaining number 19% couldn't remember having things explained and 7% said it was explained but they struggled to understand. 9% said that it wasn't explained.

When asked about the reasons for choosing the council to arrange services (if they did) the majority (55%) said that it was their choice. Of the rest, 17% liked the idea of having more control but were worried about finding the right services, or receiving the right advice. The remaining number (in roughly equal proportions) didn't really understand the other options, didn't have other options explained or thought that buying and arranging their own support sounded too hard.

What we did:

Two social workers recruited to work with carers improving access to personalised support including personal budgets. Work includes the development of systems for allocation.

Older People Residential & Day Care - Phase 1 of the Programme include de-commission of four day centres and three residential homes which is now complete, with a further two residential homes to be de-commissioned at a future date pending alternative provision. In addition there is a potential community Asset Transfer Bid at Dolphin Manor and integrated Community Intermediate Care in development at Harry Booth House.

Better Lives Programme - A proposed outline service model to transform Mental Health day services was presented to ASC Department Leadership Team on 7th June 2012 .Overall, the focus of the new model will be a 'move-on' policy, where service users are supported to recovery and do not become dependent on services. Next steps will include liaison with elected members, consultation with stakeholders from July-September 2012.

Through the Leeds Health and Social Care Transformation Programme, the following key actions have been undertaken:

- Roll out of Risk Stratification has continued across the city, with in excess of 450 Health and Social Care staff trained to use the risk stratification tool across the city.
- Further Integrated Health and Social Care Team demonstrator sites have been identified in the following areas: Chapeltown, Armley and Hunslet.

What worked locally /Case study of impact:

The Community Diabetes Specialist Nurse Service Feedback

- *The nurses were very knowledgeable and it has helped me with my diet control and helped me understand my diabetes. I wish I had known about this service much earlier"*
- *"The nurses have really helped me and I am feeling better in myself because my diabetes is now under control – which I could not manage before"*
- *It is a shame this course hasn't been around longer – as I feel my diabetes may have not got as bad as it has. This course is very useful – following week 2 my GP put me on Metformin and I feel much less tired and I feel much better. I would recommend anyone with diabetes to come on a course like this – my results are coming down and so hopefully my weight will also come down.*
- *I feel very grateful for all of the information and help given to me by the two excellent leaders on this course – they have taken away my fear of diabetes. Excellent 6 weeks with a brilliant team – I would highly recommend this course; I have also lost 1stone in weight whilst been on the course*

New Actions:

Work is being undertaken to develop a model with partners in the third sector which supports people to use their personal budgets to commission support services. Commissioners are currently developing the model in partnership with providers. The aim is to establish the service by the Autumn.

'Making it Real,' includes a framework for measuring progress in the establishment of personalised, community based support. Leeds Adult Social Care (ASC) has made a commitment to progress the delivery of personalisation in co-production with people who use services. A forum of service users has been identified to start identifying priority areas for improvement.

Progress continues in developing a model for utilising direct payments in community based organisations to extend choice and provide personalised support people with social care needs. Within the Combining Personalisation with Community Empowerment (CPCE) project 14 service users have been identified and support plans are being developed. Examples include enabling people to re-establish and maintain social networks as well as support with practical tasks such as meal preparation..

Better Lives Programme - A cross directorate project team is undertaking further work to analyse the demand and supply for older peoples housing and care options and will take a report to Executive Board in July 2012.

Through the Leeds Health and Social Care Transformation Programme, the following key actions will be undertaken:

- Year of Care Pilot – work will commence nationally to take this forward, Ensuring close links are made to the current integration agenda within Leeds. The pilot will commence in July 2012 for a 10 month period.

Data Development:

A revised JSNA with a sharper focus upon community and networks has been published in May 2012. Health and social care are looking to procure software which can be used to collate and analysis data from both organisations.

Risks and Challenges:

- Adult Social Care fails to manage the changing service and workforce requirements through the transformation programme to deliver personalised services within available financial resources.
- Adult Social Care and Health fail to develop and maintain effective partnership working and processes at locality and city-wide strategic level between partners to reduce health inequalities.
- There is a risk of inadequate resources being available to support Leeds Health and Social Care Transformation Programme and project infrastructure and the implementation stage of the projects.
- Adults' Social Care fails to deliver the whole of its Business Systems Transformation Programme.
- Insufficient or poor quality Business Intelligence has a detrimental effect on the ability to meet overall objectives.

Meeting: Health and Wellbeing Board **Population:** All people in Leeds

Outcome: Best City for Health and wellbeing **Priority:** Make sure that people who are the poorest improve their health the fastest.

Why and where is this a priority. 20 % of the population of Leeds live in the 10% most deprived Super Output Areas (SOAs) in England accounting for approximately 150,000 people. There are also significant numbers of vulnerable people living across Leeds. There are range of social, economic and environmental factors that affect their health and wellbeing and which are contributing to the growing health inequalities within Leeds for men and women by areas of deprivation: 1)There is a 10.1 year gap in life expectancy for men between City & Hunslet and Harewood (71.6 years:81.7years) 2)There is a 9.6 year gap in life expectancy for women between City & Hunslet and Adel/Wharfedale (76.1year:85.7years)

Overall Progress:

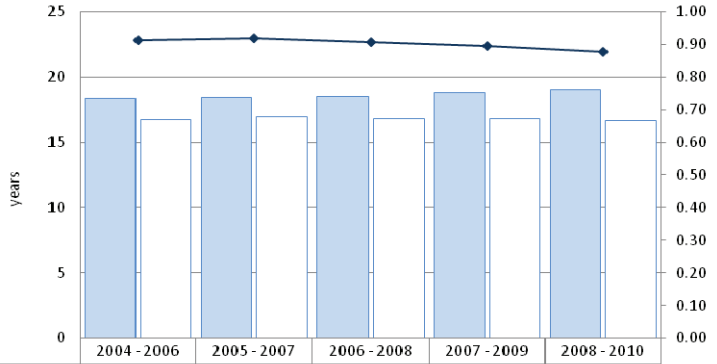
Red

Headline Indicator

- Reduce the differences in life expectancy between communities
- Reduce the difference in healthy life expectancy between communities

Story behind the baseline: Overall life expectancy in Leeds is increasing however there is a much lower level of life expectancy for those living the most deprived areas of Leeds and the absolute gap between these statistics is increasing. The key causes of premature mortality are cardiovascular disease, cancer, and respiratory disease. All premature mortality data for these diseases in Leeds have a significant gap between the rates in the non deprived areas and the deprived areas of Leeds. For some diseases such as respiratory and stroke mortality rates are showing an increase. Causes of mortality from these diseases are multifaceted and include the impact of the wider determinants of health such as housing, transport, employment and poverty, as well an individual's lifestyle (in relation to smoking/alcohol/physical activity and healthy eating) , and their access to appropriate and effective services.

Life Expectancy at 65, 2004-2006 to 2008-2010, three year averages, Leeds, Leeds Deprived



	2004 - 2006	2005 - 2007	2006 - 2008	2007 - 2009	2008 - 2010
Leeds	18.34	18.42	18.52	18.77	18.99
Leeds Deprived Population	16.75	16.92	16.77	16.82	16.63
Relative Gap Leeds Deprived* vs Leeds	0.91	0.92	0.91	0.90	0.88

data source: Hospital Episode Statistics (HES); GP registered Populations

What do key stakeholders think. The Vision for Leeds consultation confirmed that the public expected:

• people have the opportunity to get out of poverty; • education and training helps more people to achieve their potential; • communities are safe and people feel safe; • all homes are of a decent standard and everyone can afford to stay warm; • healthy life choices are easier to make; • people are motivated to reuse and recycle; • there are more community-led businesses that meet local needs; • local services, including shops and healthcare, are easy to access and meet people's needs; • local cultural and sporting activities are available to all; and • there are high quality buildings, places and green spaces, which are clean, looked after, and respect the city's heritage, including buildings, parks and the history of our communities.

What we did

Limit impact of poverty on children under 5 yrs:

- **Early Start Service**: Alignment and establishment of Early Start Teams completed. Programme of core workforce development for each Early Start Team in place. Integrated service specification agreed
- **Family Nurse Partnership** Third sector provider facilitating service user involvement in FNP Board .Positive feedback from DH FNP central team during last month's Annual Review. Sublicensing agreements signed with Department of Health to deliver FNP model in Leeds
- **Child Death Overview Panel** Annual Report 2011-12 published including analysis of causes of child death in Leeds and key recommendations

Increase advice and support to minimise debt and maximise income

- Introduced telephone Debt advice gateway with one common phone number for use across all advice agencies. Volunteers now operating three days a week (Mon, Tue, Fri) for 6 hours each day
- Fuel poverty mail-out completed to 9,500 households likely to be eligible for Government Warm Front scheme to increase take-up of heating and insulation measures.
- Promoting 'Wrap up Leeds' free loft and cavity wall insulation scheme, available to all, and targeted at low income areas with large number of suitable properties.
- Leeds has generated 39 hotspots referrals during April, 22 in May and 16 in June

Healthy Employment

- Working Well Steering Group developed action plan
- Commissioned Leeds Occupational Health Advisory Service to deliver occupational health for the City until 2014

Ensure equitable access to services that improve health

- All GP practices, prisons and York St practice for the homeless all now offering NHS Health Check
- Commissioned third sector to support sustained case finding of lung cancer in Inner East / Inner South Leeds by campaigns led by Community Health Educators

What worked locally /Case study of impact

'Come Dine with me' – led by Leeds Credit Union and Zest Health for Life in Meanwood has recruited 8 disengaged people through the school clusters network from the Beckhill estate. They learnt cooking skills and eating on a budget. All of them have stayed engaged with other group activities or have become volunteers. Zest is one of the third sector organisations commissioned to provide Community health development.

New Actions

Limit impact of poverty on children under 5 yrs:

- **Early Start Service:** Expansion of service agreed over next 3 years through additional Health Visitor resource. Performance dashboard in development to measure coverage and impact of transformation. Implementation of service to be completed by September 2012
- **Infant Mortality:** Develop social marketing materials from findings of insight work with Pakistani community on understanding of genetic risk and cousin marriage
- Evaluation of co-sleeping social marketing campaign completed by Autumn 2012
- Helping Hand training rolled out to every team from July 2012
- E learning for GPs to increase breastfeeding to be launched
- Mothers Learning about Second Hand Smoke scheme will develop resources and an intervention based on findings from focus groups

Increase advice and support to minimise debt and maximise income

- Review underway to explore funding and location of debt advice
- Fuel poverty: Work with city region to develop Green Deal/ECO framework assisting vulnerable people particularly living in older, hard to treat properties; involving community groups and employers.
- Affordable credit: Further funding being explored.

Healthy Employment

- Explore expansion of Leeds Occupational health Advisory Service
- Work with those supporting people into employment to increase understanding and links to mental health services
- Develop toolkit to increase economic development through improving health and wellbeing of staff

Ensure equitable access to services that improve health

Wellbeing portal: website that provides information on services that are in place across Leeds to improve health and wellbeing will be launched with professionals and the public

Data Development

- Detailed reports on outputs from NHS Health Check to be completed
- Results from Healthy Lifestyle survey using the Citizens Panel and extended use of Healthy Lifestyle survey with priority populations to increase understanding of lifestyle behaviour

Risks and Challenges

- Reduced incomes for households in Leeds as a result of the economic climate and the national changes to benefits and tax credits system
- Sustainability of and scale of funding available to meet the needs of the size of the population in Leeds
- Increase in energy prices and other costs living with increases risk to health and wellbeing of more vulnerable people
- Impact of economic recession

2012/13 Adult Social Care Directorate Scorecard

Reporting Period : **Quarter 1 2012/13**

Contribution to Cross Council Priorities	Progress Summary	Overall Progress	Supporting Measures	Target	Q1	Q2	Q3	Q4	Executive Portfolio
Appraisals	A large piece of work has been carried out on ensuring that the SAP structures are correct. Processes have been agreed for those ASC staff who are managed by Health employees and exemptions agreed for those staff on maternity leave, long term sickness and career breaks. Appraisal Champions and local HR staff have all been trained on the Performance and Learning system to support managers in the use of the PAL system. HR/OD Business partners have attended Senior Management Team meetings to ensure all appraising managers are briefed on the Performance and Learning System and the deadlines for inputting to the PAL system. Progress updates are taken to DSMT and DLT.	Amber	Every year 100% of staff have an appraisal	100%	N/A				Neighbourhoods, Planning and Support Services
Staff Engagement	Overall the findings from Q1 demonstrate very little change from the November survey, however there are some notable changes at Service level. HR Business Partners are discussing the findings at Service level at Senior Management Team Meetings and action plans are being amended appropriately. A series of Employee Engagement events have been delivered. The events planned for October/November are currently being promoted on the Adult Social Care Learning and Development calendar.	Amber	increase the level of staff engagement	74%	71%				Neighbourhoods, Planning and Support Services
Consultation	There was 100% compliance with the criteria. Quality assurance showed a mix of very good and acceptable report-writing in section 4.1. The report on Neighbourhood Network contract renewals in East Leeds gave very good detail on the process, outputs and outcome of user involvement, and showed how users can be involved in procurement. However, other reports were comparatively light on the details, in particular on what impact, if any, user views had on the final decision. Reports that state that consultation will take place in future would benefit from giving at least an outline of the scope of these proposed activities. Also, reports that reference historic consultations as evidence need to provide summaries or links to background papers showing the extent and results of that work.	Green	Every year we will be able to evidence that consultation has taken place in 100 per cent of major decisions affecting the lives of communities	100%	100%				Leader
Equality	Improvements have been made this quarter. A QA has been undertaken to determine how due regard to equality is demonstrated within reports. Overall across the board, report writers are complying with the requirements of the report writing guidance with relevant narrative explicitly referencing potential impacts and findings from the screening and EIAs. Only a few minor improvements are needed in terms of ensuring that EIAs and screening forms are routinely referenced with Background papers. The outcomes from the QA exercise will be discussed within the Directorate to inform future reports and the report clearance process.	Green	Every year we will be able to evidence that equality issues have been considered in 100 per cent of major decisions	100%	100%				Leader
Keep within budget	Overall this directorate is projecting a balanced position, although the delivery in full of all budgeted savings carries some risk and cannot yet be confirmed.	Green	No variation from agreed directorate budget in the year	£0	£49k				Leader

Directorate Priorities	Progress Summary	Overall Progress	Supporting Measures	Target	Q1	Q2	Q3	Q4	Executive Portfolio
Deliver the Health and Wellbeing City Priority Plan	Work is in train to develop a Health and Wellbeing Strategy. This builds upon the current Health and Wellbeing City Priority Plan and allows for emerging priorities based upon; progress to date, analysis of the new JSNA and a wide range of consultation with key stakeholders.	Green	N/A	N/A	N/A	N/A	N/A	N/A	Health and Well Being
Help people with poor physical or mental health to learn or relearn skills for daily living	The new Integration of ICT and Reablement Project was officially launched on 23rd March 2012, and project management and governance arrangements agreed. An outline business case is now being developed, and a visioning workshop was held in May to review results from research, the options appraisal etc. In July presentation of the model for integration will be made to the Health and Social Care Integration Programme Board. Reablement (SkILs) teams have been established across the city. Acitvity has been limited by shortage of supervisors. The Directorate are looking to make up this shortfall from supervisors currently within the long term home care service or to recruit to vacancies where this is not possible. Pathways are open to receive referrals from the community, on existing service users and following hospital discharge. Performance data indicates that the service compares very favourably with national high performers, with 70% of customers requiring no ongoing package of care once reablement complete	Amber	Increase the number of people successfully completing a programme to help them relearn the skills for daily living.	2000	187				Adult Social Care / Health and Well Being

2012/13 Adult Social Care Directorate Scorecard

Reporting Period : **Quarter 1 2012/13**

Extend the use of personal budgets	Leeds Adult Social Care exceeded it's target in 2011/12 to ensure 45% of people were in receipt of self directed support with 52% of eligible service users meeting the criteria. Although progress to date has been steady, it will need to take a further step change forward if Leeds is going to meet local ambitions to ensure that self directed social care is available to all. The major vehicle for the development of personalised social care is through the 'Think Local Act Personal' concordat. A part of this work is 'Making it Real,' which includes a framework for measuring progress in the establishment of personalised, community based support. Leeds Adult Social Care (ASC) has made a commitment to progress the delivery of personalisation in co-production with people who use services. A forum of service users has been identified to start identifying priority areas for improvement.	Amber	Increase percentage of service users and carers with control over their own care budget	100%	42%				Adult Social Care
	A survey about self directed support was undertaken with social care service users during April and May 2012. The results show that the majority of people who don't manage their own support choose council managed support. A proportion, however, said that they chose not to manage their own budgets as they are concerned about how they will find services, etc. These results will inform further work to increase support for people to use direct payments. Two social workers recruited to work with carers improving access to personalised support including personal budgets. Work includes the development of systems for allocation. A project has been established to develop personal health budgets (PHB) and personalised care planning (PCP) for individuals eligible for Continuing Health Care (CHC) Funding within NHS Leeds. This is a two year DH approved pathfinder project to develop systems and processes and facilitate a culture shift in commissioning behaviours and care planning		Increase percentage service users who feel that they have control over their daily life.	85%	68%				
Improve the range of daytime activities for people with eligible needs	A proposed outline service model to transform Mental Health day services was presented to ASC Department Leadership Team on 7th June 2012 .Overall, the focus of the new model will be a 'move-on' policy, where service users are supported to recovery and do not become dependent on services. Next steps will include liaison with elected members, consultation with stakeholders from July-September 2012. A report with recommendations will go to Executive Board in November 2012. Continue to roll out the day service modernisation programme in the south and west of the city for adults with learning disabilities. Undertake an options appraisal about the future service delivery model in the east of the city in advance of seeking approval to implement the model in that area of the city.	Green	N/A	N/A	N/A	N/A	N/A	N/A	Adult Social Care / Health and Well Being
Ensure more people with poor physical or mental health remain living at home or close to home for longer	Adult Social Care, health and partners are working to develop a one stop shop for assistive technology in Leeds - the 'AT Hub',. The project is at the stage of the outline design for the building refurbishment and establishing detailed costs and timescales. A consultation event with older and disabled people will take place in September 2012.	Green	Reduce number of bed weeks care in residential and nursing care homes for older people supported by the local authority	138000	32117 (est year end 128469)				Adult Social Care / Health and Well Being
Support adults whose circumstances make them vulnerable to live safe and independent lives	At the end of 2011/12 Adult Social Care had received 3,430 referrals with a safeguarding reason of which 36% led to an investigation. 38% had an outcome of log details only and the remainder led to some other type of activity such as an assessment or unscheduled review.	Amber	Increase percentage of safeguarding referrals which lead to a safeguarding investigation	45%	29.5%				Adult Social Care / Health and Well Being
Ensure resources are efficiently matched and directed towards those with greatest need	Transformation programmes are on course to deliver savings from directly provided services	Green	Delivery of efficiency savings for directly provided services	£7.2m					Adult Social Care
Provide easier access to joined-up health and social care services	Development of a joint information sharing protocol for Health and Adult Social Care is progressing and will be presented to the Leeds Informatics Board. This will underpin the sharing of information / data across the Integrated Health and Social Care Teams.	Green	Reduce number of delayed discharges from hospital due to adult social care only (per 100,000 adult population per week)	1.50 (9.28 people per week)	1.92				Adult Social Care / Health and Well Being
People with social care needs receive coordinated and effective personalised support from local health and wellbeing agencies	The Leeds Health and Social Care Transformation Programme, continues work to coordinate and integration support from health and social care agencies. The roll out of Risk Stratification has continued across the city, with in excess of 450 Health and Social Care staff trained to use the risk stratification tool. Further Integrated Health and Social Care Team demonstrator sites have been identified in the following areas: Chapeltown, Armley and Hunslet. This is in additional to the three that have been established. There are 12 planned across the city - 4 per area Work continues on Mental Health Area Teams integration. Consultation with social workers is underway regarding secondment and a partnership agreement being drafted. The original timescale of March 2012 to have the partnership agreement in place will not be met resulting in slippage of timelines for transfer, but this will not delay development and implementation of the integrated service model.	Green	Increase proportion of older people (65 and over) who were still at home 91 days after leaving hospital into rehabilitation services	90%	89.5%				Health and Well Being

2012/13 Adult Social Care Directorate Scorecard

Reporting Period : **Quarter 1 2012/13**

Encourage existing and new kinds of enterprise to develop in the Leeds care market which will provide a variety of services that are geared to respond to people's specific needs.	Work is being undertaken to develop a model with partners in the third sector which supports people to use their personal budgets to commission support services. Commissioners are currently developing the model in partnership with providers and have identified a number of service users interested in using the service. The aim is to establish the service by the Autumn 2012. Progress continues in developing a model for utilising direct payments in community based organisations to extend choice and provide personalised support people with social care needs. Within the Combining Personalisation with Community Empowerment (CPCE) project 14 service users have been identified and support plans are being developed. Examples include enabling people to re-establish and maintain social networks as well as support with practical tasks such as meal preparation. A great deal of work is ongoing to develop the model, including tools and arrangements between partners.	Green	N/A	N/A	N/A	N/A	N/A	N/A	Adult Social Care
Create a mosaic of types of housing (including residential and extra care) with support suited to and adaptable for people's changing needs.	Better Lives Programme - A corporate initiative "The Older People's Housing and Care Programme" has combined the knowledge of City Development, Environment and Neighbourhoods and Adult Social Care to assess the demand, the delivery route and the design of future accommodation for older people. The outcome of this work which includes a detailed analysis of demographics, communities, current provision, planned provision and development opportunities will help to achieve affordable housing and care options on a city-wide basis. A report to go to Executive Board in Autumn 2012. Phase 1 of the Older People's Residential & Day Care Programme included the de-commission of 4 day centres and 3 residential homes, with a further 2 residential homes to be de-commissioned at a future date pending alternative provision. In addition there is a potential Community Asset Transfer Bid at Dolphin Manor and integrated Community Intermediate Care in development at Harry Booth House. The Leeds Dementia Strategy (2012) is being developed with an overarching plan to make Leeds a dementia friendly city. This will support people with dementia to live their lives to the full as part of the community. Leeds Adult Social Care has introduced a "quality framework" for residential and nursing home care. This will require providers to sign-up to a set of quality standards that are directly related to the care fee. This will give the Council greater influence over the cost and quality of independent sector care.	Green	N/A	N/A	N/A	N/A	N/A	N/A	Adult Social Care
Creating the environment for partnership working so that a range of Adult Social Care and Health services will become more closely integrated and people's experience of the support they receive in older age, illness or disability will be more positive	Leeds continues to work to work in partnership to pilot approaches which enable the identification of people who are most a risk of losing their independence and enabling them to manage long term conditions through a unified proactive approach. Recent work through the Leeds Health and Social Care Transformation Programme; • Roll out of Risk Stratification has continued across the city, with in excess of 450 Health and Social Care staff trained to use the risk stratification tool. Self-management approaches are being developed at a neighbourhood level in conjunction with service users and the voluntary sector. • Further Integrated Health and Social Care Team demonstrator sites have been identified in the following areas: Chapeltown, Armley and Hunslet in addition to the initial three.	Green	N/A	N/A	N/A	N/A	N/A	N/A	Adult Social Care / Health and Well Being

City Priority Plans	Overall Progress	Headline Indicator	Q1	Q2	Q3	Q4	Executive Portfolio
Make sure that more people make healthy lifestyle choices.	Amber	Reduce the number of adults over 18 that smoke.	22.7%				Health and Well Being
Support more people to live safely in their own homes.	Amber	Reduce the rate of emergency admissions to hospital.	See report card				Adult Social Care / Health and Well Being
		Reduce the rate of admission to residential care homes.	See report card				
Give people choice and control over their health and social care services.	Green	Increase the proportion of people with long-term conditions feeling supported to be independent and manage their condition.	42%				Adult Social Care / Health and Well Being
Make sure that people who are the poorest improve their health the fastest.	Red	Reduce the differences in life expectancy between communities	See report card				Health and Well Being

Self Assessment

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Leeds CITY COUNCIL

Report author: Steven Courtney
Tel: 24 74707

Report of Head of Scrutiny and Member Development

Report to Scrutiny Board (Health and Well-Being and Adult Social Care)

Date: 26 September 2012

Subject: NHS Airedale, Bradford and Leeds Corporate Performance, Quality and Safety Transitional arrangements and the Corporate Performance Report – September 2012

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

Summary of main issues

1. To complement the 2012/13 Quarter 1 performance report (presented elsewhere on the agenda) members of the Scrutiny Board are presented with a copy of a report presented to the NHS Airedale Bradford and Leeds Cluster Board in July 2012. This report details the transitional arrangements for Corporate Performance, Quality and Safety, as Leeds' three Clinical Commissioning Groups progress through the authorisation process, ahead of their formal and statutory duties from April 2013. A summary of the report is also provided.

2. In addition, members will also be presented with the September 2012 performance report scheduled to be considered by the NHS Airedale Bradford and Leeds Cluster Board at its meeting on 28 September 2012. At the time of writing this report, that report was not publicly available, but will be issued ahead of the meeting – as a supplementary paper.

3. The performance report will provide an overview of performance against key performance indicators for both NHS Leeds and NHS Bradford and Airedale (i.e. the constituent Primary Care Trusts of the NHS Airedale Bradford and Leeds Cluster). The report will highlight the key performance issues facing the Cluster organisation.

Recommendations

4. That Members consider the information presented in the NHS Airedale Bradford and Leeds Cluster Board reports and identify any areas where additional information is needed and/or that require further scrutiny.

Background documents [1]

- None used

[1] The background documents listed in this section are available for inspection on request for a period of four years following the date of the relevant meeting. Accordingly this list does not include documents containing exempt or confidential information, or any published works. Requests to inspect any background documents should be submitted to the report author.

Summary of agreed changes to performance management systems, in the transition to CCG management.

1 Background

1.1 The NHS is undergoing structural changes, in which PCTs will cease to exist after Mar 31 2013. The functions of the PCT are to move, in large part, to new bodies, known as Clinical Commissioning Groups (CCGs). These new bodies are to be led by GPs. There will be three CCGs in Leeds, known as Leeds North, Leeds West and Leeds South & East. Some of the work of the three Leeds' CCGs will be conducted collaboratively, where it makes sense to work this way.

1.2 Some of the 'backroom' support work in commissioning healthcare for the people of Leeds will move to a new body, covering the whole of West Yorkshire. This body will be the West Yorkshire Commissioning Support Unit (WYCSU). It will not be an accountable body in the same way the CCGs will be, but will simply work to support the discharge of the duties of the CCGs.

1.3 Due to the changes, it will be necessary to transfer some processes, duties and responsibilities, including performance matters, over to the new bodies, with CCGs being held to account for large parts of the performance of the NHS, through a developing system known as the Commissioning Outcomes Framework (COF).

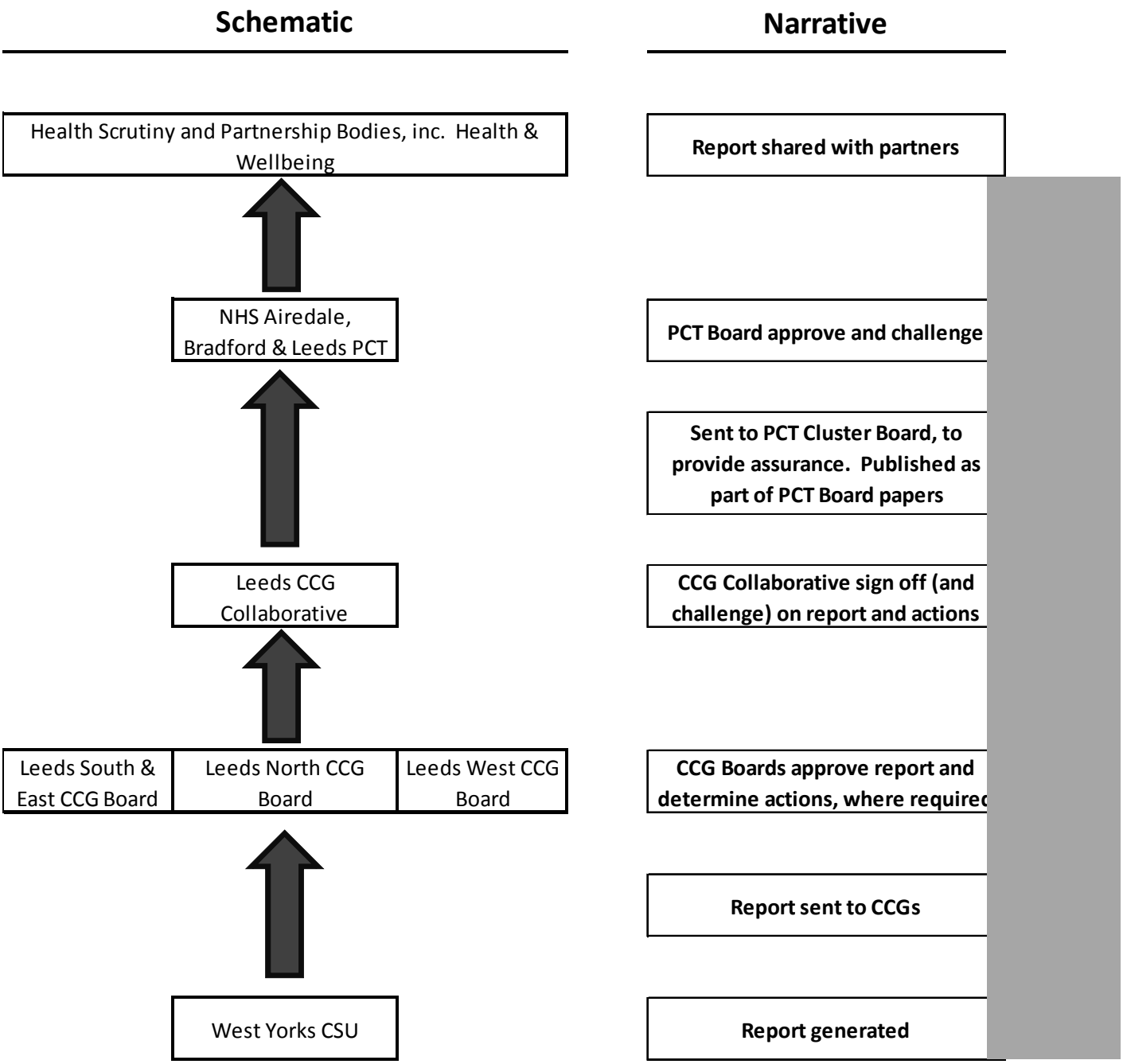
2 Information

2.1 It has been agreed that, to facilitate the move to the new bodies, performance matters for the Leeds patch will be delegated to the CCGs. This has been brought into effect by the agreement of the CCGs and the PCT Cluster Board to the attached more detailed paper. A diagram is also provided overleaf to help explain the process in strategic terms.

2.2 In principle, the process is fairly simple. It involves routing the reporting of performance to CCGs, rather than the PCT Board. The PCT though will secure assurance on performance matters from the CCGs. It will be the responsibility of the CCGs to direct action with health providers, where performance is not to expectations. CCGs will then provide information on performance and associated remedial actions, should they be required, to the PCT Board. This process will then close the governance loop. It will mean that CCGs will formally sign off on performance reports and any actions, but so will the PCT Board.

2.3 The delegation of performance (and other) matters to CCGs is seen as essential to the authorisation process that all CCGs have to take part in. CCGs are already taking a lead in some of the partnership bodies on behalf of the NHS in Leeds, including some of those with Leeds City Council.

2.4 The WYCSU will support the work on performance for the CCGs, by providing performance reports to CCGs and by working with CCG teams to ensure that performance actions are recorded and reported accurately. It will do this by using NHS data provided through the NHS Information Centre.


Schematic
Narrative
Health Scrutiny and Partnership Bodies, inc. Health & Wellbeing
Report shared with partners
NHS Airedale, Bradford & Leeds PCT
PCT Board approve and challenge
Sent to PCT Cluster Board, to provide assurance. Published as part of PCT Board papers
Leeds CCG Collaborative
CCG Collaborative sign off (and challenge) on report and actions
Leeds South & East CCG Board
Leeds North CCG Board
Leeds West CCG Board
CCG Boards approve report and determine actions, where required
Report sent to CCGs
West Yorks CSU
Report generated

NHS

NHS Airedale, Bradford and Leeds

	Agenda Item: PU2012/90	
DATE OF BOARD MEETING: 26 July 2012	**Category of Paper** **Tick(✓)**	
Executive Director Lead: Philomena Corrigan, Director of Delivery & Service Transformation	**Decision and Approval**	
Paper Author: Graham Brown	**Position Statement**	✓
Paper Title: Corporate Performance, Quality and Safety Transition Proposal	**Information**	
	Confidential Discussion	

SUMMARY

1. This paper has the purpose of describing the processes to establish how CCGs in the ABL Cluster will deliver and manage corporate performance and quality matters.

2. The paper is set out in three sections. This section describes the process that will provide for the PCT Cluster to receive assurance from CCGs on performance and quality matters, with the purpose of enabling the PCT Cluster to discharge its performance obligations, as required by DH. Two appendices cover the processes that CCGs will use in managing the performance and quality agenda, covering Leeds CCGs and Bradford & Airedale CCGs.

3. The development of CCGs and the pathway to authorisation of them as fully accountable bodies requires them to take charge of many of the duties and responsibilities of the PCT. Performance and quality issues are a significant part of this. The PCT Cluster though will remain as the accountable body until the point of CCG authorisation is reached. This means that if CCGs take the responsibility of managing corporate performance and quality during the time leading up to full authorisation, they will have to provide both solid governance and robust assurance back to the PCT.

BACKGROUND

4. Presently, the performance and quality agenda is covered by a combination of monitoring, improvement reporting and active management. Performance and quality data is generated and flows towards compilation of a performance and quality report, which is interpreted and analysed and is then forwarded to Senior Management. At this stage active Performance Management and assurance mechanisms takes place through either the Contract Management Board or individual performance and quality meetings with providers. These processes are supported through reporting to the Trust Board formally bi-monthly, formal sub-committees, executive team meetings and informally to senior managers, often resulting in decisions to generate actions in response to adverse quality concerns and performance. During the remainder of 2012/13 performance reporting to the Board remains the responsibility of the Director of Delivery & Service Transformation who should gain assurance form the CCGs. Which in the case of key access standards (A&E 4 hour wait, 18 week RTT etc…) will be LTHT - Leeds West CCG;

BTHT – Bradford Districts CCG; and Airedale Hospital – Airedale, Wharfedale & Craven CCG

5. In the immediate and medium term future, performance and quality management and governance arrangements are set to be more diversified, in that there are a greater number and range of bodies becoming involved. The process surrounding decisions on actions in response to poor performance and quality issues needs to clearly communicated

6. It also means that processes will have to be established that bridge the gap between the present and the future states, ensuring that sufficient grip is maintained on performance and quality matters. The main risks in not delivering this are that performance and quality issues go unchallenged, and the PCT reputation is damaged, and that the CCG authorisation process could be delayed. To do nothing though, by maintaining central PCT control is also damaging, in that the CCGs would find it extremely difficult to gain authorisation, if they have not taken control of this key element of their future work

PROPOSALS

7. The proposals in this section of the paper are described in strategic terms. They are intended to provide a clear statement describing the relationship between the local CCGs and the PCT Cluster. The main aim is to ensure that as the accountable body, the Cluster PCT, in delegating responsibility for performance and quality management matters to CCGs, receives robust assurance that performance and quality remains on track. Where performance and quality in any area is not positive, the PCT Cluster will need to be assured that the appropriate action is being taken.

8. The key principles are that:

- This arrangement will be in place until CCG authorisation is gained, or March 31 2013,. The arrangements detailed here will take immediate effect.
- Performance and quality reporting on the NHS Operating Framework 12/13, the NHS Outcomes Framework and quality dashboard (when launched) will be undertaken by CCGs. This will be delivered through support to CCGs from staff currently within the Cluster with the appropriate CCG staff and under CCG direction.
- Performance and quality reporting and management of matters outside the Operating Framework and Outcome Framework will be under the control of CCGs directly and do not directly form part of this programme.
- CCGs will provide, through monthly meetings at the collaborative level and joint monthly CCG/Cluster EMT meetings, written assurance to the PCT Cluster (using the performance and quality reports as evidence, amongst other things), on all corporate performance and quality matters.
- CCGs will take the chair and leadership of all provider contract management bodies. This will be on the basis of the lead CCG for specific contracts.
- CCGs will take the chair and leadership of provider quality and safety forums.
- CCGs will direct and lead the processes around determining the actions to be taken where performance and quality is not at the required level, in conjunction with service providers.
- Agreed performance remedial actions and any associated plans will be presented within the collaborative contacting framework contractual

penalties, task and finish groups for urgent issues and escalation to CQC if required,

- The PCT Cluster will provide challenge back to CCGs, where performance and quality is adverse or where there is a risk that it will be in the future. The forum for this will be EMT and the bi-monthly Trust Board meeting.
- CCGs will be required, as part of this challenge process, to ensure that they provide evidence of the required 'grip' of individual performance and quality issues, through a clear audit trail of actions and responses to instances of adverse performance.

9. Appendix 1 and 2 describe how the CCGs will organise how the performance and quality issues and addressed across the health economy.

SAFEGUARDING

10. Safeguarding functions will be delegated to CCGs in Bradford and Airedale, however it will remain with the Cluster Director of Quality and Nursing in Leeds until such time the Executive/ senior nurse for West, South and East and North is in post. This is time limited as recruitment for the CCG nurses are imminent.

NURSING LEADERSHIP AND NURSING/CARE STANDARDS

11. Likewise, in the absence of the Executive /Senior Nurse in Leeds, nursing leadership and nursing/care standards will remain with the Cluster Director of Quality and Nursing, supported by CCG aligned staff , for example the Clinical Quality Manager and Head of CHC. In Bradford and Airedale, the current quality and nursing team will be managed on an interim basis by designated CCGs, to maintain business continuity, in the first instance and until new CCG structures are put in place.

12. Effective working relationships between the CCGs in Leeds and the current cluster nurse will need to be agreed so as not to fragment the assurance on the totality of the quality agenda.

RECOMMENDATIONS;

13. The Board are ask to:

(a) **endorse** the implementation of the following actions:

i. Staff currently undertaking performance monitoring and management functions being managed on an interim basis by designated CCGs to maintain business continuity
ii. Staff currently undertaking functions related to quality and safety being managed on an interim basis by designated CCGs to maintain business continuity
iii. Safeguarding staff in Bradford and Airedale PCT being managed on an interim basis by designated CCGs to maintain business continuity
iv. Safeguarding staff in Leeds PCT remaining under the leadership of the Director of Nursing for the PCT cluster until substantive appointments are mage to the CCGs Director of Nursing role
v. The cluster PCT receiving a report to EMT monthly detailing performance, quality and safety indicators and actions
vi. The Trust Board also receiving a report detailing performance and quality issues and action plans from the CCGs
vii. The Accountable Officers of each attending EMT monthly and the Trust Board when scheduled for the remaining of the transition period.

Appendix 1

Leeds CCGs: Corporate, Quality and Performance Management Framework

1. Summary and Introduction

This report sets out proposals for CCGs to develop a system with the purpose of managing performance reporting and monitoring, quality reporting and the reporting of outcomes during and beyond the transition.

The structure will describe how the NHS Operating Framework 2012/13 will be delivered and reported throughout the year, but as importantly, it will set out a process to preparing for implementing the NHS Commissioning Outcomes Framework from 2013/14 and broader quality assurance mechanisms required.

In addition the proposed approach would;-

I. provide assurance that its statutory duties are being met and that CCGs are effectively both contributing to delivery of NHS indicator targets and that they take full ownership of the full scope of commissioning responsibilities.

II. provide CCGs with evidence of their collaborative commissioning governance arrangements for the CCG authorisation process

III. prepare CCGs for implementing the NHS Commissioning Outcomes Framework in 2013/14 and other quality assurance measures such as those in the NQB quality dashboard (soon to be launched)

IV. confirm the performance and quality indicators for reporting and for broader governance functions.

It is important that the reports and infrastructures proposed here should be seen as developmental which will also allow flexibility to adapt to meet the needs of CCGs whilst ensuring appropriate assurance to the cluster executive and Board that CCGs are fulfilling their delegated responsibilities.

It is clear that CCGs will also have their own reporting format and arrangements to support their local member Practices and local priorities for improved patient experience and broader quality improvement, which this structure can complement and combine with if required.

2. Background

PCTs are accountable for high quality services and targets agreed with the SHA for delivering the Operating Framework during 2012/13 and broader

quality outcomes. However, during this year, CCGs are also required to demonstrate their contribution to performance delivery, quality, and that robust systems and processes are in place to support authorisation. At the point of authorisation it is clear that CCGs will become fully responsible for performance delivery and securing high quality care for the population within the overall duties required of commissioning organisations. This includes effective clinical, corporate and financial governance.

The Leeds CCGs have been demonstrating their ability to take on performance management functions in partnership with the Cluster PCT, for example in chairing the Health and Social Care Transformation Board. This proposal builds on that experience, enabling CCGs to further demonstrate their readiness to take on the responsibility for performance and other commissioner duties such as quality - patient experience, clinical effectiveness and patient safety (including safeguarding).

3 Collation of Performance and quality intelligence:

City wide and CCG-level indicators, whether addressed by the Collaborative Forum or individual CCGs, would in the future be compiled by the Commissioning Support Service, which would also produce a commentary to accompany detailing actions. In the interim it is proposed that staff undertaking the functions of Performance, quality, corporate and clinical governance and information are aligned to Leeds West CCG.

4 CCG Governing Body

Initially, performance and quality data will need to be collated and reported, but as CCGs develop local commissioning priorities new indicators will be added.

Each CCG Governing body will receive a monthly report which will cover;

1) All indicators which were previously presented to the Cluster Board broken down to either City wide or CCG level,

2) Narrative explanation on the actions being taken to address the performance issues,

3) Quality standards and measures that are not covered by the national performance systems, including – workforce data, professional standards, complaints; serious incidents, patient & public involvement. This will also include key external report such as regulatory activity by CQC and monitor.

CCGs will also receive monthly reports on resource and reform indicators, including QIPP service transformation milestones.

In the interim these performance reports will continue to be collated by staff in the quality, governance and performance function of the PCT and aligned on an interim management basis to Leeds West CCG until the Commissioning Support Service is established.

5 The role of Contract Management Boards;

Each CCG is taking responsibility for leading provider Contract bundles as listed below;

North CCG – LYPT
West CCG – LTHT
South/East CCG – Leeds Community healthcare Trust, third sector, nursing homes

Each Accountable Officer will chair the Contract Management Board which will discuss activity, finance, performance, quality and patient safety. Representation from respective CCGs is achieved by attendance at the Provider Management Groups which meet monthly.

6 Other systems

The recently released NHS Performance Framework has to be implemented by non-FT hospital trusts and has to be included in contract performance monitoring. A similar system also applies to FTs, but this is managed by Monitor.

Other national and city wide performance and quality requirements will almost certainly need to be mapped to the proposed reporting systems. This includes for example, the Leeds City Council led Children's Outcome Framework, where joint planning and monitoring for shared LA & CCG indicators might be through the Children's Trust Board or the Health & Wellbeing Board and also contribution to the statutory Leeds Safeguarding Children's Board (LSCB) and equivalent for adults, Safeguarding Adults Board (SAB). The CCGs will also support the delivery of public health measures and innovations, specifically where these read across to the Commissioning Outcomes Framework.

7 The role of the CCG Collaborative Commissioning Forum

The Collaborative Commissioning Forum would oversee collaborative commissioning arrangements in relation to performance and quality issues, and ensure that effective risk management strategies are being deployed across the system. It would consult with CCG Clinical Senates and other professionals on strategic and planning issues arising from performance and quality improvements, for example where patient pathways and experience of care need to be improved. It would not replace or duplicate the accountability or

responsibility of individual CCG Governing Bodies . All performance indicators will be reported at the CCG level, unless there is a justification for not doing this.
The main purpose of the Forum is to ensure that city wide issues are discussed collaboratively to ensure the strategic or political consequences of proposed decisions are agreed and understood. In a health economy as large as Leeds this is crucial.

The Forum would be chaired by CCG Accountable officers. Chairs of provider contracting and quality groups will invited, if required, to consider areas of risk flagged in their commentary.

It is envisaged that the Forum would address performance and quality issues where:

I. Provider-level specific data only is available, and where that is not disaggregated at CCG level

II. Citywide benchmarks need to be agreed

III. Data to support performance delivery is only available at Leeds whole city level

IV. Quality assurance and improvements are required across providers

8 CCG level performance activity and patient experience - GP practice indicators

There may be cases where outcomes data is readily available at CCG but not at member Practice level. Examples of this type include mental health crisis resolution/home treatment. There may be opportunities to use GP level data to compare with national definitions and therefore allow benchmarking, comparison and further analysis to seek improvements in the care pathways.

9 Shared local authority (and Public Health) and NHS outcome indicators

Public health mortality and morbidity outcome indicators form part of the Joint Strategic Needs Assessment (JSNA).

Public health analysts compile the public health and morbidity and mortality reports on behalf of CCGs and Leeds City Council. CCGs will offer commentary on their plans, as they contribute to jointly held indicators, and it is proposed this will be provided by the lead CCG where they hold the lead contracting responsibility. CCGs will need to work with PH to ensure a dovetailing of measures across health and public health – for example harm and avoidable deaths, infection prevention and control, and public safety.

Indicators relevant to services for children and young people would be reported to and assured by the Children's Trust Board (CTB) and Leeds Safeguarding Children's Board (LSCB).

10 Preparing for the NHS Commissioning Outcomes Framework for 2013/14

The Commissioning Outcomes Framework, to be issued later this year, will replace the NHS Operating Framework for the planning round for 2013/14, as it applies to commissioning bodies within the NHS. It is anticipated that indicators within the Operating Framework that presently map across to the NHS Outcomes Framework indicators will feature in the NHS Commissioning Outcomes Framework.

It is clear that much further development work will be required in year to:

I. develop data collection and reporting once the DH publishes fuller technical guidance where it is absent

II. provide CCGs with a baseline and benchmark for anticipated NHS Commissioning Outcome Performance which can be used when identifying priorities and targets for plans for 2013/14, as well as subset data that might be included in GP practice level reports.

III. constantly review performance reports for consistency of approach and alignment with the NHS Commissioning Outcomes Framework for 2013/14

IV. analysis of indicator subset data and target setting for 2013/14 will require support from the Cluster PCT/CSS commissioning, public health information analysts, CCG commissioning clinical and management leads.

Appendix 2

Bradford & Airedale CCG Corporate, Quality and Performance Reporting & Management

1. The shadow accountable officers of the 3 CCGs have the following arrangements in place to support the discharge of delegated responsibilities from the Airedale, Bradford and Leeds Cluster Board during the transitional period. These will continue to evolve and develop.

CCG Shadow Governing Body

2. CCG Boards have been meeting on a monthly basis to receive a copy of an integrated performance report that covers:

- All national performance indicators (including quality) for the PCT statutory body(previously reported to the cluster board)
- A CCG tailored report setting out those indicators that can be specifically attributed to individual CCGs
- A CCG finance report describing the year to date financial position and a forecast for the year. This reconciles back to the overall financial position of the PCT. A CCG consolidated report will be sent to the cluster on a monthly basis.

3. At this monthly meeting performance issues are discussed and remedial action plans for non delivery explored and challenged.

4. In addition, specific discussions have taken place about quality matters. As part of the development of our governance arrangements each CCG is reviewing how it reports on and provides assurance in respect of performance and quality.

Bradford City and Bradford Districts

5. Subject to agreement through the Councils of Representatives for both CCGs, the governance arrangements have been reviewed and from August Bradford City and Districts CCGs will have a properly constituted shadow governing body that will start meeting monthly in public. The minutes of these meetings and the performance scorecard will be sent to the cluster on a monthly basis. At this meeting the Audit and Governance Committees, Remuneration Committees and Quality Committees will be formally established.

Airedale, Wharfedale and Craven CCG

6. The governance arrangements for AWC are currently being reviewed. Subject to approval by the Council of Members on 28th June, there will be a properly constituted Governing Body as well as an Executive Group. Performance will be formally reported to the Governing Body which will meet in public bimonthly. The Executive will meet on a monthly basis and to review and manage any performance issues. Further assurance around the delivery of both finance and performance will be facilitated by a finance and performance committee which will meet monthly. The minutes of these meetings and the performance scorecard will be sent to the cluster on a monthly basis.

Contract Management Arrangements

7. CCG leads have chaired the Contract Management Boards for both acute Trusts for over a year with other PCT support staff present. These arrangements will continue. The service development group and quality and performance groups are chaired by CCG support staff with CCG managerial and clinical representation.

8. As part of each organisations' development process these arrangements are being kept under review. The 'don't throw the baby away with the bathwater' principle applies to all issues under review.

Collaborative Arrangements

9. CCGs have agreed a programme of collaboration to provide further assurance around the delivery of a number of priority areas that cut across the 3 CCGs. In order to facilitate collaborative working the CCGs meet together on a monthly basis at the collaborative commissioner forum (terms of reference agreed). The overall purpose of the forum at present is to share intelligence, shape joint strategic direction and provide a collective commissioner voice on major service issues. Any formal decision making is referred back to each CCG.

The forum has established a programme of work to ensure that collaboration works operationally. This is particularly important for contracts where each CCG has a major interest such as Bradford District Care Trust. This may result in a formal set of management arrangements to support collaboration.

Financial Performance Management

10. The financial position for the PCT is coordinated and managed by the shadow CFO for the 3 CCGs. The overall PCT position is reported on a monthly basis to the GP collaborative meeting. These minutes are sent to the Cluster on a monthly basis. In addition, the financial position of individual CCG is reported to CCG's boards described in point 1 above.

11. Current robust budgetary management arrangements will continue which includes regular budget holder meetings and monthly meetings between the CFO and senior finance managers.

QIPP

12. A Bradford and Airedale wide QIPP meeting takes place on a fortnightly basis. The meeting is chaired by the CFO from the 3 CCGs with membership made up of senior managers from all PCT current functions plus 3 GPs - 1 from each of the 3 CCGs. The group is responsible for overseeing the delivery of the QIPP plan for 2012/13 and will start to plan for future QIPP Plans.

Other meetings

13. CCG staff and clinicians are involved in a range of regular 1:1 meetings with provider colleagues to provide further assurance around the delivery of our performance targets and the wider strategy. These include meetings between CCG CFO:Trust DOFs, CCG CFO: Trust directors of performance, Trust MDs: CCG lead GPs, CCG AO: Trust CEOs, CCG lead nurse:Trust DNs.

Authored by Helen Hirst, Interim

Bradford & Airedale CCG responsibility matrix

	CCG overall Lead	Lead Contracting manager	Lead Performance Manager	Lead Clinician
Contracting				
Airedale Hospital	**Jane H**	**Sue P**	**Kerry W**	**Phil P**
BTHFT	**Jane H**	**Cathy B**	**Kerry W**	**Andy W**
BDCT	**Jane H**	**Ali Jan H**	**Kerry W**	**C Harris/A Khan/B Kennedy**
Yorkshire Clinic	**Jane H**	**Sue P**	**Kerry W**	**Phil P**
Eccleshill & Yorkshire Eye	**Jane H**	**Cathy B**	**Kerry W**	**A Khan**
Other IS	**Jane H**	**Cathy B**	**Kerry W**	**Andy W**
YAS	**Jane H**	**Cathy B**	**Kerry W**	
Continuing Care	**Nancy O'N**	**Ali Jan H**		**See note**
Out of hours	**To be determined – current arrangements to continue**			**See note**
Prescribing	**To be determined – current arrangements to continue**			**See note**
Safeguarding	**Liz Allen**	**As above**	**As above**	**See note**
Patient safety	**Liz Allen**	**As above**	**As above**	**See note**
Patient experience	**Liz Allen/Fiona Stephens**	**As above**	**As above**	**See note**
Quality assurance	**Liz Allen/Kerry Weir**	**As above**	**As above**	**See note**
Prof standards and workforce assurance	**Liz Allen**	**As above**	**As above**	**Liz Allen**
Serious incident performance management	**Liz Allen**	**As above**	**As above**	**See note**

Note: there are a range of clinical leads covering all these areas

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